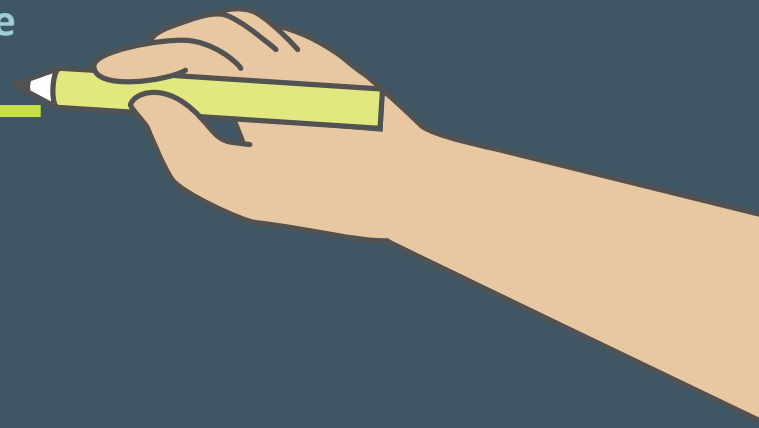
Greater Manchester Health and Social Care Partnership

NHS Greater Manchester and Eastern Cheshire Strategic Clinical Networks

Greater Manchester and Eastern Cheshire SCN

Palliative and End Of Life Care Team



GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

THE NATIONAL PROGRAMME BOARD (PALLIATIVE & END OF LIFE CARE)

Professor Bee Wee, National Clinical Director for Palliative and End of Life Care, NHS England and NHS Improvement

Sue Bottomley, National Head of Programme, Palliative and End of Life Care, NHS England and NHS Improvement

Sheree Fagge, Head of Nursing, National Palliative and End of Life Care Programme, NHS England and NHS Improvement

You can link into the National Programme by joining the NHS Future Collaborative by emailing Sherree Fagge at: sherree.fagge@nhs.net

THE NATIONAL AMBITIONS FOR PALLIATIVE AND END OF LIFE CARE

What this should look like for people?

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)."

Permission: NHSE/I Palliative & End of Life Care National Team

PEoLC Delivery Plan

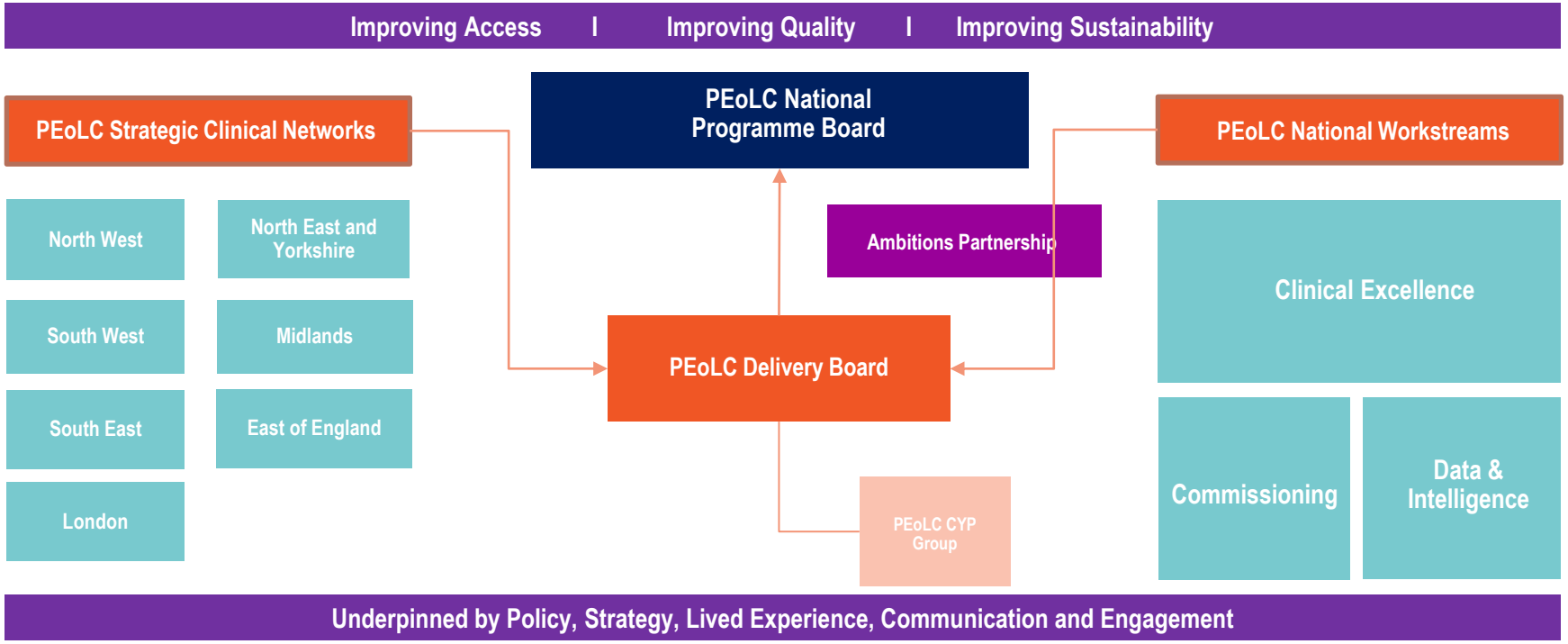
Our NHSE/I contribution into transforming PEoLC

