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# Palliative and End of Life Strategic Delivery Plan for Lincolnshire 2017 - 2022

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Working together to identify all patients deteriorating from a life limiting condition in Lincolnshire, and to provide the highest quality care, communication and support.

November 2017



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# Introduction

## **‘How people die remains in the memory of those who live on’**

Dame Cicely Saunders (1918 – 2005)

Founder of the modern hospice movement

End of life care is one of life’s few certainties: it happens everywhere to everyone.

The aim of this strategy is to help those people in Lincolnshire with advanced, progressive and incurable illness, whatever the diagnosis, to live as well as possible until they die. It aims to provide a framework to support individuals and their carers and loved ones through the prevention and relief of suffering. This framework is made up of five themes:

- Recognition
- Communication
- Supportive care
- End of life care
- Organisation of palliative resources

Good end of life care is everyone’s responsibility and demands a collaborative approach and teamwork to provide support wherever the individual is. By the whole system working together and including professionals from medicine, nursing and allied health and social care, the voluntary and community sector, the care home and domiciliary care sector and informal carers, , and by placing the individual at the centre of all decisions and actions this can be achieved.

The landscape in Lincolnshire is changing:

- There are increasing numbers of people, with increasingly complex needs, requiring effective end of life care.
- The demography of the county is changing and there are increasing numbers of people who are ‘hard to reach’ with complex long term conditions.
- The structure of health and social care in Lincolnshire is changing at pace, moving towards an integrated approach, with care being delivered by multi-disciplinary teams closer to home (to meet the objectives of the Lincolnshire Sustainability and Transformation plan). , The vastness and extreme rurality of the county means that what we do to achieve our strategic ambitions will be different depending on the locality.

Taking these challenges into consideration, and anticipating the future needs of our population, means that this strategy takes a transformational approach to change the delivery of good end of life care the long term

# Principles

In developing this strategy we have applied certain principles to everything we will do:

- We will promote the following Self Care principles:
  - The community is the heart of the ‘neighbourhood team’;
  - The approach involves all ages and is not just focused on people already receiving health or care services;
  - The approach builds on the assets that already exist in the community;
  - The community are equal partners in changing behaviours, building resilience and providing mutual support;
- Staff involved in neighbourhood teams have an equal journey in changing behaviours, building resilience and providing mutual support to each other<sup>1</sup>.
- Collaborative working. We working together as a whole system around the individual
- Fair access will exist irrespective of diagnosis, age, gender, sexual orientation, social or cultural factors.
- Every patient and those important to them have the right to expect honest, informed and timely conversations about death, dying and bereavement.
- We will work according to the following principles which have been identified in ‘Every Moment Counts’ A narrative for person centred co-ordinated care for people near the end of life<sup>2</sup>.
  - We work for my goals and the quality of my life and death
  - I have honest discussions and the chance to plan
  - The people who are important to me are at the centre of my support
  - My physical, emotional, spiritual and practical needs are met
  - I have responsive, timely support day and night
- We will ensure that we are aligned with, but not constrained by other concurrent transformation plans.

## How we have developed this strategy

In developing this strategy, we have taken the following approach:

- We have based our strategic aims on the “Ambitions for Palliative and End of Life Care” document<sup>3</sup>. This is a framework for action in making palliative and end of life care a priority at local level, produced by the National Palliative and End of Life Care Partnership, made up of statutory bodies including NHS England, the Association of Adult Social Services, charities and groups representing patients and professionals.
- We have identified the needs of the county, its population and the organisations who provide services by utilising a self assessment tool based on the six ambitions for palliative and end of life care developed by the National Palliative and End of Life Care Partnership<sup>4</sup>. This is a nationally recognised document and the framework has been used by stakeholders to identify unmet need and gaps in service provision in the county.
- We have consistently taken a collaborative approach in the assessment of need and the development of the strategy, involving partners from the NHS, NHS providers, Lincolnshire

County Council Adult Social Care and Public Health, the Voluntary, Community and Charitable sector and the private sector.

