CÙRAM IS SLÀINTE NAN EILEAN SIAR

WESTERN ISLES HEALTH AND SOCIAL CARE PARTNERSHIP

PALLIATIVE CARE COMMISSIONING PLAN

Report by Chief Officer, Health and Social Care

20 June 2019

PURPOSE OF REPORT

1. To update members on the development of a Palliative Care Commissioning Plan.

COMPETENCE

2. There are no legal or HR issues which emerge. The commissioning plan will have a financial consequence, which is picked up in the body of the report.

SUMMARY

3. The development of effective palliative and end of life care is an essential part of any health and care system and a central priority of the Western Isles Health and Social Care Partnership. Effective support at end of life and investment in supporting people in all settings, but especially at home, can have a beneficial impact on maintaining support at home, the quality of care, and achieving the desired place of death for the person.

4. Against this background, a new Memorandum of Understanding (MoU) has been drafted to signal the partnership agreement between IJBs and Independent Hospices. It is designed to take the place of CEL (12), which was the previous guidance note from the Scottish Government which described the commissioning relationship between Health Boards and Hospices and which has no practical application to the work of IJBs. The MoU that has been developed is now put to the IJB for approval.

5. Locally, we have also developed a new commissioning plan, which is designed to guide the development of services over the next three years. It has been put together by a multi-professional, multi-agency working group, and has as its main focus the aspiration to support more people to die at home or in a homely setting. Again, this is put forward for agreement.

6. Finally, to give effect to this MoU, a number of strategic and procurement arrangements need to be put in place, the most urgent of which is the renewal of the SLA with Bethesda. Negotiations have been complex and it is therefore recommended that as a means of drawing these negotiations to a close, the Chief Officer and the Chief Executives of NHS Western Isles and the Comhairle meet with the leadership of Bethesda to come to a reasonable agreement about the funding package required to sustain and improve local service arrangements.

RECOMMENDATIONS

7. It is recommended that the IJB:
   a) Approves the national MoU which has been drafted to replace CEL 12
   b) Approves the local Palliative and End of Life Care Commissioning Plan and directs the Comhairle and NHS Western Isles accordingly (as described at paragraph 31)
   c) Agrees that the Chief Officer and Chief Finance Officer continue to negotiate with Bethesda, in pursuit of a revised SLA.

Ron Culley,
Chief Officer, CÙRAM IS SLÀINTE

NHS Eileanan Siar Western Isles

NATIONAL POLICY CONTEXT

8. The development of effective palliative and end of life care is an essential part of any health and care system and a central priority of the Western Isles Health and Social Care Partnership. Palliative care is about providing good care to people who have a life limiting illness or who are dying. Its function is to enhance quality of life, to supports a person's goals and to ensure that they are able to live during the time they have left in accordance with what matters to them.

9. Getting health and social care right for people is a vital aspect of Health and Social Care Partnerships' role in planning, commissioning and delivery, and this is especially important at the end of life. When we do get it right, it is typically by working with everyone involved to provide holistic, multi-disciplinary and personalised care and support.

10. There is good evidence that people provided with early palliative care and support in all settings have better outcomes, with a better quality of life, fewer depressive symptoms, and on average live longer, despite opting for less curative treatment. Effective support at end of life and investment in supporting people in all settings, but especially at home, can have a beneficial impact on maintaining support at home, the quality of care, and achieving the desired place of death for the person.

11. At a national level, the Strategic Framework for Action on Palliative and End of Life Care is Scotland's national policy and is a direct response to the resolution passed in 2014 by the World Health Assembly, requiring all governments to recognise palliative care and to make provision for it in their national health policies. Launched by Cabinet Secretary for Health, Wellbeing and Sport in December 2015, it outlines the key actions to be taken that will allow everyone in Scotland to receive services that respond to their individual palliative and end of life care needs. The Framework seeks to drive a new culture of openness about death, dying and improvement and sets out to achieve the following outcomes:

    - People receive health and social care that supports their wellbeing, irrespective of their diagnosis, age, socio-economic background, care setting or proximity to death.
    - People have opportunities to discuss and plan for future possible decline in health, preferably before a crisis occurs, and are supported to retain independence for as long as possible.
    - People know how to help and support each other at times of increased health need and in bereavement, recognising the importance of families and communities working alongside formal services.
    - People access cultures, resources, systems and processes within health and social care services that empower staff to exercise their skills and provide high quality person-centred care.

