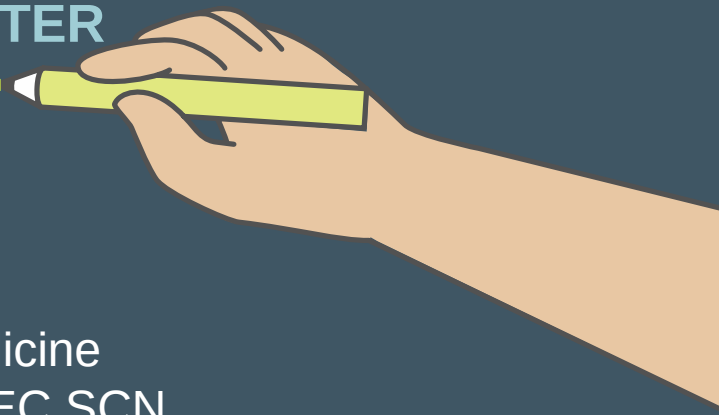
Greater Manchester
Health and Social Care Partnership

PALLIATIVE AND END OF LIFE CARE

IN GREATER MANCHESTER



Dr David Waterman
Consultant in Palliative Medicine
Palliative Clinical Lead for GMEC SCN

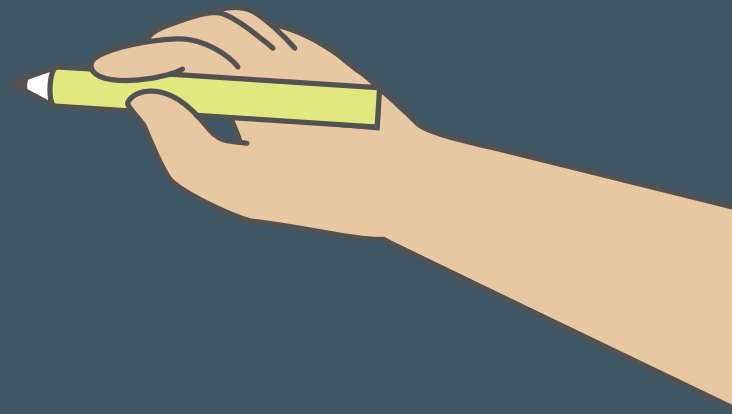
GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Health and Social Care Partnership

BACKGROUND

IN GREATER MANCHESTER



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The North West End of Life Care Model

Advancing disease → Increasing decline → Last days of life → First days after death → Bereavement

Identify that the patient is in the last year of life -
GSF triggers, disease specific criteria, AMBER, PIG, check for CMC entry, check for SPCT involvement, check GSF register, cancer MDT outcome for BSC.

↓

Discuss with the patient and person important to the patient that has life limiting condition/recovery is uncertain.

↓

Assess patient and carer needs - holistic assessment, iPOS, psychological needs, social needs, carers needs assessment.

Plan and deliver care -
consider treatment plan, advance care planning discussion, ceiling of care, DNA CPR status, medical anticipatory care plan, RESPECT, entry on GSF, entry on CMC, discuss ADRT/ LPA/will, deactivation of IDCD, blue badge, benefits, care needs, OT/ physio assessment and equipment.

↓

Review Care Plan -
at planned meetings, at GSF meetings, at emergency admissions.

Refer to SPCT if complex needs or support required.

Diagnose that patient is dying

↓

Care in the last days of life -
EOLC plan/principles of care, update CMC, anticipatory meds, offer choices e.g donation, handprints, consider early referral to bereavement.

Care after death -
Verify and certify death, consider referral to the coroner, consider referrak to bereavement, up date CMC/GSF, inform agencies.

Bereavement support -
consider bereavement call, referral to bereavement, referral to palliative care counsellors, CODE questionnaire and feedback.

Refer to bereavement team if additional support needed or anticipated complex grief.

