Item 5 Enclosure 1

End of Life Care Review

Summary of End of Life Care Indicators and an Overview of End of Life Care Services for Coventry and Warwickshire

1. INTRODUCTION

This report includes national indicators and locally analysed data from national data sets to help describe the range of factors that influence demand for End of Life Care (EoLC), reflect the supply of services and/or indicate outcomes from EoLC services across Coventry and Warwickshire.

It is recognised that currently there are no routinely available outcome measures that reflect the delivery of EoLC. What is important to patients and their carers is that they are treated with dignity and respect, have control and choice over plans and that their loved ones are involved in decisions as appropriate. Good EoLC includes the management of symptoms such as pain, breathlessness and nausea, ensures that comfort and well-being is maximised and that psychological, spiritual, social and cultural needs are met. (1) As there is no routine measurement of these important factors proxy process and outcome measures are used and whilst these do have significant limitations, such indicators are included in the national EoLC profiles.

Place of death is considered important and 75% of people say they would prefer to die in their usual place of residence while only 45% actually do. However the research on preferences has been called into question with the suggestion that quality of care may be more important than the place of actual death (2). The national VOICES survey of bereaved people found that 69% of respondents rated care in hospital as outstanding, excellent or good, which is significantly less than 83% for a hospice death, 82% in a care home and 79% for those who died at home (3). It is also interesting to note that in this survey 73% of respondents felt hospital was the right place for the patient to die, despite only 3% of all respondents stating the patient had wanted to die in hospital.

The evidence indicates that where End of Life (EoL) is identified as being likely - and patients are engaged in a conversation about their EoL preferences they are much more likely to die in their place of choice (often home) and are less likely to have futile and costly hospital admissions. Evidence also shows that people from particular groups, including people with a diagnosis other than cancer, those with complex conditions and those who are vulnerable because of their circumstances, experience EoLC, which is of poorer quality and does not always meet their needs. Unwarranted variations in care related to diagnosis, geography, age, ethnicity, culture and sexuality are nationally recognized (4). In addition poor coordination of care contributes to inequalities in care and EoLC outcomes, which are also well documented nationally (4).

The data and indicators included in this report are based on a sub-set of the indicators used in the national End of Life Care profiles. These national profiles are produced for upper tier authorities and as such are not helpful in describing the population and service differences that exist across Coventry and Warwickshire. Hence, where possible, statistics have been produced at District and Borough level. Figures for the Coventry population have been drawn from the national profiles where more recent data has not been available.

A summary of all of the indicators for each local authority area across Coventry and Warwickshire is shown with the England value in appendix 1. Appendix 2 shows the national profile for Warwickshire County Council.

The indicators included in appendix 1 and described below fall into the following categories:

- Population Characteristics (age profile, deprivation, BME, crude death rate)
- Deaths by Age
- Deaths by Cause
- Deaths by Place
- Deaths by Cause and Place
- Health and Social Care service statistics

In addition the report includes information on relevant services and the specialist workforce available by CCG together with some limited service access data, reflecting the use of hospice services by the respective CCG populations. It also includes a brief summary of the recently published national clinical audit of deaths in hospital and a summary of the achievements and challenges associated with delivering the 'Foundations' for good EoLC across Coventry and Warwickshire from the perspective of the local Specialists in Palliative Care.

2. EXECUTIVE SUMMARY

Population characteristics

These are summarised for District, Boroughs and CCGs. Details of the following are included:

% of population >=65 years:	It can be seen that the proportion ranges from 14.5% in Coventry to 24.9% in Stratford. By CCG the proportions range from 15.5% in Coventry to 21.1% for SWCCG
% growth in population +85 years:	The percentage of growth by 2037 ranges from +107.6% in Coventry to +206.4% in Stratford District.
BME populations:	It can be seen that local values range from 4.1% in North Warwickshire Borough to 33.4% in Coventry, as compared to values of 20.2% for England and 11.5% for Warwickshire.
Deprivation:	the proportion of local populations living in the most deprived national quintile ranges from 0% of the Stratford population to 33.4% of the Coventry population.
Crude death rate:	Nationally, the crude death rate is 0.88% and for Warwickshire it is 0.92%. For local populations it ranges from 1.05% in North Warwickshire Borough to 0.82% for Coventry.

Death Data

Data about deaths; numbers, place and cause are summarised and show:

Numbers of deaths per annum:	In Warwickshire there were 5080 deaths in 2013 and 2713 deaths were recorded for the Coventry population. It is estimated that 75% of all deaths (5845 across C&W) would benefit from EoLC.
% deaths 75+/85+:	The proportion of deaths in +75s ranges from 63.7% in Coventry to 72.1% in Stratford and the proportion in +85s ranges from 34.8% in Coventry to 45.8% in Rugby.
Death by cause:	Warwickshire has similar proportions of death by underlying cause as England as a whole for deaths from Cancer, CVD, respiratory and other but there is some variability across districts and boroughs, as shown in figure 8.
Place of Death:	Most recent data is included in appendix 4. This shows that 47.4% of deaths in England occurred in hospital as compared to 54.4% for the Nuneaton and Bedworth and 43.4% for the Stratford Upon Avon populations, both of which are statistically different to the England value. Variations in Place of Death for District and Borough populations are shown in Figure 10 and in appendix 4.

Deaths in 'usual place of residence': Data in appendix 4 shows the England value for 2014 as 44.7%. WNCCG has the lowest value at 42.1%, which is statistically lower than the national rate. For CRCCG at 44.1% the value is similar to the England average, whilst SWCCG is statistically higher at 47.3%.

Deaths by Place/Cause: Place of death varies by for the England population and for the Warwickshire population depending on cause of death. In summary:
For all deaths in hospital the Warwickshire proportions follow a similar pattern by underlying cause, with the largest difference seen in respiratory deaths where a higher proportion (69.4%) occur in hospital in Warwickshire than for England (63.4%).
For deaths at home, the proportions of all deaths by underlying cause across Warwickshire follow a similar pattern to England, with the largest difference again seen in respiratory deaths where a lower proportion (11.9%) occur at home in Warwickshire than for England (15.4%).
For deaths in a hospice, the proportion by underlying cause across Warwickshire follow a similar pattern to England, with no striking differences although the proportion in Warwickshire due to cancer is slightly lower (15.2%).
For deaths that occur in a residential home, the proportions by underlying cause across Warwickshire follow a similar pattern to England, with no notable differences.

Social care indicators

WCC funded care home placements: As with health indicators there are no social care indicators that specifically measure delivery of EoLC or EoLC outcomes. However a range of indicators that reflect the provision of social care are included although interpretation is complex particularly in the context of differing financial eligibility for social care support... However, a snapshot of the WCC funded care home placements (rate per 1,000 75+ years) indicates a range of funded placements across Districts and Boroughs from 23.5 in Warwick to 32.8 in North Warwickshire, with an average of 29.8 funded placements. Estimated costs per annum per 10,000 75+ years average £6,405,500.

Emergency admission indicators

% of terminal admissions emergencies % of terminal admissions LOS >8 days These indicators reflect the use of hospital services on an unplanned basis towards End of Life. For both indicators the Warwickshire value is a little less than the England value (although the time periods differ), but there is variation across the District and Boroughs as shown in Table 3.

Primary Care EoLC Registers GP EoLC registers were introduced to improve EoLC, enabling better communication and support for patients and families. A sample of register data from each CCG indicates that between 0.15% (WNCCG) and 0.62% (SWCCG) of practice populations are included on an EoLC register... On average approximately 1% of a practice population might be expected to be in the last year of life whilst nationally just 0.3% of the population are included on a register. . Summary details are provided in appendix 5.

Overview of Services and Support Tables 4, 5 and 6 (in appendix 6) include details of the workforce and facilities key to delivery of EoLC, as available within each CCG. It can be seen that across Coventry and Warwickshire there is a shortfall in Palliative

Medicine consultants as compared to commissioning recommendations. Whilst WTE specialist nurses meet recommended levels there is variability in the wider workforce and facilities available in different areas.

Access to Specialist Palliative Care

The aim of specialist palliative care is to provide physical, psychological, social and spiritual support and evidence suggests that patients who access such support do have a better end of life experience. Data collection processes by Trusts vary such that access rates can't be reliably calculated. However comparisons of the proportion of patients by age and diagnosis, show that locally there is more scope to provide access to specialist support for older patients and for those with a non-cancer diagnosis.

Hospice Access

The Arden CSU report detailing access to all hospice inpatient provision for 2013/14 gives differential access rates (bed days per 1000 population 65+ years) ranging from 31.5 per 1000 65+ for WNCCG to 59.6 bed days for SWCCG population. Data provided by Myton for 2014/15 indicates that CRCCG has the highest access to their services and WNCCG the lowest access. 78% of referrals are for cancer patients and there is variability in terms of sources of referral by CCG. Where ethnicity is recorded the data shows that 92% of all recipients of Myton services are 'white British'

National Clinical Audit

The 3 acute Trusts participated in a national clinical audit of hospital deaths which included a clinical case note review and an organisational review of services and protocols. The results are summarised in appendix 7.

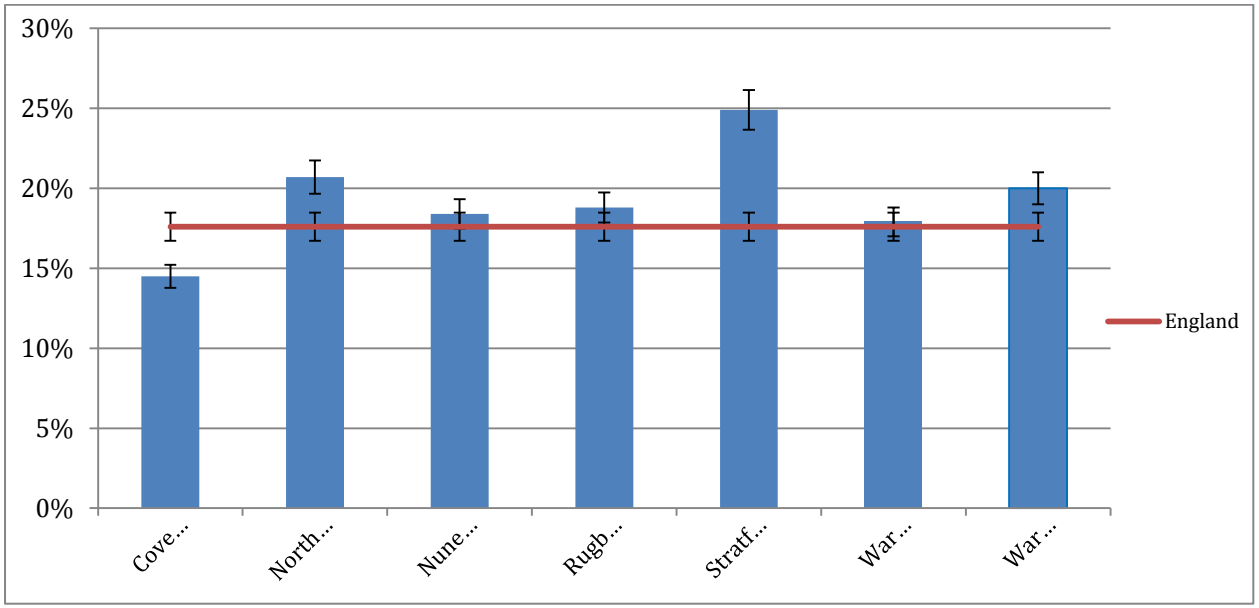
Summary of Foundations for Good EoLC

The palliative care specialists provided a summary of their perspective on the Foundations for Palliative and End of Life Care across Coventry and Warwickshire. This includes a summary of recent developments and achievements and is included as appendix 8.

3. POPULATION CHARACTERISTICS

Figure 1 shows the proportion of the population that are aged 65+. Whilst this is not a direct indicator of the need for End of Life Care, as most deaths occur in those aged 65+ it does provide some indication of the relative need for health and social care services within a community. Higher values generally reflect an older, healthier population surviving into old age. It can be seen that the proportion ranges from 14.5% in Coventry to 24.9% in Stratford.

Figure 1. Proportion of Local Authority Populations Aged 65+



(*Source: ONS mid-2014 poulation estimates***)**

Appendix 1 includes further population data, including the proportion of lower tier local authority populations aged over 75 years and over 85 years. The proportion of the populations aged 75+ ranges from 6.8% in Coventry to 11.4% in Stratford-on-Avon District (9% for Warwickshire and 8.1% for England). The proportion of the population aged 85+ ranges from 2.1% in Coventry and Nuneaton & Bedworth Borough to 3.5% in Stratford-on-Avon District (Warwickshire 2.7% and 2.4% for England).

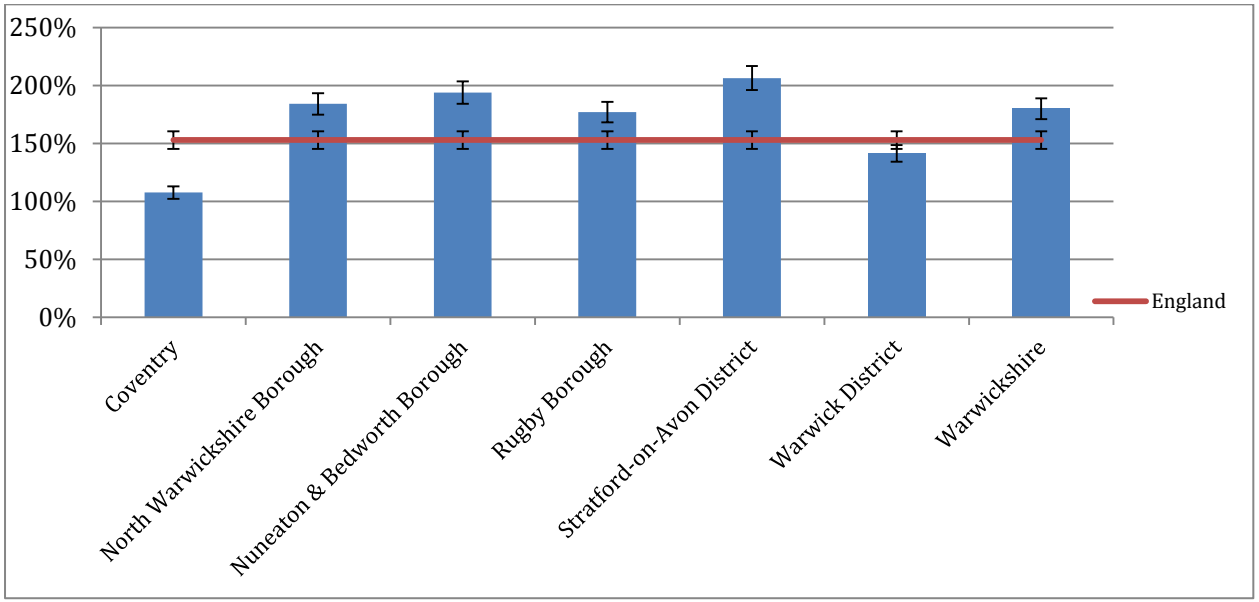
Figure 2 shows the proportion of CCG populations that are 65+. It can be seen that these range from 15.5% to 21.2%.