Priority	Outcomes	Outputs and Measures 2024/25
1. Improving Access	1.1. People are identified as likely to be in the last 12 months of life and are offered personalised care and support planning 1.2. Staff, patients and carers can access the care and advice they need, whatever time of day 1.3. Equitable access to PEoLC for all, focussing on locally identified under-served populations	1.1. There will be X% increase in those identified and X% of people offered PCSP compared to baseline 1.2.1. Phase 1: 24/7 generalist PEoLC services provided across all regions 1.2.2. Phase 1: 24/7 remote access to specialist palliative care advice for staff and carers provided across all regions 1.2.3. Phase 2: 7-day face to face specialist palliative care services provided across all regions 1.3.1. PEoLC SCNs can evidence improved access for locally identified under-served populations from a baseline.
2. Improving Quality	2.1. High quality palliative and end of life care for all, irrespective of condition or diagnosis 2.2. A confident workforce with the knowledge, skills and capability to deliver high quality PEoLC 2.3. High quality PEoLC across all systems	2.1 PEoLC SCNs can evidence improved quality for locally identified priority groups from a baseline 2.2.1 PEoLC SCNs can evidence improved staff confidence, knowledge and skills in PEOLC from a baseline 2.3.1 X% of acute settings rated as good or outstanding in all domains 2.3.2 0% of acute settings rated as inadequate 2.3.3 PEoLC SCNs can evidence improved patient/carer experience from a baseline.
3. Improving Sustainability	3.1 PEoLC is sustainably commissioned 3.2 The PEoLC workforce is fit-for-purpose, now and in the future 3.3. Personalised and community focused approaches are fundamental to improving the PEOLC experience	3.1 Framework for best practice commissioning and funding for PEoLC embedded in at least 50% of ICSs in each region 3.2. Each ICS has a workforce plan for PEoLC and demonstrates year on year improvement 3.3.1 X% increase in referrals to social prescribing for PEoLC from baseline within each PCN 3.3.2 Each PCN has an identified social prescribing lead for PEoLC 3.3.3 ICSs evidence improved patient experience in personalised and community focused approaches to PEOLC

