2015/16 SCN commissioning recommendations

The London Strategic Clinical Networks work inclusively on a pan London basis to ensure best practice, optimum patient outcomes and economic benefits to commissioners.

These commissioning intentions provide a basis for robust engagement with providers of services, and are intended to drive improved outcomes for patients, and transform the design and delivery of care, within the resources available.

Mental health – *See Appendix 1*

1. Access to effective treatments
   - An effective mental health crisis/urgent care pathway that delivers parity of access
   - Universal and timely access to early intervention in psychosis services
   - Access for all Londoners to 24/7 mental health support online
2. Prevention - A strong focus on early years, supporting resilience and wellbeing in young people
3. Bridging the mind/body divide
   - Adequate and effective mental health liaison services in all acute settings
   - Supporting integration between health and social care, and physical and mental health – particularly the integration of mental health expertise into all long term condition care pathways
   - Increased emphasis on addressing physical health of those with serious mental illness
4. Primary care mental health
   - Improving access to psychological therapies for those with complex difficulties, within primary care
   - Supporting the development of primary care to meet the challenge of managing more mental health within a primary care setting – including workforce development (competence, confidence and capacity) of primary care

Dementia – *See Appendix 2*

1. All services are commissioned to respond to the needs of people with dementia and their carers.
2. Diagnosis – by March 2015 two-thirds of the estimated number of people with dementia in England to have a diagnosis, with appropriate post-diagnosis support.[1]
3. People with dementia are supported to live well with dementia – with post diagnostic support, so that timely diagnosis includes information on the condition and referral to local services which are already available.[2] This support to be delivered by clinicians in primary, community and secondary care, social care and the voluntary sector.
4. Care for people with dementia is coordinated - use of technology, systems such as “this is me” and embracing standards to be proposed by the dementia SCN so that all

[1] NHS Mandate 2014-15
[2] NICE, Dementia quality standard, 2010

services work together to ensure patients and carers are supported to manage the impact of their condition and avoid crisis (reducing admission to hospital and/or care homes).[3]

5. Use of training standards and recognition schemes in services so that staff in health and social care are able to recognise dementia and respond to it appropriately

Neuroscience – *See Appendix 3*

Although some neurology services are commissioned by NHS England (specialised commissioning), other services required by patients are commissioned by CCGs and local authorities (services from local hospitals, community services and social care).

1. All patients with a chronic neurologic condition are identified, and a plan is developed to ensure these patients receive local existing integrated care models of care. These models shoud deliver essential components of integration including: risk stratification, prospective case management and strategies to manage unpredictable deterioration.
2. Pathways are developed with local providers that give responsive access to expertise where needed but also support the management of common neurologic conditions within primary care (eg headache, dizzy spells and transient loss of consciousness, or 'blackouts').
3. Appropriate capacity for specialist community rehabilitation is commissioned, and that patients are placed appropriately into Level 1, 2 and 3 services by need.
4. Emergency access is commissioned for patients with serious neurological conditions to facilities with appropriate expertise. This would require collaborative discussions with other commissioners and providers around regional models, such as those developed for stroke.

Children and Young People – *See Appendix 4*

1. CCGs will commission children's inpatient care against the Children's Strategic Clinical Network healthcare standards.
2. Providers and commissioners will collaborate through Children's Healthcare Networks to deliver best practice.
3. Commissioners and providers will collaborate to develop integrated ways of working across health and social care to deliver the NICE asthma guidance (revision is due September 14) and Quality Standards (QS25) which include the use of a recognised management plan and regular reviews.

Maternity – *See Appendix 4*

1. CCGs are requested to include the adoption of the Growth Assessment Protocol (GAP) programme for detection of fetal growth restriction in commissioning plans to reduce the number of stillbirths across London.
2. CCGs and providers will collaborate to ensure implementation of the SCN post-partum haemorrhage (PPH) toolkit.

[3] NICE, Dementia Pathway

Cardiovascular

Cardiovascular disease (CVD) is an overarching term that describes the family of diseases sharing a common set of risk factors. These are:

- Cardiac
- Vascular
- Stroke
- Diabetes
- Renal disease

The London Cardiovascular Strategic Network (which includescardiac, vascular, stroke, diabetes and renal networks) recommends the following commissioning intentions to London's CCGs for inclusion in negotiations with service providers for 2015/16 contracts:

CVD

1. Hold service providers to account for delivery of the NHS Health Check programme to ensure action is taken on identified health risks.
2. Promote best practice exercise based vascular prevention programmes.