Figure 2. Proportion of CCG Populations Aged 65+

(*Source: ONS mid-2014 population estimates***)**

Figure 3 shows the projected increase in the proportion of the population 85+ by 2037, taken from ONS estimates. Nationally the increase is expected to be +152.9% and across Warwickshire higher than this at 180%. This is used as an indicator of future demand for social care and health services.

Figure 3. Projected Increase (%) in Population Aged 85+ by 2037

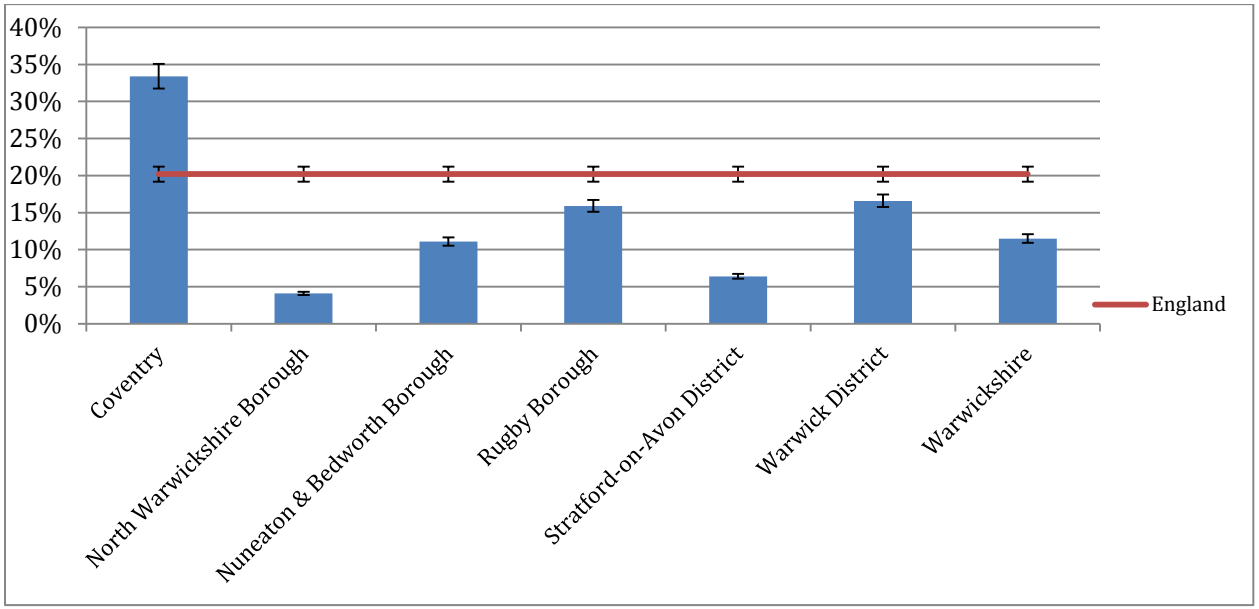


(*Source: ONS 2012-based subnational population projections***)**

It can be seen from figure 3 that the percentage of growth ranges from +107.6% in Coventry to +206.4% in Stratford-on-Avon District.

It is important to consider the Black and Minority Ethnic (BME) profile of a local population as differing cultures have differing care needs at the End of Life. It is also the case that some communities can have difficulty accessing services for a range of different reasons. Figure 4 shows the BME profile for Coventry and Warwickshire lower tier authorities. It can be seen that local values range from 4.1% in North Warwickshire Borough to 33.4% in Coventry, as compared to values of 20.2% for England and 11.5% for Warwickshire.

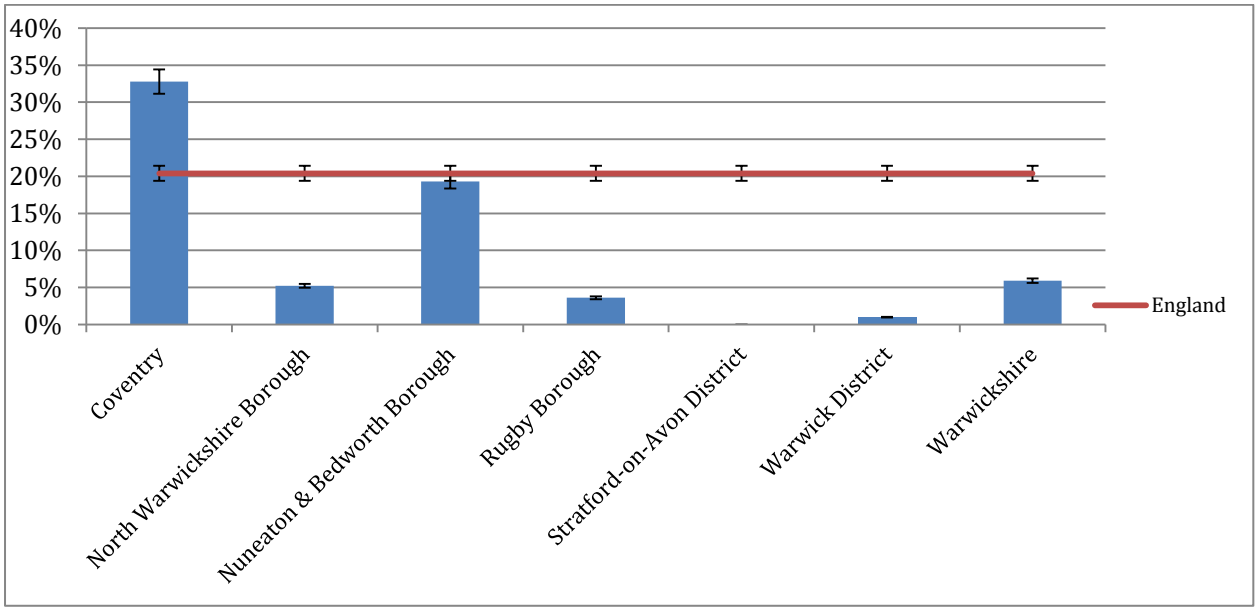
Figure 4. Proportion of Local Authority Populations from BME Groups



(*Source: 2011 Census***)**

It is also relevant to consider the relative deprivation of local populations, as differences may indicate particular demands for EoLC, differing home circumstances, patterns of morbidity and ability to access services. Figure 5 shows that the proportion of local populations living in the most deprived national quintile ranges from 0% of the Stratford population to 33.4% of the Coventry population. By definition 20% of the England population live in the most deprived quintile while5.9% of the Warwickshire population do.

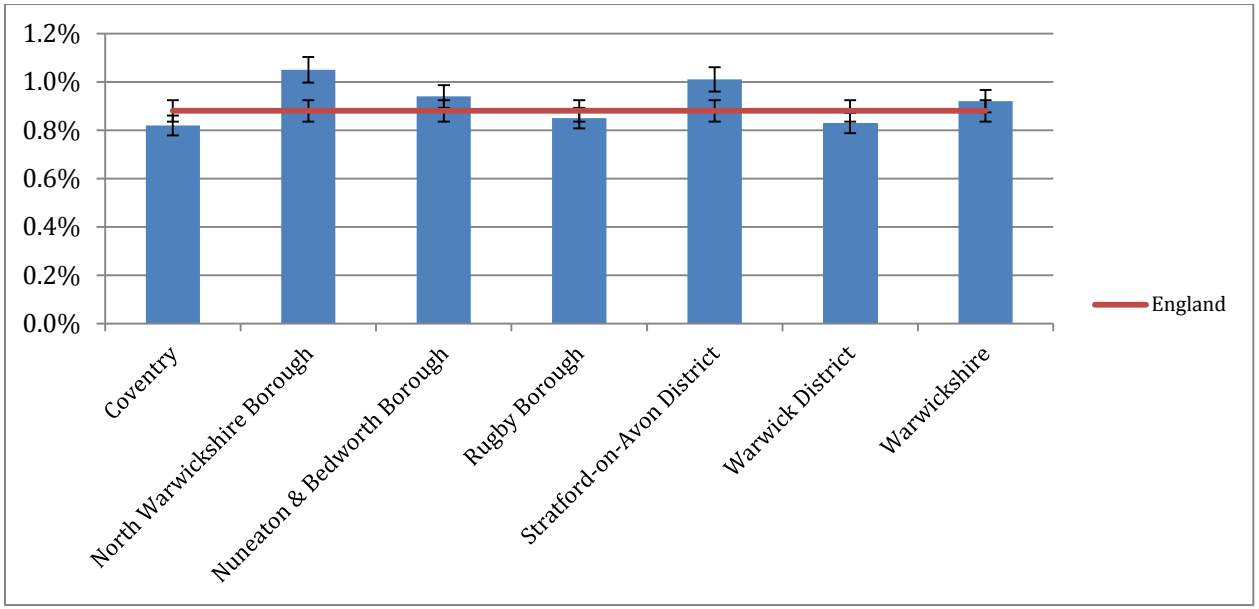
Figure 5. Proportion of Local Authority Populations in Most Deprived National Quintile



(*Source: ONS moi-2014 population estimates and Indices of Multiple Deprivation 2010***)**

The crude death rate for the population is relevant as a higher crude rate suggests a higher per capita demand for End of Life services, irrespective of the age or other characteristics of the population. Nationally, the crude death rate is 0.88% and for Warwickshire it is 0.92%. For local populations it ranges from 1.05% in North Warwickshire Borough to 0.82% for Coventry as shown in Figure 6.

Figure 6. Crude Death Rates (%)



(*Source: ONS Vital Statistics Tables 2013***)**

4. DEATHS AND BY AGE

There were a total of 5080 deaths in Warwickshire in 2013 and annual deaths for Coventry were reported as 2713 in 2013. Deaths by CCG were 2377 in SWCCG, 1842 for WNCCG and 3574 for CRCCG (861 for Rugby + 2713 for Coventry).

Table 1 shows the proportion of all deaths in those aged 75+ and 85+ for England, for Warwickshire and by District and Borough. A higher proportion of deaths occur in both age groups in Warwickshire, compared to England indicating an older population locally. In contrast, Nuneaton & Bedworth Borough can be seen to have the lowest proportion of deaths in these age groups, followed by the second lowest in North Warwickshire Borough. The highest proportion of deaths in the two groups can be found in Stratford-on-Avon District.

The values for Coventry taken from the national EoLC profiles as shown in appendix 1 are lower than for the Warwickshire District and Boroughs at 63.7% for the 75+ and 34.8% for those aged 85+, reflecting the lower average age in Coventry.

Table 1
Proportion of all deaths aged +75 and +85 years for England, Coventry and Warwickshire by District and Borough

	Age 75+	Age 85+
Coventry	63.7%	34.8%
North Warwickshire Borough	65.7%	36.1%
Nuneaton & Bedworth Borough	64.5%	35.6%
Rugby Borough	69.9%	45.8%
Stratford-on-Avon District	72.1%	43.4%
Warwick District	69.6%	42.2%
Warwickshire	69.2%	41.2%
England	68.3%	39.1%

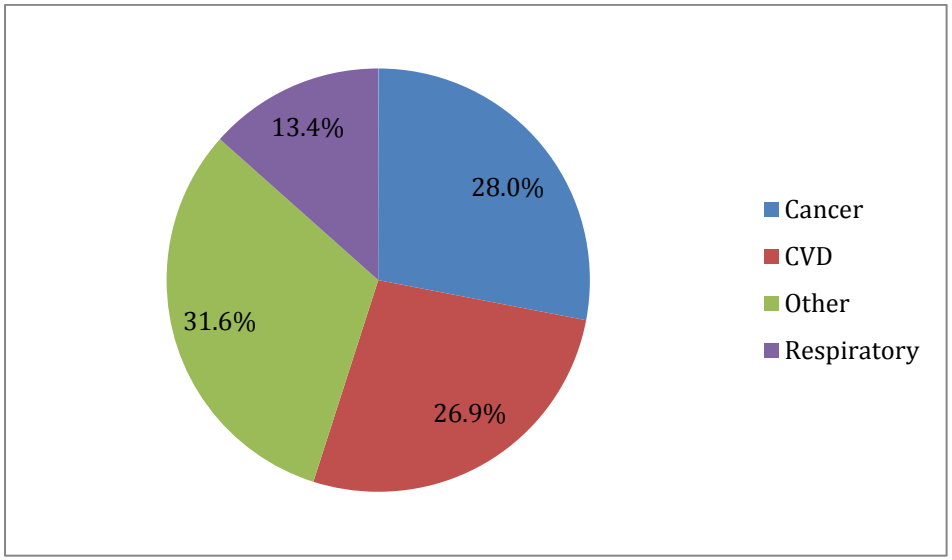
(*Source: End of Life Care Profiles/HSCIC Primary Care Mortality Database 2013***)**

5. DEATH BY CAUSE

It is important to understand the cause of death in local areas as this can reflect the balance of demand within End of Life services driven by different patterns of disease within the population. It is also helpful in comparing the casemix (in terms of cause of death) for groups of individuals who access End of Life Services.

