Project Crib Sheets

August 2024

Health & Social Care Team

Social Finance, 87 Vauxhall Walk
London, SE11 5HU

Macmillan End of Life Care Fund

SOCIAL FINANCE | MACMILLAN CANCER SUPPORT

Macmillan End of Life Care Fund

The fund will see Macmillan invest up to £36m in end of life care services across the UK.

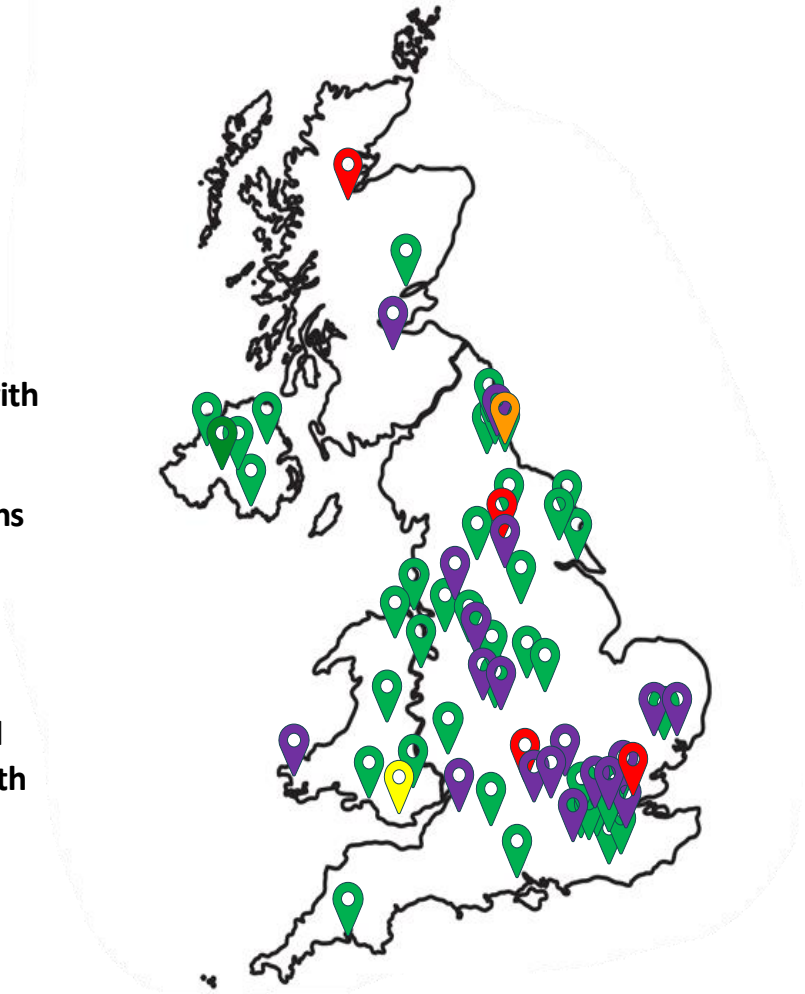
Macmillan provides up-front funding for services which is repayable if mutually agreed outcomes are met, thereby absorbing the financial risk of non-delivery.

Aims of the Macmillan EOLC Fund:

- Ensure that people approaching end of life are identified early and have access to high-quality, personalised EOLC services.
- Make sure people receive equitable EOLC that takes into account their choices, wishes and preferences.
- Support health and social care professionals to work in an integrated way across organisational boundaries.
- Promote outcomes-based contracting for end of life across the UK.

Overview of the Macmillan End of Life Care Fund

- Live site
- Conversation had with potential partner
- 2023 EOI applications received
- Wales workshop delivered
- Northern Ireland workshop delivered
- North East and North Cumbria workshop delivered



In 2021 Macmillan Cancer Support launched their End of Life Care Fund in partnership with Social Finance.

Since then, the Team has engaged with over 100 partners across the UK and received 80 formal applications in 2021 and 2023. Most applications averaged £2m over 3 years with the most popular service elements being advance care planning, single point of access and rapid response.