Stroke

To consolidate the improvements in hospital outpatient and inpatient episodes, length of stay and social care costs CCGs and CSUs will:

1. Hold service providers to account via the actions of CCGs and CSUs to sustain the successes of HASU and ASU provision.
2. Commission locally based community rehabilitation services to further improve stroke patient outcomes.

Atrial fibrillation

1. Service providers will implement NICE AF guidance, CG180 and CCGs and CSUs will manage through provider contracts. This will reduce the number of strokes, save lives, reduce disability and generate cost savings for CCGs, NHS and social care.

Cardiac

1. CCGs and CSUs to hold service providers to account through ensuring NICE guidance is effectively implemented.
2. Improvements in heart failure care will lead to reduced hospital admissions.

Diabetes

1. Commissioners should ensure that NICE guidance is followed for patients with diabetes
2. Contracts with secondary care and primary care providers should include programmes to:
    a. Tackle obesity and diabetes in their workforce
    b. Local provision of detection and prevention strategies (eg, HbA1c testing to detect diabetes)

c. Reduce adverse patient outcomes (eg amputations, renal replacement therapy) based on NICE guidance CG87
d. Identify people at risk of developing diabetes

Renal

1. In 2015/16 CCGs to develop outcome based, co-commissioning with providers across the whole patient pathway to decrease demand for renal dialysis and other long term conditions.
2. CCGs to develop with NHS England and service providers co-commissioning opportunities to ease transition from specialised to non-specialised care.

Tuberculosis (TB)

London's 32 clinical commissioning groups (CCGs) collaboratively commission some services on a 'once for London' basis. This is usually where the service is small or where governance arrangements concern all London CCGs.

The London TB Control Board requests that CCGs consider consolidating the 2014/15 pan London TB commissioning intentions into 2015/16, and extend these to include the 2014 National TB Strategy.

Commissioning intentions 1 and 2 would continue to assume overall cost neutrality for 2015/16 and focus on:

1. Best practice for service delivery by providers through the 2014 London TB service specification. This would be managed through the commissioning intentions for service provider contracts where London commissioning support units (CSUs) would lead the negotiations.
2. Hold service providers to account via the actions of CCGs and CSUs to enforce contracts and the 2014 London TB service specification.
3. CCGs would have a positive goal to reduce the London TB rate by 50 per cent during the next five years, in collaboration with the London TB Control Board, using the recommendations of the 2014 National TB Strategy. This would lead to the development in 2015/16 of a robust London TB programme plan and 'invest to save' costings.

End of Life Care – *See **Appendix 5***

The End of Life Care Clinical Network 2014/15 is spreading best practice across London to ensure that end of life care meets NICE Quality Standard 13 (QS13)*, Quality standard for end of life care for adults*.

1. The network recommends that CCGs, through commissioning intentions for service provider contracts, ensure providers deliver end of life care that meets QS13.

Appendix 1 – Mental Health

Access to effective treatments

- An effective mental health crisis/urgent care pathway that delivers parity of access
  The SCN is working to prepare clinical standards to support CCGs and providers to meet this objective.
- Universal and timely access to early intervention in psychosis services
- Access for all Londoners to 24/7 mental health support online

Prevention

- A strong focus on early years, supporting resilience and wellbeing in young people

Bridging the mind/body divide

- Adequate and effective mental health liaison services in all acute settings
- Supporting integration between health and social care, and physical and mental health – particularly the integration of mental health expertise into all long term condition care pathways
  The SCN has a guide, Commissioning recommendations for psychological support – focussing on London's diabetes care pathway (5MB), to provide recommendations for commissioners in providing emotional and psychological support on the diabetes care pathway. The report has been shaped from information gathered from discussions with professionals and people with lived experience and surveys identifying local provision in London.
- Increased emphasis on addressing physical health of those with serious mental illness

Primary care mental health

- Improving access to psychological therapies for those with complex difficulties, within primary care
- Supporting the development of primary care to meet the challenge of managing more mental health within a primary care setting – including workforce development (competence, confidence and capacity) of primary care
  The SCN has produced Strengthening Mental Health Commissioning in Primary Care - practical solutions and learning from experience (14.6MB), intended to provoke and support clinical commissioners to champion effective primary care mental health services.