Figure 7 shows the proportion of deaths by underlying cause of death for all Warwickshire residents. The proportions by cause are similar to the all England values (cancer 28.8%, cardiovascular disease (CVD) 27.7%, respiratory diseases 14.7%, other causes 28.8%). (NB: Coventry values not available through this analysis but are separately sourced in appendix 1)

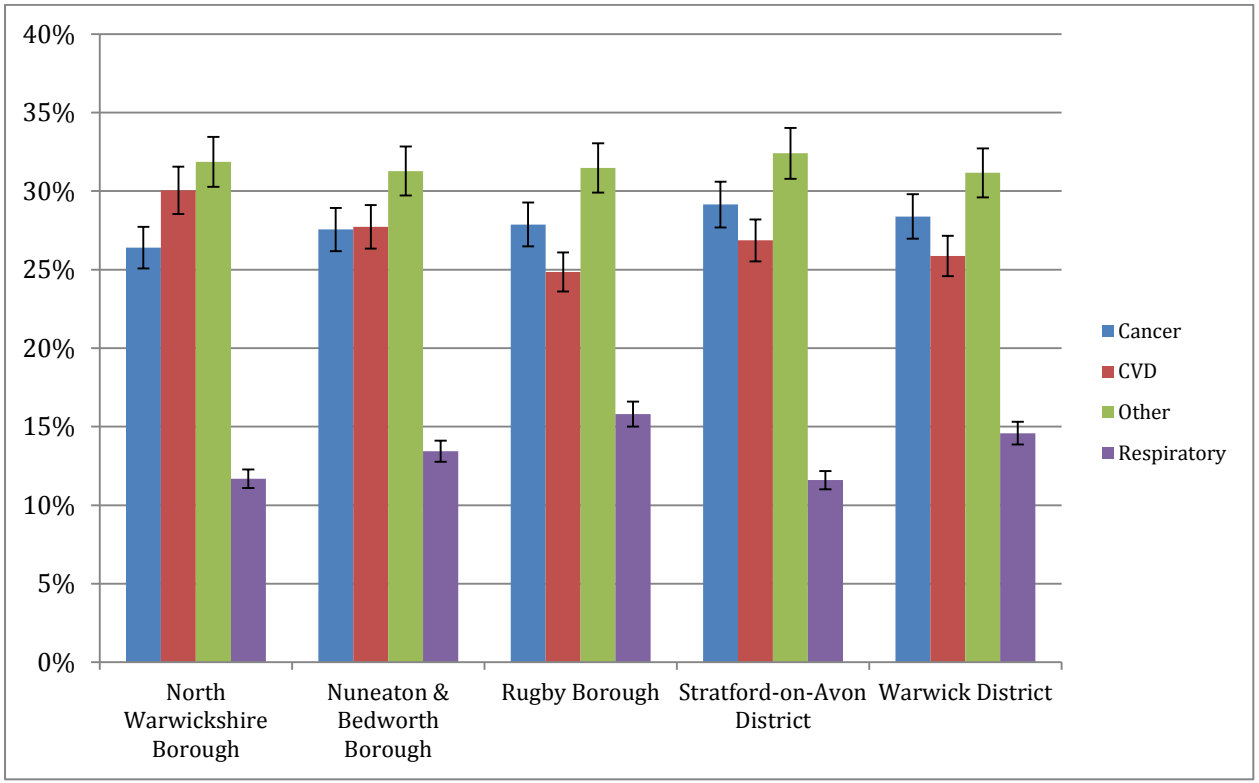
Figure 7
Warwickshire Deaths by Selected Main Diagnosis, 2013



(*Source: HSCIC Primary Care Mortality Database 2013***)**

Figure 8 shows the proportion of deaths by cause in each district or borough. It can be seen that there is some variability in terms of cause of death; for example in North Warwickshire and Nuneaton & Bedworth boroughs the highest proportion of deaths are due to CVD, whilst in Rugby Borough and Warwick District there are more respiratory deaths and in Stratford-on-Avon District the largest proportion of deaths are due to cancer. The figures for Coventry are shown in appendix 1 and similarly show that the highest proportion of deaths is due to cancer (27.3%).

Figure 8. Percentage of deaths in each District/Borough by Cause



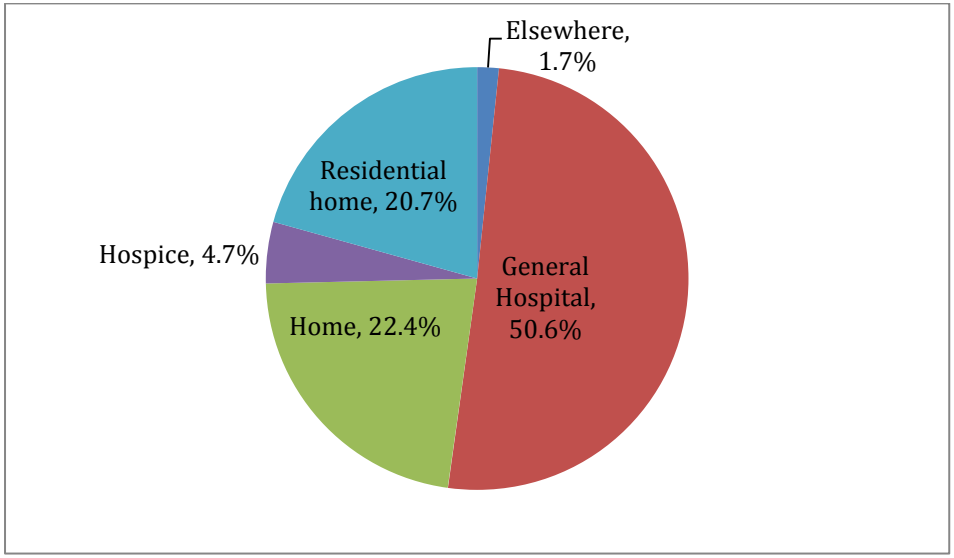
(*Source: HSCIC Primary Care Mortality Database 2013***)**

6. DEATH BY PLACE

It is important to look at deaths by place as national surveys indicate that many people would, given the choice, prefer to die at home and few wish to die in hospital. End of Life services seek to provide high quality support to individuals and their families such that they can realise their preferences for place of

death. Differences between local areas can reflect the adequacy of End of Life services as well as reflecting particular service configurations and local care pathways (for example where domiciliary EoLC services are prioritised this may be reflected in a comparatively low percentage of deaths in hospital or hospice).

Figure 9 Warwickshire Deaths by Place, 2013



(*Source: HSCIC Primary Care Mortality Database 2013***)**

Figure 9 is based on data from the Primary Care Mortality Database, showing deaths by place across Warwickshire (Coventry deaths not included but profile values are shown in appendix1).

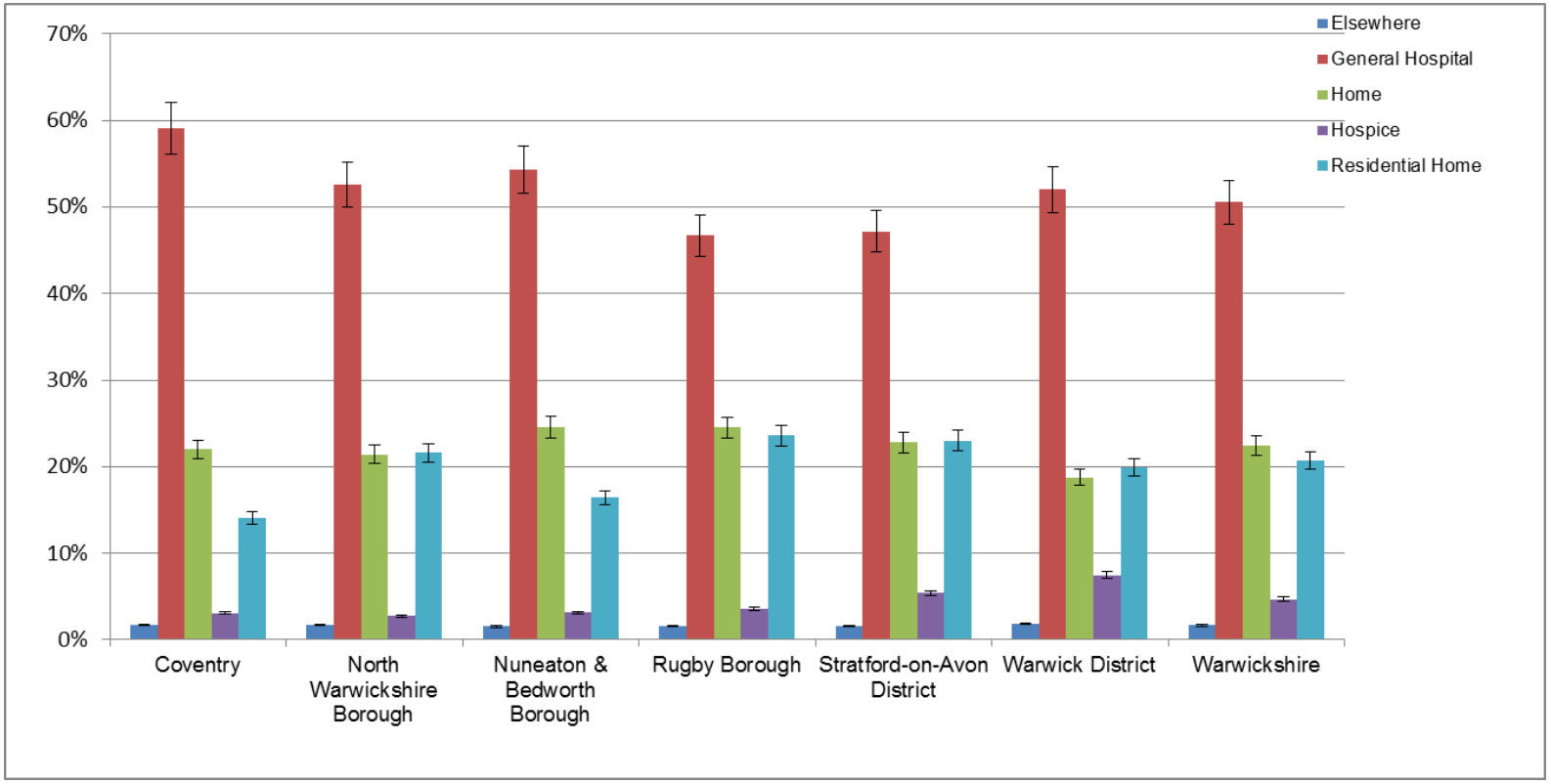
Of 5080 deaths, 50.6% occurred in hospital, 22.4% at home, 20.7% in a residential or care home and 4.7% in a hospice. The comparable values for England (taken from the national End of Life Care profile for 2012) are:

Hospital deaths	49.3%
Home deaths	22.2%
Care home deaths	20.7%
Hospice deaths	5.65%

It can thus be seen that place of death across Warwickshire closely accords with place of death nationally.

Figure 10 shows how Place of Death varies by Local Authority areas across Coventry and Warwickshire.

Figure 10 Place of death for Coventry and Warwickshire Districts and Boroughs



(*Source: End of Life Care Profiles for Coventry and HSCIC Primary Care Mortality Database 2013 for Warwickshire***)**

Figure 10 shows that the highest proportion of deaths occur in hospital for the Coventry population (59.1%) and the lowest proportion for the Rugby Borough population (46.7%).

The highest proportion of 'deaths in own home' are in Nuneaton & Bedworth Borough (24.6%) (Although this population also has the highest percentage of deaths in hospital in Warwickshire at 54.4%). The lowest percentage of deaths in own home is for the Warwick District population at 18.8%.

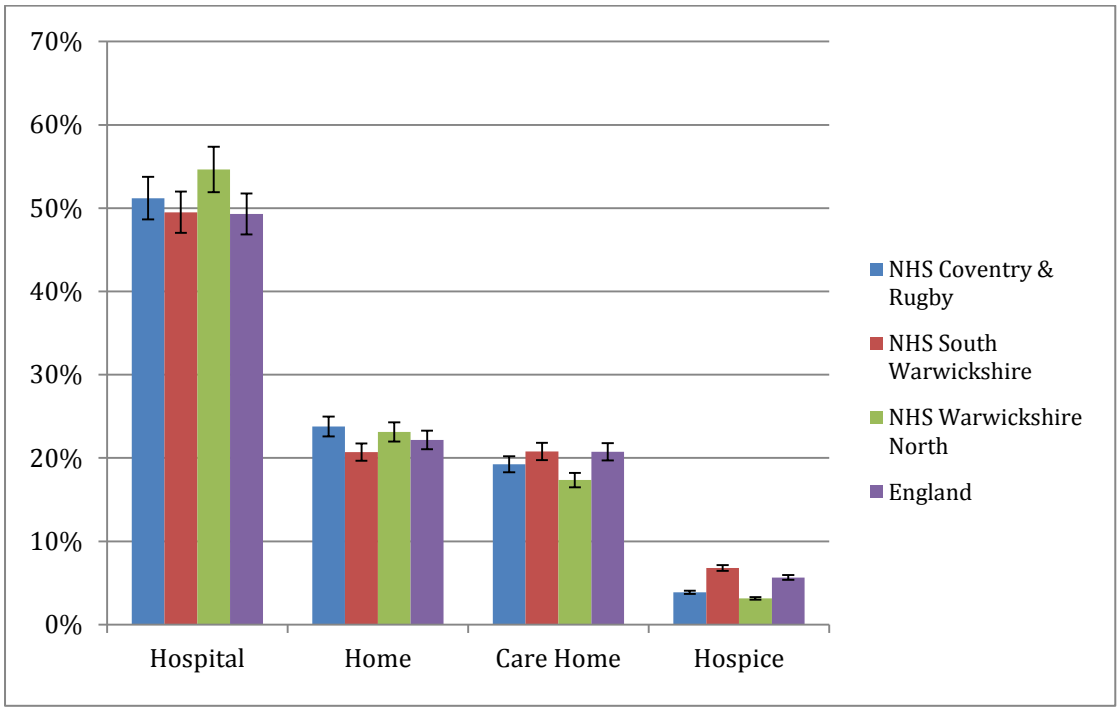
The highest proportion of deaths in a care home are in Rugby (23.6%) and the lowest are in Coventry (14.1%), although for Warwickshire the lowest rate of care home deaths is in the Nuneaton & Bedworth Borough population (16.4%).

Whilst 4.7% of all Warwickshire deaths occur in a hospice this varies from 2.7% for in North Warwickshire Borough to 7.5% of deaths in Warwick District. The national EoLC profile for Coventry shows a value of 3.1%.

Figure 11 shows the proportion of deaths by Place of Death for each CCG and England. The highest proportion of deaths occur in hospital (49.3% of all deaths across England). Both Warwickshire North CCG (54.6%) and Coventry & Rugby CCG (51.2%) have a higher proportion of hospital deaths, which is statistically significant. South Warwickshire (49.5%) has a value similar to the England average.

In April 2016 the National End of Life Care Intelligence Network updated it's information on place of death and provided the information for Districts, Boroughs and CCGs. This information is included in appendix 3.