4 services are now live in Oxfordshire, Highland, Harrogate and Mid & South Essex.

SOCIAL FINANCE | MACMILLAN CANCER SUPPORT

Macmillan End of Life Care Fund Live Projects

1 **OXFORDSHIRE**

2 **HIGHLANDS**

3 **HARROGATE**

4 **ST LUKES HOSPICE**

OXFORDSHIRE

Rapid Intervention for Palliative and End of Life Care (RIPEL)

APR 22 – MAY 25

Macmillan EOLC Fund

Partners

- **Service commissioner and provider**: Oxford University Hospitals NHS Foundation Trust
- **Co-funder**: Sobell House Hospice Charity

Aim

Provide enhanced integrated care and support for adults at the end of life in conjunction with existing services and care teams across Oxfordshire and South Northamptonshire.

Outcome Metric

Reduction in unplanned hospital bed days in the last year of life

Service

The RIPEL programme comprises four inter-related services:

- Home Hospice providing care at home for people in their last days of life;
- Hospital Rapid Response facilitating rapid supported discharge from hospital;
- An enhanced Palliative Care Hub providing telephone access to a coordinated network of clinical and support staff and
- Hospice Outreach: a virtual ward for patients with unstable or complex dying palliative care needs.

Impact

- ✓ 3,104 referrals were received by the 4 RIPEL services between Apr 22 to March 24.
- ✓ 11,729 unplanned bed days have been avoided to March 2024.
- ✓ Each programme patient spent an average of 9 days at home instead of hospital in their last year of life during the period April 2022 to March 2024.
- ✓ The financial value of bed days saved equates to £2.66m to September 2023.

HIGHLANDS

Palliative Care Response Service and Helpline

APR 22 – DEC 25

Macmillan EOLC Fund

Partners

Service commissioner and provider: Highland Hospice in partnership with NHS Highland. The service is part of the wider End of Life Care Together partnership in the Highlands.

Aim

To shift the balance of end of life care from acute hospital to community settings to deliver better care and better value.

Outcome Metric

Reduction in unplanned hospital bed days in the last year of life

Service

- The Palliative Care Response Service (PCRS) covering Inverness, provides timely access to social care at home for up to six weeks for people at end of life, to support people in the community setting and place of their choice.
- The Palliative Care Helpline (PCH) provides a single point of access for 24/7 advice, support and information for people nearing end of life, their families, carers, and professionals across Highland and Argyll and Bute.

Impact

- ✓ In 2023, the PCH received over 2,400 calls and the PCRS received 125 referrals.
- ✓ In 2023, the people who died using both services spent on average six fewer days (PCH) and on average 20 fewer days (PCRS) in hospital in their LYOL following an emergency admission than would have been expected.
- ✓ This is the financial equivalent of £3,707,910 (based on published NHS Highland bed day rates).

Note: All impact figures are totals and based on a set of assumptions agreed with NHS Highland's Public Health Intelligence Unit. The outcomes figures include all referrals to the service and are based on actual hospital bed day costs at NHS Highland.

HARROGATE

Harrogate End of Life Planning and Support Service (HELPSS)

Macmillan EOLC Fund

JAN 24 – DEC 27

Partners

- **Service commissioner**: Harrogate and District NHS Foundation Trust
- **Service providers**: Saint Michael's Hospice (SMH) and Airedale NHS Foundation Trust (Goldline)

Aim

To identify people who may be in their last year of life (LYOL), increase their access to advance/future care planning and provide those individuals and their carers with a telephone service offering clinical help, support and advice.

Outcome Metric

Reduction in unplanned hospital bed days in the LYOL

Service

- Use of a clinical reporting tool in primary care to identify LYOL
- Use of Supportive and Palliative Care Indicators Tool (SPICT) in hospital to identify LYOL
- SMH provides a service to improve access to and recording of high-quality advance/future care plans to ensure care choices at the end of life are discussed, recorded, and shared with relevant health care professionals
- Goldline provides a 24/7 telephone service offering access to clinical help, support and advice for patients in LYOL and their carers. Onward referral to appropriate services as required.