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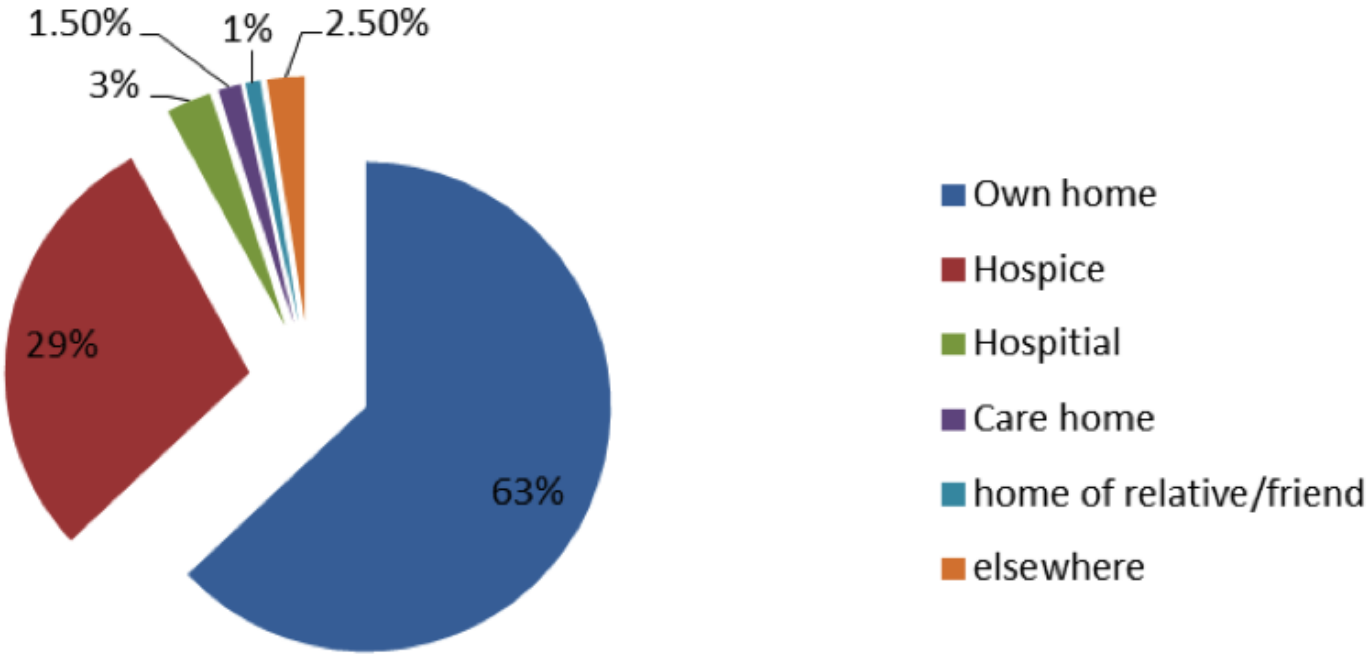
Most preferred place of death: All England

PRISMA survey 2010 (Cicely Saunders Institute)



- As age increased, a preference to die at home decreased while a preference to die in a hospice increased

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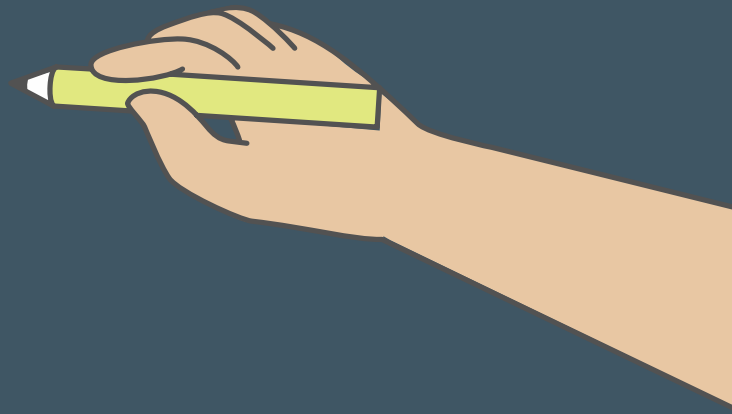
FRAMEWORK & COMMITMENTS

IN GREATER MANCHESTER



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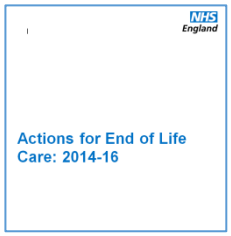
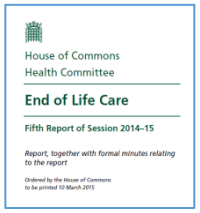
COMMITMENT STATEMENTS
ONE CHANCE TO GET IT RIGHT