Figure 11. Coventry and Warwickshire Deaths (all causes) by Place by CCG



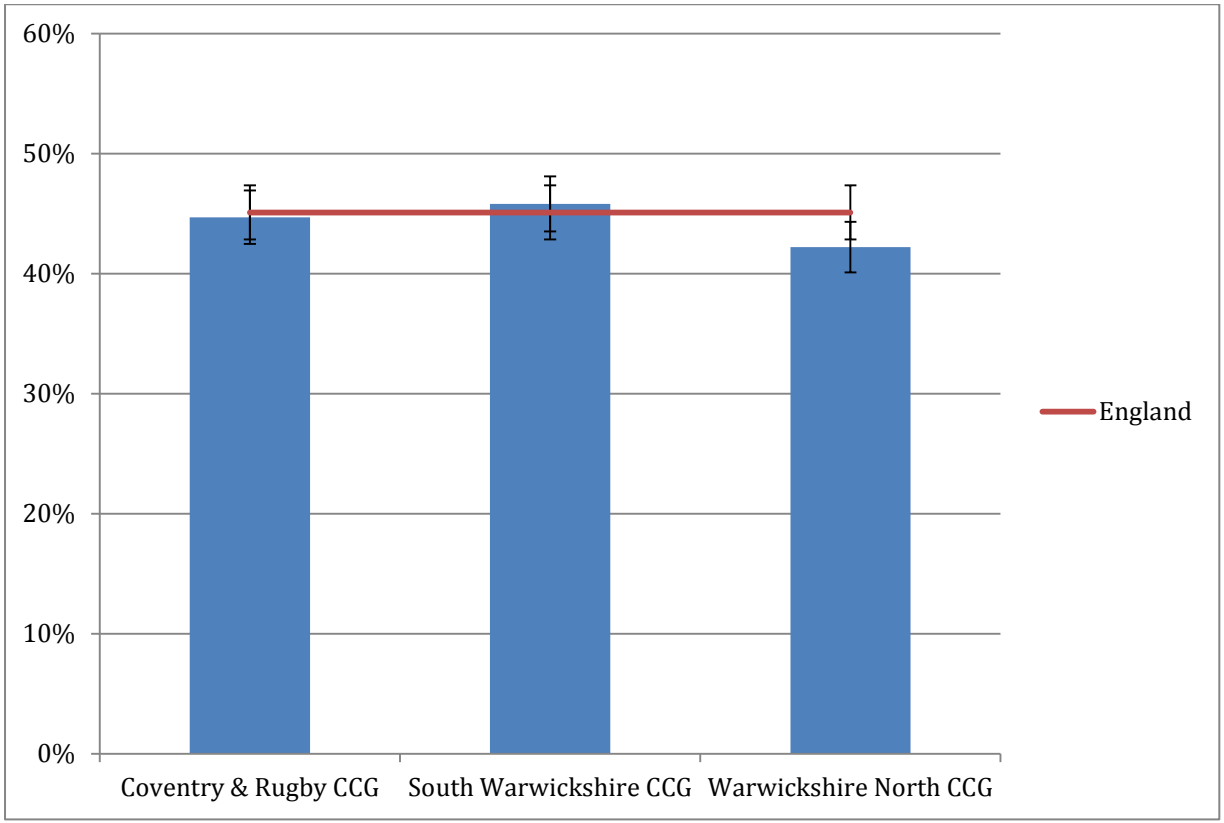
Source: ONS processed by Public Health England

Across England 22.2% of deaths occur at home. For CRCCG (23.8%) and WNCCG (23.1) the values are higher but this difference is statistically significant only for CRCCG. The value for SWCCG (20.7%) is statistically similar to the England value.

Across England 20.7% of all deaths occur in a care home. Both CRCCG (19.3%) and WNCCG (17.4%) have a statistically significant lower value, whilst for SWCCG (20.8%) the value is similar to the England rate.

5.65% of all deaths in England occur in a hospice. SWCCG (6.8%) has a statistically significant higher value; whilst for CRCCG (3.9%) and WNCCG (3.1%) have statistically significant lower rates.

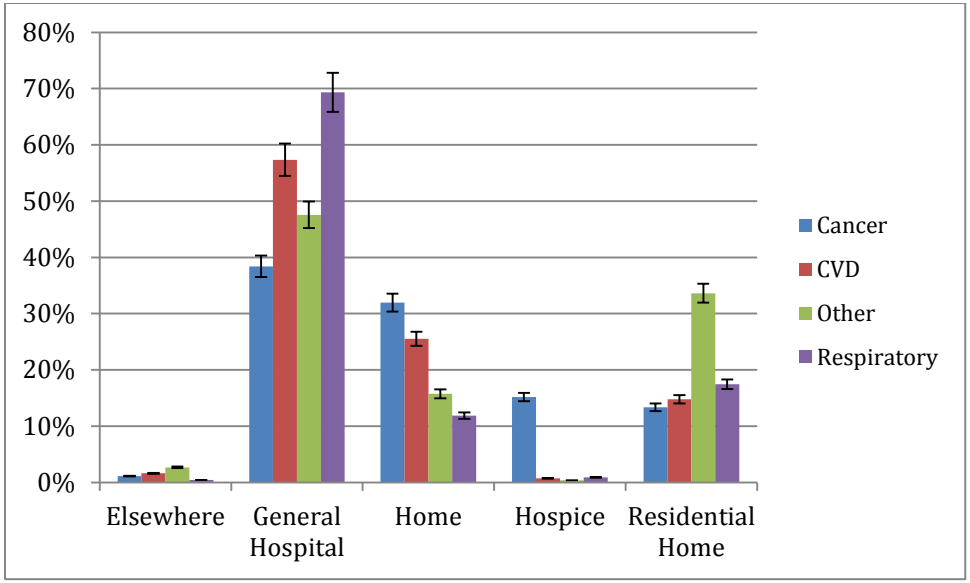
Figure 12 Proportion of deaths occurring in usual residence, by Clinical Commissioning Group and England -deaths registered between 2013/14 Q3 - 2014/15 Q2



(*Source: ONS***)**

Figure 12 shows the proportion of deaths occurring in 'usual place of residence' by Clinical Commissioning Group (CCG). For England the value for the period 1st October 2013 to 30th September 2014 is 45.1%. WNCCG has the lowest value at 42.2% but is not statistically different from the national rate. For CRCCG at 44.7% and SWCCG at 45.8 the values are also similar to the England average.

Figure 13 Deaths by Place by Cause



(*Source: HSCIC Primary Care Mortality Database 2013***)**

For England, whilst 49.3% of all deaths occur in hospital, the proportions of all deaths by underlying cause that take place in hospital are:

Cancer	37.8%
CVD	54.9%
Respiratory	63.4%
Other causes	48.2%

Across Warwickshire the proportions follow a similar pattern by underlying cause, with the largest difference seen in respiratory deaths where a higher proportion (69.4%) occurs in hospital.

For England whilst 22.2% of all deaths occur at home, the proportions of all deaths by underlying cause that take place at home are:

Cancer	29.6%
CVD	25.5%
Respiratory	15.4%
Other causes	14.9%

Across Warwickshire the proportions, of deaths at home, follow a similar pattern by underlying cause, with the largest difference again seen in respiratory deaths where a lower proportion (11.9%) occur at home.

For England, whilst 5.65% of all deaths occur in a hospice, the proportions of all deaths by underlying cause that occur in hospices are:

Cancer	17.75%
CVD	0.62%

Respiratory 0.86%
Other causes 0.96%

Across Warwickshire the proportions, of hospice deaths, follow a similar pattern by underlying cause, with no striking differences although the proportion in Warwickshire due to cancer is slightly lower (15.2%).

For England whilst 20.7% of all deaths occur in a residential home, the proportions of all deaths by underlying cause that occur in residential homes are:
Cancer 13.3%

CVD
16.9%
Respiratory
19.5%
Other causes
32.5%

Across Warwickshire the proportions follow a similar pattern by underlying cause, with no notable differences.

7. SOCIAL CARE INDICTORS

Table 2 includes two social care indicators. They are based on information provided by WCC Social Care Business Intelligence Unit and reflect a snapshot of all of the local authority funded placements in care homes during the month of July 2015. Based on address prior to placement the placements were allocated to the respective district or borough and the number of placements and the average cost of those placements is then expressed as a rate per 1,000 75+ years head of population. The table shows that local authority funded places per 75+ years head of population ranged from 23.5 placements for Warwick District residents up to 32.8 care home placements for North Warwickshire residents. The average rate of all funded placements across Warwickshire was 29.8. The estimated average annual cost of placements (per 10,000 population 75+) is also shown and can be seen to range from £5,289,900 for Rugby residents up to £7,079,300 for North Warwickshire residents with the average cost per 10,000 Warwickshire population aged 75+ years of £6,405,500.

An additional range of social care indicators is included in appendix 1 and a summary is provided in appendix 4. This describes the difficulty of interpreting social care indicators in the context of differing financial eligibility for services by different populations.

Table 2 – Care Home Placements and Cost of Care Home Placements Per 1,000 75+ years

	Warwickshire	North Warwickshire	Nuneaton & Bedworth	Rugby	Stratford-upon-Avon	Warwick
Care Home Placements per 1000 75+ years	29.8	32.8	29.7	26.3	25.8	23.5
Cost Of Care Home Placements £ per 10,000 75+ years	6,405,500	7,079,300	6,198,500	5,289,900	5,906,500	5,340,400

Source: WCC Business & Commissioning Intelligence, 2015

8. EMERGENCY ADMISSION INDICATORS

Table 3 - % of terminal admissions that were emergency admissions

	England	Warwickshire	North Warwickshire	Nuneaton & Bedworth	Coventry	Rugby	Stratford-upon-Avon	Warwick
% - terminal admissions as emergencies	89.7	87.4	87	88	94.3	91.6	82.4	88.8
% terminal admissions > than 8 days	48.8	46.9	39.4	45	47.3	50	48	50

Sources: Warwickshire data from NHS Arden & GEM CSU 2012/13, Coventry and England data from 2012 End of Life Care Profiles

Table 3 shows data where death was the outcome. Across all Warwickshire residents 87.4% of terminal admissions had been admitted as emergencies compared to an average of 89.7% for England (for the period 2010/11). The proportion of terminal admissions that had been emergency admissions ranged from 82.4% for Stratford residents up to 94.3 % for Coventry residents or 91.6% for Rugby residents.

The proportion of terminal admissions that were for 8 or more days ranged from 39.4% in North Warwickshire to 50% in Rugby and Warwick. The average across Warwickshire was 46.9%.

9. PRIMARY CARE REGISTERS

General Practice Palliative Care or End of Life Care registers were introduced as a quality and outcome framework (QOF) measure to improve the care of people at the end of their life. General practices should have a register of all patients with supportive or palliative care needs, which includes both cancer and non-cancer patients who may be in their last year of life. As approximately 1% of a practice population will die in any one year there is an expectation that the number of patients included on the register should be approaching 1% of the practice population, although this is clearly dependent on practices being able to identify all such patients. Nationally in 2014/15 just 0.3% of practice populations were on an EoLC register.

Once the patient has been included on the register there is an opportunity to regularly review the needs and support provided to patient and/or family based on an understanding of the patients' preferences. This is achieved through periodic (usually monthly) meetings, which allow for care and services to be co-ordinated and provides the potential for improved communication between different services, amongst other things.

A sample of register data was provided by each CCG as shown in appendix 5. The analysis shows that between 0.15% (WNCCG) and 0.62% (SWCCG) of practice populations were on a register. In each case there are more females than males on the registers and the average age ranges from 72.4 to 78 years. Caution needs to be exercised in interpreting the other statistics shown as these reflect items that have been READ coded and as such are thought to under-represent the number of patients to whom the characteristic applies.

This analysis will provide a useful benchmark against which changes associated with the introduction of EPaCCs (Electronic Palliative Care Co-ordination System – locally known as the CASTLE register) can be monitored. Whilst to date there has been little incentive for primary care to place patients on an EoLC register, as they have no means of sharing this information with other providers, the introduction of EPaCCS will change this. One of the measures of the success of EPaCCS will be the extent to which it helps promote the identification of palliative patients and their inclusion on the primary care EoLC register. The information recorded on EPaCCS should in turn support the primary care register meetings.

10. OVERVIEW OF SERVICES AND SUPPORT

Tables 4 (CRCCG), 5 (WNCCG) and 6 (SWCCG) are included as appendix 6 and provide a summary of the key services and support (workforce and facilities) available for delivery of EoLC in each area.

In terms of workforce Table 4 shows that compared to recommended provision across both hospital and community settings there is a 5.7 WTE shortfall in Palliative Medicine consultant time (excluding Myton posts), whilst palliative care specialist nurses can be seen to meet recommended levels. Coventry community benefits from a specialist physiotherapist and occupational therapist but has no dedicated psychology input. Rugby has specialist pharmacy and some psychology is available through Myton Hospice. CRCCG benefits from having an EoLC lead GP and is considering whether to appoint a Macmillan GP.

In terms of facilities there are no contracted palliative care nursing home beds in Coventry but Rugby has 6 beds. The Coventry and Rugby populations benefit from access to both Coventry and Myton Hospices (36 – 45 beds). Rugby has a hospice at home service. Coventry has a 24/7 community nursing service (Rugby service TBC) and bereavement services and a limited lymphedema service is available via Myton. In terms of specialist Out of Hours (OOH) cover there is palliative medicine cover across Coventry and Warwickshire 24/7 through the on call service, but there is no specialist nurse cover in Coventry.

WNCCG information in Table 5 shows that there is 0.8WTE Palliative Medicine consultant time, giving a shortfall of 2.1 WTE against commissioning recommendations (excluding Myton posts). , Palliative care specialist nurses meet recommended levels but there is little specialist support from other disciplines and there is currently no EoLC GP or Macmillan GP time.

In terms of facilities there are no contracted nursing home beds and there is limited access to inpatients hospice beds. The day hospice provides capacity for up to 15 people per day (76 patients in 2014/15) through Mary Ann Evans Hospice. There is also a limited hospice at home service, bereavement and lymphedema service. The community nursing service provides 24/7 support (but on call only from midnight). In addition to the OOH medical cover there is limited specialist nurse provision (weekend and bank holiday cover, shared with Rugby).

SWCCG information in Table 6 shows that there is a shortfall of 2.3 WTE Palliative Medicine consultant time, against commissioning recommendations (excluding Myton posts) but as for the other CCGs, palliative care specialist nurses meet recommended levels. There is some clinical psychology time and limited access to physiotherapy and occupational therapy via Myton Hospice. The CCG benefits from an EoLC lead GP and a Macmillan GP. The population has access to hospice beds and there is some day hospice provision. There is a limited hospice at home service from both Myton and Shakespeare hospices, plus some bereavement and lymphedema service provision. There is a 'young people's' hospice service available via the Shakespeare hospice.

11. ACCESS TO SPECIALIST PALLIATIVE CARE

Specialist palliative care is the active, total care of patients with progressive, advanced disease and their families. Care is provided by a multi-disciplinary team who have undergone recognised specialist palliative care training. The aim of the care is to provide physical, psychological, social and spiritual support and evidence suggests that patients who access such support do have a better end of life experience.

There are no nationally agreed criteria for referrals to Specialist Palliative Care but commonly such patients are perceived to have more complex needs. There are also known inequalities in terms of the patients who get referred for such support; for example older people, people from ethnic minority groups and those with non-cancer diagnoses tend to be under-represented in services.

Initially it was hoped that access rates to specialist palliative care services could be calculated for the CCG populations and thus acute and community Trusts across Coventry and Warwickshire were asked to provide data on their palliative care referrals. Each Trust provided a response to the request, however, interpretation of this data proved difficult given local variations in data recording processes and the complexity of the services delivered by these specialist teams. As such it was concluded that data on total referral numbers was not comparable between Trusts and not a useful or fair representation of access to palliative care.

However some analysis of the data provided by CWPT, UHCW and SWFT has been undertaken, as summarized in tables 7 and 8. Table 8 shows key characteristics of the patients referred to the respective services in 2014/15. It can be seen that the majority of patients seen by specialist palliative care services are in the 65 to 84 year age group, with a relatively small proportion of patients (16.6% to 29.6%) in the >84 years age bracket, compared to the % of deaths among this group (approximately 40% of all deaths).

