NHS
Croydon Clinical Commissioning Group

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End of Life Care Strategy
2015/16 – 2017/18

Everyone's Business
Are You Conversation Ready?

In partnership with:

Croydon Health Services NHS
NHS Trust

St Christopher's

CROSS ROADS CARE
Croydon

Marie Curie
Cancer Care

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Introduction

Croydon CCG and Croydon Council are responsible for implementing a robust End of Life Care (EoLC) strategy for people living in the Croydon borough. However it is recognised in Croydon that integrated working is a necessity if health and social care is to meet the challenge of enabling people to manage their own health and social care needs at a time of increasing demand and decreasing resources.

Therefore this strategy has been developed with our partners Croydon Health Services NHS Trust, St Christopher's Hospice Care Cross Roads Care and Marie Curie Cancer Care.

The purpose of this local strategy is to outline our plans to improve the range and quality of services for people who are nearing the end of their life.

The strategy addresses a number of issues set out in the Joint Strategic Needs Assessment (2009), including inequalities, long term conditions, and access to health and wellbeing information. It is written in the context of national, London, and local priorities and in particular a significant transformation programme that focusses on working towards less reliance on hospital care. It also links to a number of other strategies including the Health and Wellbeing Strategy, our Cancer Strategy and the Urgent and Emergency Care Strategy and a range of commissioning strategies including Dementia, Intermediate Care and Reablement, Carers, and the Voluntary and Community Sector.

Improving quality and providing people with genuine choice about where they are cared for and die are the main drivers for the development of this strategy. Research suggests that many people do not have the opportunity to consider and express their wishes about the care they would like at the end of their lives. Dependent on the availability of appropriate support and information for both patients and their loved ones up to two thirds would chose to die at home, when currently one third of deaths occur in people's own homes.

Scope

End of life care is care that: *"Helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support."* [1]

For the purposes of this strategy, End of Life Care includes:

- Adults with any advanced, progressive, incurable illness (e.g. advanced cancer, heart failure, COPD, stroke, chronic neurological conditions, end stage organ failure, and dementia)
- Care given in all settings (e.g. home, acute hospital, residential/care home, nursing home, hospice, community hospital and other institution) and by **all** providers not just those within the field of specialist palliative care
- Care given in the last year(s) of life; and
- Patients, carers and family members (including care given after bereavement).

The strategy does not address the palliative and end of life care needs of children and young people. Whilst the law regarding euthanasia and assisted suicide continues to be debated, these issues are beyond the scope of this strategy.

[1] National Council for palliative Care 2006

Our Vision

Croydon Clinical Commissioning Group Vision

Health and social care face a number of challenges over the coming years. The overall population is growing. There is an expected increase in the number of younger people living in the borough, overall life expectancy is increasing and we have an ageing population increases the demand on our services. Our population is also becoming more diverse, and so changing health need in Croydon.

There is increasing evidence that as disease patterns change increasing numbers of predominantly older people are living with advanced disease for longer periods, many with a number of different health conditions. In Croydon over 50% of residents over 50 years live in single person households, which for a population living with advancing long term conditions creates an increasing challenge for the services supporting them.

There are variations in the quality and performance of our services, leading to varying experiences of care and outcomes for people. These challenges are set in the context of a significant financial challenge as a result of an imbalance between our resources and our population needs.

Given these population needs and service challenges our key priority outcomes and subsequent indicators of delivery for the people of Croydon are:

1. Reducing potential years of life lost through amenable disease
2. Ensuring people are seen in the right place at the right time
3. Children and young people reach their full potential
4. Increased independence
5. Positive patient experience

The principles upon which we will deliver these and, indeed, all areas we commission are that:

- Prevention is better than cure but;
- When someone does become ill they are better able to manage their illness and;
- When a person does need treatment they are seen in the right place at the right time and;
- There is shared decision making between the patient and the health professional

Our End of Life Vision

Our vision for end of life supports the overall CCG vision, promoting high quality care for all adults at the end of life, through supported decision making and availability of responsive services equipped to meet needs.

We will improve access to care that meets agreed national standards for all adults approaching the end of their life.

We will commission services that provide people with genuine choice about where they are cared for and where they die.

By the end of 2017/18 will have increased the:

- Percentage of people who have expressed a preference about place of death to 80%
- Percentage of people who died who had their preferences recorded on Co-ordinate My Care to 80%
- Percentage of people identified on the supportive care register in general practice who have had anticipatory medicines prescribed to 75%
- Percentage of Multi-Disciplinary Team meetings that include anticipatory planning for EOLC to 90%
- Percentage of GPs who have completed difficult conversations training to 90%

Our Commitment

Croydon Council and NHS Croydon CCG are committed to achieving the following for the people of Croydon:

- All people approaching the end of their life will receive high quality care, treatment and support to meet their assessed needs.
- All people approaching the end of life will have the opportunity to make informed decisions about their care and treatment, in partnership with health and social care professionals and with their families and carers.
- Patients and their families will receive support appropriate to their needs to enable them, wherever possible, to die where they wish.
- Care and support will be provided in a way that preserves people's dignity and control.
- Patients and their families will receive care to alleviate discomfort and suffering. Carers and families (including children) of people approaching the end of life will have their own needs assessed and regularly reviewed, and will be offered support appropriate to their needs and preferences.
- We will develop an integrated performance management framework across health and social care that enables us to assess how well we are achieving these commitments. This will include strengthening feedback from patients and carers and working with local Dignity Champions to create user-defined measures through which we can define and monitor dignity locally.

Palliative services commissioned by the CCG and Council include:

CCG Commissions:

- St Christopher's Hospice for Palliative care
- Marie Curie night sitting service for Continuing Health Care patients
- Crossroad / Respite service
- South West Cancer network contribution
- GSF Facilitator for nursing care homes
- Six steps to success facilitator for residential care homes

Local Authority Commissions:

- St Christopher's Hospice for Domiciliary Care services
- Training from the Learning and Development team for care homes
- Care Support Team to work with care homes to improve standards

Aspects of end of life care are provided across the health and social care economy. District nurses, GPs and care assistants are fundamental to generalist palliative and end of life care needed by the majority of people at some stage. People may also receive elements of end of life care from their specialist community and secondary care teams, such as symptom management.

A smaller proportion of people will need direct access to specialist palliative care teams. These might be based in a hospital, a hospice or the community. The majority of specialist palliative care services are managed by voluntary sector organisations, not the NHS, and their commissioning arrangements with the NHS have traditionally varied substantially. Hospices and other specialist palliative care providers, however, are vital not only to the care of people with complex needs but also to training and developing the wider workforce and providing access to specialist advice and support to other professionals.[2]

[2] http://www.ncpc.org.uk/sites/default/files/AandE.pdf

The Case for Change

Population Needs Assessment

Croydon is one of the most populated Boroughs in London with a highly mobile, ethnically and socially diverse population. The borough has an aging population, but it also has an increasing population of younger people with disabilities and as a result has over 29,000 people providing informal care to relatives and friends.

The number of people living with one or more long term conditions is set to increase significantly over the next 20 years, in line with this ageing population.

As a result of the changing demographic in Croydon we are facing the following health and social care challenges:

- Increasing elderly population living for longer with one or more long term conditions
- Areas of deprivation in the borough with consequential impact on health
- Increasing numbers of younger people with disabilities requiring health and social care
- Increasing demand on mental health services
- Increasing demand taking place at a time of financial challenge for health and social care
- Increasing numbers of people living in single person households

End of Life Needs Assessment

Croydon has a growing number of older people who will need to be supported to die in the place of their choice

- There are 44,375 residents in Croydon over 65+ - 12% of the overall population. This is predicted to rise to 56,000 by 2021, a rise of 8% per annum
- 11.9% of households in Croydon are single person households (3.9% over 65+).The proportion of older people living in single person households is predicted to rise. This has significant implications to care provision at the end of life, where care from family members is critical.
- Nationally, it is reported that 70% of people do not die where they choose. A recent survey reports that 7% of people say they would prefer to die in hospital, compared to two thirds (67%) who would prefer to die at home.