- We have applied the principles from the New Priorities of Care contained in 'One Chance to get it Right'<sup>5</sup>.
- Incorporated information from 'Every Moment Counts'
- Incorporated comments from a multi disciplinary stakeholder workshop delivered on 27<sup>th</sup> September 2016.
- Developed the strategy with guidance from the Lincolnshire Palliative and End of Life Expert Reference Group.

# Ambitions for Palliative and End of Life Care

The Ambitions document contains an overarching vision: “I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s).” To bring about that vision, six ambitions were developed, with eight foundations to those ambitions, listed below. For each of our strategic aims, we have indicated which of the foundations and ambitions it correlates to.

<b>Foundation 1</b>	<b>Personalised care planning</b>
<b>Foundation 2</b>	<b>Shared records</b>
<b>Foundation 3</b>	<b>Evidence and information</b>
<b>Foundation 4</b>	<b>Involving, supporting and caring for those important to the dying person</b>
<b>Foundation 5</b>	<b>Education and training</b>
<b>Foundation 6</b>	<b>24/7 access</b>
<b>Foundation 7</b>	<b>Co-design</b>
<b>Foundation 8</b>	<b>Leadership</b>
<b>Ambition 1</b>	<p><b>Each person is seen as an individual</b>            I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what’s possible.</p>
<b>Ambition 2</b>	<p><b>Each person gets fair access to care</b>            I live in a society where I get good end of life care regardless of who I am, where I live or the circumstances of my life.</p>
<b>Ambition 3</b>	<p><b>Maximising comfort and wellbeing</b>            My care is regularly reviewed and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible.</p>
<b>Ambition 4</b>	<p><b>Care is coordinated</b>            I get the right help at the right time from the right people. I have a team around me who know my needs and plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time day or night.</p>
<b>Ambition 5</b>	<p><b>All staff are prepared to care</b>            Wherever I am, health and care staff bring empathy, skills and expertise and give competent, confident and compassionate care.</p>
<b>Ambition 6</b>	<p><b>Each community is prepared to help</b>            I live in a community where everybody recognises that we all have a role to play supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways.</p>

# Definitions

We understand that the language we use can be a barrier to, as well as an enabler of, understanding. For the purposes of this strategy it will be useful to define exactly what we mean, in Lincolnshire, by the following terms. The national definitions are:

## End of life Care

Support for people who are in the last months or years of their life. It should help you to live as well as possible until you die, and to die with dignity. (NHS Choices)

**or**

Care for people who are likely to die within 12 months, people with advanced, progressive, incurable conditions and people with life-threatening acute conditions. It also covers support for their families and carers. (NICE 2011)

## Palliative Care

An approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:

- provides relief from pain and other distressing symptoms
- affirms life and regards dying as a normal process
- intends neither to hasten or postpone death
- integrates the psychological and spiritual aspects of patient care
- offers a support system to help patients live as actively as possible until death
- offers a support system to help the family cope during the patients illness and in their own bereavement
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated
- will enhance quality of life, and may also positively influence the course of illness
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications (World Health Organisation)

## Supportive Care

The provision of the necessary services for those living with or affected by cancer (incurable illness) to meet their informational, emotional, spiritual, social, or physical needs during their diagnostic, treatment, or follow-up phases encompassing issues of health promotion and prevention, survivorship, palliation, and bereavement. ([Curr Opin Oncol](#). 2014 Jul;26(4):372-9)

**or**

Treatment given to prevent, control, or relieve complications and side effects and to improve the patient's comfort and quality of life

## **Deterioration**

To grow worse in function or condition

However, the group recognised the barriers to achieving earlier involvement of palliative care expertise within the treatment continuum. These barriers may be largely due to the perception of palliative care by the public, patients and many health professionals - in particular the association with care at the end of life. The care that is provided for patients who are nearing the end of life needs to be extended to support them much earlier on in their illness. We undertook a survey of members of the public to better understand what they understood by the following terms and how they used them. It's clear that people place a different meaning to the terms we frequently use. As health and social care professionals we need to remain aware of this to ensure that we are communicating effectively with the people we are supporting.

Our survey suggests that in Lincolnshire the public understand the following terms to mean:

## **End of life**

Days or last hours before death.