The % of patients across the 3 Trusts with a non-cancer diagnosis ranged from 18.7% to 22%, whilst non-cancer deaths make up almost 75% of all deaths. In terms of the ethnicity of patients accessing the service data for CWPT shows that 16% of patients are from ethnic minority backgrounds, whilst for Coventry 33% and for Warwickshire 11.5% of the population are from ethnic minority groups.

GEH provided a range of data but as the level of detail was not comparable to the other sources it has not been included here.

It is anticipated that national changes to palliative care data collection will lead to more uniform collection processes and as such provide a more robust source of comparable information.

Table 7 Characteristics of Referrals to Specialist Palliative Care Services 2013/14

2013-14		CWPT	UHCW	SWFT * †
Age	16- 24	0.5	0.4	X
	25-64	27.9	31.1	X
	65-84	57.4	52.5	X
	Over 84	14.2	16	X
Disease	Cancer	76.3	85.9	88
	Non-Cancer	23.7	14.1	12
Ethnicity	White Groups	88.8		
	Asian Groups	5.9		
	Black AfroCaribb Groups	2.3		
	Any Other Ethnic Group	1.1	X	X
	Not Known	1.9	X	X

* Acute Palliative Care referral
†Ethnicity of referrals is only recorded in the medical notes
** Community Palliative Care referral

Table 8 Characteristics of Referrals to Specialist Palliative Care Services 2014/15

2014-15		CWPT	UHCW	SWFT * †

Age	16- 24	0.2	0.3	0.5
	25-64	27.9	28.7	16.2
	65-84	51.7	54.5	53.2
	Over 84	20.2	16.6	29.6
Disease	Cancer	78.4	81.3	77.5
	Non-Cancer	21.6	18.7	22
Ethnicity	White Groups	89.1		
	Asian Groups	6.4		
	Black AfroCaribb Groups	1		
	Any Other Ethnic Group	1.8	X	X
	Not Known	1.6	X	X

* Acute Palliative Care referral

† Ethnicity of referrals is only recorded in the medical notes

** Community Palliative Care referral

10. HOSPICE ACCESS

Data from the 2013/14 Arden CSU review of Hospice Care included data on access to Hospice beds for the Coventry and Warwickshire population looking at all hospices accessed. In summary it showed the following access rates:

CRCCG accessed 3963 bed days (rate per 1,000 population 65+ of 58.3)
WNCCG accessed 1138 bed days (rate per 1,000 population 65+ of 31.5)
SWCCG accessed 3285 bed days (rate per 1,000 population 65+ of 59.6)

In support of this review Myton Hospice has provided data relating to all referrals to their services for 2014/15. Overall Myton received 1003 referrals from all sources and of these 987 were for C&W patients and can be broken down by commissioner as follows:

511 CRCCG referrals giving a rate of 7.5 per 1000 >=65 years
384 SWCCG referrals giving a rate of 7.0 per 1000 >=65 years
92 WNCCG referrals giving a rate of 2.5 per 1000 >=65 years

When looked at by diagnosis of the 1003 referrals:
78% were cancer
3% CVD
6% Respiratory

13% other

Table 9: Casemix of Referrals by CCG

	CRCCG		SWCCG		WNCCG	
Diagnosis	Number	Percentage	Number	Percentage	Number	Percentage
Cancer	396	77.5%	311	81.0%	74	80.4%
CVD	17	3.3%	13	3.4%	5	5.4%
Other	73	14.3%	34	8.9%	11	12.0%
Respiratory	25	4.9%	26	6.8%	2	2.2%
Total	**511**	**100.0%**	**384**	**100.0%**	**92**	**100.0%**

Source: Myton Information 2014/15

It can be seen that whilst 78% of all referrals were for cancer this varies little by CCG ranging from 77.5% of referrals for CRCCG to 81% for SWCCG

Referrers by CCG:

Table 10 shows how the source of referral varies by CCG. Referrals from Macmillan nurses ranged from 32% of the referrals for CRCCG up to 61% of the referrals made for WNCCG patients. Community nurses made 24% of the referrals for CCRG patients, whilst they were responsible for only 4% of the referrals for WNCCG patients. GPs were responsible for a higher proportion of the SWCCG referrals (14%) than for the other two CCGs.

Table 10: Source of Referral to Myton Services by CCG

	CRCCG		SWCCG		WNCCG	
Referral source	Number	%	Number	%	Number	%
Macmillan Nurse	165	32.3%	200	52.1%	56	60.9%
Hospital	127	24.9%	66	17.2%	23	25.0%
District nurse	122	23.9%	18	4.7%	4	4.3%
GP	12	2.3%	54	14.1%	5	5.4%
Myton internal	33	6.5%	21	5.5%	1	1.1%
Other	34	6.7%	6	1.6%	3	3.3%
Other health professionals ?Internal referral	10	2.0%	13	3.4%	0	0.0%
Not known	6	1.2%	5	1.3%	0	0.0%
Not specified	0	0.0%	1	0.3%	0	0.0%
Social services	2	0.4%	0	0.0%	0	0.0%

Total	**511**	**100%**	**384**	**100%**	**92**	**100%**

Ethnicity of referrals:
Ethnicity was NOT recorded for 28% of patients. Where it was recorded 92% of the patients were recorded as being 'White British'

11. NATIONAL CLINICAL AUDIT of HOSPITAL DEATHS

Appendix 7 includes a summary of the recently published national audit of deaths in hospital in which local acute trusts participated.

12. THE FOUNDATIONS FOR GOOD PALLIATVE AND EoLC

The recently published 'Ambitions for Palliative and EoLC' includes a clear set of 'Foundations' which if delivered will secure high quality personalised EoLC for all. Appendix 8 includes a summary of the local achievements and challenges associated with these foundations, from the perspective of the local Palliative Care Specialists. A process to agree the improvements required to achieve these Foundations has been undertaken and an Improvement Plan has been developed, which will be discussed by the Warwickshire Health and Wellbeing Board.

References

1. **‘Ambitions for Palliative and End of Life Care: A national framework for local action’. National Palliative and End of Life Partnership. 2015**

2. **‘End of Life Care: Helping people to be cared for and die at home’ Housing Learning & Improvement Network. 2016.**

3. **‘National Survey of Bereaved People (VOICES): 2014’ ONS July 2015**

4. **‘Better Endings Right care, right place, right time’ NIHR December 2015**

Appendix 1 **Local Indicator Profile for Coventry and Warwickshire**

Indicator	England	Warwickshire (number)	Warwickshire	North Warwickshire	Nuneaton & Bedworth	Coventry	Rugby	Stratford	Warwick	Coventry & Rugby CCG	South Warwickshire CCG	Warwickshire North CCG	Source
Population aged 65+ %	**17.6%**	**110,439**	**20.0%**	**20.7%**	**18.4%**	**14.5%**	**18.8%**	**24.9%**	**17.9%**	**15.5%**	**21.2%**	**19.1%**	***ONS mid-2014 estimates***
Population aged 75+ %	**8.1%**	**49,565**	**9.0%**	**8.8%**	**7.9%**	**6.8%**	**8.4%**	**11.4%**	**8.4%**	**7.2%**	**9.8%**	**8.2%**	***ONS mid-2014 estimates***
Population aged 85+ %	**2.4%**	**14,682**	**2.7%**	**2.4%**	**2.1%**	**2.1%**	**2.6%**	**3.5%**	**2.6%**	**2.2%**	**3.0%**	**2.2%**	***ONS mid-2014 estimates***
Projected population increase aged 85+ (2012-2037) %	**152.9%**	**38,872**	**180.0%**	**184.1%**	**193.8%**	**107.6%**	**177.1%**	**206.4%**	**141.4%**	**126.4%**	**175.4%**	**190.4%**	***ONS 2012 SNPP***
BME %	**20.2%**	**62,867**	**11.5%**	**4.1%**	**11.1%**	**33.4%**	**15.9%**	**6.4%**	**16.6%**	**29.2%**	**11.9%**	**8.7%**	***2011 Census***
Most deprived quintile %	**20.4%**	**-**	**5.9%**	**5.2%**	**19.3%**	**32.8%**	**3.6%**	**0.0%**	**1.0%**	**25.4%**	**0.5%**	**14.6%**	***ONS mid year population estimates and Indices of Multiple Deprivation 2010***
Crude death rate %	**0.88%**	**5,075**	**0.92%**	**1.05%**	**0.94%**	**0.82%**	**0.85%**	**1.01%**	**0.83%**	**-**	**-**	**-**	***ONS VS Tables 2013***
Deaths aged 75+ %	**66.7%**	**3,515**	**69.2%**	**65.7%**	**65.0%**	**63.7%**	**70.6%**	**73.9%**	**70.5%**	**-**	**71.7%**	**65.3%**	***End of Life Care Profiles / HSCIC Primary Care Mortality Database 2013***
Deaths aged 85+ %	**36.2%**	**2,095**	**41.2%**	**36.1%**	**36.1%**	**34.8%**	**46.2%**	**44.1%**	**42.7%**	**-**	**43.4%**	**36.1%**	***End of Life Care Profiles / HSCIC Primary Care Mortality Database 2013***
Deaths in hospital %	**54.5%**	**2,568**	**50.6%**	**52.5%**	**54.4%**	**59.1%**	**46.7%**	**47.2%**	**52.0%**	**51.2%**	**49.5%**	**54.6%**	***End of Life Care Profiles / HSCIC Primary Care Mortality Database 2013***
Deaths in own home %	**20.3%**	**1,138**	**22.4%**	**21.4%**	**24.6%**	**22.0%**	**24.5%**	**22.8%**	**18.8%**	**23.8%**	**20.7%**	**23.1%**	***End of Life Care Profiles / HSCIC Primary Care Mortality Database 2013***

Deaths in care home %	**17.8%**	**1,051**	**20.7%**	**21.5%**	**16.4%**	**14.1%**	**23.6%**	**23.0%**	**20.0%**	**19.3%**	**20.8%**	**17.4%**	***End of Life Care Profiles / HSCIC Primary Care Mortality Database 2013***
Deaths in hospice %	**5.2%**	**238**	**4.7%**	**2.7%**	**3.1%**	**3.1%**	**3.6%**	**5.4%**	**7.5%**	**3.9%**	**6.8%**	**3.1%**	***End of Life Care Profiles / HSCIC Primary Care Mortality Database 2013***
Deaths in 'usual residence' %	**45.1%**	**-**	**-**	**43.3%**	**41.6%**	**43.4%**	**48.7%**	**49.7%**	**41.3%**	**44.7%**	**45.8%**	**42.2%**	***ONS***
Deaths from cancer %	**28.8%**	**1,436**	**28.4%**	**27.5%**	**27.4%**	**27.3%**	**28.0%**	**29.4%**	**29.1%**	**27.5%**	**29.2%**	**27.4%**	***ONS VS Tables 2013***
Deaths from CVD %	**27.7%**	**1,373**	**27.1%**	**30.6%**	**28.0%**	**25.6%**	**25.0%**	**26.9%**	**26.2%**	**25.4%**	**26.5%**	**28.9%**	***ONS VS Tables 2013***
Deaths from respiratory diseases %	**14.7%**	**681**	**13.5%**	**11.5%**	**13.8%**	**15.6%**	**15.6%**	**11.4%**	**14.8%**	**15.6%**	**13.0%**	**13.0%**	***ONS VS Tables 2013***
Terminal admissions as emergencies %	**89.7%**	**1,893**	**87.4%**	**87.0%**	**88.0%**	**94.3%**	**91.6%**	**82.4%**	**88.8%**	**-**	**85.7%**	**87.7%**	***NHS Arden & GEM CSU***
Terminal admissions >8 days %	**48.8%**	**1,015**	**46.9%**	**39.4%**	**45.0%**	**47.3%**	**50.0%**	**48.0%**	**50.0%**	**-**	**49.0%**	**43.2%**	***NHS Arden & GEM CSU***
Funded care home placements per 1000 aged 75+	**114.1**	**1,478**	**29.8**	**32.8**	**29.7**	**81.4**	**26.3**	**25.8**	**23.5**	**-**	**24.7**	**30.8**	***WCC Business & Commissioning Intelligence***
Delayed transfers of care per 100,000 aged 18+	**9.6**	**-**	**10.1**	**-**	**-**	**16.4**	**-**	**-**	**-**	**-**	**-**	**-**	***PHE Fingertips Tool (2013/14)***
Gross residential/nursing care cost per 10,000 aged 75+ £	**£5,984,900**	**-**	**£6,405,500**	**£7,079,300**	**£6,198,500**	**-**	**£5,289,900**	**£5,906,500**	**£5,340,400**	**-**	**£5,647,100**	**£6,510,200**	***WCC Business & Commissioning Intelligence (2014/15)***
Permanent admissions to residential and nursing care homes age 65+	**63,788**	**547**	**-**	**72**	**120**	**344**	**93**	**133**	**87**	**437**	**220**	**192**	***WCC Business & Commissioning Intelligence and HSCIC (2014/15)***

Permanent admissions to residential and nursing care homes rate per 100,000 age 65+	**668.8**	**495.3**	**-**	**556.9**	**517.6**	**705.7**	**483.4**	**441.8**	**348.2**	**642.8**	**399.4**	**531.7**	***WCC Business & Commissioning Intelligence and HSCIC (2014/15)***
People aged 65+ discharged from hospital to reablement rate per 1,000	**-**	**9.8**	**-**	**8.1**	**8.1**	**-**	**11.5**	**10.0**	**10.7**	**-**	**10.3**	**8.1**	***WCC Business & Commissioning Intelligence (2014/15)***
Persons aged 65+ receiving self directed support rate per 1,000	**-**	**69.3**	**-**	**72.4**	**81.3**	**-**	**66.0**	**61.4**	**68.9**	**-**	**64.8**	**78.1**	***WCC Business & Commissioning Intelligence (2014/15)***
Persons aged 65+ with compelete assessment rate per 1,000	**-**	**16.6**	**-**	**15.8**	**18.9**	**-**	**20.5**	**14.7**	**14.1**	**-**	**14.4**	**17.8**	***WCC Business & Commissioning Intelligence (2014/15)***
Persons aged 65+ with care package delivered rate per 1,000	**-**	**71.6**	**-**	**77.0**	**86.0**	**-**	**66.8**	**62.3**	**70.2**	**-**	**65.9**	**82.7**	***WCC Business & Commissioning Intelligence (2014/15)***
Carers aged 65+ who received social care rate per 1,000	**-**	**4.7**	**-**	**6.7**	**6.3**	**-**	**4.1**	**4.1**	**3.4**	**-**	**3.8**	**6.5**	***WCC Business & Commissioning Intelligence (2014/15)***
Carers aged 65+ who received self directed support rate per 1,000	**-**	**4.5**	**-**	**6.3**	**6.0**	**-**	**4.0**	**4.0**	**3.3**	**-**	**3.7**	**6.1**	***WCC Business & Commissioning Intelligence (2014/15)***