12. Following the establishment of Integration Authorities, the Scottish Government has also published guidance on a range of subjects, including on strategic commissioning. This was followed up by a specific publication on the commissioning of palliative and end of life care in April 2018.

13. In addition, because the responsibility for the commissioning of palliative care has transferred from NHS Boards to Integration Authorities, there has been a need to define the commissioning relationship between Joint Boards and hospices. The principles underpinning the commissioning relationship between NHS Boards and independent hospices specialising in palliative and end of life care in Scotland were set out in a Scottish Government letter to NHS Chief Executives in 2012, commonly referred to as CEL 12. This document has since governed the commissioning relationship between Health Boards and independent hospices.

14. However, following the Public Bodies (Joint Working) (Scotland) Act 2014, all Health Boards have been required to establish Integration Authorities with their Local Authority partners. Within this context, the functions and resources associated with the provision of palliative and end of life care are now the preserve of Scotland's Integration Authorities. The terms of CEL 12 do not apply to those Integration Authorities who have established Integration Joint Boards, since in these circumstances the Health Board is no longer the commissioner of palliative and end of life care.

15. In order to clarify any ambiguities in understanding in the national policy framework, a working group was established to develop a Memorandum of Understanding between Scotland's Integration Joint Boards and Independent Hospices. The Working Group involved representatives of senior management within Integration Authorities, independent hospices, the Scottish Partnership for Palliative Care, Healthcare Improvement Scotland and the Scottish Government. Scotland's independent hospices are represented by the Scottish Hospice Leadership Group, which has formed to represent the interests of independent hospices at a national level. This national MoU should now be adopted by local Integration Joint Boards and is attached for approval.

LOCAL COMMISSIONING PLAN

16. Within this context, we have developed a new commissioning plan for palliative and end of life care, which is designed to guide the development of services over the next three years. It has been put together by a multi-professional, multi-agency working group, and has as its main focus the aspiration to support more people to die at home or in a homely setting.

17. This document sets out our ambition to deliver proactive, planned and supportive palliative and end of life care across the Western Isles. It considers the national and local legislative and policy context, our current service provision, what we want to achieve and how we will deliver an improved service.

18. Its focus is on how we support adults with palliative needs. There are very few children in the Outer Hebrides who have a life limiting illness and through the NHS Board and Comhairle nan Eilean Siar we will use, where appropriate, the support of highly specialist children's hospices and hospitals to provide support

19. The commissioning plan also considers the needs of patients with different diagnoses and conditions. It is not limited to patients with a particular diagnosis or condition and indeed we bring into consideration some diseases like dementia that have not historically been considered to be life limiting. More than anything else, the plan provides a framework for professionals, carers and service users to use in the identification of effective and appropriate care and support.

20. To ensure that the changes we make to the way that we provide palliative and end of life care deliver better outcomes, the plan seeks to deliver against the following high-level objectives:

    - We shall work with community health teams to ensure that we are identifying all people with palliative care needs and actively managing support on a multi-disciplinary team basis;
    - We shall improve our recording and performance in respect of people at the end of their lives having a Key Information Summary/Anticipatory Care Plan in place - and enhance the choice and control of people over their support arrangements;

- We shall seek to increase the proportion of time spent at home or in a homely setting in the last six months of life by building on the good multi-disciplinary practice we see across all our localities, especially in Harris.
- We shall seek to provide more equitable access to end of life care and symptom control across all diagnostic categories by:

  a) Working with our local providers of palliative and end of life care to consider who accesses hospice support and in what circumstances;
  b) Developing bespoke guidance and training for members of staff and carers to reduce the proportion of people with respiratory diseases who die in hospital;

- We shall seek to ensure that all relevant staff, both within the statutory and non-statutory sectors, have received training in PEOLC;
- We shall double the amount of respite available to families supporting a person in the last days of life, to further reduce the likelihood of care arrangements breaking down.

