Palliative and End of Life Care Strategic delivery plan for Lincolnshire 2017 – 2022
STRATEGIC PLAN EXECUTIVE SUMMARY

Background

The aim of this strategic delivery plan 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.

The landscape in Lincolnshire is changing:

- There are increasing numbers of people with increasing complexity needing 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 changing structure of health and social care in Lincolnshire, 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), means that change will happen at pace.
- However, patients and populations will change much more slowly
- 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 long term.

Our vision

To work together to identify all patients approaching the end of their lives in Lincolnshire, and to provide the highest quality care, communication and support, whatever their condition.

Objectives: Ambitions for Palliative and End of Life Care

Ambition1: Each person is seen as an individual.
Ambition 2: Each person gets fair access to care.
Ambition 3: Maximising comfort and wellbeing.
Ambition 4: Care is co-ordinated.
Ambition 5: All staff are prepared to care.
Ambition 6: Each community is prepared to help

Strategic Aims

Strategic Aim 1: Recognition

- All patients deteriorating from a life limiting condition should be identified
- Signs of distress will be recognised and addressed
- The needs of families and others important to the patient will be identified.

Strategic Aim 2: Communication

- Every patient and those important to them have a right to expect honest, informed and timely conversations about death, dying and bereavement
- 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
- Clinical records will be shared between organisations

Strategic 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.
- Assessment will lead to referral to appropriate palliative services as required.

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

Strategic 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.
- Cross provider local integrated care teams will share clinical caseloads.
- All integrated care teams providing palliative and end of life care will have access to a Specialist Palliative Care MDT
- All patients will have access to specialist care advice and support 24 hours a day, 7 days a week
- High quality training will be available for all staff involved in providing palliative and end of life care
- Support will be given to create compassionate and resilient communities.

When are we going to do it by?

The timeframe for implementation of the strategic plan, and achieving the aims and ambitions is 5 years, from 2017 – 2022.

Who is going to do it?

Good end of life care is everyone's responsibility and demands a collaborative approach, and teamwork to provide support wherever the individual is. Whole system working placing the individual firmly at the centre of everything, and including professionals from medical, nursing and allied health and social care, the voluntary and community sector, the care home and domiciliary care sector and informal carers can provide this.

Where are we going to do it?

This is a Lincolnshire wide programme, however its influence will cross Trust/County boundaries as some Lincolnshire residents access palliative and end of life services out of county.

What will success look like?

- Strategic aims achieved.
- Ambitions for Palliative and End of Life realised and evidenced by completion of Self-assessment tool.

What happens next?

The practical actions required to deliver the strategic aims are:

- Reduce fragmentation of services
- Clearly define roles & responsibilities within clinical teams
- Workforce development plan
- Consistent utilisation of agreed tools e.g. EPaCCs template, Advanced Care Plan template.

Secure Project Management support to deliver practical actions.