Indicator spine chart

Domain	Indicator	LA number	LA indicator value	England average	England lowest	England range	England highest
Population	1. Percentage aged 65+ (persons)	95,011	17.8%	16.3%	7.0%		25.1%
	2. Percentage aged 65+ (males)	42,495	16.1%	14.5%	6.3%		23.0%
	3. Percentage aged 65+ (females)	52,516	19.4%	18.0%	7.7%		27.1%
	4. Percentage aged 75+ (persons)	44,106	8.2%	7.8%	3.4%		12.7%
	5. Percentage aged 75+ (males)	17,883	6.8%	6.3%	3.0%		10.8%
	6. Percentage aged 75+ (females)	26,222	9.7%	9.3%	3.8%		14.5%
	7. Percentage aged 85+ (persons)	12,392	2.3%	2.2%	0.9%		4.0%
	8. Percentage aged 85+ (males)	3,933	1.5%	1.5%	0.7%		2.8%
	9. Percentage aged 85+ (females)	8,459	3.1%	3.0%	1.0%		5.2%
	10. Percentage increase in population aged 85+ (projected to 2033)	54,500	195.8%	142.1%	24.5%		233.7%
	11. Percentage of resident population who are Black and Minority Ethnic	22,349	4.4%	9.1%	0.7%		60.6%
	12. Percentage resident in urban settlements	366,150	68.5%	81.1%	0.0%		100.0%
	13. Percentage resident in the most deprived quintile	26,431	4.9%	20.0%	0.0%		89.7%
Deaths	14. Crude death rate (persons) as a percentage	4,921	0.9%	0.9%	0.4%		1.3%
	15. Crude death rate (males) as a percentage	2,395	0.9%	0.9%	0.4%		1.4%
	16. Crude death rate (females) as a percentage	2,526	0.9%	0.9%	0.4%		1.4%
	17. Percentage of deaths aged 75+ (persons)	3,343	67.9%	66.7%	50.2%		75.3%
	18. Percentage of deaths aged 75+ (males)	1,456	60.8%	58.6%	42.2%		69.1%
	19. Percentage of deaths aged 75+ (females)	1,888	74.7%	74.2%	59.3%		82.4%
	20. Percentage of deaths aged 85+ (persons)	1,833	37.2%	36.2%	23.1%		46.4%
	21. Percentage of deaths aged 85+ (males)	660	27.6%	26.2%	14.8%		36.0%
	22. Percentage of deaths aged 85+ (females)	1,172	46.4%	45.5%	31.2%		55.4%
Place of death	23. Percentage of deaths in hospital*	2,722	55.3%	54.5%	42.2%		70.2%
	24. Percentage of deaths in own home	1,084	22.0%	20.3%	15.9%		27.2%
	25. Percentage of deaths in hospice*	167	3.4%	5.2%	0.1%		12.6%
	26. Percentage of deaths in care home	849	17.3%	17.8%	3.7%		32.1%
Cause of death	27. Percentage of deaths from respiratory disease (underlying cause)	638	13.0%	13.8%	11.2%		17.8%
	28. Percentage of deaths from respiratory disease (mentions)	1,680	34.1%	34.2%	27.9%		41.3%
	29. Percentage of deaths from cancer (underlying cause)	1,372	27.9%	27.7%	23.1%		31.4%
	30. Percentage of deaths from cardiovascular disease (underlying cause)	1,371	27.9%	29.6%	25.3%		35.3%
	31. Percentage of deaths from liver disease (mentions)	189	3.8%	3.8%	2.6%		6.7%
	32. Percentage of deaths from renal disease (mentions)	336	6.8%	5.8%	3.6%		8.2%
	33. Percentage of deaths from Alzheimers, dementia & senility (mentions)	1,043	21.3%	17.3%	7.9%		26.9%
Deaths in hospital	34. Percentage of terminal admissions that are emergencies	2,199	91.6%	89.7%	76.1%		97.0%
	35. Percentage of terminal admissions aged 85+	953	39.7%	37.8%	27.5%		49.4%
	36. Percentage of terminal admissions that are 8 days or longer	1,260	52.5%	48.8%	37.6%		57.8%
	37. Average number of bed days per admission ending in death	34,423	14.0	12.9	8.0		16.0
Care homes	38. Number of care homes per 1,000 population aged 75+	188	4.3	4.4	1.2		8.2
	39. Number of care home beds per 1,000 population aged 75+	4,631	105.0	114.1	35.7		169.6
	40. Percentage of care homes achieving Gold Standard Framework	6	3.2%	1.6%	0.0%		14.7%
Social care (SC)	41. Persons (aged 65+) discharged from hospital per 100,000 aged 65+.	355	362	425	47		2,715
	42. Average user experience score (max. score 24), persons aged 65+	5,010	18	19	17		20
	43. Persons (65+) receiving Self Directed Support (per 100,000 aged 65+)	2,075	2,118	2,935	238		7,619
	44. Delayed transfers of care: persons (all ages) (per 100,000 aged 65+)	869	887	568	21		2,026
	45. Delayed transfers of care: days (all ages) (per 100,000 aged 65+)	26,231	26,774	15,956	239		60,629
	46. Persons (65+) with completed assessment (per 100,000 aged 65+)	3,565	3,639	5,054	1,343		11,209
	47. Persons (65+) with care package delivered (per 100,000 aged 65+)	2,120	2,164	3,186	768		8,683
	48. Carers (65+) who received social care support (per 100,000 aged 65+)	3,070	3,133.5	2,003.3	400.6		5,977.1
	49. Persons (65+) who received social care support (per 100,000 aged 65+)	7,310	7,461	8,297	4,819		20,543
	50. Persons (65+) entitled to Carer's Allowance (per 100,000, aged 65+)	3,320	3,388.7	3,470.1	946.7		9,194.4
SC Expenditure (Avg annual £'000s per 100,000 aged 65+)	51. Gross residential and nursing care (£'000s per 100,000 aged 65+)	£42,623	£43,504	£59,849	£33,157		116,154
	52. As indicator 51, less NHS section 256 (£'000s per 100,000 aged 65+)	£41,749	£42,613	£57,239	£32,754		£115,930
	53. Home care (£'000s per 100,000 aged 65+)	£25,581	£26,111	£25,765	£12,518		£92,012
	54. Direct payments (£'000s per 100,000 aged 65+)	£2,596	£2,650	£3,420	£273		£15,457
	55. Day care or day services (£'000s per 100,000 aged 65+)	£2,181	£2,226	£4,246	£793		£21,608
	56. Meals (£'000s per 100,000 aged 65+)	£208	£212	£905	£0		£7,497

Appendix 3

National End of Life Care Profile Update April 2016
Place of Death by Local Authority and CCG
Based on Deaths Data for 2014

Place of Death	England	Coventry	North Warwickshire	Nuneaton & Bedworth	Rugby	Stratford upon Avon	Warwick
Hospital	47.4	52.8	49.6	54.4*	45.3	43.4*	47.2
Home	23	21.3	25.7	22.7	23.7	24	20.5
Care Home	21.7	20.9	19	17.4*	24.1	26.5*	22.2
Hospice	5.7	3.4*	3.9	3.6*	4.8	4.1*	7.4*
Usual place of residence	44.7	42.6*	45.6	40.3*	48.6*	51*	42.9

Place of Death	England	Coventry & Rugby Clinical Commissioning Group	Warwickshire North Clinical Commissioning Group	South Warwickshire Clinical Commissioning Group
Hospital	47.4	50.9*	52.8*	45.2*
Home	23	21.9	21.8	22.4
Care Home	21.7	21.7	18*	24.5*
Hospice	5.7	3.7*	3.7*	5.6
Usual place of residence	44.7	44.1	42.1*	47.3*

- **= Statistically different to England**

Appendix 4

Commentary on Social Care Indicators Included in Indicator Summary (appendix 1)

People aged 65+ Discharged from Hospital to Reablement
Reablement is a short-term (6 week) intensive service aimed at maximising the independency of people, following a period of illness (most frequently following discharge from hospital). The rate of discharge to reablement for those aged 65+ ranges from 8.1 per 1,000 65+ population in North Warwickshire and Nuneaton and Bedworth, to 11.5 for the Rugby population.
Reasons for the differences in the rate are not immediately apparent, but could reflect capacity / staffing issues that might have impacted differentially on services, as opposed to being a chance effect. It is also possible that a compensatory volume of referrals were made for the North Warwickshire and Nuneaton and Bedworth populations, to an alternative service (Community Emergency Response Team) although this would require further exploration.

Average Users aged 65+ Experience Score
This score provides an indication of the reported satisfaction level of social care users aged 65 and over. A higher score represents greater satisfaction.

Persons aged 65+ Receiving Self-Directed Support (SDS)
Self-directed support reflects access to a Personal Budget and as such, the vast majority of people eligible to receive social care support are included in this measure. The rate of individuals in receipt of SDS ranges from 61.4 (per 1,000 >65+) in Stratford on Avon to 81.3 in Nuneaton & Bedworth, reflecting need and eligibility (financial) for support among the different populations.

Persons aged 65+ with Complete Assessment
A person with a complete assessment has been referred and then gone on to receive a full social care assessment. Many individuals are referred and following preliminary enquiry / assessment are discharged without having a full assessment. The rates differ from 14.1 in Warwick to 20.5 in Rugby. Differences largely reflect different population needs and eligibility.

Persons aged 65+ with Care Package Delivered
This is a measure of individuals in receipt of long-term support – or a substantive social care package. The rate ranges from 62.3 in Stratford on Avon to 86 in Nuneaton & Bedworth, reflecting need and eligibility.

Carers aged 65+ who Receive Social Care
This is a measure of carers receiving support to enable them to fulfil their caring responsibilities, but it is not always well recorded (in particular where the carer is receiving a service as a client rather than as a carer). The rate ranges from 3.4 in Warwick to 6.7 in North Warwickshire, which again reflects need and eligibility.

Carers aged 65+ who Received Self-Directed Support
This measures carers who receive a personal budget to enable them to fulfil their caring responsibilities. The range reflects access to a carer's social care package, as above.

Persons aged 65+ Permanent Care Home Admissions

This measures individuals considered at a point in time to be a permanent admission to residential care. Permanent placements range from 348.2 per 100,000 (will be changed to rate per 1,000 as the other measures) in Warwick District to 556.9 in North Warwickshire, reflecting need and eligibility.

Appendix 5

Primary Care End of Life Care Registers

CCG	South Warwickshire	Warwickshire North	Coventry and Rugby
Number of Practices in CCG	36	28	75
Number of Practices in sample with EoLC Register	34	10	67
Practice Population	277521	58,000	448,267
Number of practice patients on the register (% of population)	1719 (0.62%)	87 (0.15)	796 (0.18)
Average age and age range of patients on the register	78 (18-106)	74 (32 – 100)	72.4 (22 – 105)
Number of males (% of those on register)	668 (38.9%)	33 (38%)	375 (47.1)
Number (%) on register with cancer diagnosis	624 (36.3%)	59 (68%)	526 (66.1%)
Number (%) on register with Advanced Care Plan	18 (1.04%)	4 (4.6%)	5 (0.6%)
Number (%) on register with carer identified	156 (9.1%)	11 (12.6%)	139 (17.5%)
Number (%) on register with key worker identified	2 (0.12%)	0	0
Number (%) on register with DNAR identified	876 (50.9%)	18 (21%)	
Number (%) on register with anticipatory medication	15 (0.9%)	2 (2.3%)	3 (0.3%)
Number (%) on register with Lasting Power of Attorney identified	9 (0.6%)		7 (0.85)

Appendix 6

End of Life Care (Adult): Overview of services and support

This appendix includes Table 4 (CRCCG) Table 5 (WNCCG) and Table 6 (SWCCG) detailing workforce and facilities available.

Table 4
Coventry and Rugby CCG

Population: 450 000
Acute hospital beds: 1250
GP practices: 75

STAFF	Overall provision	Recommended provision (based on estimates per population 250 000/per 250 bed hospital*)
Palliative Medicine consultant time	Coventry Community: 0.9 WTE Coventry UHCW NHS Trust (University Hospital and Hospital of St Cross) 1.2 WTE Rugby Community: 0.1WTE Myton*:-(0.2 + 0.5 WTE) = 0.7 WTE Coventry Myton Hospice and 0.55 WTE Warwick Myton Hospice Consultant sessions supporting patients from all 3 CCGs	3.6 WTE *→Short by 2.7WTE* 5 WTE hospital *→Short by 3.0 WTE* *(excluding Myton posts)*
Supporting Palliative Medicine doctor time (StR, specialty doctor)	StRs in Palliative Medicine (variable) - Up to 2 WTE Coventry community/Myton Specialty doctor - 0.7 WTE Coventry Myton (from Nov 2015)	3.6 WTE *→Short by at least 0.9WTE*
Palliative Care Specialist Nurse time	Coventry Community: 6.0 WTE Band 7 1.0 WTE Band 6 1.0 WTE Band 8a Head of Service (non-clinical) *Cover 0830-1630 Mon-Fri* Rugby Community: 2.0 WTE Band 7 *Part of 7 day service in Warwickshire (started Sept 2015)* University Hospital Coventry: 1.0 WTE Band 8 (seconded from band 7 post) 4.0 WTE Band 7 (2 posts vacant) 0.8 WTE Band 6 CQUIN post (vacant) 1.8 WTE Care of the Dying Nurses	9.0 WTE community *→Meet recommendations* 5.0 WTE hospital *→Meet recommendations*

	0.8 WTE Nurse Educator for Transform Programme *Cover 0830-1630 Mon-Fri* Rugby St Cross: 0.2 WTE Band 7	
Other Specialist Clinicians - therapy/ psychology etc.	Coventry Community: 1.0 WTE Physiotherapist 1.0 WTE Occupational Therapist No dedicated clinical psychology time, but may access 1.42WTE Community Pathways Psychologists- a shared service with District Nurses and Intermediate Care (includes 2.5hrs level 2 support for team supervision) Rugby Community: None UHCW: 1.0 WTE Specialist Palliative Care Pharmacist (with wider C&W support). Chaplaincy support. Myton Hospices Coventry and Rugby: 0.4 WTE Band 8a Clinical Psychologist 2.0 WTE Level 3 counsellors Access to inpatient hospice OT/physio/ chaplaincy**	
CCG GP EOLC lead *Macmillan GP*	Yes No (under consideration)	
FACILITIES		
Acute hospital palliative care beds	None dedicated	
Community hospital palliative care beds	None	
Care home palliative care beds	Coventry: No contracted beds (previously 19 at Abbey Park) Rugby: 6 beds at Overslade NH	
Hospice beds	Access to Coventry and Warwick Myton Hospices** *(NB. Hospice grant allocations from CRCCG to Katharine House Banbury, Marie Curie Solihull, St Giles Lichfield, Shakespeare Stratford, but not accessed)*	36-45 beds
Day hospice	Access to Myton Hospices (Rugby, Coventry, Warwick)**	
Hospice at home	Rugby:	

service	Provided by Myton Hospices. 7 day service; max 4 visits/day and 3 night sits; run by 1 RN and 7 NA's.	
Palliative support service	Coventry: 1.0 WTE Band 7 co-ordinator (now acting up as Head of Service for Palliative Care) 9.0 WTE Band 3 HCAs *NB. Plans to recruit Band 5/6 nurses on hold*	
Community nursing service i.e. DNs/matrons	Coventry: 24/7 service Rugby: 'Face to face' service 8.30 to midnight. Limited on-call service midnight to 8.30am plus access via OOH provider	
Bereavement services	Via Myton Hospices for patients who have accessed services: 2.2 WTE counselling (3 staff) across all three sites plus one secretary, supported by 21 volunteers. Average caseload 90 clients across all three sites at any one time.	
Lymphoedema service	Via Myton Warwick: Mon-Fri 9am-5pm, 2 practitioners, capacity around 25 – 30 patients per month, roughly a 50% split between SW CCG and C&R CCG patients.	
OOH palliative care provision	Coventry: 24/7 community nursing Rugby: community nursing information unavailable (SWFT) Palliative care CNS: No OOH cover in Coventry. One CNS on duty 9-5 Saturday, Sunday and Bank Holidays providing urgent face to face reviews for Rugby/WN community and GEH. Palliative medicine consultant: 24/7 on call rota accessed via Myton Hospice for telephone advice (covers all CCGs)	