Case study

Croydon has a high number of older people dying in hospital

John was an 89 year old man. His wife died in May 2014, he had looked after her for 10 years, she had dementia. They did not have any children. John was in hospital with uncontrolled heart failure when his wife died. The hospital were considering giving him a pacemaker to help his heart failure.

John had carers helping him in the morning and evening and in January 2015 he had a stair lift fitted. The district nurses visited regularly to take his blood, and dress a wound, but they did not know what the cardiologists were planning or what his prognosis was. In January the cardiology team told him that they did not think he would benefit from a pacemaker. He was referred to the hospice service. In collaboration with John and his GP a DNACPR decision was made. John wanted to stay at home until he died, he was not afraid of dying but he found it hard to talk about and to make plans. He was keen to 'keep going' and be independent for as long as possible, but he wanted to be at home when he died.

In February 2015 he had 2 falls and he was feeling very weak and he recognised that he needed more care to keep safe. He did not want to go into a nursing home but recognised that to stay at home was not realistic he agreed to go to a hospice with the hope that he could regain some strength to go home again, but in the knowledge that he would be safe. 10 days after going into the hospice he died peacefully with close friends at his bedside.

Dorothy was 94 she was a widow who lived alone but her daughter lived nearby. Dorothy had lived with COPD and heart failure for 10 years. Her daughter and son-in-law had both recently been diagnosed with COPD. Dorothy had lived independently with help from her daughter with shopping and cooking

Dorothy could not walk very far and she was breathless even when sitting. She was keen not to be a burden on her daughter. She wanted to stay at home for as long as possible but recognised that she was getting weaker, but she still wanted to 'carry on'. She agreed with her GP that she should not be resuscitated. Other than her GP she did not have any services visiting.

In January 2015 her GP diagnosed a chest infection and started antibiotics, after 2 days things were worse and Dorothy agreed to go to hospital to see if intravenous antibiotics would help. She was discharged from hospital the following day.

At home Dorothy was very distressed every breath was difficult and she felt frightened particularly at night, she was worried about her daughter. Her GP visited again and Dorothy decided to go back to hospital, she died there 2 weeks later, her daughter was with her.

- In Croydon, the annual average number of deaths per year between 2010-12 was **2,423** with a majority of those coded as expected deaths from chronic conditions; predominantly cancer, respiratory or cardiovascular disease and to some extent dementia

- **1,946** of the 2,423 deaths in Croydon occurred in the over 65s. This equates to 80.3% of all deaths in Croydon.

- 54.2% over 65 deaths in Croydon occurred in hospital during that period. This is higher than the national average (51.3%). In the best performing borough, 38.2% over 65s die in hospital. More women than men between 65-84 years old die in hospital (54.7% women compared with 50.3% men in this age group). More men than women aged 85 years old die in hospital (54.9% men compared with 50.5% women in this age group).

- The reasons for hospitalisation are multifactorial, however intensive work in Nursing Homes in Croydon has demonstrated that improving healthcare professional's skills and understanding of end of life care reduces hospitalisation (from 60% home death rate to 80%).

- The National Audit Office has suggested that 40-50% of those who died in hospital could have died at home (NAO, 2009). Applying the lower estimate of 40% to Croydon's over 65 population who die in hospital, this suggests that approximately 422 over 65s who died in hospital (2010-12 data) should actually have been able to die at home.

Croydon has a slightly lower than average number of older people dying in care homes (nursing or residential)

Judith was an 86 year old retired business woman, she was a widow. She had one daughter. She had lived with dementia for 5 years and 3 years ago had moved to a residential home. She had never discussed her wishes with her daughter and her daughter did not have power of attorney. Nobody had every discussed future plans with either Judith or her daughter and now Judith did not have capacity to make a decision.

In January 2015 the residential home manager asked the GP to visit Judith as she was sleepy and weak and not eating much. The GP last saw Judith in September following a fall. The GP thought this time that she had pneumonia. He had not spoken to her daughter before and she was not available on the day he visited. Since he did not know what Judith would wish he sent her to hospital mentally deciding to speak to the daughter when she was discharged. Judith died in hospital 2 days later.

- In Croydon, 22.9% over 65 deaths occur in care homes. In the over 85s, 31.8% deaths occur in care homes. Nationally, 24% over 65 year olds die in care homes.

- In England, the borough with the highest number of care home deaths in the 65-84 year old category has 22.4% of this age group dying in care homes, compared to the Croydon rate of 13.9%. The borough with the highest number of care home deaths in the over 85 year old category has 50.2% of this age group dying in care homes, compared to the Croydon figure of 31.84%.

- 25.9% women over 65 die in care homes in Croydon, compared to 18.8% men over 65 years old.

In a person's last year of life they will typically be admitted to hospital 3 times, and in Croydon they will spend an average of 14 days in a hospital bed (compared with the England average of 12.9 days). Not all of these admissions are appropriate.

- The average cost of an emergency hospital admission ranges between £2,506 - £3,900

- In Croydon 88.7% of terminal admissions to hospital were emergency admissions, rather than being planned (2010/11 data).

- The Care Quality Commissioning (CQC) found that of all deaths in hospital, 36% occurred within 3 days of admission; 56% occurred within 7 days of admission; and 40% occurred between 8-90 days following admission (2010 report). In Croydon, the percentage of terminal admissions that are 8 days or longer is 53%, compared to the England average of 48.8% (2010/11 data).

- The Nuffield Trust (2010) found that the cost of admissions that end in death increases for those who die after 8 days, and that hospital care is estimated to cost twice as much as social care towards the end of life.

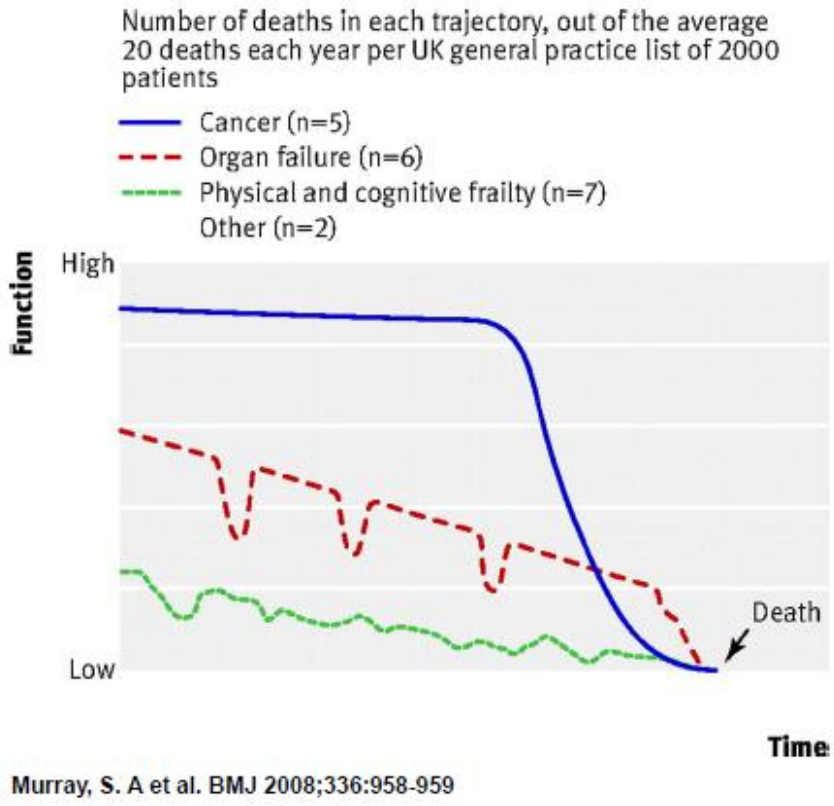
The local number of emergency attendances and admissions to hospital from care homes in Croydon are higher than the national average – 21% against 12% nationally.