## **Palliative care**

Medical and nursing care to provide comfort and to ease pain and symptoms for people with a range of life limiting conditions

## **Supportive care**

Enabling a person to live helping everyday needs including emotional and practical support, supporting patient, family and bereaved.

## **Deterioration**

Declining health (physical and/or mental); progressive worsening of someone's condition.

Therefore whilst we acknowledge the national definitions that exist, we have chosen not to use the term "end of life" to refer to the last year of life, as this is not widely understood by patients. Instead, we have reserved this for the last few hours or days of life. In order to ensure palliative patients are identified in a timely way, we have chosen to focus on patients who are felt to be deteriorating, and who might benefit from supportive care.

# Our Strategic Vision

Working together to identify all patients deteriorating from a life limiting condition in Lincolnshire, and to provide the highest quality care, communication and support.

## Our Strategic Aims

### **Aim 1: Recognition**

Identifying patients who are deteriorating from a life-limiting condition, to include those who might not otherwise have been considered for palliative care, and to allow for planning how to support these individuals and those important to them. Furthermore, signs of distress should be recognised and addressed.

### **Aim 2: Communication**

Every individual and those important to them have a right to expect honest, informed and timely conversations about deterioration, , dying, death and bereavement. The care that is available for individuals nearing the end of life, and what they can expect, should be accessible to everyone and communication between organisations should be easy and effective.

### **Aim 3: Supportive Care**

All individuals who are identified as deteriorating should have access to a Supportive Care Assessment, and referrals to appropriate palliative care services should be robust.

### **Aim 4: End of Life Care**

When an individual is nearing the last few days or hours of life, this should be recognised and be communicated with the patient and those important to them, to the degree to which they wish. The five priorities of Care of the Dying Person should be applied.

### **Aim 5: Organisation of palliative care resources**

The most appropriate framework for provision of palliative care across Lincolnshire will be developed, with clear roles and responsibilities for organisations and individuals providing care, which will enable fair and equal access for all. There should be access to specialist palliative care advice and support 24 hours a day, seven days a week. Integrated care teams will have access to appropriate training. Communities should be recognised as equal partners in Neighbourhood and integrated care teams to build resilience and compassion.

# Our Palliative Care Delivery Plan

## Aim 1: Recognition

- All patients deteriorating from a life-limiting condition should be identified
  - There will be a systematic way for clinicians to identify these patients and a simple mechanism in place to ensure a comprehensive assessment of their needs will be carried out by the most appropriate healthcare professional
  - Fair access will exist irrespective of diagnosis, age, gender, sexual orientation, social or cultural factors

Foundation 1	Personalised care planning
Foundation 5	Education and training
Ambition 1	Systems for person centred care
Ambition 2	Community partnerships Unwavering commitment
Ambition 3	Skilled assessment and symptom management
Ambition 4	Everyone matters Continuity in partnership
Ambition 5	Professional ethos

- Signs of distress will be recognised and addressed
  - Whether the distress is physical, psychological, social or spiritual in nature

Ambition 3	Recognising distress whatever the cause Addressing all forms of distress
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- The needs of families and others important to the patient will be identified
  - Including bereavement needs

Foundation 4	Involving, supporting and caring for those important to the dying person
Ambition 1	Good end of life care includes bereavement
Ambition 4	Everyone matters