Contact details

For more detailed information about these proposals please contact:

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Appendix 2 - Dementia

1. All services are commissioned to respond to the needs of people with dementia and their carers. *The Network has prepared a commissioners checklist –outlining what needs to be commissioned in health and social care dementia services at each stage of care; from risk reduction through to end of life.*
2. Diagnosis – by March 2015 two-thirds of the estimated number of people with dementia in England to have a diagnosis, with appropriate post-diagnosis support.[4] *The network will support CCGs to meet this ambition, including providing clinical advice, the coding of people with dementia in primary care, a memory services network to develop best practice standards.*
3. People with dementia are supported to live well with dementia – with post diagnostic support, so that timely diagnosis includes information on the condition and referral to local services which are already available.[5] This support to be delivered by clinicians in primary, community and secondary care, social care and the voluntary sector. *The Network is preparing guidance for immediate post diagnosis support.*
4. Care for people with dementia is coordinated - use of technology, systems such as "this is me" and embracing standards to be proposed by the dementia SCN so that all services work together to ensure patients and carers are supported to manage the impact of their condition and avoid crisis (reducing admission to hospital and/or care homes).[6]
5. Use of training standards and recognition schemes in services so that staff in health and social care are able to recognise dementia and respond to it appropriately. *The Network has produced a training standards framework and guidance on the use of recognition schemes.*

Contact details

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[4] NHS Mandate 2014-15
[5] NICE, Dementia quality standard, 2010
[6] NICE, Dementia Pathway

Appendix 3 - Neuroscience

Although some services are commissioned by NHS England (specialised commissioning), much of a patient's time can be spent receiving services from local hospitals, community services and social care, which are commissioned by CCGs and local authorities.

We recommend that:

1. All patients with a chronic neurologic condition are identify in the population. Plans are agreed of how and when patients with such conditions are adopted into local existing integrated care models. These models should deliver essential components of integration including risk stratification, prospective case management and strategies to manage unpredictable deterioration. These patients are at high risk of unplanned care.

   The London Neuroscience SCN is piloting with CCGs and social care services to incorporate a neurological pathway into their integrated care system. Currently this has focussed on an anticipatory care model to manage unpredictable deterioration. It introduces innovative approaches to self-help, access to specialist neurological input to local decision making and local management (including infection), rather than attendance at A&E or a regional neuroscience centre.

2. Pathways are developed with local providers that give responsive access to expertise where needed, but also support the management of common neurologic conditions within primary care (eg headache, dizzy spells and transient loss of consciousness).

   The London Neuroscience SCN is piloting in two CCG areas a headache pathway – the most common neurological presentation in primary care – which provides podcast access to critical information to assist GPs to manage headache without recourse to refer to a regional centre. The aim is to achieve ownership of the pathway but with educational support and access to specialist input.

3. Appropriate capacity for specialist community rehabilitation is commissioned, and that patients are placed appropriately into Level 1, 2 and 3 services by need.

   The rehabilitation needs for neurological patients are similar to stroke patients; they both need rehabilitation to enable them to achieve the optimum independence possible and receive support to help manage the long term disabilities.

   Due to the successful re-organisation of stroke services, an inequity has arisen in the provision of rehabilitation between stroke patients and other neurological conditions. This could be addressed through stroke and neurological conditions rehabilitation services and managed by specialist in these conditions. (See stroke rehabilitation commissioning intentions.)

   The London Neuroscience SCN does not have a rehabilitation project at present. A specialised commissioning review of specialised rehabilitation against service specification compliance was carried out in 2013. The NHS England Rehabilitation

Delivery Board has also been established to manage national rehabilitation work programmes. The national rehabilitation lead for strategic clinical networks has established a rehabilitation work programme. Imperial College Healthcare NHS Trust has an acquired brain injury rehabilitation project. The SCN has representation on these programmes.

4. Emergency access is commissioned for patients with serious neurological conditions to facilities with appropriate expertise. This will require collaborative discussions with other commissioners and providers around regional models, such has been developed for stroke. CCGs and NHS England should seek expressions of interest for early adopters / evaluators of local secondary acute neurology services, in which patients assessed and admitted from emergency departments are managed by appropriately trained neurology personnel from the outset of their care.

   The London Neuroscience SCN will be establishing a project in September 2014 to design a Hyper Acute Neurology Unit which will provide 24/7 access to appropriate neurologic expertise and care. It will support patients attending through the A&E pathway or requiring an urgent intervention by ensuring they are managed at the outset by neurological specialists rather than general physicians, receive immediate specialist diagnostics, rapid management and discharge to appropriate services, and support other services through advice and telemedicine.