- The CQC's thematic review of hospital deaths in 2010 found that of the total number of people who died in hospital in that year, 12% were admitted from a care home. In Croydon however the picture is far worse as almost double the national figure. Data from the Secondary User Service (SUS) system suggest that 21% of hospital deaths were from care homes – 7% residential and 14% nursing

- During 2013/14 there were 755 Deaths from Care homes and patients own homes in Croydon in the over 65 year olds this was at a cost of £3,008,338 including excess bed days and market forces

- 600 of the 755 patient deaths were deaths from patients own home, at a cost of £2,690,853. With 53 of these deaths from residential care homes and 102 were deaths from nursing care homes at a cost of £531,464 including excess bed days and market forces

- It is assumed that the emergency attendances/ admissions to hospital from care homes are likely to relate to either cancer, organ failure or frailty (see illness trajectories below)



Murray, S. A et al. BMJ 2008;336:958-959

Hospital, community and care home services are not aligned and integrated in Croydon to support people in their last year of life

- There is a total of 144 Care homes in Croydon registered with the Care Quality Commission (CQC) providing care for people including the 65+ population, mostly frail and elderly with number commodities including Learning Difficulties and dementia.

- 23% of these homes have nurses in the homes – Nursing homes (33in total), and 74% of the homes in Croydon are for residential purposes – Residential homes with no nursing support (107 in total). 3% of the homes provide both nursing and residential care (3 in total)
- Most of the residential homes (74%) are likely to rely on GPs, District nurses, GP out of hours, 111 or other health professionals when crisis arise. However, the current arrangements and service are not consistent

- Services are fragmented; lack coordination and the provision may not always be person-centred.

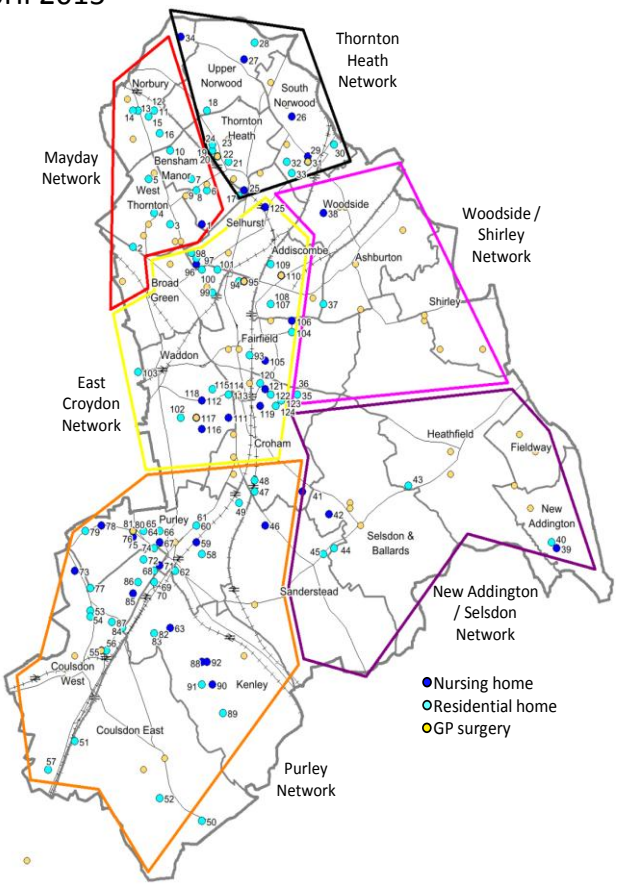
- Patients do not receive robust care based on their Advanced Care Plans (ACP) as most of them will not have one. Less than 5% of the over 65 population in Croydon will have ACP in place

- There are about 22 different services that provide care for patients residing in care homes but a lot of the times the services are disjointed with care home staff ending up calling ambulances when crisis sets in. with most patients being patients at the end of life

- Croydon has a higher than average number of residents registered on the palliative care register which should enable early planning for end of life[3]

Croydon care homes by GP network, April 2015

MAYDAY NETWORK	43 Heatherway Resource Centre	85 Amberley Lodge – Purley
1 Kavita Chumroo - 44 Kimberley Road		
2 Stewart Lodge Care Home	44 Addington House	86 The Manor
3 BDC-Northern House	45 Sylvanhurst House	87 Care Management Group - Smitham Downs Road
4 Bovell's Lodge Limited	**PURLEY NETWORK**	88 Hill House Care Home
	46 Wells Place Care Home	
5 Klearwater Adult Services Limited	47 Angel Lodge	89 Morven House
6 21 Lucerne Road	48 Hunters Lodge	90 Acorn Lodge – Croydon
7 Alpha Home - Thornton Heath	49 Tigh Sogan	91 Acorn House – Croydon
8 Heathvale House	50 8-10 Newlands Cottages	92 Hayes Court
9 Thornton Lodge Limited	51 The White House Care Home	**EAST CROYDON NETWORK**
		93 Carlton House
10 Warwick House	52 Lilias Gillies House	94 Speakers Court
11 Elmfield Lodge	53 Caretech Community Services Limited - 100 Woodcote Grove Road	95 Albany Lodge Nursing Home
12 Norcrest	54 Crystal	96 Elmwood Nursing Home
13 The Chestnuts	55 Abbey Lodge - Coulsdon	97 North Downs Villa
14 Roselands Residential Care Home	56 Clifton House	98 44 Broad Green Avenue
15 Norbury Hall	57 Croftdown House	99 Oak Field
16 Hazeldene Residential Home	58 Warren Court	100 80 St James Road
THORNTON HEATH NETWORK	59 Liberty Lodge	101 Shepherds Corner
17 Rosenmanor Limited		
18 Care Management Group - Brickfield Road	60 851 Brighton Road	102 Blake Court
19 Beulah Lodge	61 Rosina Gardens	103 Care Management Group - 72 Croydon Road
20 Care Management Group - Beulah Road	62 Foxley Lodge Residential Care Home	104 Wilhelmina House
21 Mrs Daphne Mahoney - 23 Liverpool Road	63 Highfield House	105 Red Court Nursing Home
22 Care Management Group - 95 Parchmore Road	64 CareTech Community Services Limited - 7 Russell Hill	106 Thackeray House
23 Retreat Lodge	65 Esther Care Home	107 Oval Residential Home
24 Graceland Care Home	66 Russell Hill Lodge	108 Oval Residential Home - 170 Oval Road
25 Clarendon Nursing Home	67 Sunrise Operations Purley Limited	109 Anand Lodge
26 Lakeside Nursing Home	68 Alice Lodge	110 Barrington Lodge
27 Parkview Nursing Home	69 Brighton Road	111 Whitgift House
28 High View Care Services Limited - 9 High View Road	70 Rosemanor 2 Residential Care Home	112 Mary's Home
29 Acacia Care Centre	71 Purley View Nursing Home	113 Jordan Lodge
30 Qualities Services Ltd	72 Carlene House	114 Scott House
31 The Manse	73 Woodlands Nursing Home	115 Jean Garwood House
32 Whitworth Lodge	74 The Params	116 James Terry Court
33 Whitworth House	75 Heatherwood Nursing Home	117 St Johns Nursing Home Limited
34 Gibson's Lodge Limited	76 Independence Homes Limited - 37 Foxley Lane	118 Oban House
WOODSIDE/SHIRLEY NETWORK	77 Gate Lodge	119 Villa Maria Private Nursing Home
35 Coombe Road		
36 Lloyd Park Nursing Home	78 Westside Care Home	120 Evergreen Lodge
37 Northampton Lodge	79 White Lodge	121 Tudor House Nursing Home
38 Woodside Court	80 Beech Tree Care Home Limited	122 Care Management Group - 7 Birdhurst Rise
NEW ADDIINGTON/SELSDON NETWORK	81 Roselawn House	123 Unicorn House
39 Addington Heights		
40 St Edwards Close	82 Ferncroft	124 Tree Tops
41 Croham Place	83 Heathercroft	125 Heavers Court
42 Langley Oaks	84 Mrs Agnes Harriette Lucinda Coker - 211 Brighton Road	



National Context

The Five Year View reiterated the promise to make good the NHS's longstanding promise to give patients choice over where and how they receive care as well as continuing the drive towards enabling patient choice and developing services that are responsive to individual needs (or 'personalised'). Whilst this was set out in the Five Year Forward, these have been themes for many years.