<b>What good looks like</b>	<b>Where are we now?</b>	<b>What needs to change?</b>	<b>What actions do we take?</b>	<b>What measures our success?</b>
<p>The locality can demonstrate how end of life care services have been influenced by local population based needs assessments.</p> <p>Clinicians can recognise when patients with life-limiting illness are deteriorating, can recognise all forms of distress, and know how to ensure a comprehensive assessment is carried out.</p> <p>Patients and families have timely access to counselling and bereavement support.</p>	<p>We need a local population based needs assessment.</p> <p>Patients may not be recognised as palliative until very late in their illness.</p> <p>Late identification of patients can lead to inappropriate hospital admission, investigations and treatments, and failure to achieve preferred place of care and death.</p> <p>There is poor awareness of the different palliative care services available, and referral to these services is often late and goes to the wrong place.</p> <p>There is a lack of timely counselling and bereavement support available.</p>	<p>Understanding of our local populations, and understanding who is not receiving appropriate care.</p> <p>Recognising when people have palliative care needs, when people are deteriorating and when people are in the last few days of life.</p> <p>Consistently using the 'frailty tool' to ensure all patients approaching end of life have a personalised needs assessment.</p> <p>Ensuring that signs of distress in the patient and their family are identified.</p> <p>Recognising that care extends beyond the end of life for carers, families and loved ones.</p>	<p>Perform a population based needs assessment.</p> <p>Develop better terminology to help identify patients at an earlier stage.</p> <p>Develop an education strategy for palliative care in Lincolnshire, with a focus on earlier identification.</p> <p>Improve access to counselling and bereavement support across the county.</p>	<p>Population based needs assessment completed, and gaps in provision identified, whether based on location, age, diagnosis, social or cultural factors.</p> <p>New terminology developed and agreed by clinicians and patient groups.</p> <p>Education strategy developed and put into effect, and training programmes delivered with focus on improving identification.</p> <p>Increase in numbers of patients and families able to access counselling and bereavement support.</p>

## Aim 2: Communication

- Every patient and those important to them have a right to expect honest, informed and timely conversations about deterioration, dying, death, and bereavement
  - Conversations should be offered proactively
  - All staff involved in the care of dying patients will receive appropriate communication skills training

Foundation 5	Education and training
Ambition 1	Honest conversations Good end of life care includes bereavement
Ambition 5	Professional ethos Knowledge based judgement Awareness of legislation

- Clear statements of what patients nearing the end of their life can expect and the care that is available to them will be easily accessible to all

Ambition 1	Clear expectations Helping people take control
Ambition 4	Clear roles and responsibilities
Ambition 5	Using new technology
Ambition 6	Public awareness

- Clinical records will be shared between organisations
  - Patient's consent to share their clinical records with all those involved in their care will be requested and acted upon as part of their initial assessment
  - EPaCCS will be in place to ensure relevant information is shared effectively

Foundation 2	Shared records
Ambition 4	Shared records A system-wide response Continuity in partnership
Ambition 5	Using new technology

<b>What good looks like</b>	<b>Where are we now?</b>	<b>What needs to change?</b>	<b>What actions do we take?</b>	<b>What measures our success?</b>
<p>The locality has an Education Strategy that includes communication skills training for all staff involved in the care of dying patients, appropriate to their particular needs.</p> <p>The locality can evidence the number of people accessing communication skills training at various levels.</p> <p>Clear statements of what patients nearing the end of their life and their families should be able to expect in Lincolnshire are freely available and widely advertised.</p> <p>Patients should be asked once during an initial supportive care assessment if they are happy for their clinical</p>	<p>Need for communication skills training has been recognised across whole health &amp; social care system.</p> <p>Data can be accessed but it is patchy. Numbers can be obtained but qualitative data as to effectiveness of training not available.</p> <p>Statements of what patients should be able to expect in Lincolnshire, written in accessible language, are not yet in place. The End of Life Care Website is well placed to host such statements. <a href="http://www.eolc.co.uk/">http://www.eolc.co.uk/</a></p> <p>Sharing of clinical records is problematic, and concerns about information governance seem to take precedence over clinical care. Patients are asked</p>	<p>A Palliative and End of Life Care Education Strategy needs to be developed and agreed for Lincolnshire, setting expectations that all staff caring for dying patients would receive communication skills training.</p> <p>Making sure that statements are developed and put onto the End of Life Care website so they are available to patients.</p> <p>We need to overcome the IG issues which are preventing sharing of records, with a focus on putting the patient's care needs first.</p> <p>Ensuring EPaCCS templates are widely used to support patient choice, and accessible to all organisations including in secondary care.</p>	<p>Develop Education strategy through the Lincolnshire Palliative and End of Life Care Education Group.</p> <p>Develop statements of what patients can expect, in accessible language and using the new agreed terminology.</p> <p>Set clear expectations, agreed at CCG level, around sharing of clinical records within the teams caring for palliative patients when they agree to this, ensuring robust information governance while not preventing appropriate access.</p> <p>Support the increased use of EPaCCS templates, and ensure these are made available to secondary care and other organisations</p>	<p>Education Strategy developed and agreed at the Expert Reference Group, and circulated to all providers for implementation.</p> <p>Statements for patients and their families made available via the End of Life Care Website.</p> <p>An effective system in place for ensuring consent to share is enacted.</p> <p>Increased use of EPaCCS templates across Lincolnshire, and access available to all organisations who need it.</p>

