NHS
North East London
Integrated Care Board

Whipps Cross Hospital catchment area end of life (EOL) programme update report

Whipps Cross Joint Health Oversight and Scrutiny Committee meeting
Tuesday 19 March

Presented by:

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1. Introduction

The purpose of this report is to provide an update on the Whipps Cross Catchment Area EOL programme. The programme was established to address how best to provide EOL services in the future, including in the context of the proposed new Whipps Cross Hospital. This would mean the services currently provided in the Margaret Centre facility - an 11-bedded acute palliative care unit that sits alongside the existing hospital – would need to be incorporated into the new hospital in some way or re-provided elsewhere.

In January 2023 several high-level options for the future provision of services were developed.

This paper summarises the work that has been progressed since this time and makes recommendations for the next phase of the programme highlighting the need to prioritise investment in community services and to review the timing of any formal consultation options to be progressed.

2. Progress update

2.1 Working alongside a Clinical Reference Group (CRG)

A clinical reference group (CRG) has been established and a high-level model of service delivery has been agreed by clinicians.

See diagram to the right.

The CRG has also been extensively involved in a thorough assessment of current EOL services in Redbridge and Waltham Forest ensuring gaps and priorities are understood and agreed.

2.2 Engaging with our communities

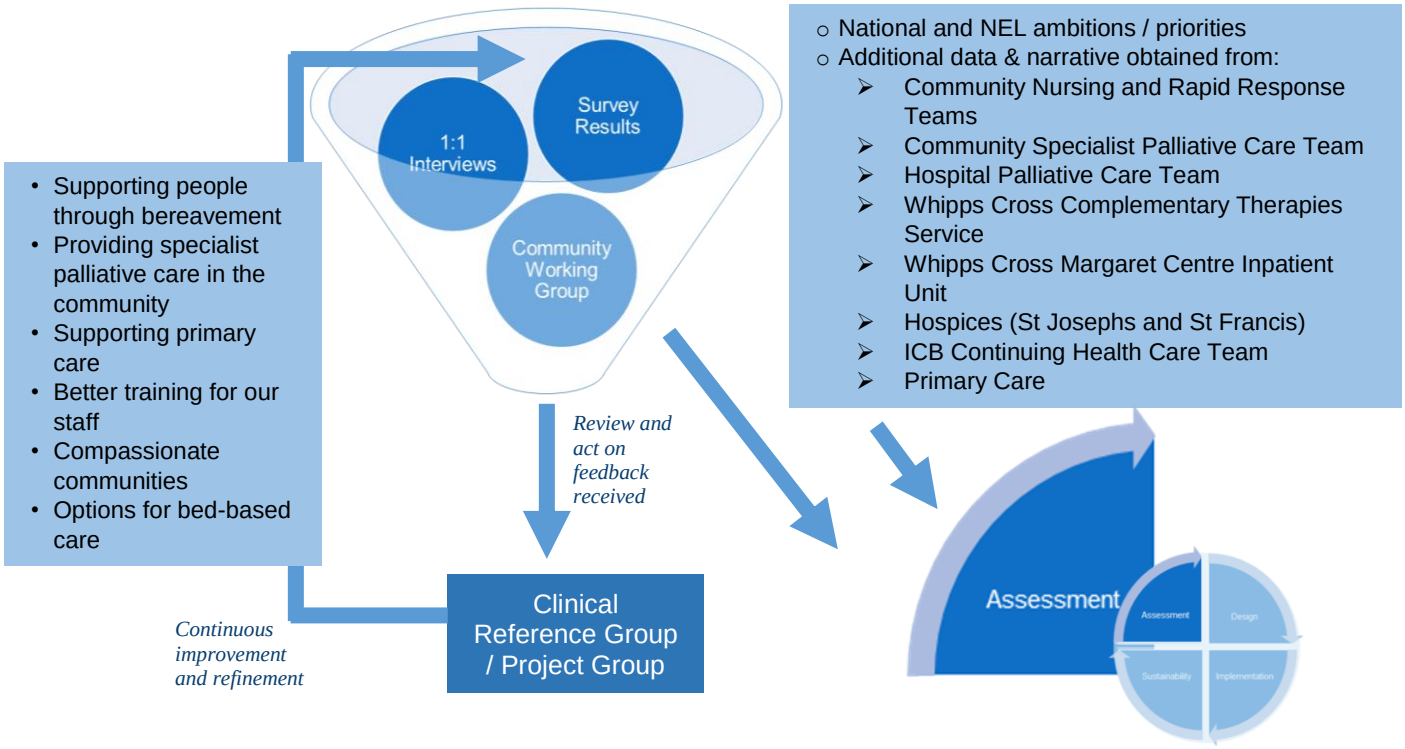
A comprehensive programme of community engagement has taken place to influence the service model, and ensure the resident voice is at the heart of future provision. This has included the establishment of a community working group, gathering insight via surveys, and the collection of detailed patient stories. This has been a powerful exercise highlighting many issues with our current service provision. This work has also shaped the EOL assessment report (a project resource pack) and the subsequent priorities.