Permission: NHSE/I Palliative & End of Life Care National Team

National PEoLC Structure

High Quality Personalised PEoLC for All in All settings



Permission: NHSE/I Palliative & End of Life Care National Team

GREATER MANCHESTER AND EASTERN CHESHIRE STRATEGIC CLINICAL NETWORK

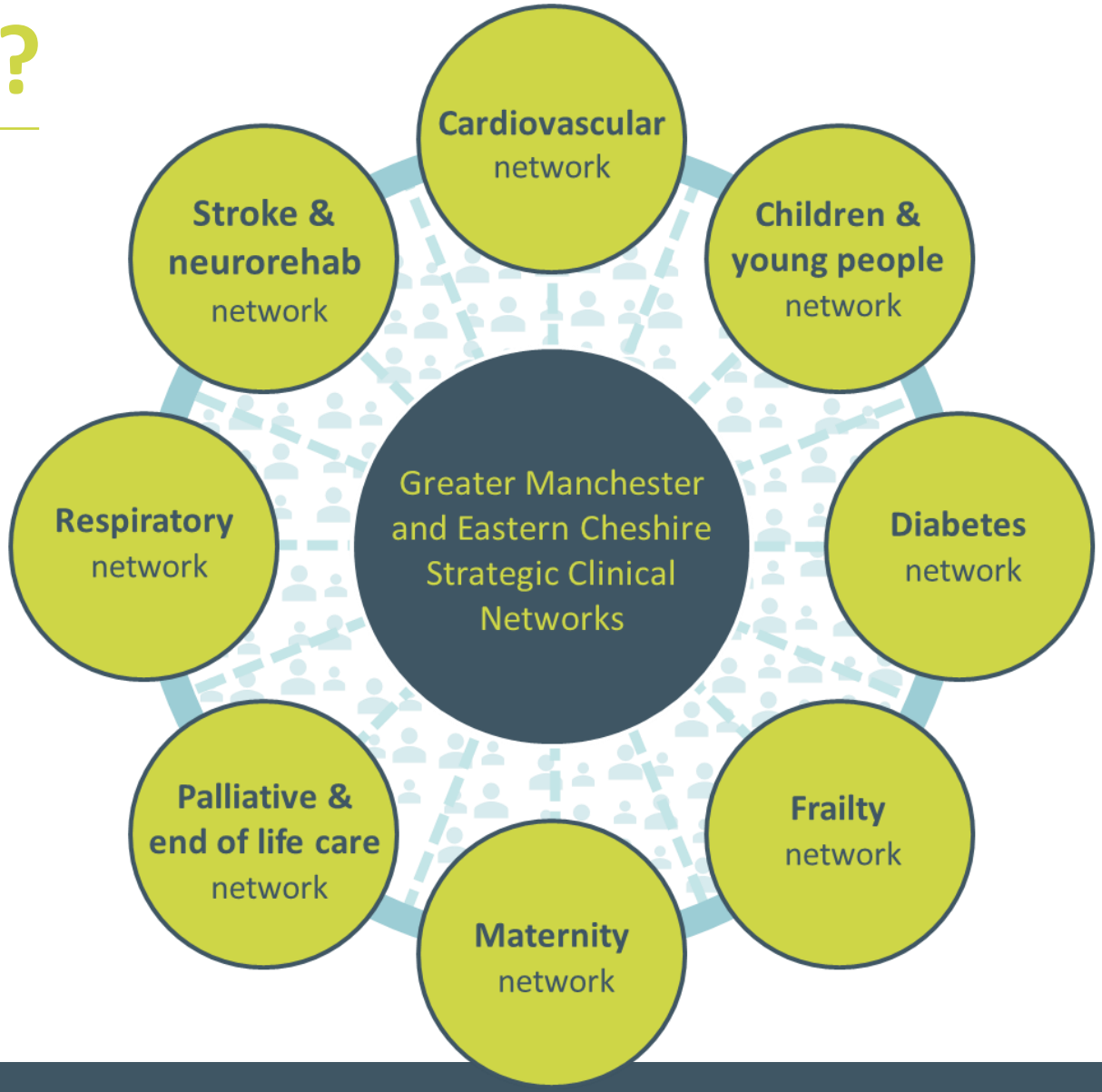
Palliative and End of Life Care Team

Who are we?

We are a collection of clinical networks that are led by clinicians.

We have a proven track record of leading successful improvements in the region.