Impact

- ✓ Outcome metrics expected from February 2025.

ST LUKES HOSPICE

Hospice Community Services Locality Teams

May 24 – April 27

Macmillan EOLC Fund

Partners

- **Service provider**: St Luke's Hospice, Mid & South Essex

Aim

To strengthen care at home for people in LYL by providing a high quality, responsive and flexible palliative and end of life care service

Outcome Metric

Reduction in unplanned hospital bed days in the last year of life

Service

- Three multi-disciplinary Locality Teams who, within the patient's place of residence will offer:
  - Specialist palliative and end of life care
  - Personalised care based on need
  - Symptom management
  - Non-medical prescribing
  - Emotional and wellbeing support
- Service available 24/7
- Referrals via a healthcare professional, a formal or informal carer, a family member or self referral

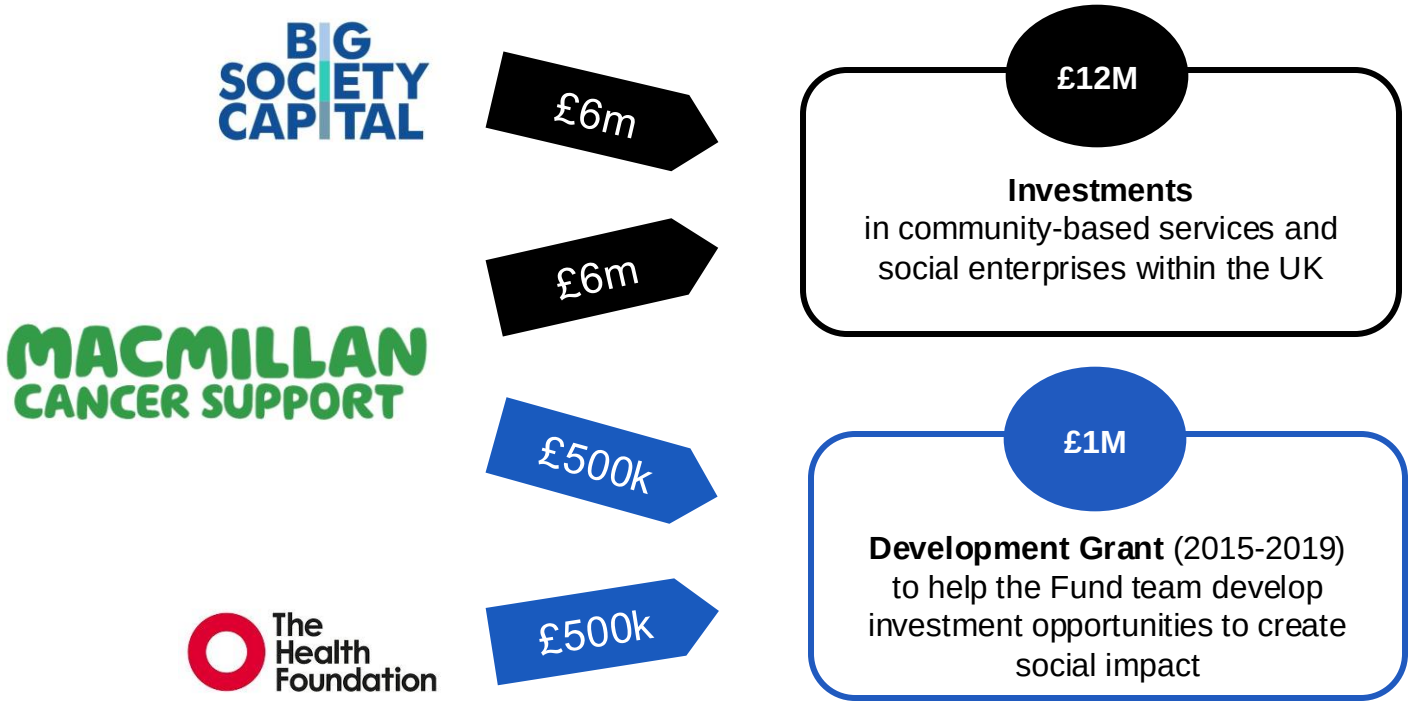
Impact

- ✓ Outcomes metrics expected from January 2025.

