London Vision

Improving care and support at the end of life

Our ambition: every Londoner is able to die at home or in a place of their choice, comfortably, surrounded by people who care for them.

Our commitment: we will ensure that all Londoners in their last year of life have access to personalised care planning and support that enables them to die in their preferred place

The challenge we face...

Londoners are disproportionately dying in hospital. The NHS Long Term Plan supports the need to personalise care and to improve end of life care. People entering their last year of life can be identified and offered personalised care and support planning

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89%

of people would prefer to die at home or in a hospice

The overall cost of care is understood to be lower outside of hospital settings

London also has the highest average length of hospital stay for people with a terminal illness compared to other regions in England

6%

There is a considerably higher proportion of hospital deaths in London, which is 6 percentage points higher than the national average

15%

of all emergency hospital admissions in England belong to the 1% of people in their final year of life

The increase in the number of those with long-term health conditions means that people are more likely to require complex care for an extended period of time before their death

Our actions so far...

- Developing a programme of work in all STPs focused on **improving the experience of End of Life Care** (EOLC)
- Supporting health and care staff to **identify people who are likely to be in their last year of life** and offer them personalised care and support planning
- Giving **particular consideration to people likely to have specific needs**, for example those with learning disabilities and people who are homeless
- Supporting the implementation of 'Coordinate my Care' (CMC) for people in their last year of life, ensuring that important **information like wishes and preferences is shared with services** providing urgent or unplanned care
- Developing and supporting CMC in all care settings in London including **monitoring the quality of records** created
- Disseminating a resource developed by the EOLC Clinical Network to support primary care in **achieving the new 2019/20 quality improvement indicators** of the Quality and Outcomes Framework

Our next steps...

- NHS London will continue development and implementation of Coordinate My Care (CMC) through a lead commissioner approach, optimisation of digital enablers and wider clinical engagement education and training
- We will support adherence to the upcoming NICE guidance on EOLC service delivery across London
- The EOLC Clinical Network will complete a project with Newham CCG primary care using an electronic identification search tool and clinical pathways to improve EOLC identification and personalised care and support planning. Learning from this will be spread regionally
- Led by the EOLC Clinical Network; London's hospices, community services and acute Trusts will come together with the aim to create a single medication administration record chart
- The Metropolitan Police, London Ambulance Service, 111 services and the EOLC Clinical Network will create a protocol for responding to expected deaths in the community and associated training materials