Specifically the Department of Health White Paper Our Health, Our Care, Our Say (2006) set out the development of End of Life Care objectives of providing services that are responsive to individuals' needs and providing care closer to patients' homes.

End of life Care was one of the care pathways included in the NHS Next Stage Review, the final report (2008) calls for greater dignity and respect for patients receiving end of life care and a desire to have twenty four hour access to palliative services.

[3] Croydon Practice Profiles 2014/15

The national strategy aims to bring about improvements in access to high quality care for all people approaching the end of life. NHS England's Actions for End of Life Care 2014-2016 (2014) outlines the move to a new commissioning system for end of life care. It set out strategic commissioning objectives based on the House of Care model. It highlights a focus of removing inequality in end of life care provisions; the need to develop outcomes based service evaluation and commissioning. It pledges support for a care coordination model of person centred care. [4]

A number of other national and regional policies also provide significant direction as to the standards patients can expect from enhanced palliative care. These policies include:

- The Cancer Reform Strategy 2007
- National Service Frameworks for; Coronary Heart Disease, Older People, Long Term Conditions, Renal and Neurological Conditions
- National Dementia Strategy (2009)
- Mental Capacity Act (2005)
- NICE, Improving Supportive and Palliative Care in Adults with Cancer (2004)
- Healthcare Commission Heart Failure Review report (2007).

Mental Capacity Act (2005)
The Mental Capacity Act came into force in 2007. It made law governing the way in which decisions are made on behalf of people with impaired mental capacity to make decisions for themselves. The Mental Capacity Act has a significant impact on palliative and end of life care. Some of the most important features were new statutory tests:

- to assess capacity
- to determine best interests

The Gold Standards Framework
The Gold Standards Framework (GSF) is a systematic evidence based approach to optimising the care for patients nearing the end of life. It is concerned with helping people to live well until the end of life and includes care in the final year of life for people with any end stage illness in the community.

The Department of Health End of Life Care strategy (2008) states that: "Every organisation involved in providing end of life care will be expected to adopt a co-ordination process such as the GSF".

GSF have developed programmes specific to work with people living in their own homes, those living in nursing homes and people in hospital. In Croydon GSF has been introduced in many GP practices and across most nursing homes. In particular the impact in Nursing Homes is most noticeable with a reduction in hospital admission at death by 77% in 2014.

At its peak, 53 practices in Croydon were following the GSF model and holding MDT meetings on a monthly basis. The advent of Admission avoidance MDTs has altered the focus of these meetings and it is not currently known how many practices are continuing with the GSF model. Clearly there will be great benefit in aligning the objectives of the admission avoidance and GSF MDTs to achieve optimum impact.

[4] http://www.england.nhs.uk/wp-content/uploads/2014/11/actions-eolc.pdf

South West London Context

The CCGs across South West London have agreed to work jointly to develop new strategies for local health services. Our services are inter-dependent and the challenges we face cross borough boundaries. Closer working between our hospitals and also between the hospitals, GPs, community and mental health services will improve the quality for everyone in south west London and make the local NHS sustainable. We do not believe it would be possible to achieve the scale of change that is needed by working independently at borough level. A five year strategic plan for south west London has been developed to support this.

A key outcome is to make significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care. Elimination of avoidable deaths in hospital will be addressed primarily through the development and achievement of a minimum set of clinical standards to which all CCGs will commission. However this will go hand in hand with increased support for people near the end of life in the community, so that the majority of people can die in their preferred place of death.

The strategy sets out a vision for integrated care which combines the six CCGs' local ambitions for community-based health and social care services. It describes the need to help people requiring end of their life care to be supported to receive their care and to die in their preferred place. People who are identified as being at the end of their lives are registered on Coordinate My Care which will hold information about their preference of care and place of death and prevent unnecessary admissions to hospital.

Data from the Royal Marsden NHS Foundation Trust (2014) shows that 80% of patients registered on CMC died in their preferred place and 18% of such patients died in hospital, compared with the 54% national picture. It is important to recognise that the CMC just records the outcome of shared decision making between patients, families and healthcare teams, and therefore underpinning of CMC is the need for clinical teams to be confident and competent to engage in decision end of life decision making with patients and families. Therefore a consistent approach for end-of-life care in South West London is needed and all commissioners are in agreement to encourage and incentivise the use of CMC locally. For this to be optimally effective all clinical teams delivering care to people with advanced disease should be 'Conversation Ready'

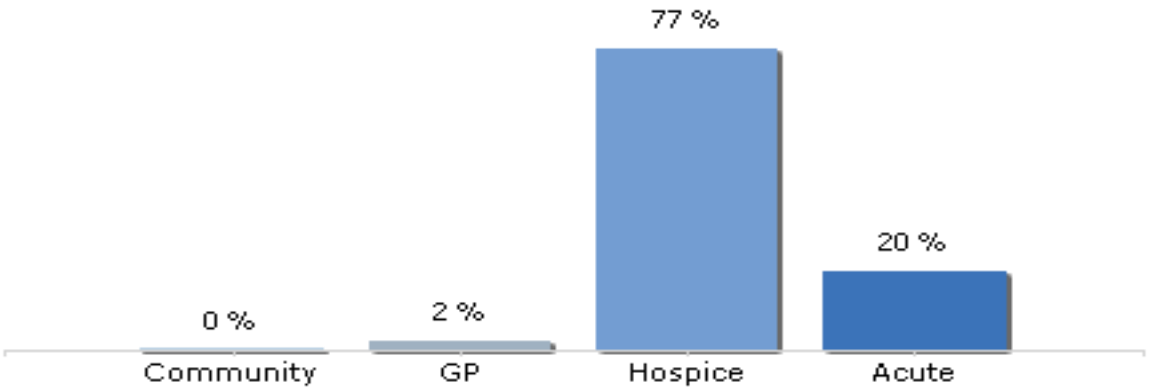
The strategy also sets out that South West London cancer services will focus on prevention of disease, early diagnosis and patient experience of treatment with an emphasis on patient choice and care provision in the community during active treatment, recovery, and, where necessary, the end of life phase. Every patient will be treated as an individual and offered the full support of the healthcare professionals involved. Patients have the right to decide where they would like to die and must be supported in their decision and allowed to die with dignity in their location of choice.