<p>records to be shared with other organisations that provide palliative care, and if they agree then an effective mechanism exists to ensure this happens.</p> <p>All identified patients have the opportunity to create an EPaCCS template, and this information is shared with the following services:  NHS 111  Care Homes  Social Care  Secondary Care</p> <p>The locality has mechanisms in place for the person approaching end of life to review and update their wishes and preferences within their electronic record.</p>	<p>multiple times to allow information to be shared with each organisation involved in their care.</p> <p>EPaCCS programme is having ongoing conversation with DHU (111 contract holders)  Care Homes can't use N3 connection, not all have electronic record system, some have paper records.  Domiciliary care - could be addressed through PCCC.</p> <p>Care Portal and My Right Care wish to develop systems to update the wishes and preferences of people at end of life and Care Portal has plans in place.</p>		<p>who require access to this information.</p>	
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### Aim 3: Supportive Care

- All patients identified to be deteriorating will have access to a standardised Supportive Care Assessment, to be performed by the most appropriate healthcare professional; this should include the following elements:
  - Pain and symptom review
  - Psychological, social and spiritual needs, including need for welfare benefits
  - Information needs
  - Family and carer needs
  - Opportunity for advance care planning, including a DNACPR decision, Advanced Decisions to Refuse Treatment and preferred place of care and death
  - Consent to share information with all care providers

Foundation 1	Personalised care planning
Foundation 2	Shared records
Foundation 4	Involving, supporting and caring for those important to the dying person
Ambition 1	Honest conversations Systems for person-centred care Clear expectations Access to social care Helping people take control Good end of life care includes bereavement
Ambition 2	Community partnerships
Ambition 3	Skilled assessment and symptom management Priorities for care of the dying person Rehabilitative palliative care
Ambition 4	Shared records A system-wide response Continuity in partnership
Ambition 5	Professional ethos Awareness of legislation

- Assessment will lead to referral to appropriate palliative care services as required
  - Timely access to counselling and family support services, including bereavement services

Foundation 4	Involving, supporting and caring for those important to the dying person
Ambition 1	Systems for person-centred care Good end of life care includes bereavement
Ambition 3	Addressing all forms of distress Specialist palliative care Rehabilitative palliative care
Ambition 4	A system-wide response Everyone matters

<b>What good looks like</b>	<b>Where are we now?</b>	<b>What needs to change?</b>	<b>What actions do we take?</b>	<b>What measures our success?</b>
<p>Clinicians in all settings know how to refer to ensure a comprehensive assessment is carried out.</p> <p>Patients receive holistic assessments following a standardised template, which includes the opportunity to engage in advance care planning.</p> <p>Plans are shared with all care providers.</p> <p>Patient assessments lead on to referrals to appropriate palliative care services.</p> <p>The locality is utilising validated tools (e.g. IPOS) to measure patient outcomes against an individual's personally defined goals.</p>	<p>Terms such as "palliative" and "end of life" may create a barrier, leading to late identification.</p> <p>Referrals often occur late, and may be misdirected leading to delays.</p> <p>Many patients miss out on the opportunity to engage in advance care planning.</p> <p>Measuring person centred outcomes measures currently only through CQC monitoring. Inequity for non-cancer patients due to current badging of specialist Palliative Care posts.</p> <p>Comprehensive plan required based on strategy and new skills profile which links with the wider workforce STP work.</p>	<p>When patients with life-limiting illness are recognised to be deteriorating, clinicians need a simple mechanism to refer for a Supportive Care Assessment which is well advertised and quick to access, ensuring that patients are identified early.</p> <p>Consistent use of the standardised tool to ensure all patients with supportive care needs have a personalised needs assessment.</p> <p>All identified patients will be given the opportunity to create an advance care plan.</p> <p>Access to counselling and family support services including bereavement support and especially for children and young people.</p>	<p>Develop a referral framework/guidance to improve identification and referral.</p> <p>Create a single point of access for referrals for supportive care assessments, which can then be passed on to the most appropriate healthcare professional in each case.</p> <p>Improve training for all staff to ensure they can perform a comprehensive assessment effectively, including the use of a validated outcome measure such as IPOS.</p> <p>Improve access to counselling and bereavement support services.</p>	<p>Mechanism in place for patients to be referred for supportive care assessments, and increasing use of this pathway across providers.</p> <p>Increasing numbers of patients being assessed.</p> <p>Increasing numbers of patients on palliative care services' caseloads.</p> <p>Use of a validated tool to assess patient outcomes and to benchmark services.</p> <p>Increase in numbers of patients and families able to access counselling and bereavement support.</p>