NHS England
Actions for End of Life Care: 2014-16

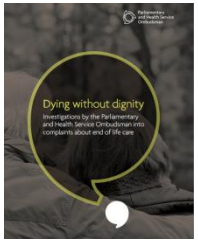
Every Moment Counts
A narrative for person centred coordinated care for people near the end of life

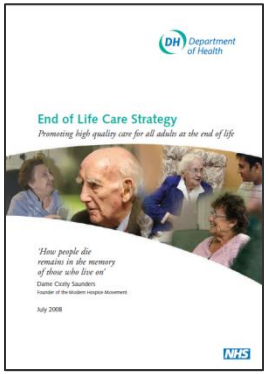
What's important to me.
A Review of Choice in End of Life Care
Published by The Choice in End of Life Care Programme Board
February 2015

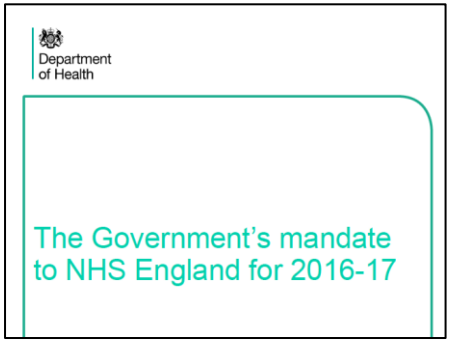

House of Commons
Health Committee
End of Life Care
Fifth Report of Session 2014–15
Report, together with formal minutes relating to the report
Ordered by the House of Commons to be printed 10 March 2015

MORE CARE, LESS PATHWAY
A REVIEW OF THE LIVERPOOL CARE PATHWAY

Ambitions for Palliative and End of Life Care:
A national framework for local action 2015-2020
National Palliative and End of Life Care Partnership


Dying without dignity
Investigations by the Parliamentary and Health Service Ombudsman into complaints about end of life care


DH Department of Health
End of Life Care Strategy
Promoting high quality care for all adults as the end of life
'How people die remains in the memory of those who live on'
Dame Cicely Saunders
Founder of the Modern Hospice Movement
July 2008
NHS


Department of Health
The Government's mandate to NHS England for 2016-17

Care Quality Commission
A different ending
Addressing inequalities in end of life care
Overview report
MAY 2016

Department of Health
Our Commitment to you for end of life care
The Government Response to the Review of Choice in End of Life Care

Response to Review of Choice in EoLC

Choice Review: 7 Main Themes – I Want……..	Government Commitment: 7 Actions – We Will…	Ambitions for Palliative & EoLC: 6 Ambitions
To be cared for and die in a place of my choice	Develop more personalised care for people approaching EoL	Each person is seen as an individual
Involvement & control over decisions about care	Put in place measures to improve care quality across settings	Each person gets fair access to care
High quality care given by well trained staff	Identify and spread innovation in delivery of high quality care	Maximise comfort and well-being
Right services when needed	Lead on EoLC nationally and provide local leadership support	Care is co-ordinated
Support for my holistic needs	Ensure we have the right people with right knowledge and skills	All Staff be prepared to care
Right people to know my wishes at the right time	Work together with system partners and voluntary sector	Each community is prepared to help
Those important to me to be involved in my care	Strengthen accountability and transparency to improve	**SUPPORTED BY EIGHT FOUNDATIONS**

Six ambitions to bring that vision about

01 Each person is seen as an individual

02 Each person gets fair access to care

03 Maximising comfort and wellbeing

04 Care is coordinated

05 All staff are prepared to care

06 Each community is prepared to help

"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)."

National Palliative and End of Life Care Partnership
www.endoflifecareambitions.org.uk