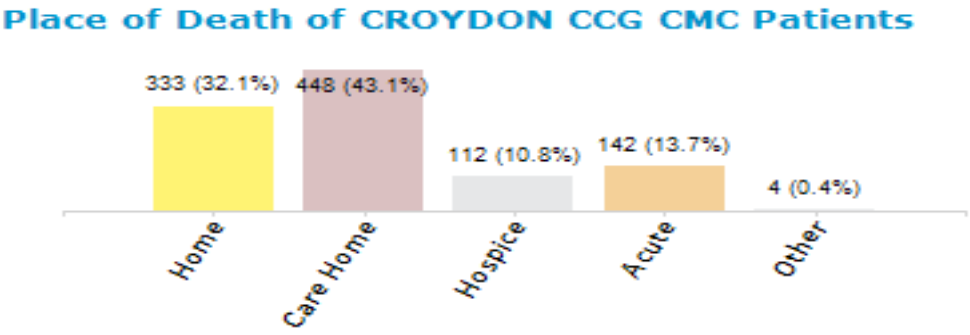
CMC May 2015 report – Royal Marsden

The graph below depicts the use of CMC among health professionals who provide care at the End of life to patients in Croydon. Even though the picture painted signifies Croydon GPs are documenting patient's wishes and preferences on the system – 99%, it is worth noting that GPs in Croydon actually populate the 2% of the actual data. 20% of the data is populated by the Palliative care team in the acute setting (CUH) leaving St Christopher's populating the bulk of the data for patients in care homes 77% on behalf of GPs.

It is worth noting at this stage that St Christopher's are being funded to input patient's wishes and preferences on CMC but good practice is that patient's wishes are discussed by GPs and District Nurses and uploaded on to CMC by them.

Professional Group adding to CMC





Croydon Context

Croydon health and social care are facing a number of challenges, as set out in our Operating Plan 2015/16. In order that we can address the needs that result from the changes in population, service quality and service performance we must fundamentally change how we commission, deliver and use health and care services. This is not about unnecessary structural change; it is about finding ways of doing things differently to ensure that services are sustainable for the future.

Our transformational programme will mean we will work towards less reliance on hospital care through improved primary and community provision and continuing to develop our approach to prevention, self-care, and shared decision making.

Specific transformation programmes that will impact on end of life care are:

- Outcomes Based commissioning for over 65s - Currently the CCG and the Council are working to commissioning services for over 65s on an outcome basis, leading to new models of care.
- Transforming Adult Community Services – The development of new services and co-ordination of current services to ensure patients receive a wide range of support in their own homes, and rapid response teams to provide early intervention when things go wrong

A number of other local strategies also provide significant direction as to the standards patients can expect from enhanced palliative care. These include:

- Cancer Strategy
- Urgent and Emergency Care Strategy
- Dementia Strategy
- Health and Wellbeing Strategy

End of Life Care is everyone's business everyone will at some point go through this process thus the process has to be right in order to get people to achieve the death they wish for. EoLC impacts all other commissioning areas for older people and needs to align to all services commissioned for older people in order to get the right outcomes for older patients. Getting the process right will enable most people over 65 years old have a care plan in place, which will help with robust monitoring of older people.

Map of providers in Croydon

End of Life services support those with advanced, progressive, incurable illnesses to live as well as possible until they die. This strategy incorporates the full spectrum of end of life care including early conversations, which help patients and their families to prepare for the decisions needed in the future. It is essential that there is effective end of life care among all health professionals involved in the care and support of those with non-curative progressive illness making it 'conversation ready". Direct care to support patients is provided by a wide range of health and social care professionals across a range of providers in Croydon.

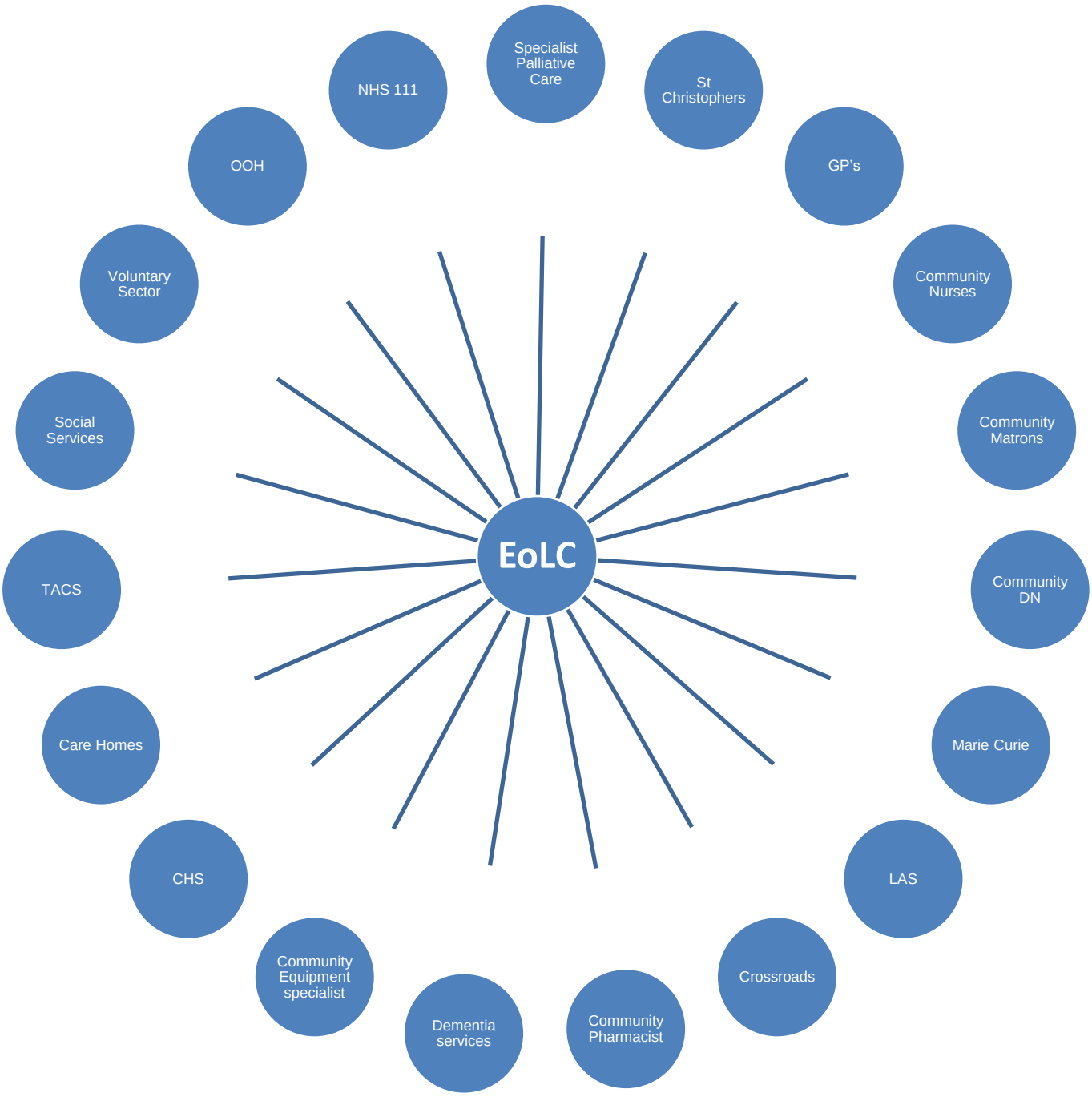
This strategy includes the objective to identify core skills required and used by all clinical teams to ensure that patients are given appropriate information to enable them, if they wish, to make decisions about their future care, supported by their health and social care team. Being 'conversation ready' needs to permeate all areas of health and social care. Discussing dying is often difficult for people and there is great individual and cultural variation in beliefs, the challenge in developing this work is to do so in a way that it remains a person centred agenda of supporting people to make hard choices.

The current arrangements for Croydon patients at the end of life illustrated in the diagram below, even though providing a variety of key services, is somewhat not fit for purpose: provision of services is fragmented, care is often uncoordinated, and overall outcomes are not satisfactory. There are high numbers of call outs to emergency services from care homes, which is costing the health economy significant amount of money.