Care and Wellbeing Fund

Care and Wellbeing Fund (CWF)

In 2015 we launched a £12M Fund to test whether social investment could improve outcomes in health and social care



The Care and Wellbeing Fund's objective is to explore how social investment might:

- Improve outcomes by shifting the focus from activity
- Increase sustainable community-based models of care
- Drive new types of partnerships between charities and the statutory sector

Care and Wellbeing Fund

End of Life Care Integrator Projects

BRADFORD

APR 22 – MAY 25

Reactive Emergency Assessment Community Team (REACT)

C&WF EOLC

Partners

- **Service Provider**: Marie Curie
- **Service Commissioner**: Bradford Teaching Hospital FT

Aim

To reduce reliance on acute services and identify people approaching end of life in a timely way and maintain communication about their choices and wishes

Outcome Metric

Reduction in unplanned hospital bed days in the last year of life

Service

A specialist palliative care in ED to help identify end of life patients and influence their management including hospital avoidance and a rapid response community service that can receive patients discharged from ED and provide care up to 72 hours until mainstream services can be mobilised

Impact

- ✓ 801 referrals into the service from Apr 22 to March 2024.
- ✓ For those patients who died up until December 2023, the average number of unplanned bed days per patient in the last year of life was 17, compared to baseline of 38
- ✓ In total, 8,344 unplanned hospital bed days were avoided till December 2023

NORTH WEST LONDON

DEC 18 – SEPT 22

Telemedicine for Care Homes

C&WF EOLC

Partners

- **Commissioner**: North West London CCG
- **Providers**: London Central & West Unscheduled Care Collaborative, West London Mental Health Foundation Trust, & St John's Hospice

Aim

To set standards that the NWL CCG requires from its providers to ensure high quality, safe and personalised care home services that promote choice and dignity for all residents

Outcome Metric

Reduction in unplanned hospital bed days for patients who come from care homes

Service

With a joint partnership between West London NHS trust and LCW UCC, the telemedicine service was made up of a clinical lead, advanced clinical practitioners (ACPs), and telephone triage nurses (TAS). The team provided clinical assessment, advice, intervention, support and referrals to appropriate services for further assessment and treatment where required to care home residents within eight NWL borough using virtual telephone or video consultation.

Impact

- ✓ 9,884 total people were supported. In March 2022, 303 total NEL admissions were avoided, and overall there was a 28.7% reduction in NELs from a baseline of 14,176 NELs
- ✓ During the Covid pandemic, support to care homes in the area was greatly enhanced and although successful, the service was not sustained. However, the learning from this fed into the development of enhanced care in care homes in the NWL region.

SUTTON

Palliative Care Coordination Hub

APR 20 – MAR 23

C&WF EOLC

Partners

- **Service Provider**: Sutton Health and Care Provider Alliance
- **Service Commissioner**: NHS South West London ICB

Aim

Aiming to better coordinate end of life care in Sutton, facilitate early identification, holistic assessment and support and ensure equitable care provision across all settings

Outcome Metric

Reduction in unplanned hospital bed days in the last year of life

Service

The hub team provides a single point of access for people aged 18 and over who are likely to die within 12 months, delivering care coordination and communication for professionals, individuals, families and ensure carers are better supported

Impact

- ✓ 622 patients in the service have died from April 2020 to the end of project (March 23). 494 of these were eligible for outcomes, resulting in 9,360 total bed days in the hospital avoided.
- ✓ The hub was re-commissioned at the end of the service and adaptations were made based on the learning.