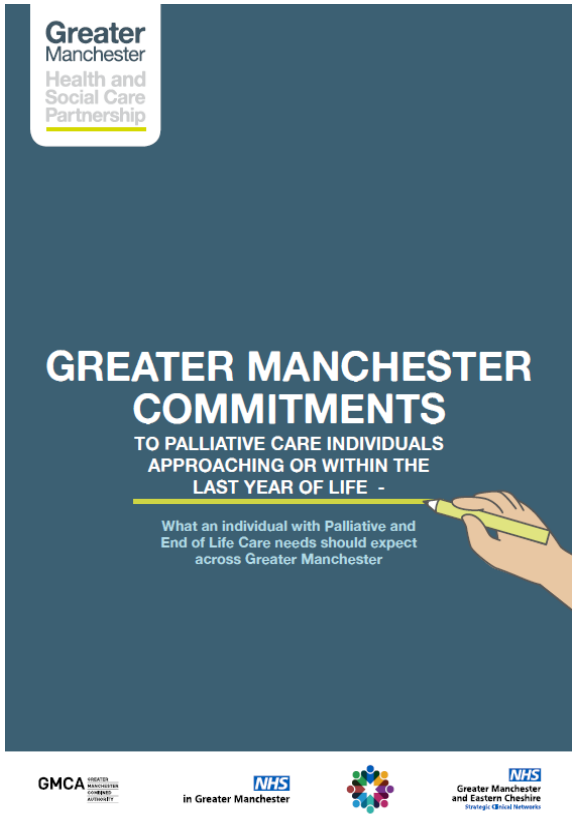
We are part of the NHS and hosted by the Greater Manchester Health & Social Care Partnership.



GREATER MANCHESTER COMMITMENTS TO INDIVIDUALS WITH PALLIATIVE CARE NEEDS APPROACHING OR WITHIN THE LAST YEAR OF LIFE

The Commitments set a number of objectives and outline the outcomes that the people in Greater Manchester can expect: to live well during the last year of life with dignity, in the place of their choice, regardless of disease, setting, age and circumstance.

There are 12 individual focused commitments and 4 system enabling commitments which need to be retained and built upon to:



