Palliative Care in partnership

Palliative Care Policy into Practice
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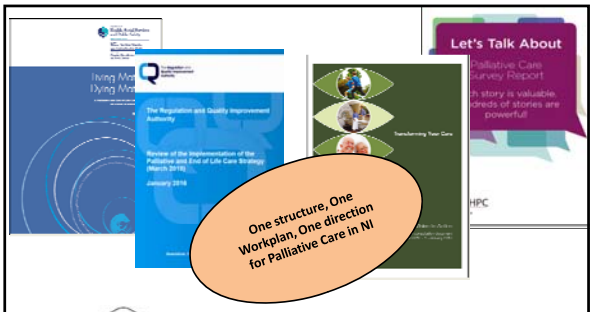
Dame Cecily Saunders, founder of the modern Hospice movement, said:

"You matter because you are you, and you matter to the end of your life. We will do all we can not only to help you die peacefully, but also to live until you die."

"How people die remains in the memory of those who live on."

Palliative Care in partnership



Palliative Care in partnership

Regional Palliative Care Programme - Palliative Care in Partnership

One structure, One Workplan, One direction for Palliative Care in NI

Department of Health

Regional Palliative Care Programme Board
PHA & HSCB Directors with responsibility for Palliative Care

Clinical Engagement Group

Palliative Care Leads (HSCB, PHA)
Palliative Care Service Team

Supported by PCIP Project Manager

Service User & Carer Reference Group

Palliative Care Locality Boards
Belfast, Northern, Southern, South Eastern & Western

Please note: These structures may be subject to organisational change

Palliative Care in partnership

Southern Area Hospice Services
HSC Public Health Agency
ihcp
Marie Curie
Royal College of Nursing
HSC Northern Health and Social Care Trust
HSC South Eastern Health and Social Care Trust
HSC Southern Health and Social Care Trust
Quality Care - for you, with you
Health | Sláinte
HSC Western Health and Social Care Trust
HSC Northern Ireland Ambulance Service Health and Social Care Trust
RCGP Royal College of General Practitioners
Northern Ireland Hospice
Patient and Client Council
HSC Belfast Health and Social Care Trust
caring supporting improving together
FOYLE HOSPICE TOGETHER WE CARE
BMA
WE ARE MACMILLAN. CANCER SUPPORT
Integrated Care Partnerships
AIIHPC
HSC Health and Social Care Board

Projected Deaths and Palliative Care Need in Northern Ireland

	2016	2020	2030	2040
Deaths all ages (NISRA projected)	15,401	15,800	17,750	20,261
Projected Palliative Care Need*	11,551	11,850	13,313	15,196

* Using 75% of all deaths (Gomez and Batiste *et al*)

The Palliative Care Need of our population will **increase by 31%** by 2040!

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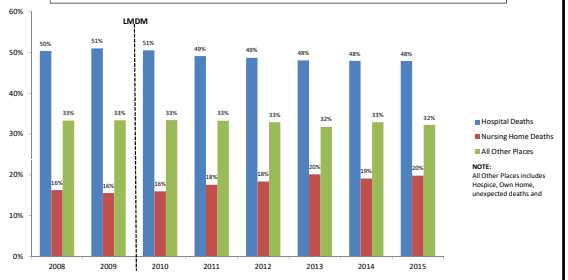
Source: PHA, data on file (2017)

Recorded Place of Death (NI)

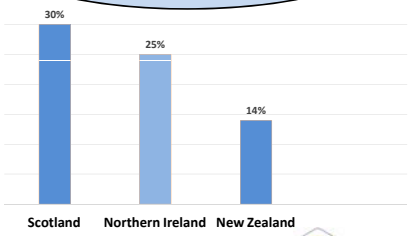


- **48% of people die in hospital** –down from 53% in 2006
- With the projected increase in deaths and palliative care need, there could be an **additional 1,750 people per year dying in hospital by 2040.**

Source: PHA, data on file (2017)