Table 5
Warwickshire North CCG
Population: 184 000
Acute hospital beds: 352
GP practices: 28

STAFF	Overall provision	Recommended provision (based on estimates per population 250 000/per 250 bed hospital*)
Palliative Medicine consultant time	0.8 WTE for North Warwickshire Community and George Eliot Hospital NHS Trust Myton*:- 0.7 WTE Consultant sessions at Coventry Myton Hospice and 0.55 WTE Consultant sessions at Warwick Myton Hospice supporting patients from all 3 CCGs	1.5 WTE + 1.4 WTE hospital *→Short by 2.1 WTE* *(excluding Myton posts)*
Supporting Palliative Medicine doctor time (StR, specialty doctor)	No other doctors in palliative medicine in community or hospital	1.5 WTE *→Short by 1.5 WTE*
Palliative Care Specialist Nurse time	WN Community: 4.0 WTE Band 7 1.0 WTE Band 6 *Cover 0900-1700, 7 day service (5+2 model started Sept 2015)* GEH: 2.0 WTE Band 7 Macmillan CNS (one employed by SWFT, the second as a pilot post in Acute Medical Unit funded by Macmillan for three years) 1.0 WTE Lead Nurse for EOLC 0.5 WTE Support Nurse for EOLC (currently working 0.8 WTE using HEE funding to support the team in delivering communication skills training at GEH) *Cover 0900-1700, 7 day service (5+2 model started Sept 2015)*	3.7 WTE community *→Meet recommendations* 1.4 WTE hospital *→Meet recommendations*
Other Specialist Clinicians - therapy/ psychology etc.	Chaplaincy support through Mary Ann Evans (MAE) and GEH. No specialist physiotherapy, occupational therapy or pharmacy. No dedicated clinical psychology (NB. 0.4 WTE 8a Clinical Psychologist employed by CWPT to work within GEH for oncology only).	

CCG GP EOLC lead *Macmillan GP*	No No	
FACILITIES		
Acute hospital palliative care beds	None dedicated	
Community hospital palliative care beds	None	
Care home palliative care beds	No contracted beds	
Hospice beds	Access to beds at Coventry and Warwick Myton Hospices**, St Giles Lichfield, Marie Curie Solihull (NB. limited use)	15-18 beds
Day hospice	Mary Ann Evans: Mon-Fri, up to 15 people a day, open 0830-1630. 1.0 WTE Band 6, 1.6 WTE RN, 1.4 WTE HCA – including dedicated activities co-ordinator role, complementary therapist team lead 0.6 WTE. Plus volunteers. (April 2014-March 2015 cared for 76 individual patients-2034 attendances)	
Hospice at home service	Mary Ann Evans: Cover 7 days and nights a week – currently not operational 1630 – 2100 as evening district nursing service in WN. Staffing very lean: 1.0 WTE Band 6 Team Lead, 1 Band 4 SHCA as co-ordinator and care provider, 4.0 WTE SHCA on day rota, 2.6 WTE on night rota (April 2014-March 2015 cared for 195 patients, of which 187 were new referrals to the service)	
Palliative support service	n/a	
Community nursing service i.e. DNs/matrons	'Face to face' service 8.30 to midnight. Limited on-call service midnight to 8.30am plus access via OOH provider.	
Bereavement services	Mary Ann Evans: Bereavement support service for all ages - approx 70 volunteers and 3 part-time staff (trained counsellors on board to help with the more complex referrals)	
Lymphoedema service	Mary Ann Evans (completely non NHS funded service): 0.8 WTE CNS, 1.0 WTE Band 4 Assistant Practitioner, 1.0 WTE Band 3	

	HCA – operates 5 days/week including a day and evening sessions of "Healthy Steps" programme. (2014-15 provided 2447 attended appointments)	
OOH palliative care provision	District nursing service working on call after midnight Palliative care CNS: One CNS on duty 9-5 Saturday, Sunday and Bank Holidays providing urgent face to face reviews for Rugby/WN community and GEH. Palliative medicine consultant: 24/7 on call rota accessed via Myton Hospice for telephone advice (covers all CCGs)	

Table 6
South Warwickshire CCG
Population: 270 000
Acute hospital beds: 383
GP practices: 36

STAFF	Overall provision	Recommended provision (based on estimates per population 250 000/per 250 bed hospital*)
Palliative Medicine consultant (and associate specialist) time	SW Community: 0.4 WTE and 0.05 WTE Shakespeare Hospice South Warwickshire NHS Foundation Trust 1.0 WTE Myton*:- Warwick Myton Hospice Consultant sessions supporting patients from all 3 CCGs 0.55 WTE with 0.7 WTE Consultant sessions at Coventry Myton Hospice	2.2 WTE *→Short by 1.7 WTE* 1.5 WTE hospital *→Short by 0.6 WTE* *(excluding Myton posts)*
Supporting Palliative Medicine doctor time (StR, specialty doctor)	StRs in Palliative Medicine (variable) - Up to 1.0 WTE Warwick Myton	2.2 WTE *→Short by at least 1.2WTE*
Palliative Care Specialist Nurse time	SW Community: 1.0 WTE Band 8b 4.0 WTE Band 7 2.0 WTE Band 6 *Cover 0900-1700, 7 day service (5+2 model started Sept 2015)* Hospital: 1.0 WTE Band 8a Lead Nurse 0.6 WTE Band 7 CNS 1.0 WTE Band 6 CNS *Cover 0900-1700, 7 day service (5+2 model started Sept 2015)*	5.4 WTE community *→Meet recommendations* 1.5 WTE hospital *→Meet recommendations*
Other Specialist Clinicians - therapy/ psychology etc.	0.6 WTE 8b Clinical Psychologist in Warwick Hospital employed and funded by SWFT 0.4 WTE 8b Clinical Psychologist in Warwick Myton Hospice employed by SWFT and funded by Myton Hospices Chaplain support at Warwick Hospital MDT. Access to Myton chaplaincy support.	

	Access to Myton Hospices OT/physio** - outreach to community	
CCG GP EOLC lead *Macmillan GP*	Yes Yes	
FACILITIES		
Acute hospital palliative care beds	None dedicated	
Community hospital palliative care beds	None dedicated	
Care home palliative care beds	*Unknown*	
Hospice beds	Access to beds at Coventry and Warwick Myton Hospices**, Katherine House Banbury, Marie Curie Solihull.	22-27 beds
Day hospice	Myton Hospices (Rugby, Coventry, Warwick)** Shakespeare Hospice, Stratford-upon-Avon: Mon –Thurs 10-3pm One Wednesday each month service runs a late night 10-8pm (supports people still working/childcare issues) Monday – is for carers and bereaved carers (can attend by appointment rather than the whole day) Tues and Thurs – patients with advanced life limiting illness Weds – younger age group some of whom are undergoing treatment 15 places 0.6 WTE Complementary therapist co-ordinator 0.8 WTE Band 6 Team leader 1.52 WTE Band 5 0.8 WTE Band 3	
Hospice at home service	Myton: Warwick & Leamington M@H – currently Mon-Fri 9am-5pm – moving to 24/7 in the autumn. Run by 1 RN and 6 NA's. Shakespeare Hospice: Work 08.30-22.00 then 22.00-08.30 – on call service 24 hour service 7 days a week including bank holidays. Cover large geographical area South Warwickshire, North Cotswolds Kenilworth and Southam. Capacity determined via level of need and where patients are geographically. 1 WTE Band 6 Team Leader – vacant 3.3 WTE Band 5 1.6 WTE Band 3	

	Shipston Home Nursing (charity): service for Shipston, Kineton, Wellesbourne and the surrounding areas. 13 RGNs.	
Palliative support service	n/a	
Community nursing service i.e. DNs/matrons	'Face to face' service 8.30 to midnight. No on-call service from midnight but is access via OOH provider	
Bereavement services	Via Myton Hospices for patients who have accessed services: 2.2 WTE counselling (3 staff) across all three sites plus one secretary, supported by 21 volunteers. Average caseload 90 clients across all three sites at any one time. Via The Shakespeare Hospice (Family Support services): 0.6 WTE B6 Adult Bereavement Counsellor – provides counselling and bereavement support both pre and post. 0.8 WTE B7 Team Leader (Social worker) – psychosocial support and advice. Both services supported by volunteers. Friday – bi-weekly 10-12.30 – bereavement group (self supporting) See also Young People's service below.	
Lymphoedema service	Via Myton Warwick: Mon-Fri 9am-5pm, 2 practitioners, capacity around 25 – 30 patients per month, roughly a 50% split between SW CCG and C&R CCG patients.	
OOH palliative care provision	Community nursing information unavailable Palliative care CNS: One CNS on duty 9-5 Saturday, Sunday and Bank Holidays providing urgent face to face reviews for SW community (inc. community hospitals) and Warwick Hospital. Palliative medicine consultant: 24/7 on call rota accessed via Myton Hospice for telephone advice (covers all CCGs)	
Other	Shakespeare Hospice Young People's service: 0.8 WTE B6 – Transitional care nurse providing bespoke day care for young people 16-24 with a life limiting illness individual or groups dependent on need. Supported by Day Hospice team and Bank staff. 0.6 WTE Children's bereavement practitioner – supported by volunteers providing one to one and groups for pre and post bereavement support for children.	

	1 WTE B6 Youth and community worker – runs a young carers group in partnership with Warwickshire Young Carers project – Wednesday evenings 5-7pm – Junior group one week then Senior group the next week (alternating). Also supports youth volunteering and work experience alongside running a youth advisory group and Student ambassadors programme.	

***Per population of 250 000 the minimum requirements are (Commissioning Guidance for Specialist Palliative Care: Helping to deliver commissioning objectives, December 2012):**

Consultants in palliative medicine – 2 WTE
Additional supporting doctors (trainee/specialty doctor) – 2 WTE
Community specialist palliative care nurses – 5 WTE
Inpatient specialist palliative care beds – 20-25

Per 250-bed hospital, the minimum requirements are:

Consultant/associate specialist in palliative medicine – 1 WTE
Hospital specialist palliative care nurse – 1 WTE

****Myton Hospices – services accessed by all 3 CCGs**
Staff
Palliative medicine consultants
*Myton sessions provide support to patients from all 3 CCGs – these consultant sessions annotated with a * in tables 4, 5 and 6 are the same posts totalling 1.25 WTE Myton Consultants across Coventry and Warwickshire.

Medical Director – vacant – 0.6-1.0 WTE (TBC)
Coventry Myton – 2 consultants – 0.7 WTE
Warwick Myton – 1 consultant – 0.55 WTE; (2 acting consultants - 1.5 WTE)

Palliative Medicine consultant on call rota: 24/7 telephone advice to community/hospital services across C&W (7 consultants)

Supporting palliative medicine doctors
Coventry Myton Specialty doctor 0.7 WTE (starting November 2015)
(StRs on rotation at Coventry and Warwick Myton)

Other specialist clinicians
5.6 WTE (8 staff) in Occupational Therapy/Physiotherapy (3x OT, 3x Physio, 2x Therapy technical instructors)
2.9 WTE (4 staff) in Chaplaincy

Nurses/HCAs

Warwick IPU: 17 RN's, 15.5 NA's
Coventry IPU: 14.5 RN's, 10 NA's
(NB. 5 RN vacancies and 3 NA vacancies across both sites)

Beds

Coventry: 10 complex care beds, 2 nurse led beds, further 4 nurse led beds opening 2nd November 2015 (capacity for 19 beds) NB. Nurse led beds almost fully funded by C&R CCG

Warwick: 20 complex care beds (number open variable at present)

Services

Day hospice services

Warwick – open 4 days a week (not Wednesday) 10am-3pm, max capacity 15, run by 4RN's and 4 NA's
Coventry – open 3 days a week (not Tues or Thurs) 10am – 3pm, max capacity 15, run by 4RN's and 1NA
Rugby – open 4 days a week (not Monday) 10am – 3pm, max capacity 12, 3 RN's and 2 NA's

Hospice at home

Rugby M@H – 24/7 service run by 1RN and 7 NA's
Warwick & Leamington M@H – currently Mon-Fri 9am-5pm – moving to 24/7 in the autumn. Run by 1 RN and 6 NA's

Bereavement services

2.2 WTE counsellors (3 staff) across all three sites plus one secretary, supported by 21 volunteers; average caseload 90 clients across all three sites at any one time.

Lymphoedema services

2 practitioners; Mon-Fri 9am-5pm; capacity around 25 – 30 patients per month; roughly 50% split between SWCCG and C&R CCG patients.

Infrastructure/Co-ordination

CRCCG

- CCG EOLC Transformation Board monthly
- UHCW EOLC Committee bimonthly (Myton hospice and CWPT community palliative team represented)

WNCCG

- GEH EOLC Meeting

SWCCG

- SWFT (SW Acute and South and North Warwickshire Community) EOLC Meeting monthly

CASTLE Clinical Implementation Group – C&W wide provider representation (meetings x4/year)

West Midlands Supportive and Palliative Care Expert Advisory Group (Strategic Clinical Network) – consultant and CNS represent C&W (meetings x2/year)

Appendix 7

Summary of End of Care Audit – Dying in Hospital
National Report for England 2016

The findings of the national audit were published in March 2016 by the Royal College of Physicians. The audit had two components; a review of the EoLC documented for a sample of patients who died in May 2015 and an organisational review of services and protocols.