<p>The locality have a framework in place for developing a skilled and competent workforce in the assessment and management of end of life symptoms.</p> <p>Bereaved people within the locality all have equal access to bereavement and pre-bereavement care, including children and young people and those affected by sudden or traumatic death.</p> <p>The locality has a process for independently analysing person centred outcome measures (e.g. IPOS) in order to hold providers to account and ensure fair access to care.</p>	<p>Support for Children and Young People is patchy, and other 3rd sector organisations have seen cuts in budgets. Inequity across localities in Lincolnshire. Scarcity of emotional and psychological support across whole system. Services may exist but not known about.</p>			
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## Aim 4: End of Life Care

- Where a patient may be in the last few days or hours of their life, this possibility will be recognised, and will be clearly and urgently communicated with the patient and those important to them, to the degree that they wish
  - This will include offering a discussion of the prognosis, plan of care and preferred place of death as appropriate

Foundation 1	Personalised care planning
Foundation 6	24/7 access
Ambition 1	Honest conversations Clear expectations Helping people take control
Ambition 3	Recognising distress whatever the cause
Ambition 5	Professional ethos

- The 5 priorities of care and Care for the Dying Patient documentation will be used for patients identified to be in the last days of life

Ambition 1	Systems for person-centred care
Ambition 3	Addressing all forms of distress Skilled assessment and symptom management Priorities for care of the dying person
Ambition 4	Continuity in partnership

<b>What good looks like</b>	<b>Where are we now?</b>	<b>What needs to change?</b>	<b>What actions do we take?</b>	<b>What measures our success?</b>
<p>Patients who may be in the last few days of life will have this possibility recognised and communicated to them and those important to them.</p> <p>End of life care will be managed appropriately, following the principles of the 5 priorities of Care for the dying person.</p> <p>The locality has robust audit plans in place to monitor the achievement of the 5 priorities of Care.</p> <p>End of Life Care is a core component of new models of care being proposed by the locality under the NHS Forward View.</p> <p>Local end of life strategy is inclusive of approaches to</p>	<p>End of life care is often recognised very late, leading to unnecessary admissions to hospital and aggressive investigations and treatments.</p> <p>Patients may have lost capacity by the time a decision to stop active treatment is made, denying the opportunity to make choices.</p> <p>The Care of the Dying Patient documentation, incorporating the 5 priorities of Care, is available across the county but is often underused.</p> <p>New models of care (MCPs) are just starting to emerge. We require a firm bidding process to develop this.</p>	<p>Ensuring that clinicians are able to recognise when patients are approaching the last few days of life.</p> <p>Ensure that patients have the opportunity to plan their care and identify what is important to them.</p> <p>Ensuring that end of life care incorporates the 5 priorities of care.</p> <p>Ensuring that the approach to end of life care, and end of life care itself, is inclusive of all everyone. Any approach needs to be population based, flexible and adaptable to our local population.</p>	<p>Improve education around end of life care, and communication skills in handling end of life conversations.</p> <p>Increase the use of the Care for the Dying Patient documentation, as an example of best practice.</p> <p>Review symptom management guidance and documentation to ensure consistency and improve prescribing at the end of life.</p> <p>Monitor different patient groups to ensure improvement across all parts of the population.</p>	<p>Education Strategy developed and agreed, to include access to training around recognition and communication at the end of life.</p> <p>Increased numbers of patients cared for using the Care for the Dying Patient documentation in all settings.</p> <p>Symptom management guidance reviewed and updated.</p> <p>Audit improvements in markers of good end of life care, such as increased use of anticipatory prescribing, and reduced hospital admissions and aggressive interventions in the last few days of life.</p> <p>Audit evidence of improvements applying to all parts of the population.</p>

the following groups: Children and young adults Those of older age and those with frailty Those with Dementia Those with Learning Disabilities				
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## Aim 5: Organisation of palliative care resources