Palliative Care in Hospitals

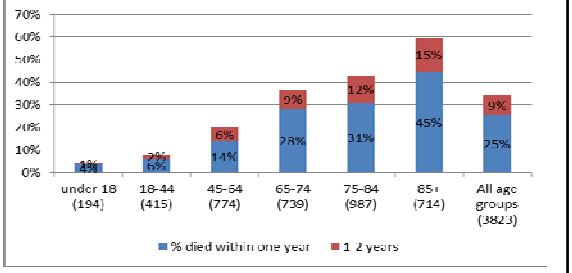
In Northern Ireland, 1 in 4 hospital inpatients (25%) will die within the next year.



Source: PHA, data on file (2017)

Palliative Care in partnership

% who died within one year of being an inpatient overnight on 5th February 2015 in NI hospitals (number of people)



Source: PHA, data on file (2017)

Palliative Care in partnership

2016 Regional Palliative Care Work Plan

To provide the regional direction so that everyone **identified** as likely to be in their last year of life (regardless of their condition) are:

- Allocated a **keyworker**
- Have the opportunity to discuss and record their **advance care planning** decisions
- Be supported with appropriate generalist and **specialist palliative care services** to die in their preferred of care (where appropriate)

Priorities → **Identification** | **Keyworker** | **Advance Care Planning** | **Specialist Palliative Care Services**

Good practice tools and guidance

2018 Palliative Care in Partnership Programme

To provide the regional direction so that everyone **identified** as likely to benefit from a palliative care approach (regardless of their condition) is:

- Allocated a **keyworker**
- Have the opportunity to discuss and record their **advance care planning** decisions
- Be supported with appropriate generalist and **specialist palliative care services**
- **Bereavement**

Priorities → **Identification** | **Keyworker** | **Advance Care Planning** | **Specialist Palliative Care Services**

Regional best practice tools and guidance
Communication
Public Health Approach to Palliative Care

PCIP PRIORITY 1

IDENTIFICATION: Why is it important?

- Around **15,000 people die each year** in Northern Ireland
- Estimated **11,250 of those could benefit** from palliative care approach
- Given the choice, most people want to be cared for and die at 'home'
- **47% of people in NI die in hospital each** year and it is estimated that **40% of those have no clinical reason to do so**

Identification

- To improve identification of people with palliative and end of life care needs. Aim 1% of the population

QoF Palliative Care Registers for NI GP Practices

Prevalence	Number of GP Practices 2016	Number of GP Practice 2017
Less than 0.25%	196	216
0.26 – 0.50%	104	92
0.51 - 0.75%	35	22
0.76 – 1.00%	7	9
Above 1%	5	5
Total number of practices:	347	341

Source: Department of Health (2017)

Early Identification Prototype aims:

- Improve identification of people who could benefit from a palliative care approach
- Build local relationships and capability to enable healthcare professionals to deliver palliative care at 'home'
- Support people to live well for longer in their own 'home'
- Enable people to plan and consider their end of life choices – ***Advance Care Planning***
- Avoid crisis situations which lead to poor quality of life or an avoidable hospital admission

EIP is based on the findings from 2 previous projects..

LOTHIAN EARLY IDENTIFICATION PROJECT (2015)

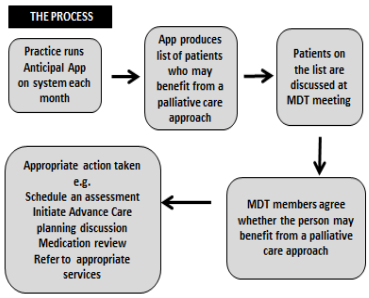
Edinburgh University & Marie Curie
Method: Developed a computer based algorithm (based on SPICT indicators) to search primary care records and identify patients who may be suitable for a palliative care approach and who were not already on the Palliative Care Register.
Findings: Clinicians judged that 30-60% of the patients identified by the algorithm could benefit from a palliative care approach.
Algorithm used became **Anticpal app**

In 2015 Mason, Boyd, Murray showed it is possible to significantly improve the identification of patients for palliative care needs assessment using a computerised search (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4529731/) and, this year have presented new findings that GP practices can use computer searching to generate lists of patients for review and care planning (https://bjgp.org/content/early/2018/03/26/bjgp18X695729)

EIP is based on the findings from 2 previous projects..