The services below need to be more coordinated in providing care. Services have to be joined up for the provision of end of life care services in Croydon and this strategy seeks to work with all stakeholders to help join up community services.

Challenges the map below causes include the lack on which stakeholder provides what service and how care homes and other providers tap into services.

Figure 2 – Current providers in Croydon



The End of Life Strategy

As our population ages and is living with a heavier burden of disease and disability the 'palliative phase' of people's illness is extending and local services are challenged with meeting long term care needs. For this to be both most effective and efficient it needs to become core care to all services. The most beneficial role of specialist palliative care services needs to be better defined but it should currently be reserved for those with complex needs which cannot be met by the usual services involved.

In order to achieve this aim, the following ten objectives have been developed

1. To increase public awareness and discussion of death and dying. This will make it easier for people to discuss their own preferences around end of life care and should also act as a driver to improve overall service quality;
2. To ensure that all people are treated with dignity and respect at the end of their lives;
3. To ensure that pain and suffering amongst people approaching the end of life are kept to an absolute minimum with access to skilful symptom management for optimum quality of life;
4. To ensure that all those approaching the end of life have access to physical, psychological, social and spiritual care;
5. To ensure that people's individual needs, priorities and preferences for end of life care are identified, documented, reviewed, respected and acted upon wherever possible;
6. To ensure that the many services people need are well co-ordinated, so that patients receive seamless care;
7. To ensure that high quality care is provided in the last days of life and after death in all care settings;
8. To ensure that carers are appropriately supported both during a patient's life and into bereavement;
9. To ensure that health and social care professionals at all levels are provided with the necessary education and training to enable them to provide high quality care; and
10. To ensure that services provide good value for money for the taxpayer.

The overarching standards for end of life care are set out in the national strategy and underpin the local objectives. These standards include patients having access to:

- The opportunity to discuss personal needs and preferences with professionals to support them
- Co-ordinated care and support, ensuring that needs are met, irrespective of who is delivering the service
- Rapid specialist advice and clinical assessment wherever the patient
- High quality care and support during their last days of life
- Services which treat patients with dignity and respect both before and after death
- Appropriate advice and support for carers at every stage.

Additional to this in order for care to be impacted positively, services will be:

- Well planned and co-ordinated, ensuring access to the care needed, when needed, irrespective of condition or setting, and that patient choice will be respected and taken into consideration
- Quality assured and delivered to a high standard
- Monitored and assessed to ensure quality
- Informed by the experience of others who have been in a similar situation.

Outcomes

Based on our challenges and the case for change, the difference we will make is set out below.

Outcomes	2014/15 Actual	2017/18 Plan
End of Life Care an agenda item on CCG / Council & CHS Board meetings	Limited evidence	Strong evidence
Percentage of people who have expressed a preference about place of death	10%	80%
Percentage of people who died who had their preferences recorded on Co-ordinate My Care	10%	80%
Percentage of people identified on the supportive care register in general practice who have had anticipatory medicines prescribed	Data is currently not comprehensive	75%
Percentage of Multi-disciplinary team meetings that include anticipatory planning for End of Life Care	Data is currently not comprehensive	90%
Percentage of GPs who have completed difficult conversations training	0%	90%

Objectives and Initiatives

The goals and the initiatives to deliver the outcomes above are summarised below. Appendix 1 sets out the detail of the initiatives and the implementation plans to achieve our planned change.

Goals	Initiatives	2015/16	2016/17	2017/18
Make talk of death and dying normal	Develop awareness	▲	▲	
	Engage with 'hard to reach group's		▲	▲
	Establish 'death' cafes		▲	▲
Identify all people nearing the end of life	Local services proactively identify people	▲	▲	
	Sharing of information on Coordinate my care	▲		
	All service providers share information electronically		▲	
Effective Care Planning	Implementation of GSF across all services	▲	▲	
	All peoples wishes recorded in care plans		▲	▲
	All providers use care plans		▲	▲
	Develop local workforce	▲		

Goals	Initiatives	2015/16	2016/17	2017/18
	Develop systems ensure assessment of continuing care needs		▲	
Person Centred Co-ordinated Care	All persons receive person centred co-ordinated care		▲	
	Address variances in care	▲	▲	
	Patients and cares have necessary resources	▲		
	Monitor quality of care	▲	▲	▲
	Accessible routes to access advice, support and urgent care		▲	
Care in the last days of life	Clinic teams have the necessary skills	▲		
	Clinical teams provide support to family and friends		▲	
	Monitor the quality and effectiveness of last days of life		▲	
	All services communicate and document treatment decisions		▲	▲
	All providers have end of life policies	▲	▲	
Involve and support family and friends	Family and carer involvement in decision making and planning	▲	▲	▲
	Carer assessments		▲	▲
	Information is available on all local services		▲	▲
Develop competencies of the workforce	All professionals will have a collaborative approach to care		▲	▲
	Minimum competency standards in place	▲		
	Monitoring and evaluation of skills		▲	▲
	Collaborative working when specialist advice required		▲	▲
Develop a robust monitoring and performance tool	Develop a performance management system to monitor quality , outcomes and expenditure	▲	▲	▲
	Improve patient and carer feedback	▲	▲	▲

Implementation and Monitoring Arrangements

The implementation and monitoring of the strategy will be governed by the End of Life Care Steering Group supported by the End of Life Care Clinical Reference Group. The Steering Group reports to the CCG QIPP Operational Board (QOB) and will report progress to the Health and Wellbeing board.

A detailed implementation plan will be developed in partnership with the Clinical Reference Group, the Clinical Leadership Group and a network of local stakeholders. This will be agreed by the Steering Group who will monitor implementation to ensure that the strategy is shaping services in the way intended.

A lead commissioner from the CCG and the Local Borough of Croydon will be tasked with working with the Steering Group and Clinical Reference Group to deliver the implementation plan and report progress and issues to all relevant local boards and stakeholders.

The End of Life Care Steering Group and Clinical Reference Group will also have a lead role in the development of a communication and engagement plan that will set out:

- how implementation of the strategy will be communicated to key stakeholders and members of the public; and

- How stakeholders will be engaged throughout the implementation.

An integrated performance management system across health and social care will be developed to enable us to monitor quality, outcomes and expenditure. An annual progress report on implementation of the strategy will be published and will report on progress towards implementing agreed commissioning intentions as well as key performance metrics.

Appendix 1 End of Life Care Strategy Implementation Plan DRAFT

OBJECTIVE	INITIATIVE	GAP	SOLUTION (TBC)	TIMEFRAME	OWNER
1. Make talk of death and dying normal.	Engage with local communities to develop awareness and break down taboos and encourage people to talk about their wishes towards the end of their lives, including where they want to die and their funeral plans with friends, family and loved ones. Develop a 'Conversation Ready' health and social care workforce.	No record of initiative involving the general population to reduce taboos around death and dying	Develop a communication strategy to promote public awareness with regard to issues around death, dying and end of life care	May 2015	Strategy Board - EoLC Commissioner
			Make EoLC issues a regular agenda item in key board / other key events in Croydon. Work closely with all health professionals promoting EoLC matters within the area of work. Consider running a death cafe in Croydon	Ongoing	Strategy Board (EoLC Commissioner) Clinical Reference Group (CRG) Chairs
	Engage with potential users of end of life care services who belong to vulnerable, marginalised or socially excluded communities to raise awareness of end of life care services.	No record of social and healthcare teams utilising engaging with the Dying Matters Coalition to promote general awareness	Hold regular communication events, linking to national initiatives such as 'Dying Matters week'.	18-24 May	Clinical Reference Group (CHS Clinical lead)