- The most appropriate framework for provision of palliative care across Lincolnshire will be developed.
  - Clear roles and responsibilities will be produced for organisations and individuals providing care
  - There will be fair and equal access for all.

Foundation 7	Co-design
Foundation 8	Leadership
Ambition 4	Clear roles and responsibilities Continuity in partnership
Ambition 5	Executive governance

- Cross-provider local Integrated Care Teams will share clinical caseloads
  - Team members from different organisations will share clinical records and have joint clinical assessments and care plans
  - Teams will share local clinical leadership, data and data collection

Foundation 3	Evidence and information
Foundation 7	Co-design
Foundation 8	Leadership
Ambition 1	Systems for person-centred care Integrated care
Ambition 2	Using existing data Generating new data
Ambition 3	Rehabilitative palliative care
Ambition 4	Clear roles and responsibilities A system-wide response Continuity in partnership
Ambition 5	Support and resilience

- All integrated care teams providing palliative and end of life care will have access to a Specialist Palliative Care MDT
  - Patients with significant identified needs will be brought to the MDT for discussion

Ambition 1	Systems for person-centred care Integrated care
Ambition 3	Skilled assessment and symptom management Specialist palliative care
Ambition 5	Support and resilience Knowledge based judgement

- All patients will have access to specialist palliative care advice and support 24 hours a day, seven days a week
  - Face to face review will be available seven days a week, wherever the patient is located

Foundation 6	24/7 access
Ambition 3	Addressing all forms of distress Specialist palliative care
Ambition 4	A system-wide response
Ambition 5	Support and resilience

- High quality training will be available for all staff involved in providing palliative and end of life care

Foundation 5	Education and training
Ambition 5	Professional ethos Knowledge based judgement Using new technology Awareness of legislation

- Support will be given to create compassionate and resilient communities
  - Co-ordination with volunteers and community organisations to provide holistic support for patients and those important to them

Foundation 7	Co-design
Foundation 8	Leadership
Ambition 1	Good end of life care includes bereavement
Ambition 2	Community partnerships
Ambition 4	Continuity in partnership
Ambition 6	Compassionate and resilient communities Public awareness Practical support Volunteers

<b>What good looks like</b>	<b>Where are we now?</b>	<b>What needs to change?</b>	<b>What actions do we take?</b>	<b>What measures our success?</b>
<p>Palliative care services are commissioned and organised in a way that works for patients first, rather than providers, and enables changes to be implemented across the whole system.</p> <p>Provider organisations and individuals have a clear understanding of their roles and responsibilities, and work together across organisational boundaries in a truly integrated way.</p> <p>All teams caring for palliative patients can readily access Specialist Palliative Care support and advice where needed, and can discuss their patients on a regular basis at SPC MDTs.</p> <p>The locality have a strategy for providing Education</p>	<p>Communication and co-operation between providers is improving, but implementing change remains challenging.</p> <p>Organisations do still make decisions without full regard of the knock-on effects on patients and other providers.</p> <p>A 24 hour SPC advice line exists, but this is not commissioned and is under-utilised. Patients do not always have access to palliative care 7 days a week, depending on location and provider.</p> <p>SPC MDTs exist, but these are not always well attended, and patients in some localities do not have teams accessing this resource.</p>	<p>Developing the most appropriate framework for provision of palliative care across Lincolnshire, with clear roles and responsibilities for organisations and individuals providing care, and fair and equal access for all.</p> <p>Integrated care teams across different provider organisations, with shared clinical caseloads and local clinical leadership, with a member of the team attending weekly specialist palliative care MDT.</p> <p>Specialist palliative care advice and support needs being available 24 hours a day, 7 days a week, and face to face review available 7 days a week irrespective of patient location.</p> <p>Building resilience in local communities, neighbourhoods and families by promoting</p>	<p>Commission the most appropriate framework for provision of palliative care across Lincolnshire will be developed with clear roles and responsibilities for organisations and individuals providing care, and fair and equal access for all.</p> <p>Develop integrated care teams, combining Palliative Care Clinical Nurse Specialists, Hospice at Home teams and Marie Curie Rapid Response teams.</p> <p>Consider co-location of teams in each locality to facilitate joint working, possibly at the site of community palliative care beds where available.</p> <p>Ensure integrated care teams are providing a 7 day</p>	<p>The most appropriate framework for provision of palliative care across Lincolnshire will be developed with clear roles and responsibilities for organisations and individuals providing care, and fair and equal access for all.</p> <p>Integrated care teams established and functioning successfully across the county.</p> <p>Increasing numbers of patients on integrated care team caseloads.</p> <p>All integrated care teams providing a 7 day face-to-face service, and sending representatives to the weekly SPC MDT in their locality.</p> <p>Increased awareness and utilisation of the 24 hour SPC advice line.</p>