PENINSULA PROJECT (2014-15)
South Eastern Health & Social Care Trust
Method: Piloted monthly practice MDT meetings to discuss and proactively plan for patients who would benefit from a palliative care approach with a view to improving patient experience and avoiding unnecessary hospital admissions.
Findings: 81% of patients received palliative care in their place of choice, 57% reduction in emergency hospital admissions.
Source : HSCB

Early Identification Prototype



POSSIBLE ACTIONS TO BE TAKEN:

- Add to Palliative Care Register
- Start Key Information Summary
- Allocate Palliative Care Keyworker
- Initiate Advance Care Planning discussions
- DNACPR / ADRT discussions
- Discuss with Specialist professional (if involved in current care)
- Schedule visit for assessment
- Refer for review by Social Work/ AHP
- Refer to Specialist Palliative Care Team
- Consider referral to other support services – e.g. respite, sitting services
- Medication reviews

Slide 13

D1 I suggest moving the slide that defines QoF before this as you use the QoF acronym here
Dominic, 22/01/2018

Early identification Prototype: Moving forward

- Prototype currently running in 46 GP practices using Vision system
- Initially 6 months – with Transformation funding able to extend to 9 months (to Mar 19)
- Collate & evaluate findings, refine Local Enhanced Service accordingly
- Plans to enable AnticiPal on EMIS clinical systems
- Recruit up to 100 additional practices for Phase 2 (2019/20)

Palliative Care Keyworker:

Definition: 'The palliative care keyworker is an identified individual with responsibility for **planning** and **co-ordinating care** for patients who (as a minimum) have been identified as likely to be in their last year of life. This should include **co-ordinating care across interfaces** (within and between professionals, teams and care settings) and promoting continuity of care.'

4 operational elements of the keyworker function:

- Identification
- Contact & co-ordinating care
- Care in the last weeks/days of life
- Bereavement follow up

In the community the Keyworker agreed regionally as **'typically the District Nurse'** – role shared with registered nurse for Nursing Home residents.

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Advance Care Planning:

Communicating wishes and preferences to other care providers through:

- **Advance Care Planning Summary**
- **Key Information Summary**

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Specialist Palliative Care Services:

Specialist Palliative Care for 'complex and unresolved needs':

→Fatigue
→Breathlessness
→Anxiety
→Unintentional weight loss
→Dysphagia
→Communication Difficulties
→Lymphoedema
→Emotional & psychological needs

Specialist Palliative Care Workforce Review currently underway, looking at the SPC Professionals to meet the population needs to 2024 and associated training requirements.

Palliative Care in partnership

Regionally agreed Palliative Care Tools & Guidance

- SPICT: Supportive & Palliative Care Indicators Tool
- ELCOS 2017
- Prompts to aid ELCOS
- Palliative Care Aide Memoire (based on NISAT)
- Palliative Care Keyworker Role & Function
- Your Life, Your Choices- Plan ahead
- Advance Care Planning Summary
- Specialist Palliative Care Referral Guidance & Service Directory
- NICE NG31: Care of dying adults in the last days of life
- RPMG End of Life Guidance (2018)
- PANG: Palliative Care Adult Network Guidelines
- Management of Symptoms in Palliative Care: Role of SPC AHPs

Awaiting approval/ updating:

- DNACPR Policy for NI
- Revision Advance Care Planning Operational Guidance for Healthcare professionals

What I Have observes about how research can be translated to Policy and Practice

- Influence with Heart and the Head
- Engage early
- New knowledge is important but need to align to current priorities and work
- Timing
- Its all about the people!

Thank you
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