The foundations for the ambitions

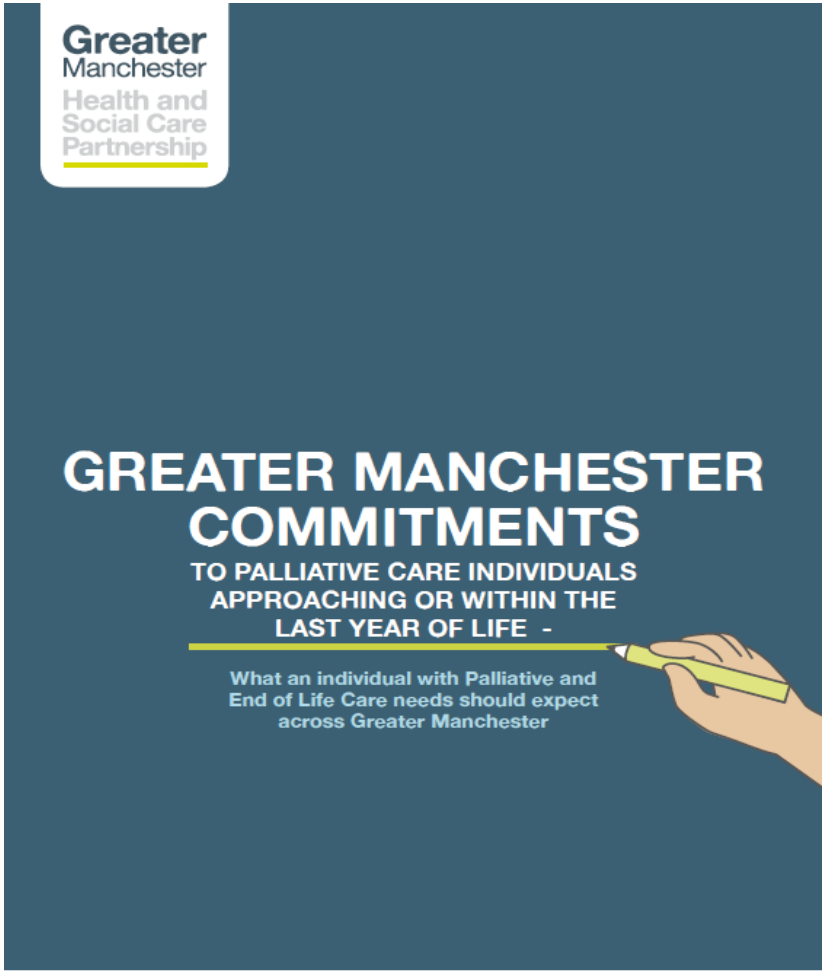
Personalised care planning	Shared records
Education and training	24/7 access
Evidence and information	Involving, supporting and caring for those important to the dying person
Co-design	Leadership

Greater Manchester Commitments

A pledge to the Citizens of Greater Manchester

- Ensure individualised care when palliative and end of life care is required
- Maintain and improve standard of delivery to provide high quality care
- Address holistic needs of the citizens of GM
- 4 System commitments to underpin front line delivery of the 12 commitments.