<p>and Training to all paid carers and clinicians at every level of expertise.</p> <p>The locality has established systems in place to ensure rapid access to needs based social care at the end of life.</p> <p>The locality is supporting people to take control and to tailor their end of life care through the use of personal budgets.</p> <p>The locality has a robust method of including all groups in informing the strategy, and the locality fully understands the current reach of palliative and end of life care services across different diseases and groups and are using this information to plan future services.</p> <p>The locality are routinely monitoring and reviewing</p>	<p>Workforce/OD workstream of STP will address development of skilled and competent workforce, but detailed plan is not in place.</p> <p>Issues in the community include access to care packages, rapid access to Palliative Care, and contracting. The IT system (Mosaic) is unstable, and is creating delays.</p> <p>Plans are in place as part of the integration agenda; EPaCCS will report as well. OACC measures are being implemented.</p> <p>It is not apparent whether relevant Public health data is currently collected, as relevant population data is not easily accessible.</p> <p>We have a fragmented system with manifold monitoring systems.</p>	<p>practical support, information and training in end of life care.</p> <p>Lincolnshire qualitative data and patient stories are routinely collected by Public Health and other organisations and shared across the system to ensure improvement and local needs are met.</p> <p>End of life care is a core component of new models of provision.</p>	<p>face-to-face service, and commit to attending a weekly local SPC MDT.</p> <p>Commission and widely advertise a 24 hour specialist palliative care advice line, available to all care providers across Lincolnshire.</p> <p>Develop Education strategy through the Lincolnshire Palliative and End of Life Care Education Group, to improve knowledge and skills within palliative care providers.</p> <p>Develop End of Life Care Facilitator roles based within the community in each locality to strengthen the skills and training within these teams.</p>	<p>Education strategy developed and put into effect, and training programmes delivered.</p> <p>End of Life Care Facilitators in post and providing education to integrated care teams.</p>
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<p>data relating to place of death, and deaths in usual place of residence (DiUPR) and are using this data to inform, and to evaluate service developments in Palliative and End of Life Care.</p> <p>The locality has accountability mechanisms in place to demonstrate equity of access and responsiveness for palliative and end of life care services.</p> <p>Practical support, information and training in end of life care is available to local families, neighbours and community organisations.</p>	<p>We need to link new organisations and new initiatives; the EOLC website needs to develop further and focus further upstream. A single point of contact needs to be developed, this could be easily achievable.</p>			
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## References

- 1** Lincolnshire Sustainable Services Review 11<sup>th</sup> November 2013: A Blueprint for Future Health and Care Services in Lincolnshire.
- 2** 'Every Moment Counts' A narrative for person centred co-ordinated care for people near the end of life. Produced by National Voices and the National Council for Palliative Care, in partnership with NHS England. Published March 2015.
- 3** Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020. Produced by the National Palliative and End of Life Care Partnership in 2015.
- 4** 'Self Assessment Tool: Palliative and End of Life Care' NHS North West Coast Strategic Clinical Networks End of Life Partnership
- 5** '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. June 2014.