Please find the summary of community engagement findings in Appendix 1.

2.3 Gaining a full understanding of current provision

Working alongside the CRG and using insight from engagement activity has allowed us to undertake a full assessment of end of life (EOL) care services across Waltham Forest and Redbridge.

The below diagram demonstrates the flow of insight between the engagement activity, CRG and project group, which consists of key individuals from across NEL ICB place based teams and the Whipps Cross redevelopment team, with all insight being utilised to provide a thorough assessment of EOL care provision currently.



From this assessment work undertaken a number of key issues within current provision of EOL services have emerged:

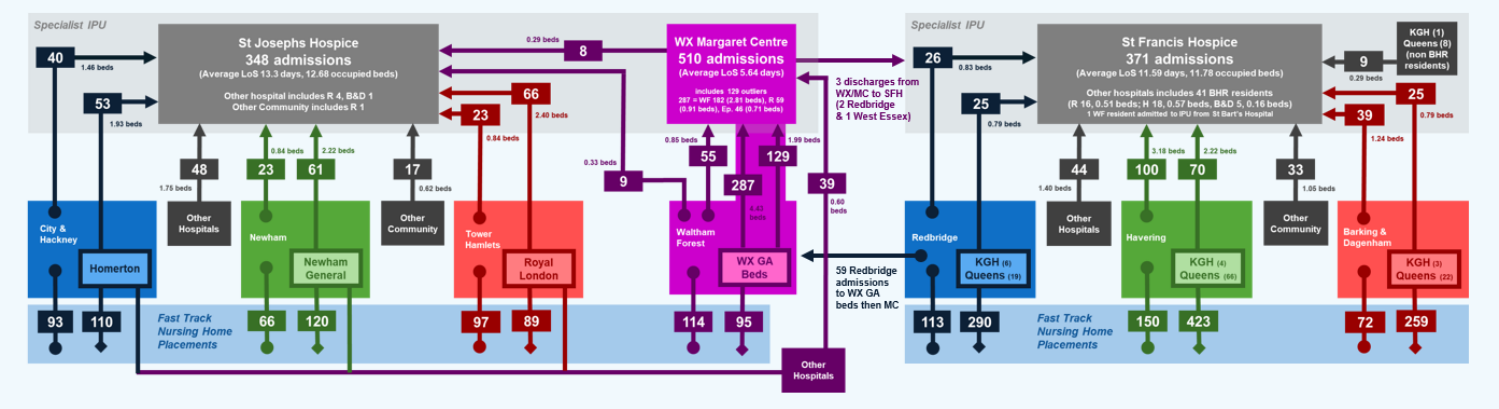
- Community palliative care offer is inconsistent, services are too reactive and are not joined up
- Waltham Forest Specialist Palliative Care Team (Hospital and Community) do not work weekends

- Resource pressures across both specialist and generalist teams impacts on the timeliness to see some new patients and the ability to review existing patients
- Medication is not easily available on an urgent basis, particularly out of hours
- Advanced care planning and Universal Care Plans are being underutilised
- There is a need to further understand strategic overview of CHC (Continuing Health Care) Fast Track spend
- Generally, people are struggling to know who to go to for help / support / information
- People do not know what to do when somebody dies, particularly in the community
- There is currently inadequate support / information for carers
- There is no consistent offer for people who are bereaved

2.4 Undertaking an analysis of bed-based patient flow

An analysis of current flows of palliative care bed use has been completed to better understand future bed needs. This has helped us to understand that bed use in Waltham Forest is different to other north east London boroughs.

The below diagram demonstrates the flow of patients in the EOL care system, across both inner and outer north east London between April 2022 and March 2023.



A larger version of this diagram can be found in Appendix 2.

This data shows the average use of inpatient EOL care beds across north east London.