21. The commissioning plan is submitted to the IJB for approval.

PROCUREMENT OF SERVICES

22. The Commissioning Plan has implications for three Service Level Agreements the Health Board has with providers of different types of care and support: the SLA with NHS Grampian for specialist palliative care advice and support; the SLA with Marie Curie for the delivery of additional support in the home at end of life; and the SLA with Bethesda for the delivery of hospice care.

23. Of these, the SLA with Bethesda requires the most immediate attention (the other two will continue as they are for the time being). For some time now, we have been negotiating a new SLA with Bethesda, which is complicated by the changing national context and the advent of the IJB. In broad terms, the job of the IJB is to define its strategic intentions and resource allocation in a direction to the Health Board, which would then devise and put in place an SLA. The work of the IJB is guided not by CEL 12 but by the MoU, which promotes a new financial governance framework.

24. Specifically, CEL 12 proposed that 50% of agreed running costs be met by Health Boards, and the CEL 12 letter defined the parameters of what could fall within the scope of agreed costs. However, this led in some instances to a transactional relationship developing between Health Boards and hospices. As such, the MoU does not prescribe the proportion of agreed costs to be met by Integration Joint Boards but rather asks for a transparent assessment of the total costs of service provision, analysed through an open book approach between Integration Joint Boards and independent adult hospices. The MoU also recognises the need for independent hospices to provide pay increases in line with NHS arrangements and promotes a three year agreement as the preferred means of delivering financial stability.

25. Local negotiations are further complicated by the fact that Bethesda operates two further services for the health and social care partnership: residential care and respite care. Much of our recent work to assess the financial position of the organisation has therefore had to consider Bethesda's three income sources: monies raised from charitable giving (circa £631,000); the Health Board contribution to the cost of delivering hospice care (circa £186k); and the sum provided by the Comhairle for the provision of residential care and respite (circa £1,123k).[1]

[1] Figures from the last audited accounts, 2017/18

26. Within this context, the core dilemma has been the degree to which the contribution to hospice care can be inflated given the IJB's wider financial challenges, as against the stability of the charitable income generated by Bethesda given that there are now a wide variety of locally based charities competing for the disposable income of the local community. The optimum outcome will be for the IJB to deliver an effective and sustainable funding arrangement which contributes to the overall financial health of Bethesda as a highly valued local partner.

27. In order to find resolution, an informal proposal was put to the Bethesda team to have the IJB fund an increase of 3% per year for three years on the 2018/19 baseline, in return for a new SLA which supported outreach activity and which assumed staff pay increases in line with NHS Scotland. This would create a cost pressure for the IJB over three years of £34k and would raise the year three funding level by £17k over the 2018/19 baseline.

28. However, this offer was rejected by the Bethesda negotiating team, who argued instead for a higher baseline position to reflect a projected deficit in their finances – under this proposal, Bethesda is seeking (on the basis of their draft accounts for 2018/19) an additional £138,000 per annum from the IJB.

29. Given the size of the gap separating the negotiating parties, it has not been possible to reach agreement on a realistic settlement that can be put to the IJB and to the Board of Bethesda but both negotiating parties recognise the importance of achieving an agreed position. To that end, the Chief Officer and Chief Finance Officer will reconsider the informal offer and come back to the IJB in September.

DIRECTION

30. In light of the attached Commissioning Plan, the IJB should issue the following direction:

Direction – 2019/June/2		
1	Date direction issued by Integration Joint Board	20th June 2019
2	Date from which direction takes effect	20th June 2019
3	Direction to:	Comhairle nan Eilean Siar and NHS Western Isles
4	Does this direction supersede, amend or cancel a previous direction – if yes, include the reference number(s)	No
5	Functions covered by direction	Community Nursing; Palliative Care; Homecare; Residential Care
6	Full text of direction	Comhairle nan Eilean Siar and NHS Western Isles will put into effect the operational arrangements envisaged in the Palliative and End of Life Care Commissioning Plan
7	Budget allocated by Integration Joint Board to carry out direction	The revenue budgets are as described in *Direction – 2019/March/1* and in *Direction – 2019/March/2*
8	Performance monitoring arrangements	IJB Budget monitoring processes
9	Date direction will be reviewed	Following a report back to the IJB in June 2020