OBJECTIVE	INITIATIVE	GAP	SOLUTION (TBC)	TIMEFRAME	OWNER
		There is national evidence of key groups who are unlikely to receive end of life care, such as homeless. People, those with mental health problems or learning disabilities	Work with public health, GPs and other key professional groups to develop work streams to promote equity of end of life care provision	April 2017	Strategy Board (Public health/ EoLC Commissioner)
2. Identify all people nearing the end of life	All providers will have processes in place to identify those approaching the end of life.	Approximately 1% of the population die annually. In England, GP practice supportive care register identify 0.27% of their registered patients who are thought to be in their last year of life. In Croydon the supportive care registers vary between the networks from 0.21% to 0.64%.	Identify barriers to use of supportive care register	April 2016	CRG (GP Lead)
			Identify effectiveness of processes of identification of patients admitted to hospital and how this is communicated to patients, family and friends, and other professionals involved in care.	July 2016	CRG (CHS Clinical lead)

OBJECTIVE	INITIATIVE	GAP	SOLUTION (TBC)	TIMEFRAME	OWNER
		Further work needs to identify whether those identified on the supportive care register are appropriate and which groups of people are not currently being identified. Some healthcare professionals have difficulty in identifying when those with non-malignancy are reaching the end of their life	Further develop and integrate GSF and steps to success models in residential and nursing home care to engage all relevant members of the health and social care team	July 2015 – April 2017	Strategy Board (EoLC Commissioner)/ CRG (St Christopher's Care Home lead)
			Annually report on proportions and profile of patients identified on supportive care register	Annually in May	Strategy Board (Public health/ EoLC Commissioner)
	Ensure global use of the local electronic palliative care coordinating systems sharing system across all service providers.	Use of the electronic record is not universal across Croydon and therefore information held on the record is not being accessed by all and not	Work with CMC to further develop the electronic record Work with social and Healthcare professionals to promote use of electronic record (CMC)	December 2015	CRG (GP Lead/ CHS Clinical lead)

OBJECTIVE	INITIATIVE	GAP	SOLUTION (TBC)	TIMEFRAME	OWNER
3. Effective care Planning	Effective implementation of good practice models, such as the Gold Standards Framework across secondary care, primary and community care, care homes, local authority services.	Unknown effectiveness of implementation of the models in some areas	Develop measures of quality of model implementation	July 2015	Strategy Board (EoLC Commissioner)
	All people approaching the end of life should have their needs assessed, their wishes and preferences discussed and an agreed set of actions reflecting the choices they make about their care recorded in a care plan.	Varying implementation of care plans Varying quality of care plans Unknown impact of care plans	Support care planning process development in nursing and residential homes by embedding and streamlining GSF and steps to success	July 2015- April 2017	Strategy Board (EoLC Commissioner)
		Identifying possibility of EoLC questions within social care assessments	Conduct an in depth review of practice of end of life care planning in key health care settings Conducting mini pilot programmes with teams such as TACS to endure robust relationships with GPs MDTs etc.	Report April 2016	CRG (GP support)

OBJECTIVE	INITIATIVE	GAP	SOLUTION (TBC)	TIMEFRAME	OWNER
		No set standard of what is expected of all healthcare professionals involved in end of life care	Develop a core skill set for those in the planning of care for those at the end of life	April 2016	CRG (CHS Clinical lead/ GP Lead)
	The local workforce will have the appropriate skills to support patients and their carers and enable them to make decisions and choices about their care	GP and District nursing surveys have demonstrated lack of confidence in having discussions about end of life care with patients and families, frontline social work staff, care homes and care agencies	Identify learning needs of all social & health professionals who care for patients with respect to effective care planning for people at the end of their life	April 2016	CRG (GP Support)
	Ensure appropriate systems are in place with assessment of continuing care needs utilising this to support patients to make choices about care.	Anecdotal evidence of inequality of provision of continuing care, favouring people with cancer	Develop a plan to review applications for continuing care based on EOLC need, by provider applying and outcome	April 2016	Strategy Board (EoLC Commissioner)
	Care plans should be available to all providers, including those providing services out of hours and emergency services via shared electronic records and these should be up to date, accurate and able to guide emergency	The electronic communication system for key decisions in	Encourage the use of CMC and across all health and social care professionals Develop standard for communication while CMC in transition	December 2015	CRG (CHS Clinical lead/ GP Lead)

OBJECTIVE	INITIATIVE	GAP	SOLUTION (TBC)	TIMEFRAME	OWNER
	professionals on the plans for care.				
4. Co-ordinated care across organisations	Ensure that everyone approaching the end of their life receives person centred co-ordinated care, in accordance with their care plan, across sectors, in all place of residence and at all times of day and night.	No evidence of universal use of care planning to identify future wishes and preferences	Support care planning process development in nursing and residential homes by embedding and streamlining GSF and steps to success. Aim for process of end of life care planning for residents in care homes a core element of usual care by primary care and community teams by April 2017.	July 2015- April 2017	Strategy Board (EoLC Commissioner)/ CRG (St Christopher's care home support lead)
	Ensure that everyone approaching the end of their life receives person centred co-ordinated care, in accordance with their care plan, across sectors, in all place of residence and at all times of day and night.	No evidence of universal use of care planning to identify future wishes and preferences	Project to develop standardised process of recording Care plans, using a person centred approach	Project plan agreed September 2015 Pilot start April 2016 Evaluation June 2017	CRG (all: Coordinated by District Nursing lead/ Supported by GP support)

OBJECTIVE	INITIATIVE	GAP	SOLUTION (TBC)	TIMEFRAME	OWNER
		Electronic record is not widely used by those outside specialist palliative care	Identify use of CMC by broad healthcare team and work with individual providers for universal use	December 2015	CRG (CHS Clinical lead/ GP lead)
		Skills and confidence to recognise end of life care needs and provide care is not universal across all services delivering care to people at the end of life	Develop a core skill set for those in the delivering care to coming to the end of their life	April 2016	CRG (District Nurse lead/ Care home manager St Christopher's)
			Have agreed standards for safeguarding and dignity issues	September 2015	Strategy Board (Local Authority Senior Responsible Owner - SRO)
	Ensure that the specific needs and variance in different settings are explored and addressed, for example for those living alone, those living in nursing and residential homes and those in hospital.	Greater understanding of most cost effective, quality interventions and services will support patients and their carers A robust discharge pathway plus services available 24/7 are a main barrier to	Explore use of PDDS and commissioning meetings provide route to promote reflective analysis	September 2015	Strategy Board (CCG SRO)

OBJECTIVE	INITIATIVE	GAP	SOLUTION (TBC)	TIMEFRAME	OWNER
		moving resources to the community			
			Work with GSF teams to conduct analytical after death analysis to identify common problems.	April 2016	Strategy Board (GP Support)
		Need for a more robust examination of the care requirements to manage rapidly changing health status	Conduct a review of emergency hospital admissions resulting in death	April 2016	Strategy Board (Public Health)
	The local workforce will have the appropriate equipment to provide care and treatment to patients	Anecdotal issues of lack of access to crisis medications at the end of life. No previous systematic equipment needs assessment done	Work with local provider teams to identify equipment needs	September 2015	CRG (District Nurse lead)