- Barking & Dagenham - 2.19 beds at St Francis Hospice
- Havering - 5.97 beds at St Francis Hospice
- **Redbridge – 2.13 beds at St Francis Hospice and 0.87 beds at the Margaret Centre** (3 in total)
- **Waltham Forest – 0.62 beds at St Joseph's Hospice and 3.66 beds at the Margaret Centre** (4.28 in total)
- City & Hackney – 3.39 beds at St Joseph's Hospice
- Newham – 3.06 beds at St Joseph's Hospice
- Tower Hamlets – 3.24 at St Joseph's Hospice

The conclusions that have been drawn from this analysis are:

- The Margaret Centre is primarily functioning as an **acute hospital ward**, but it is likely to be also being used as an alternative to hospice provision, as use of hospice beds in Waltham Forest is low compared to other NEL boroughs. However, the Margaret Centre does not offer the full range of multi-disciplinary services that you can access in a hospice.

- **Direct access to EOL care from the community** in Waltham Forest is low when compared to Redbridge, with only 18% of patients accessing services not via admission to a general hospital bed.
- **Redbridge residents use less beds** in the Margaret Centre. This is likely to be because there is a Hospice at Home service in Redbridge, a higher use of nursing home beds for palliative care and a smaller "catchment" population than Waltham Forest.
- **Waltham Forest residents are not getting good, proactive, access to admissions** for symptom control and pain management. These admissions are often for 2 weeks, followed by discharge home or to a nursing home.
- **Too many Waltham Forest residents are going into general acute beds in Whipps Cross via A and E** – if community services were improved, these patients could be supported within their own home, or alternatively be referred straight to a hospice or the Margaret Centre.
- Our **community palliative care services in Waltham Forest are not integrated** and do not all function 7 days per week.
- Many nursing home beds (612 people), especially in Redbridge are being used for people at the EOL funded through Fast Track EOL. There is an opportunity to look at this data further to explore whether resident experience and outcomes could be improved by establishing a dedicated nursing home facility locally with wrap around community palliative care service support.

2.5 Looking ahead at opportunities to improve services

Having undertaken this work to assess current community and inpatient provision, the current options and opportunities in relation to EOL care have been framed as follows:

2.5.1 Acute EOL Hospital Beds

The 11 beds in the Margaret Centre form part of the total number of general acute beds in Whipps Cross Hospital. The roll out of the Gold Standard Framework (GSF), which the hospital is planning to expand further this year, means that high-quality specialist EOL care, traditionally associated with the Margaret Centre, will increasingly be delivered on more wards in the hospital. This means that Whipps Cross is moving away from solely having a dedicated ward for specialist EOL care, which is important given that most people that die in the hospital do so on an acute ward.

The current inpatient ward configuration – with a limited number of single rooms - is a limiting factor to having this model rolled out to all wards currently, but this will not be the case in the proposed new hospital, with all wards having a minimum of 70% of beds in single rooms.

Whipps Cross Hospital aims to enable a gold standard of care for all people in the last years of life, supporting them to live well until they die. This approach will ensure that the teams are proactive in being able to identify patient in the last year of life, providing a person centred and systematic approach to care.

Ahead of the new Whipps Cross Hospital being completed, Barts Health NHS Trust will need to make decisions about how acute bed-based EoLC will be organised and delivered in the new hospital. An appraisal of the options will need to take several things into account, including emerging clinical and design standards associated with the national New Hospital Programme (NHP), the views of clinical specialists and the ongoing engagement with patients, the public and their representatives.

Potential opportunities:

- Provide EoLC on both general acute wards and a dedicated Acute Palliative Care Unit (APCU) within the new hospital
- Provide EoLC on general wards without a dedicated APCU
    - The allocation of bed/ward specialisms in the new hospital will be undertaken nearer to build completion. There may be an opportunity to allocate a cohort of EoLC beds at this point and, as per above, this would be determined by a number of things, including the extent to which clinicians are confident that the GSF can be delivered right across the new hospital when it opens.

2.5.2 Hospice Inpatient Beds

Our analysis of bed-based flow shows us that Waltham Forest residents, unlike all other NEL boroughs do not have easy access to hospice beds and the range of additional services and support this brings. We also understand that bed use in St Joseph's and St Francis hospices has been declining and both hospices have capacity to admit more people. Work has commenced to improve the awareness of and access to St Joseph's hospice for those Waltham Forest residents who would choose to use the service. This service is already commissioned by NHS NEL so it's important to ensure Waltham Forest residents have equitable access.

Potential opportunities:

- Residents of Waltham Forest and Redbridge continue to access beds within St Joseph's and St Francis.
- Hospice inpatient provision could be provided within Waltham Forest or Redbridge if there was enough demand for inpatient provision to sustain this model.