Contact details

For more detailed information about these proposals please contact:

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Appendix 4 - Children and Maternity

Purpose

This document outlines the recommendations from the London Strategic Clinical Networks (SCN) for Maternity and Children's for CCG commissioning intensions for 2015/16.

The SCN is requesting that all CCGs consider the agreed priorities of the SCN in commissioning plans to align SCN work with that of CCGs.

The SCN has involved clinicians and commissioners from across London in designing these initiatives. The SCN is offering support in delivering specific programmes of work. The offer is in the form of the co-ordination of efforts to improve service and collation of best practice for dissemination across London. The key outputs will be disseminated across London to enable delivery of the projects.

Background: Children

The Children and Young People (CYP) SCN was formed in April 2013 with the aim of delivering transformational change for CYP services in London. Professor Russell Viner, consultant in adolescent medicine at UCLH is the clinical director. A Strategic Clinical Leadership Group and Commissioning Advisory Group has been established to determine the clinical issues facing the care of CYP in London. This comprises clinicians from all care settings as well as voluntary sector and local authority representation. In its first year the SCN has undertaken a number of pieces of work to map and understand the issues affecting CYP services in London. One of these is an extensive case for change. As a result of these the SCN has determined a number of priority areas which require a transformational approach.

There are more than two million children growing up in London. Services are currently fragmented and delivered across a number of providers. Commissioning of children's services is complex and involves NHS England (specialised and primary care commissioning), CCG commissioning and local authorities. There needs to be greater collaboration and innovation between these organisations in order to improve services for children. In addition, there are numerous standards existing across diverse organisations, making it difficult for commissioners to ensure standards are being delivered.

Commissioning against existing children's healthcare standards

Numerous standards exist in diverse locations which describe how healthcare for CYP should be delivered. These emanate from NICE, Royal Colleges, professional organisations, as well as those from London, such as the London Quality Standards. The SCN has been mapping these standards of which there are more than 800 in existence. The SCN is currently gathering these into one document to be used as an overarching commissioning resource enabling effective commissioning and delivery of acute children's care. Further chapters are proposed including one for community children's nursing and (Child and Adolescent Mental Health Services (CAMHS). The commissioning group has strongly supported the development of this resource.

- **Commissioners to work with providers *to use the overarching standards document as a future commissioning resource within plans.***

Support and involvement in the population-based children's networks

In addition to the overarching standards, the SCN has undertaken work which has reinforced the understanding that provision of healthcare for CYP is highly fragmented. For example, there are more than 80 discrete geographical sites for CYP inpatient services across London. This supports feedback from CYP and their families that they experience care as disjointed. Additionally, analysis of serious incident across London has demonstrated poor relationships and linkages between providers as a contributory factor in a number of these incidents. The SCN has sought to alleviate this situation by developing a network model for linking providers, commissioners and public health together to enable a population based view to be taken when planning for CYP healthcare in defined areas of London. These could be based on area teams or SPG footprints. There has already been support for this development in some areas and the SCN is asking ***CCGs to consider developing a model of population based CYP healthcare networks in their plans as a way of reducing fragmentation of care delivery.***

Children and young people with asthma

Asthma is the most common long term condition in CYP with over 200,000 living with the condition in London. The SCN has identified a number of issues for these children and young people. Compared with national figures London has:

- High variation in diagnosis, treatment and care
- High number of respiratory deaths
- High rates of admission to hospital
- Low numbers of children with an asthma plan or having had an asthma review
- CYP with asthma featuring strongly in the review of serious incidents and child deaths in London

We have identified a GP to lead the SCN work on asthma and established an asthma clinical advisory group comprising expert clinicians in the field. There are a number of examples of best practice in asthma management in London and we are ensuring this expertise is utilised in developing the work.

An approach to asthma improvement has been established based on five workstreams:

- Prevention
- Early and effective diagnosis
- Self-care
- Improved access to timely interventions (primary, secondary and tertiary care)
- Education

CCGs are requested to include management of children and young people with asthma in commissioning plans to improve outcomes for children and young people with asthma across London.

Mental health

Mental health has been identified as a priority for the Children's SCN. Therefore, a *Children and Young People's Mental Health Strategic Leadership Group* will be established for London to promote and improve the emotional wellbeing of children and young people in

every aspect of their life. The group will focus on the whole child/young person including their mental health, family, school, community and wider support network.

There are areas to be addressed, such as:

- Transition (0-25 years)
- Tier 4 review
- Parity of esteem
- Service transformation of CAMHS (including CYP Improving Access to Psychological Therapies, or IAPT, programme)

However, the specific priorities for London will be developed and agreed by the group. Membership of the group will include representatives from a range of services including health, local authority, education, social care and the voluntary sector. Expressions of interest have been disseminated and the group is likely to meet for the first time at the end of autumn 2014.