The care delivered to patients was measured in relation to five indicators, shown below with the average % achievement nationally:

Documented evidence that:

- 1. EoL was recognised (83%)
- 2. EoL had been discussed with loved ones (79%)
- 3. That patient concerns were listened to (84%)
- 4. That the concerns of loved ones were identified (56%)
- 5. That a holistic assessment of patient needs was undertaken (66%)

Table 11

Summary of Achievement by Trust Against Clinical Indicators

Indicator	England Average (Range)	GEH	SWFT	UHCW
EoL was recognised	83% (64% to 100%)	75%	89%	73%
EoL discussed with loved ones	79% (60% to 100%)	73%	89%	69%
Patient concerns listened to	84% (41% to 100%)	85%	87%	68%
Concerns of loved ones were identified	56% (9% to 95%)	58%	70%	58%
Holistic assessment of needs undertaken	66% (4% to 100%)	52%	43%	42%

It should be noted that the audit was based on documented evidence of achievement and as such it is possible that action was taken by those providing care but was not recorded. In that context it can be seen in Table 7 that:

South Warwickshire Foundation Trust (SWFT) compared well against the national average for each of the above measures except indicator 5, where the value achieved (43%) featured in the bottom quartile of values (Q4 range 4% to 50%)

George Eliot Hospital (GEH) performed better than the national average in relation to indicators 3 and 4, but less well than average on indicators 1 (75%), which was in the bottom quartile of values (Q4 range 64% to 77%) and indicator 2 (73%) which was in the bottom quartile of values (Q4 range 60% to 74%) and 5 (52%), which was in the middle quartiles.

University Hospitals Coventry and Warwickshire (UHCW) performed less well on all the indicators except indicator 4 achieving 73% for indicator 1 (in Q4), 69% for indicator 2 (in Q4) 68% for 3 (in Q4) and 42% for 5 (in Q4).

The organisational audit looked at indicators of:

- Board leadership in relation to EoLC (lay member)
- Whether the views of bereaved families are sought
- The provision of training to key staff groups
- The availability of 'face to face' SPC services at least 9 to 5, each day of the week
- The appointment of at least one EoLC facilitator.

The findings shown in Table 8 indicate variability across the Trusts in relation to each of the indicators, with SWFT providing a positive response to 6 of the 8 indicators, GEH providing a positive response to 4 of them and UHCW responding positively to 3 of the 8 indicators.

Table 12

Summary of Achievement by Trust Against Organisational Indicators

	England Average	GEH	SWFT	UHCW
Board Leadership	49%	No	No	Yes
Views of bereaved families	80%	Yes	Yes	Yes
Training of medical staff	63%	Tes	Yes	No
Training of nursing staff	71%	Tes	Yes	No
Training of nursing assistants	62%	No	Yes	No
Training of AHPs	49%	No	Yes	No
Access to SPC services	37%	No*	No*	No
At least one EoLC Facilitator	59%	Yes	Yes	Yes

*** Service development in Sept 2015 introduced cover 9 to 5, each day of the week**

It is expected that each Trust will review the measures required to improve the delivery of EoLC in light of these findings.

Appendix 8

End of Life Care Briefing Paper: Progress and challenges in relation to the foundations required to achieve the 'Ambitions for Palliative and End of Life Care'

Local Developments

The Care and Support Towards Life's End (CASTLE) Clinical Implementation Group represents clinical providers of palliative and end of life care across Coventry and Warwickshire and has led, supported and co-ordinated a number of developments locally. Achievements have included the following:

- Development of a system for Advance Care Planning (ACP), based on local action research, with staff education and evaluation, that includes;
  - a unified local policy, process and documentation across Coventry and Warwickshire,
  - information and training resources for health and social care professionals,
  - literature for patients and carers.
- Agreement of a Unified Coventry and Warwickshire Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) policy, process and documentation; allowing DNACPR decisions in one care environment to be transferred to another.
- Introduction of 'Greensleeves' a recognisable plastic wallet to hold ACP and DNACPR documents in hospital, hospice and community which moves with the patient.
- The three acute hospital trusts, (GEH, UHCW, SWFT) are implementing the Transform programme (NHS IQ Improving EOLC in acute hospitals).
- The specification for a shared clinical information system – Electronic Palliative Care Co-ordination System (EPaCCS), locally known as the CASTLE Register, that will be accessible to all relevant care providers in and out of hours, ensuring that staff are aware of patients' wishes and that these are met wherever possible. ***Shared records and personalised care planning are key foundations for the ambitions.***
- Development of a Coventry and Warwickshire Individualised Plan of Care for the Dying Person with education and roll out across all the acute trusts, community settings and inpatient hospice units.
- Review of prescribing guidance at the end of life in an attempt to unify this across hospital, hospice and community across Coventry and Warwickshire
- Development and ongoing support to the CASTLE website, providing information and resources for health and social care staff across Coventry and Warwickshire
- Regular "CASTLE Study Days" delivered free to a multi-professional audience and held four times per year across Coventry and Warwickshire – Rugby, North Warwickshire, South Warwickshire, and Coventry.
- Training in partnership with Myton Hospices for acute nursing staff. QELCA© (Quality End of Life Care for All) Training was developed at St Christopher's Hospice and acute palliative care and hospice staff trained as trainers to support Band 6/7 nurses from GEH, SWFT and UHCW to experience hospice care, reflect upon the challenges within the acute environment and commit to lead a small change in their area. Action Learning provided ongoing to support to ensure success.
- Co-ordinated the specification of bids for training monies and/or delivered training to key staff groups to increase EOL knowledge and skills, including
  - ACP education funded through a bid secured from the old SHA which has allowed twelve sessions of experiential learning to take place across Coventry and Warwickshire
  - Health Education West Midlands money secured by each acute trust- GEH used this to fund a Support Nurse for End of Life Care to help deliver on the 5 Key Enablers for the Transform Programme,

    - A collaborative Coventry and Rugby fund secured backfill for QELCA trainers and trainees, printing of ACP stationary for professionals in the hospital, community and hospice settings in Coventry and Rugby and education and training resources for the implementation and roll-out of the Transform programme at UHCW NHS Trust.
    - LETC funding has been secured by each acute trust and by CWPT to provide training for communications skills at the end of life. Each trust is developing its own plans based on the needs of their organisation.
- Transitional Care steering group and MDT to ensure smoother and safer transition of patients from paediatric to adult services

In South Warwickshire a GP lead for EOLC has been identified and, in addition to the above, recent developments have included:

- As commissioned by the South Warwickshire CCG, The Myton Hospices are providing education and training in EOLC to Care Homes and GP practices. This "Good to Great" programme is increasing staff knowledge and skills and care processes in both identifying and caring for people in the last year or so of life.
- SWFT has secured funding from Macmillan to allow delivery of a seven day face to face Macmillan CNS in Palliative Care service. This is a Warwickshire wide project covering GEH, SWFT and SW, WN and Rugby communities.
- "Death and Cake"- an initiative to build the confidence and competence of all staff in talking about death and dying, based on the Dying Matters Good Death Café model

In Coventry and Rugby a GP lead for EOLC has been identified and, in addition to the above, recent developments have included:

- A CCG EOL care transformational board which meets monthly.
- A CCG led 'End of Life Care Services' survey looking at how people currently access information and support around EOL care and whether development of a patient information portal would be beneficial.
- Allocation of a Palliative Care Clinical Nurse Specialist to each of the 7 GP clusters in Coventry to further support and develop links with primary care.
- Ongoing review and development of the Palliative Support service in Coventry and Myton Hospice at Home service in Rugby, to improve support for patients dying at home.
- New nurse-led beds commissioned at Coventry Myton Hospice: 2 opened in September with a further 4 due to open in November 2015.
- The UHCW NHS Trust End of Life Care Committee co-chaired by the Chief Nursing Officer and Palliative Medicine Consultant was established in March 2013 to establish an end of life care action plan for the Trust. Issues being addressed include: EOLC education and training, roll-out of the Transform Programme and the 5 key enablers (advance care planning, AMBER care bundle, care in the last days, rapid discharge and EPaCCS development), measurement and quality assurance, patient and carer involvement, bereavement and discharge. The UHCW EOLC Committee promotes integrated working with the community and hospice sectors with representatives from both now attending meetings.
- Coventry Integrated MND MDT meeting and clinic takes place monthly to discuss all patients with MND. Attended by palliative care professionals working in the community, hospital and hospice, alongside consultants in neurology and respiratory medicine, AHPs and MNDA regional advisor. Rugby also hold a regular MDT.
- Coventry Integrated Breathlessness MDT meeting takes place monthly to discuss patients with advanced non-malignant respiratory/cardiac disease. Attended by palliative care professionals working in the community, hospital and hospice, alongside consultants and specialist nurses from COPD, ILD and heart failure teams.
-

In Warwickshire North, the CCG are in the process of identifying a GP lead and recent developments, in addition to the above, have included:

- The RIPPLE (Realising Individual Patient Preferences at Life's End) project enabling hospital discharge through multi-agency co-ordination.
- GEH EOLC Strategy with clinical champions identified in each clinical area (CQC assessment identified EOLC at GEH as outstanding in 2014).
- GEH Bereaved Carers survey recently launched to provide information to support the future development of services.
- Increased service for palliative patients from Oasis - a volunteer delivered complementary therapy service at GEH.
- Appointment of a Macmillan Nurse for AMU after a successful bid to Macmillan for funding (allowing patients to be identified early to improve the experience and outcomes of care).
- Submission of a bid to Macmillan for a Palliative Care Psychologist to work across GEH, Mary Ann Evans and WN Community.
- GEH hospital palliative care team has been nominated for a Compassionate Care Award at the Health Service Journal Awards 2015 (to be announced in November).
- SWFT Macmillan Nursing Team commissioned to provide education in WN Nursing Homes sharing good practice and building skills and confidence in colleagues.
- MND MDT – all professionals involved in the care of patients with MND within WN are discussed at the regular MND MDT meetings. This meeting is attended by a Consultant Neurologist, Palliative Medicine Consultant, Macmillan nurses, MNDA regional advisor and allied health professionals.
- The Good Death Café – a forum with over 200 attendees where EOL services and resources were showcased to staff, patients and carers.
- At Mary Ann Evans Hospice: opening of Warren building and significant development in volunteer bereavement provision – now including children's service and developing pre- bereavement support; partnership working with GEH Specialist Palliative and End of Life Care team and supporting rapid discharge from acute setting to home (RIPPLE project); development of complementary therapy service for patients and carers

Issues to be addressed

Patients with terminal illnesses often have complex needs: physical, psychological, spiritual and social. Despite considerable progress across Warwickshire and Coventry there remain a number of challenges and issues to be addressed, including the following, which reflect the recently published 'foundations':

Leadership

- Clinical Leadership in the development of the majority of these local EOLC initiatives has been provided by a small but dedicated and expert group of Palliative Medicine Consultants engaging with appropriate executive leads within both the acute and community sectors and CCG EOLC leads. This can be challenging across three CCGs, three acute trusts and two different community providers as well as hospices, independent sector and social care. Co-ordinated leadership from CCGs, H&WBBs and Local Authorities is also required.

Staffing

- The region requires extensive investment to provide the level of support identified in commissioning guidance in 2012. Coventry and Warwickshire has insufficient consultant support to sustain the service and yet developments continue due to the commitment of the teams (see full review of service provision).
- The multidisciplinary input in each area is very limited and there is inequity as a result. For example, psychological services for patients and families are under resourced and only one of the MDTs has input from specialist palliative care OT/Physio.

Integration, Equity and 24/7 access

- There is a need to eliminate inequalities in access to good EOL care (whether due to diagnosis, geography and/or social circumstances).
- There needs to be an improved ability for the EOLC services/wider system to respond to a crisis rapidly. This is currently challenging in and out of hours and can result in unnecessary hospital admissions.
- 24/7 access to community/district nursing is essential across Warwickshire. District nurses provide the majority of good EOLC in the community with support from specialist palliative care services.
- Delays in accessing Continuing Health Care assessments can result in delays to obtaining a package of care or a care home bed. This can lead to patients dying inappropriately in hospital, or without the support they need at home, or delays in discharges from hospice beds.
- There is inequitable and limited access to 'hands on' carers in the community, which is needed to allow more patients to die at home. These include agency carers provided by Continuing Health Care funding, Palliative Care Support workers in Coventry, and Hospice at Home services in Rugby and SW/WN.
- In order for palliative patients to die in the community, an appropriate resource of care home beds is also required to manage those patients whose needs cannot be met at home and to avoid inappropriate hospital admissions. The number of beds in care homes suitable for palliative patients across Coventry and Warwickshire is limited and reducing. For example19 palliative care beds at Abbey Park Nursing Home in Coventry are no longer available.
- Access to inpatient specialist palliative care beds at The Myton Hospices is limited and use can be influenced by geography, for example these beds are underused by Warwickshire North patients due to complex reasons which include geographical and transport issues.
- There needs to be engagement of key client groups who are currently particularly under-represented in EOLC services: the frail elderly, homeless, people with mental health problems including dementia, prisoners and those with learning disabilities for example.
- There is a need to expand and better co-ordinate existing services in a system which patients, carers and staff can navigate more effectively. Streamlining the patient journey, requires improved co-ordination/integration of services involved: GPs/primary care, domiciliary care, social services, palliative support/hospice at home, community nursing, specialist palliative care teams, acute hospitals, ambulance service, care homes, hospices and other third sector providers and carer support services.

Engagement/ Co-design

- There is variable engagement and communication with key stakeholders (health, social, 3rd sector) providing EOLC across Coventry and Warwickshire/ within each CCG area, resulting in duplication of effort as well as gaps in provision.
- Patient and user involvement needs to be strengthened to understand what our communities need.

Involving and caring for those important to the dying person

- Bereavement services in particular are limited and wider access is necessary.

Education and Training

- There is a need to provide ongoing information, education and support for professionals, patients, carers and the wider public.
- The challenge for Palliative Medicine as a very small specialty is to support all professionals working in primary and secondary care and with patients with cancer and non-cancer diseases to identify individuals who are approaching the end of life, early enough to ensure timely proactive planning for these individuals.
- Improving education within primary care is essential, for example to ensure the 1% of the population who die each year are identified and offered the support needed.
- Care homes and other providers e.g. OOH services need support to ensure they are competent to deliver their role in good end of life care. Many care homes do not have staff with the clinical skills to care for patients at the end of life, or the ability to manage equipment such as syringe drivers.

Evidence and information

- The importance of outcome measurement and quality assurance in EOLC is ongoing and challenging in this field. Local services need support to participate in national initiatives to improve data collection and outcome measurement.
- Continuous audit and research is required to inform EOLC clinical practice and developments.
- The need to promote community conversations about death and dying is recognised nationally, ultimately allowing end of life issues to be more easily discussed with patients and families, with options and choices more readily identified.
- There is a need to strengthen consistent and systematic implementation of the CASTLE developments listed above, enabling more people to achieve their preferences at the end of their life.

Funding

- Secure funding streams are needed; much of the recent funding for local developments has been on an ad-hoc basis according to available bids.
- The sustainability of current projects, such as the Transform programme, including Amber Care Bundle is threatened because staff contracts can only be offered on a fixed term basis.