12 X COMMITMENTS:

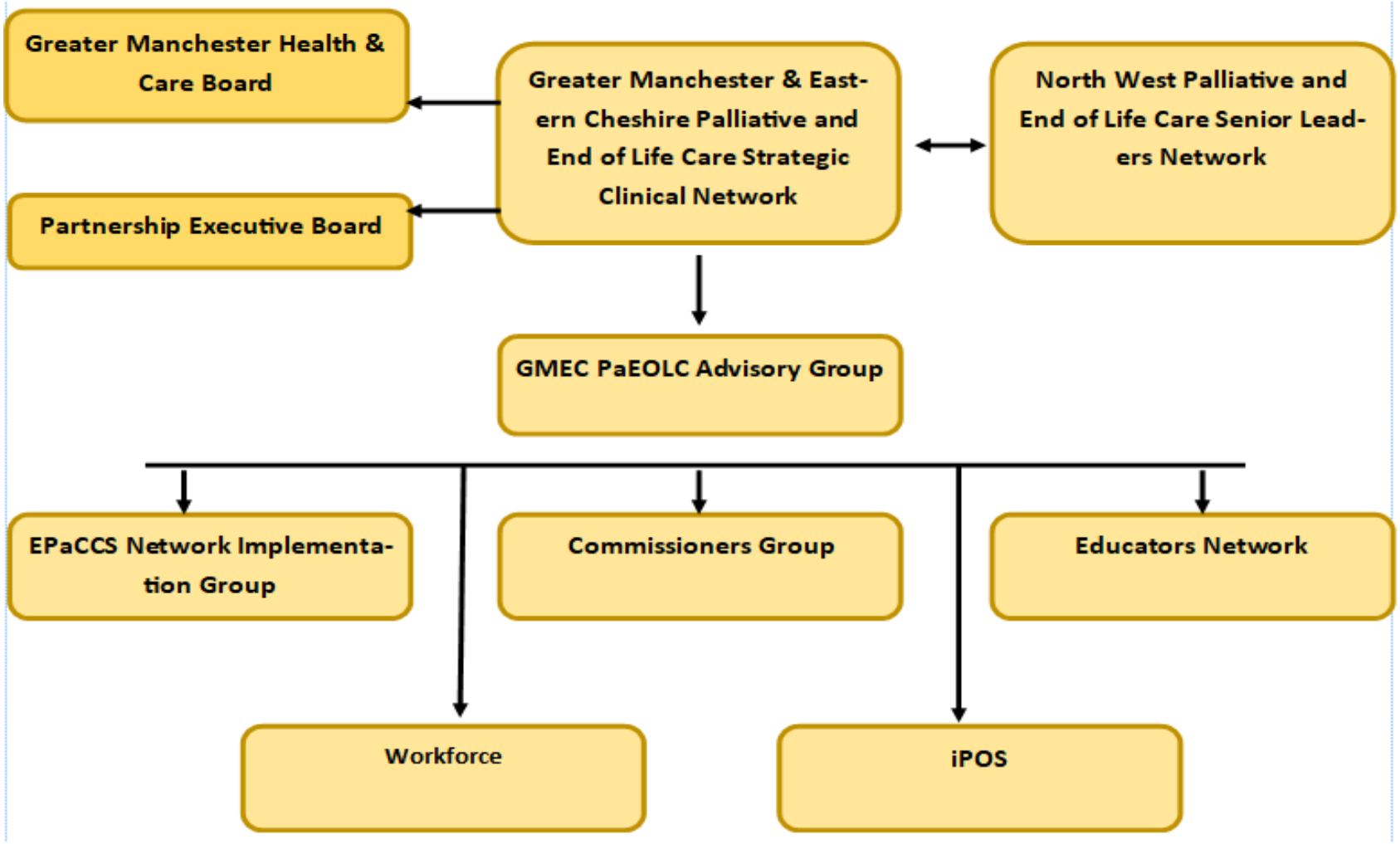
Identify
Assess
Plan Care
Communicate & coordinate
Deliver Care
Support Carers
Proactive Care
Review – Crisis Care
Identify Dying
Plan of Care for the Last Days of Life
Care After Death
Bereavement Support

4 X UNDERPINNING ADDITIONAL COMMITMENTS:

Specialist Palliative Care Services
Health, Social, Voluntary and Other Care Services
The Community
Evaluation

HOW DO THE GMEC SCN DELIVER THE WORK?

- Clinically led, supported by a project team.



Meet the team…..

Dr David Waterman, Palliative Care Consultant, Clinical Lead

Dr Liam Hosie, GP (Primary Care) Clinical Lead

Elaine Parkin, Programme Manager, Palliative & End of Life Care

Gill Bailey, Project Manager, Palliative & End of Life Care

Christine Taylor, Project Manager, Palliative & End of Life Care

Shelley Cunliffe, Project Officer, Palliative & End of Life Care

Denise Woolrich, Business Support, Palliative & End of Life Care

GREATER MANCHESTER AND EASTERN CHESHIRE STRATEGIC CLINICAL NETWORK

Personalised Care: A shift in relationship between health and care professionals and people.

Being seen only as a patient with symptoms or separate conditions that need treating.

SHIFTS TO...

Being seen as a whole person with skills, strengths and attributes as well as needs to be met.

Being asked 'What's the matter with you?'

SHIFTS TO...

Being asked 'What matters to you?'

Being told what is wrong with you and how your health needs will be met.

SHIFTS TO...

Being valued as an active partner in conversations and decisions about your health and wellbeing.

Not having the information and support you need to make informed health and wellbeing choices and decisions.

SHIFTS TO...

Having the information and support you need to make informed choices and decisions.

Health and care professionals believing they have all the knowledge, expertise and responsibility for your health and wellbeing.

SHIFTS TO...

Feeling powerless against a complex health and care system.

SHIFTS TO...

Working in partnership with health and care professionals and sharing power.

A 'One-size-fits-all' approach to meeting your health and wellbeing needs.

SHIFTS TO...

Having more choice and control so your health and wellbeing needs are met effectively in a way that makes sense to you.