OBJECTIVE	INITIATIVE	GAP	SOLUTION (TBC)	TIMEFRAME	OWNER
	Ensure that there is appropriate monitoring to evaluate quality of care, equality of care and identify the need for further service redesign or improvement.	EoLC outcome measures are not currently included for all providers involved in care	Work with all commissioners to ensure that contract discussion and service evaluation are informed by national end of life quality markers	April 2016	Strategy Board (CCG SRO)
5. Care in the last days of life	Ensure that clinical teams caring for people in the last days have the skills to manage the patient's holistic care needs (physical, psychological, social and spiritual)	No method of evaluating skills within teams i) to deliver care to patients and ii) to support family members	Develop a core skill set for those in the delivering terminal care.	September 2016	CRG (GP Lead/ Care home manager, St Christopher's)
	Monitor the quality and effectiveness of care in the last days of life Ensure there is positive risk taking among all staff. There is often conflict between services and families when DNACPR or advanced decisions have been made.	No method to evaluate the standard of care	Agree local standard to support and evaluate terminal care.	September 2015	CRG (GP lead/ CHS Clinical lead)
		No review of local VOICES survey locally	Review evidence of quality of terminal care	April 2016	Strategy Board (Public Health)

OBJECTIVE	INITIATIVE	GAP	SOLUTION (TBC)	TIMEFRAME	OWNER
	Ensure all services dealing with people at the end of life follow agreed national guidelines about communicating and documenting treatment decisions such as Advance Decisions to Refuse Treatment (ADRT) and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders, and support patients and carers in the process of agreeing these decisions.	No previous audit on the use of tools to document advance decisions and care planning	Conduct audit of the use of tools to aid decisions and communication of decisions made	December 2015	Strategy Board (GP Support)
6.Involve and support friends and families	Ensure health and social care professionals involve family and carers in decision making and advance planning.	No data available currently on how family and carers are supported to be involved in decision making	Review after death complaints Ensure that 'difficult conversations' training includes session on carer involvement	July 2015	Strategy Board (EoLC Commissioner)
	Ensure that clinical teams caring for the dying provide support for family and friends	Routine data not currently collected on how the carers support is planned and delivered	Develop and conduct a survey of carers to identify gaps	September 2016	CRG District Nurse lead)

OBJECTIVE	INITIATIVE	GAP	SOLUTION (TBC)	TIMEFRAME	OWNER
	Ensure that the rights of carers to an assessment of needs are upheld.	No data available on use of carer assessments for those looking after someone who is dying	Work with the local authority to identify if carers needs, of those caring for people at the end of life, are currently being assessed	April 2016	Strategy Board (Local Authority SRO)
	Ensure that information is readily available on all local services, which will support those approaching the end of life and the bereaved, including: community support, funeral directors, social and health services, and the voluntary sector. A joint communication strategy around providing shared advice and information in place	Various information sources available but not clear if it is a) current b) how accessible it is	Review information sources and work with JCU to ensure that service information is readily accessible by all	September 2016	CRG (Social service lead/ District Nurse lead Community nurse lead)
7.Develop the competencies of workforce	All health and social care professionals working with people approaching the end of their life will be prepared to	GPs, District nurses and social workers have identified learning needs in the	Commission training on advance care planning and evaluate	July 2015	Strategy Board (EoLC Commissioner)

OBJECTIVE	INITIATIVE	GAP	SOLUTION (TBC)	TIMEFRAME	OWNER
	have a supportive role in that person's care and when appropriate the planning of their future care needs.	delivery of care to people at the end of life	Review themes from complaints to identify further learning needs	April 2016	CRG (CHS Clinical lead/ Head of nursing St Christopher's)
	Local services will have minimum standards competency in key core end of life skills which healthcare professionals delivering care to those at the end will have. It is expected that these will include skills in communication and care planning	No standard of skill set for key clinical groups specific to end of life care. Work to develop skill sets may identify further training needs	Work with those developing skill sets to identify training support	September 2016	CRG (GP education lead/ District Nurse lead)
	Service monitoring will include evaluation of key core end of life skills	Service contracts do not routinely include outcomes relating to EoLC service delivery currently	Include EOLC skill set in contract discussions	April 2017	Strategy Board (CCG SRO)
8.Develop a robust monitoring and performance framework	Develop a robust integrated performance management system across health and social care that enables us to monitor quality, outcomes & expenditure.	Need to review key quality indicators for EoLC	Work with commissioning colleagues to include Quality indicators and measure for EoLC	April 2016	Strategy Board (EoLC Commissioner)
			Quarterly review of complaints relating to EoL	Quarterly	Strategy Board (EoLC Commissioner)

OBJECTIVE	INITIATIVE	GAP	SOLUTION (TBC)	TIMEFRAME	OWNER
		Need to engage with other commissioners and individual service providers to develop individual measures of quality	Work with providers to develop local quality markers	April 2016	Strategy Board (GP Lead)/ CRG (CHS clinical lead)
		Need to review outcome of the national VOICES survey	Identify what information there is locally on VOICES survey	September 2015	Strategy Board (Public health)
	Strengthen feedback from patients and carers and develop mechanisms to enable involvement in the design, development and delivery of services.	No current specific initiative to engage & incorporate patient and carer experience into service evaluation	Work with service providers develop processes to include patient and carer feedback in service evaluation	July 2016	Strategy Board (EoLC Commissioner)

Appendix 2 Needs Assessment Chapter References

1) Croydon Observatory Website, www.croydonobservatory.org

2) Office of National Statistics Website, www.statistics.gov.uk

3) Greater London Authority Website, www.london.gov.uk

4) Borough Profile Quarterly Report January 14, Kritah A., Strategic Intelligence Unit, Croydon Council, 8th August, 2014.

5) National General Practice Profiles, Public Health England Website online calculator resource, http://fingertips.phe.org.uk/profile/general-practice/data

6) ONS & GLA Population Projection Models, Croydon Observatory Website, http://www.croydonobservatory.org/Populations_Projections

7) See additional Borough Ward Map Enclosure for more detail.

8) For example, any of a number of DoH papers referencing Mental Illness

9) for example, any of the numerous recent HSJ references on Mental Illness

10) Projecting Adults Needs and Service Information (PANSI), www.pansi.org.uk

11) Dementia Projection in Croydon: Source: Projecting Older People's Population Information (POPPI), www.poppi.org.uk.

12) Croydon Observatory Website, www.croydonobservatory.org. – Population Details

13) See for example the ONS website which provides Excel-based tools to break down populations by year

14) Long-term Condition Projection for Croydon: 2012-2

Other References **Appendix 3**

1. The NHS Cancer Plan: a plan for investment, a plan for reform. Department of Health, London. September 2000

2. Improving Supportive and Palliative Care for Adults with Cancer. National Institute for Clinical Excellence, 2004

3. Our Health, Our Care, Our Say. DH, 2006

4. End of life care strategy; promoting high quality care for all adults at the end of life. DoH, July 2008

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7. Higginson, I. Priorities for end of life care in England, Wales and Scotland. NCPC 2003

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9. Strategic Plan for Palliative Care Services for the Borough of Croydon on behalf of the Croydon Palliative Care Forum. Saunders,Y. Horak,E. Jowett,C. Aldous,J. Bunker,L. Murdoch,I. Elvin,S. Fearnside,E. October 2005. http://www.croydonhealthservices.nhs.uk/services/Palliative%20care/

10. The Croydon Hospital and Croydon Primary Care Trust: Specialist Palliative Care Services Annual Report 2008
11. http://www.croydonccg.nhs.uk/getinvolved/consultations/pages/betterservicesbettervale.aspx Croydon CCG Website

12. End of Life Care Strategy: Quality markers consultation. November 2008. DH

13. End of Life Care Strategy: 4th Annual Report. October 2012. DH

14. ONS Deaths Registration Data

15. One Chance to Get it Right: Improving people's experience of care in the last few days and hours of life. Leadership Alliance for the Care of dying people ref 01509

16. Royal College of General Practitioners Guidance to Commissioning End of Life care http://www.rcgp.org.uk/policy/~/media/Files/CIRC/EOLC/RCGP-EOLC-Guidelines-Apr-2013.ashx

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