2.5.3 Nursing Home Fast Track

If someone requires the care of a nursing home at the end of their life, this is currently bought on an individual basis (spot purchased) and paid for by the NHS through the Continuing Health Care Fast Track process. We have started work to better understand how this resource is being spent and whether we can improve our offer to residents/patients by using this resource differently.

Potential opportunities:

- Consider a block contract(s) with a dedicated provider(s) for a specialist EOL nursing home provision, and facilitating collaboration between nursing home providers and hospices.

2.5.4 Community services provided within a person's own home

There are significant a number of opportunities to improve services provided within a person's home. These include:

- Providing a Single Point of Access to make accessing services simple for patients and their families/carers
- Ensuring 24/7 specialist community palliative care service is in place
- Improving access to medication within the community 24/7
- Improving provision of Care-coordinators
- Utilising Health Care Assistants (HCAs) to directly support district nurses
- Joining up services, considering who is best placed to deliver which services and creating accountability
- Improving access to hospice at home services in Waltham Forest

2.5.5 Supporting primary care

Potential opportunities:

- GP register of EoLC patients
- Promoting the use of advanced care planning with regular reviews
- Increasing MDT (multi-disciplinary team) working and the use of Universal Care Plans
- Ensuring there is a process for signing off death certificates out of hours
- Increasing training and education around EOL for all staff across primary care

2.5.6 Compassionate Communities

Potential opportunities:

- Ensuring information, advice and guidance is available to all who need it – considering language and accessibility
- Ensuring there is a joined-up bereavement 'offer' which is easy to access and navigate
- Providing training for family carers
- Creating befriending schemes
- Increasing the provision of complementary therapies

2.5.7 Training for staff

Potential opportunities:

- Providing a thorough workforce enabling workstream which prioritises training of generalist and specialist workforce across the EOL care system

2.6 Update from West Essex Health and Care Partnership

From the detailed assessment work undertaken by North East London ICB, the data has identified that the use of the Margaret Centre for West Essex patients is small and not significant within the current usage and flow.

Residents in West Essex have access to community-based EOL care and support delivered by enhanced Primary care, Essex Partnership University NHS Foundation Trust, St Clare Hospice and other system partners including 111 Out of hours and Essex County Council Adult Social Care.

In the south part of West Essex, (Loughton, Buckhurst Hill and Chigwell) EOL care is also provided by a number of Care Homes with support from the integrated community based EOL services and especially enhanced primary care.

The range of services operate in collaboration and partnership to deliver patient centred palliative care including access to 2 community hospitals, St Clare Hospice inpatient unit, hospice at home and community nursing including access to specialist palliative care when required.

For the West Essex Health Care Partnership (Hertfordshire and West Essex ICB Place) frailty and EOL care continue to be a priority in order to support more people to die in their preferred place, and to give the opportunity to choose not to die in hospital a reality.

3. Next steps

3.1 Identifying areas of high impact improvement

Several areas have been identified, where change could be implemented to have a high impact on both services and patient experience, these are detailed below.

Area of high impact improvement	Our commitment	Priority in Waltham Forest	Priority in Redbridge	How will this be achieved?
Implementing 24/7 specialist community palliative care	Ensuring all people, who need it, have easy access to specialist community palliative care 24 hours a day and 7 days a week.	Yes	Service already in place in Redbridge	• Ensuring our fragmented community services are integrated • Securing new investment to increase the number of clinicians available to work in the integrated team. • Agreeing a recruitment plan for new clinical staff • Recruiting staff to deliver new clinical model
Creating a single point of access, improving care co-ordination and establishing a Hospice at Home services in Waltham Forest	Ensuring residents have easy access to telephone help and support. Ensuring residents have an EOL care plan and their care is care coordinated To increase the number of residents who have access to hospice at home services at the end of their lives to enable them to stay at home safely and comfortably.	Yes	Already in place via St Frances Hospice Yes Hospice at Home available in Redbridge	• Ensuring there is capacity in the community to provide dedicated EOL care coordination and improved use of Care plans by primary care and community services • Putting in place support mechanism e.g. telephone line to provide advice and support
Improving access to hospice inpatient care and to the Margaret Centre directly from the community	Fewer Waltham Forest residents will need to attend emergency department to access inpatient EOL and hospice care.	Yes	Hospice care accessible for Redbridge residents	• Mapping the referral pathway between community care providers and hospice care • Identifying barriers within the current referral pathway preventing people from using hospice beds