You and your health and care professional sharing knowledge, expertise and responsibility for your health and wellbeing.

Having to tell your story again and again.

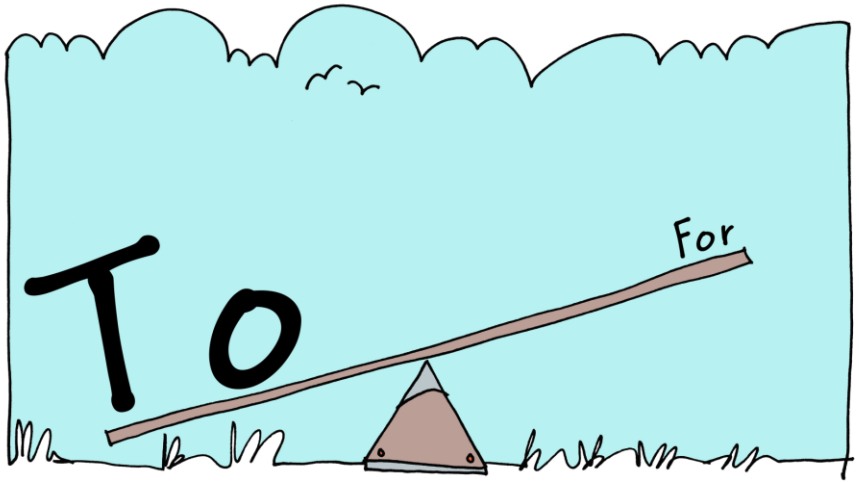
SHIFTS TO...

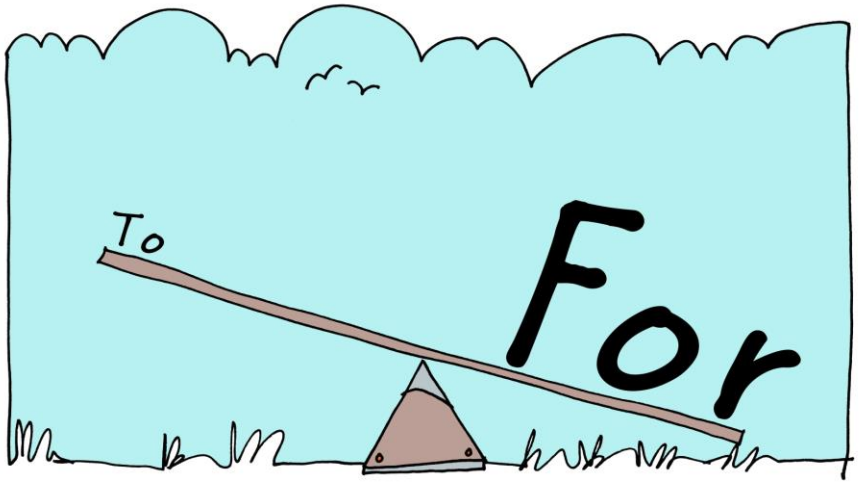
Only needing to tell your story once.

This illustration was developed by the Personalised Care Strategic Coproduction group.

Jon

People want to have the best quality of life they can while they are living with advancing illness, and to have the most peaceful death they can, where they want to be, surrounded by those they choose.





Balance means……

EARLY IDENTIFICATION SEARCH TOOL:

- The tool searches SNOMED CT codes based on the Gold Standard Framework Proactive Identification Guidance (GSF PIG) and the Supportive and Palliative Care Indicators Tool (SPICT) resources
- Runs in EMIS, SystmOne and Vision IT systems.

WHY THE EARLY TOOL WAS DEVELOPED

To identify those who are likely to be in their last phase of life.

To offer personalised care planning to those identified as being in their last year of life.

This enables:

- Better quality of care
- Reduction in unwanted admissions
- Increase in the proportion of patients offered personalised care and support plans (Advance Care Planning Conversations)
- Increases potential for patients achieving their wishes and preferences at the end of life

EARLY IDENTIFICATION SEARCH TOOL:

Previously worked with 6 Primary Care Network's piloting the EARLY Tool as a part of the North West programme.