Summary of CYP commissioning intensions

- **CCGs will commission children's inpatient care against the Children's Strategic Clinical Network healthcare standards**
- **Providers and commissioners will collaborate through Children's Healthcare Networks to deliver best practice**
- **Commissioners and providers will collaborate to develop integrated ways of working across health and social care to deliver the NICE asthma guidance (revision due out September 14) and Quality Standards (QS25) which include the use of a recognised management plan and regular reviews**

Background: Maternity

The Maternity SCN was formed in April 2013 with the aim to improve outcomes for pregnant women and their babies within London. The SCN is co-chaired by Professor Donald Peebles, consultant obstetrician at UCLH, and Donna Ockenden who represents midwifery.

The Maternity SCN has established priorities centred on: 1.) the reduction in stillbirths; 2.) reduction in maternal death and morbidity; and 3.) improving women's experience of maternity care.

The Maternity SCN continues to reinforce the work with the five local networks across London and the SCN meets bi-monthly with a pan-London maternity commissioning advisory group to ensure that maternity commissioning is taken forward in partnership with all CCGs in London and maternity priorities are reflected locally.

In addition to the three main priorities above, the SCN aims to ensure that maternity is provided in such a way as to optimise each of the three priority areas. The topics being tackled by a sub group of the SCLG are: early access to antenatal services; postnatal care; continuity of care and an increase in the number of women delivering in midwifery led settings.

Stillbirth

London has the highest stillbirth rate of all regions in the United Kingdom at 5.3 stillbirths per 1,000 live births, and a key priority for the Maternity SCN is to reduce this figure. The SCN is aiming to address this objective by improving the detection of fetal growth abnormalities (FGR), through use of customised fetal growth charts which provide a more accurate representation of fetal growth and improve the recognition of babies that are pathologically small.

In the UK, the charts are available as part of the comprehensive Growth Assessment Protocol (GAP) programme, designed to improve quality assurance. This has been associated with a significant reduction in stillbirths in three regions (West Midlands, Yorkshire and the Humber and the North East) due to fewer deaths of babies with FGR and a substantial increase in antenatal detection. By 2012, the West Midlands had seen a 22 per cent reduction in the stillbirth rate, equivalent to 92 fewer deaths a year. Extrapolated to the rest of the UK, it is estimated that the GAP programme has the potential to save more than 1,000 babies a year.

Since 2013, GAP has been adopted by more than half of the UK maternity units but the uptake in London has remained very low. The SCN has therefore developed a good practice fetal growth detection toolkit underpinned by the programme.

The GAP programme comprises of three core elements and is available to all NHS Trusts at a small cost (see Appendix 4a) from the Perinatal Institute:

- Implementation of evidence based protocols and guidelines
- Training and accreditation of all staff involved in clinical care
- Rolling audit and benchmarking of performance

The toolkit was launched at a Maternity SCN event in September 2014 with commissioners and healthcare professionals from across London. It will be disseminated during the autumn for implementation.

The next phase of the project will aim to standardise the process for training and testing competence in fetal monitoring during labour. This will include assessing the level of cardiotococography (CTG) training and competency testing in London and a good practice toolkit will be produced for fetal monitoring in labour interpretation and management. The group also has representation in a national NHS England project to develop a stillbirth reduction care bundle and continues to share learning and align interventions with this group.

- ***CCGs are requested to include the adoption of the GAP programme for detection of fetal growth restriction in commissioning plans to reduce the number of stillbirths across London.***

Maternal deaths

The maternal death rate in London is twice the rate of the rest of the UK. Factors for this include delays in recognising a woman's high risk status, junior staff not being properly supervised and delay in referrals to an appropriate specialist leading to delays in or inappropriate treatment. The Strategic Clinical Leadership Group (SCLG) has therefore

chosen to prioritise the establishment of an external panel and process to review all maternal deaths in London on an ongoing basis.

The external review panel will be established drawing on members from the Maternity Strategic Leadership Group and maternity networks across London to review serious incident reports and provide an analysis in order to identify learning and produce local recommendations for implementation. Furthermore, the reviews will consider whether the SCLG can take forward work to reduce the occurrences. The commissioning advisory group has strongly supported the development of an external review process.