when appropriate				• Working alongside St Joseph's Hospice to provide information and resources about services offer to local people in Waltham Forest
Improving access to urgent medication in the community	Ensuring all people who need EOL care medication are able to access it and have it given to them at any time it is needed.	Yes	Yes	• Carrying out an assessment of current provision of EOL care medication across north east London • Evaluating existing models to identify most effective service • Creating a single specification to implement a single system of EOL care medication provision across north east London
Improving access to information about EOL care services and support available to people and their carers	Making sure that people who are using EOL care services, and their carers, have the information they need to be able to access appropriate care services and support.	Yes	Yes	• Completing audit of information about services and support currently available • Working alongside local people to co-design relevant information and resources • Completing audit of touchpoints where information is provided to local people e.g. at diagnosis, on hospital discharge, referral to specialist palliative care, at point of registering a death • Working across partners to develop online and offline mechanisms for sharing information across all touchpoints to ensure all local people have the opportunity to access information about services and support available

Implementing these changes requires significant investment in community EOL services and a review of how the current fragmented provision can be enhanced to improve care in Waltham Forest which allows patients more choice in where they receive their care. In order to progress with making some of these improvements, a partnership with Social Finance and Macmillan Cancer Support has been explored. NHS NEL have supported in principle the development of a business case to invest in the community EOL services identified above. If successful, this would initially be funded by Social Finance and Macmillan Cancer Support,

on the understanding that the NEL system pay back the investment if the programme delivers its outcomes.

The proposals to concentrate on improving community EOL services have been endorsed by the Community Working Group and the Clinical Reference Group. The programme team have been given agreement to enter into the partnership with Social Finance/ McMillan subject to sign off on a business case/ Cost Benefit Analysis once it has been completed.

Whilst these improvements to community services identified in 3.1 are made, Whipps Cross Hospital will continue to provide EOL and palliative care services in the Margaret Centre and on their Gold Standard Framework wards. More integrated community working will mean that more people will be able to use these services directly from the community. In addition, the improvements to the referral pathway into hospice provision will ensure people across Waltham Forest and Redbridge will have more choice of where to receive their EOL care.

3.2 Evaluating the impact of initial high impact improvements

Once the improvements identified in 3.1 have been implemented, it is important for both data and patient experience insight to continue to be considered in assessing and evaluating the impact of these high impact changes. It will be important to then clarify the basis of any future EOL care consultation on the bed base moving forward.

We know that in the future there will be a need for specialist inpatient beds for EoLC and symptom management, however the bed base also needs to be viable in the long term and be able to flex to changing demand. The initial analysis of data suggests the pattern of bed use across NEL is very different to that in Waltham Forest and, therefore, more analysis is needed in order to understand and explain this.

At this time our analysis does not support re-providing the current bed-based services of the Margaret Centre - which is a combination of acute general care beds, acute palliative care beds and some hospice-like beds, mainly accessed via the hospital's Emergency Department - in a new community-based facility in the Whipps Cross catchment area.

However, no decisions about the future bed base across the catchment area have yet been made, as it is not clear what the impact of the proposed improvements to community services will be. It is therefore too soon to make firm recommendations about future bed-based options without the evidence of this impact.

3.3 Developing a programme plan

A programme plan is being produced to provide detail on the implementation of the initial high impact community improvements identified in section 3.1. Some of these actions are currently being progressed, for example, improving the availability of medication in the community.

This programme plan also provides an estimated timeline for work to progress with the other opportunities linked to the workstream identified in section 2.4, such as implementing a training programme for staff and the development of bereavement services.

As part of the programme plan, we will also ensure a focus is placed on continued investigation of data around EOL services in order to ensure any improvements made are informed by up to date data and analytics.

The plan also reflects the commitment to continuing engagement with local people who have experience of using EOL care services, and this is a vital part of the programme moving forward. We will continue to involve people in the design of any future services in order to ensure they are informed by real experiences and respond to the needs of local people.

4. Ask to JHOSC members

To note the completion of the detailed assessment of EOL care services in Redbridge and Waltham Forest and the issues and opportunities raised, and the significant contribution of the CRG and engagement insight to this work.

To support the areas of priority that have been identified to improve EOL care in the community and the partnership with Social Finance/ Macmillan to progress this. In particular:

- Investing in specialist community palliative care services to enable seven-day cover in Waltham Forest
- Making hospice care at St Joseph's more accessible to Waltham Forest residents
- Improving access to hospice at home for residents in Waltham Forest
- Improving access to EOL medication in the community

To support the proposal to revisit options about future bed-based care once the high impact community changes have been delivered and evaluated. When the impact on bed use has been understood future bed needs can be better determined.