PROJECT GOING FORWARD:

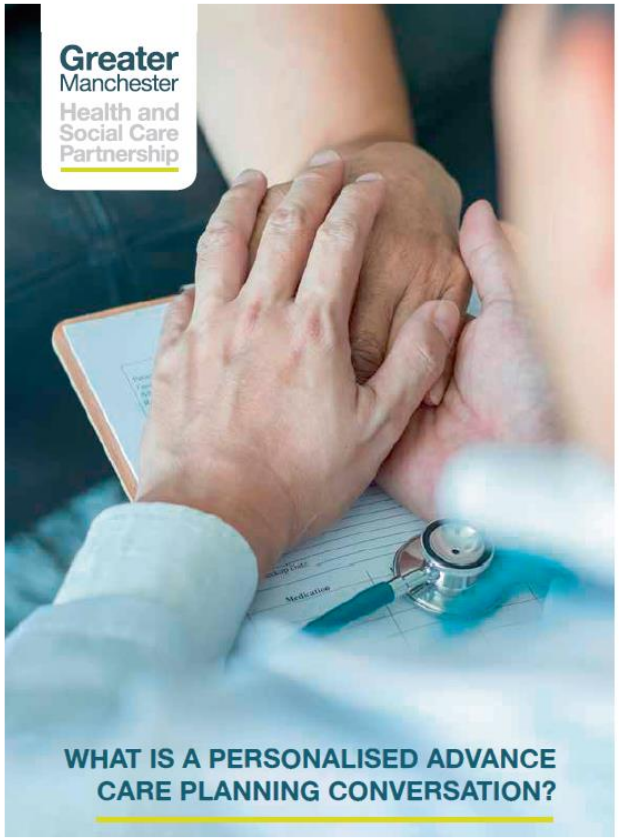
Now looking to rollout across GMEC between September 2021 and April 2022.

THE OFFER:

- A GP facilitator supporting the recruited PCN's
- A series of webinars for the GP's who are involved:
- An introduction to the EARLY tool
- Principles of Validation
- ACP and Personalised Care Conversations
- DNACPR and Shared Decision Making.
- Ongoing one to one peer support from a GP lead on the project to April 2022.

Suggested individual support we can provide:

- Running the EARLY Search Tool
- Case review with an EARLY Case review with an EARLY GP facilitator to help with patients who are difficult to clinically validate.
- Joint patient review with an EARLY GP facilitator for an advance care planning conversation.
- Support with how to record advance care planning conversations.
- EARLY GP facilitator to attend practice palliative care meeting for support and guidance.



These prompts have been designed to support a personalised approach to advance care planning conversations.

Given that we have now recognised that your condition is beginning to increasingly impact on your life.....

1 What is important to you now?

- Who are the important people in your life?
- What routines are important for you to keep / tell me about your day to day life
- Are there any places that you like to spend time?

2 Is there anything that you would like to happen or rather not happen to you in the future?

Consider health, social, and practical situations. Examples are listed overleaf in further suggested conversation topics.

3 Who would you like to speak on your behalf if you were unable to speak for yourself?

This is a person whose opinion would need to be considered if the person loses capacity.

Further suggested conversation topics. To be personalised: For the right person, at the right time.

- Preferred place of care
- Preferred place of death
- Treatment escalation plans
- Resuscitation status
- Power of Attorney
- Advance decision to refuse treatment
- Organ donation
- Religion/spirituality
- Carers
- Caring responsibilities

Resources available at
https://www.cheshire-epaige.nhs.uk/wp-content/uploads/2021/02/20201408-NorthWest-Early-Identification-and-Personalised-Care-Planning-NWV3.pdf

- People with conditions other than cancer
- Older people
- People with dementia
- People from black, or minority ethnic (BME) groups
- Lesbian, gay, bisexual and transgender people (LGBT)
- People with a learning disability
- People with a mental health condition
- People who are homeless
- People who are in secure or detained settings
- Gypsies or travellers

To access our material, please use these following PDF's:

851B7E6C.pdf

674AF3E8.pdf

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THANK YOU