SOMERSET

'Talk About' Volunteer Led Advance Care Planning

C&WF EOLC

APR 21 – SEP 23

Partners

- **Service Provider**: Marie Curie
- **Service Commissioner**: Somerset ICB

Aim

To create holistic advance care plans for people at end of life, including patient and carers in discussion and ensuring that documentation is uploaded to GP notes

Outcome Metric

Reduction in unplanned hospital bed days in the last year of life

Service

Delivered by Marie Curie and led by trained, supported and managed volunteers to deliver a service that provides an opportunity for people in Somerset to share their thoughts and wishes for their future. If the person wishes to have a record of the conversation uploaded onto the Somerset Integrated Digital e-Record System, this can be facilitated.

Impact

- ✓ During the period from April 2021 to June 2023, the service received 1,013 referrals and 155 had completed an Advance Care Plan.

HARINGEY

Advance Care Plan Facilitator in Care Homes

C&WF EOLC

APR 17 - MAR 19

Partners

- **Service Provider**: Osborne Grove Nursing Home, Priscilla Wakefield Nursing Home
- **Service Commissioner**: Haringey CCG

Aim

To proactively identify care home residents approaching end of life, understand how to have discussions and document and record patient's wishes about their future in two nursing homes in Haringey

Outcome Metric

Reduction in unplanned hospital bed days in the last year of life

Service

The project recruited a dedicated ACP Facilitator within specified care homes to change the conversations care home staff had with patients about EOLC and overtime with support, their approach and focus became more holistic

Impact

- ✓ Emergency admissions into hospital were reduced by 14%. 23 non-elective admissions were avoided. 94% (44/47 users) who had an admission with an Advance Care Plan (ACP) had it in line with their ACP.
- ✓ The project was sustained after the social investment project finished, with nurses continuing to work in the care homes.

HILLINGDON

Your Life Line 24/7

SEP 18 - DEC 21

C&WF EOLC

Partners

- **Service Provider**: Central and North West London NHS Foundation Trust
- **Service Commissioner**: Hillingdon CCG

Aim

To improve the integration of the specialist services for people at end of life, to support people remain in their preferred place of care and reduce unnecessary hospital admissions

Outcome Metric

Patients dying in their usual place of residence

Service

Two components: a 24 hours / 7 days a week dedicated Single Point of Access offering telephone advice and coordination with other palliative care services in the local area from 8:00am to 8:00pm; and a palliative overnight nursing service, with trained nurses who can offer urgent 2-hour response home visits from 8:00pm to 8:00am

Impact

- ✓ The service has been recommissioned by the CCG and is embedded permanently in the care system.
- ✓ Since inception in 2018, the service accepted 2,275 referrals, and of those 1,908 people have since died (85%). Of those accepted referrals 93% achieved death in their preferred place and 91% achieved death in their usual place of residence

WALTHAM FOREST

System Transformation

JAN 19 – MAR 21

C&WF EOLC

Partners

- **Service Provider**: North East London Foundation Trust and Barts Health
- **Service Commissioner**: Waltham Forest CCG

Aim

Aimed to bring together the EoLC system in Waltham Forest – local services and organisations working with end of life care patients, carers and

Outcome Metric

Reduction of unplanned admissions, deaths in hospital and A+E admissions

Service

Programme made up of a series of workstreams including an EPIC service to provide hands on nursing care for end of life care patients, an end of life care education strategy for professionals, the development of a system wide dashboard, creation of an end of life steering group and increasing the usage of Coordinate My Care ACPs

Impact

- ✓ This programme successfully unified the end of life care system in Waltham Forest. The engagement with the local authority has remained robust and enduring after the service concluded.
- ✓ From Apr - Jan 2021, 79.3% of patients with a CMC care plan died in their preferred place of death. 297 CMC Care Plans were viewed by urgent care services in December 2020, an increase from 154 in April 2020.