In addition, the SCLG have identified post-partum haemorrhage (PPH) as an important cause of maternal morbidity and mortality; the use of different definitions and protocols across London makes assessment difficult. To standardise and improve the management of PPH the SCN has produced a "best practice" toolkit that has been circulated to trusts.

Summary of maternity commissioning intentions

- ***CCGs are requested to include the adoption of the GAP programme for detection of fetal growth restriction in commissioning plans to reduce the number of stillbirths across London.***
- ***CCGs and providers will collaborate to ensure implementation of the SCN PPH toolkit.***

Ongoing involvement in the future determination of other priorities for the SCN is also offered through continued membership of the London CYP and Maternity commissioning advisory groups.

Contact details

For more detailed information about these proposals please contact:

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Appendix 4a - Costs for implementation and maintenance of GAP Programme

Size of Trust births per annum	**Set up cost** Incl. local training	**2013/14** pro-rata of	**Annual Cost** from 2014/5
<3000	£ 500	£ 1500	£ 1500
3000-5000	£ 500	£ 2000	£ 2000
>5000	£ 500	£ 2500	£ 2500

Reference:
http://www.perinatal.org.uk/FetalGrowth/PDFs/GROW_Programme_2013_New_Units.pdf

Appendix 5 – End of Life Care (EoLC)

Identification of need

- Assess local unmet needs based on review of existing services, related local performance indicators; and engaging with local service user groups, including hospice carer groups and Healthwatch. These needs should be reflected in the joint strategic needs assessment (JSNA), all CCG plans, and Health and Wellbeing Boards plans, including the *Better Care Fund*.
- Development of robust system across all disciplines for regular, proactive identification and anticipatory management of patients and carers in the last year(s) of life, irrespective of presenting condition or disability or of care setting.
- Enable key staff to have awareness of identification at the point of access in order to facilitate rapid assessment and management of patient and carer needs across settings.

Provision of compassionate care to patients and carers in the last year(s) of and at the end of life and active engagement in holistic care plans

- Ensure London residents affected by terminal illness and their carers are actively engaged in preparing their own holistic care plans (including spiritual needs) in which their individual voices, needs and preferences are heard.

Whole system integration

The development of a robust system to manage populations of patients and carers across disciplines based on holistic patient care plans/ carer assessments to:

- Support GP leadership of care
- Promote / support palliative care MDT meetings within the health and social care economy on a regular basis
- To act as a forum for liaison with health, social care and voluntary sector organisations (eg hospice, specialist palliative care services, community nursing, primary and secondary care, etc.)
- Supportive Care Register (SCR) kept up to date; this is a gateway for patients to gain better access to local end of life care services
- Ensure a key worker is appointed for each patient; reception staff should be aware who is on SCR
- After death analysis undertaken on all patients who were on SCR at time of their death
- Enable appropriate access to specialist palliative care services
- Support use of a shared electronic record to improve communications with all involved healthcare staff, especially ambulance and out of hours (OOH) services

Training and education

- Multi-professional education and training programme to support 24/7 service delivery, and to ensure professionals from all health and social disciplines are actively trained to an agreed competency level irrespective of their profession. This will equip professionals to understand the bespoke needs of people facing a terminal illness

and provide information and support from a practical perspective, as well as empower people to derive maximum life quality. This will include compassion, capacity, symptom control, local relevant data, local access/availability, MDT working, communication skills, 'one chance to get it right'.

- To actively engage in research and audit to identify service gaps and to improve best practice

Provision of 24/7 services by trained integrated multi-professional specialist and generalist services

Robust integrated system for 24/7 support of patient and carer preference to provide rapid equitable access to coordinated services providing continuity of care in which information is communicated once and the multi-service agencies across the health, social and voluntary sector boundaries involved in delivery of their care act in unity. This will include:

- Access to specialist palliative care
- EoLC/palliative care drugs
- Equipment
- Continuing care
- Carer support (both formal and informal caregivers)
- Transport to enable prompt transfers between hospital, home and hospice as needed
- Support to care homes
- Bereavement and psychosocial support

Promoting community engagement with the issues around end of life care

- Engaging the general public more in decisions about what is important in "good" in the last year(s) or and at the end of life; ensuring we have effective feedback on the outcomes of services in the community, what is working well and where important improvements could be made
- Ensuring that we are inclusive of all people with EoLC needs, taking account of the wishes and preferences of different cultural, faith and ethnic communities and those groups that are "hard to reach"
- Maintaining the focus on the patient and family, centred on their local community and aiming always to achieve the person's wishes and preferences for their care

Contact details

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