Approved by the GM Health and Care Board May 2019

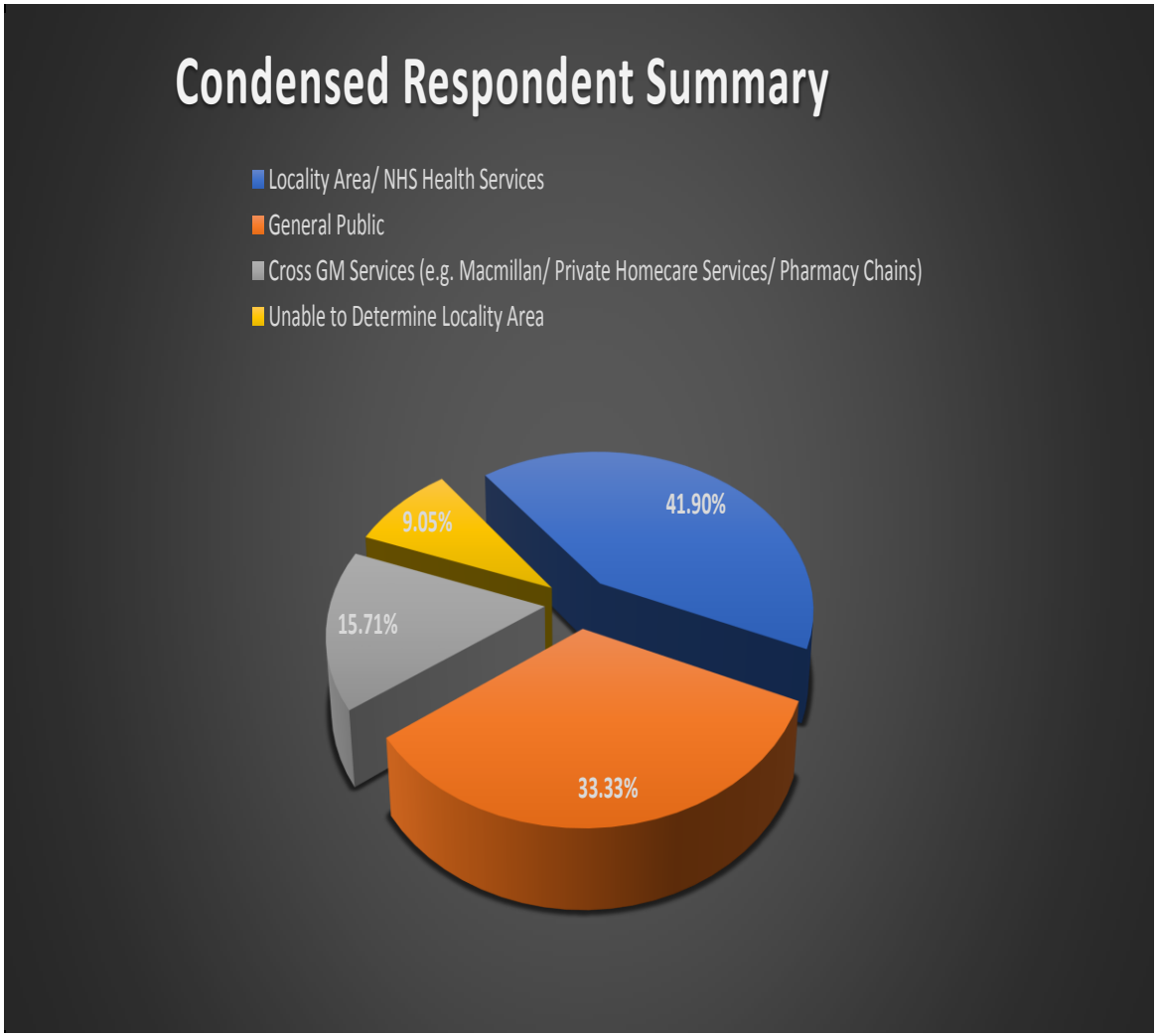


GMCA

NHS
in Greater Manchester

NHS
Greater Manchester
and Eastern Cheshire

Development of The GM Commitments



- Public consultation took place January 2019
- A total of 210 responses
- 898 individual pieces of feedback received

1 IDENTIFY

As I am approaching or within the last year of life, care professionals should recognise this where possible and, if I choose, discuss it with me and those important to me.

Individuals likely to be approaching the last year of life should be proactively identified and offered the opportunity to discuss this with an appropriate care professional. Those important to the individual should be included in this discussion, if the individual wants this.

2 ASSESS

My needs and unique individual circumstances should be assessed by an appropriate care professional.

This holistic assessment may include: physical, emotional, psychological, social, cultural, spiritual, religious, sexual and relational financial, practical, needs/ concerns.

An holistic assessment of the individual's needs should be undertaken by an appropriate care professional applying a standardised approach.

3 PLAN CARE

My existing and on-going care should be planned with me and those important to me in a sensitive way. I will also be asked about my wishes for future care including organ and tissue donation and if I choose an Advance Care Plan will be written.

A person-centred plan of care should be formulated and agreed with the individual and those important to them, by appropriate care professionals. An opportunity for future care planning should also be provided.

4 COMMUNICATE AND COORDINATE

All appropriate professionals and services involved in my care, planned or in a crisis, should be able to access the information about me and my conditions electronically, should I choose to give my consent.

All appropriate relevant professionals, including those involved in crisis care, should be able to read, update and share electronic records of care plans and Advance Care Plans if consent has been given.

5 DELIVER CARE

I should receive appropriate physical, emotional, psychological, social, cultural, spiritual, religious, financial, practical, and relational support, when I need it. This should be in the setting of my choice with all the appropriate care professionals informed of my needs and wishes.

Holistic care should be provided in the most appropriate setting (respecting the individual's choice where possible), at the right time, ensuring all appropriate medication and equipment are available, with co-ordinated care providers involved.

6 SUPPORT CARERS

The people that give me the most help and support should be identified and offered an assessment to support their needs in supporting me, if they so wish.

Informal identified carers will be recognised as being integral to care planning, delivery and review. They should be offered a carers assessment and their needs be agreed and supported, if they wish.

7 PROACTIVE CARE

My care should be reviewed at the request of me or my carers and as my needs, preferences, or situation changes and the necessary adjustments made to plans.

Individuals and their carers should be reviewed as part of a standardised assessment, on request or as their needs, preferences or situation changes, to ensure the care being provided is needs led, with adjustments made as required. This will be reflected in the individualised care plan.

8 REVIEW – CRISIS CARE

I should have an identified service/ team who will be my main point of contact and I shall be informed of who to call in a time of crisis. My plan of care should be available to me and those who require it, at all times; including at a time of crisis.

Individuals should know at all times who and how to contact services, especially in a time of crisis. Care plans should be available and accessible, and individuals should receive responsive care linked to their urgent care needs.

9 IDENTIFY DYING

If I am likely to die in the coming days, care professionals should recognise this and, if I want, discuss it with me and those important to me with my consent where possible.

Where the possibility is identified that an individual is likely to die in the coming days, they should be assessed for possible reversible causes, before being recognised as dying. If appropriate, and in accordance with the individual's wishes, the assessment should be discussed with the individual and those important to them.

10 PLAN OF CARE FOR THE LAST DAYS OF LIFE

When I am dying, I should be cared for with dignity and compassion in the place of my choice, where possible. My physical, emotional, psychological, social cultural, spiritual, religious, relational, financial, practical, and needs/ concerns should be addressed in accordance with my wishes and as my needs change.

Individuals in the last days of life should be cared for in accordance with their wishes and supported by a holistic plan of care, tailored to that individual and those important to them.

11 CARE AFTER DEATH

When I die and in the hours after, I and those important to me, should be cared for and supported according to our wishes.

Individuals who have died, and those important to them, should be continued to be cared for in a sensitive, dignified and culturally appropriate way in accordance to their wishes.

12 BEREAVEMENT SUPPORT

Those identified as important to me should know how and where to access appropriate bereavement support following my death, if it is required.

Access to appropriate bereavement support at the point of need should be available and offered or directed to as necessary.

1 SPECIALIST PALLIATIVE CARE SERVICES

I should have access to Specialist level Palliative and End of Life Care in my place of care if I need their support, advice and care.

Specialist Level Palliative Care services should be available for face to face contact seven days a week across all settings, and advice should be available 24 hours a day. Inpatient specialist palliative care provision should be available to those requiring it, with admissions seven days a week.

2 HEALTH, SOCIAL, VOLUNTARY AND OTHER CARE SERVICES

Care services are in place and available to ensure that I will receive the right care, at the right time, in the right place delivered by a skilled and competent workforce.

Services should be available, accessible, equitable and responsive so that individuals can access appropriate services including:

- Adequate provision of coordinated services, which are able to communicate effectively
- A workforce who are knowledgeable, appropriately trained, competent and have the right qualities to support individuals

3 THE COMMUNITY

I would like to live within a community that feels safe and comfortable talking about death and dying. It should be a community that supports me, if I choose, and those close to me, as I approach the end of my life and die in that community.

The community should have support structures in place to actively encourage discussions about death and dying and encourage communities to support those dying in their community.

4 EVALUATION

I would like to be given the opportunity to discuss and, if I wish, to participate in research and studies to benefit my own and others care.

All providers of care and support should promote the values of innovation, research, audit, evaluation and patient and family reported outcomes of care within their organisations. This will underpin evidence based, high quality and effective provision and delivery of care.

Greater Manchester
Health and Social Care Partnership

DRAFT

A GREATER MANCHESTER

PALLIATIVE AND END OF LIFE CARE FRAMEWORK

to support the delivery of the Greater Manchester Commitments

2019 - 2022

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Work Underway

- Framework Delivery Plan being developed
- Local Strategic Development linked to GM Commitments

Thank You

Teşekkür ederim
Allah
Je vous remercie
Dank je
Tak
Aŭ
Дякую
Дзякуй
Ευχαριστώ
Dziękuję Ci
Dankie
Tack
Dziękuję
Takk skal du ha
Thank You!
Gracias
Хвала вам
Grattas tibi
Hvala
Kiitos
Obrigado
Grazie
Paldies
Спасибо
고맙습니다
Multumesc
ありがとうございました