Lancashire and South Cumbria Health and Care Partnership

Supported by Confidence to Care

[Printable version]

[Self-assessment tool]

A Local Framework for Delivering Outstanding Palliative & End of Life Care in Lancashire & South Cumbria

I am seen as an individual

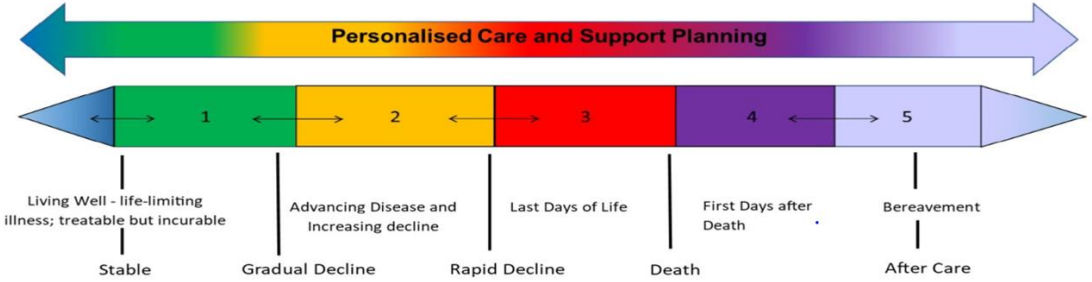
I have fair access to care

My comfort and wellbeing are maximised

My care is well coordinated

The staff looking after me are prepared to care

My community are prepared to help



Background and purpose of the framework

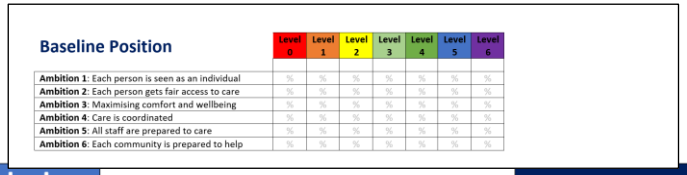
This framework has been codesigned and tested by commissioners, providers, and patient representatives from across Lancashire & South Cumbria, with the aim of raising quality and reducing variation in how palliative and end of life care services are delivered across the area. The framework describes what needs to be in place to support an exemplar patient journey, from the point of being identified as being within the last 12 months of life, through care and support, and into bereavement. The components of this exemplar journey are informed by the lived experiences of people receiving local services, as well as the working experiences of professional and paid caregivers delivering current services.

Quality Improvement methodology has also been used throughout the development phase of this framework underpinned by the following publications, to ensure alignment to national and regional priorities:

- Ambitions for Palliative & End of Life Care (2021-2026)[1]
- The North-West Model for Life Limiting Conditions (2021)[2]
- Palliative & End of Life Care Statutory Guidance for Integrated Care Boards (ICB's) (2022)[3]
- Lancashire & South Cumbria ICS Palliative & End of Life Care (PEOLC) Programme Delivery Plan (2022-23)[4]

How to use this framework

At Place Level: A self-assessment tool and improvement plan template has been developed to accompany this framework that will allow commissioners and providers to collectively benchmark current services against the components of the exemplar patient journey (see example below based around improving early identification)



Ambition 1: I am seen as an individual Place Enabler's	Baseline Position	Year 1 Ambition	Year 3 Ambition	Year 5 Ambition	Place Improvement Plan Action	Timeframe	Lead Responsible
Early identification tools are in use	Drop down 7 levels	Drop down 7 levels	Drop down 7 levels	Drop down 7 levels			

At Commissioner level: Once the place self-assessment has been completed and areas in need of improvement have been identified, commissioners of services should use the levers & measures set out within this framework to commission their local services (example below)

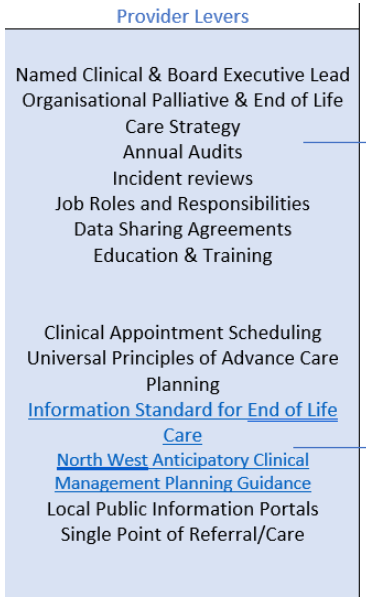
Referenced to prioritise ICB funding to this area

Use as a best practice template for local SPC Service Specifications

What other services are being commissioned against the EHCICH Framework. How can these services play a role in improving early identification?

Use of KPI measurement in all relevant provider contracts e.g. 60% of people identified at palliative/end of life will be given the opportunity to discuss a personalised care and support plan before they die

At provider level: Once the place self-assessment has been completed and gaps/ areas in need of improvement have been identified, providers of services should use the levers and measures set out within this framework to deliver their local services (see example below)



Nominate clinical and board exec leads for early identification

Include this as a priority in organisational strategy

Review current performance – audit or incidents

Include early identification in workforce education planning

Include use of electronically recorded identification coding (as per the information standard) at MDT's and within discharge letters

National Ambition 1: I am seen as an individual

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

What the citizens of Lancashire & South Cumbria say this means for them

Lancashire & South Cumbria commitments towards making this happen

Enablers and Responsibilities

Measurements of success

Best Practice Examples

National Ambition 1: I am seen as an individual

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

What the citizens of Lancashire & South Cumbria say this means for them

Being asked what matters to me as an individual is extremely important to me. Not everyone has the same needs and requirements so to have individual plans of care and conversations is good.

Regardless of my diagnosis I need to know what to expect in the future and what will happen if I am unwell.

I need people to communicate with me in a way that I understand, not using jargon.

I will be listened to and respected, even if people caring for me don't agree with my personal choices, and that I should be enabled, as far as possible, to live the remainder of my life the way I want to live it

Having a named person to turn to when I don't understand, need more information, or have things I want to say.

Keeping my information confidential and helping me to feel safe and welcome

Lancashire & South Cumbria commitments towards making this happen

- We will take the time to listen and to find out what matters to you, including understanding your goals and preferences
- We will regularly review your care to ensure any changes to your care needs, or your preferences for how you'd like to be cared for are kept updated
- We will improve the early identification of those that are likely to be in the last year of life and those approaching their final days of life
- We will support people to feel more confident and prepared for having conversations around death and dying and planning for the future
- We will provide private space and timely opportunities for end-of-life care planning conversations, if people wish to have them
- We will value people as active partners in their care and decision making, so that they are supported to retain as much control as they wish to have
- We will provide accessible information so that people will know what palliative, end of life and bereavement care and support they can expect
- We will provide people with personal health budgets to allow them to personalise and coordinate their own palliative and end of life care
- We will ensure (with your consent), all health and social care professionals have the necessary information to be able to care for you effectively
- We will provide safe and efficient transportation to your preferred place of care where this is available and appropriate to your care needs
- We will work together across services to assess and respond to the care and support needs of a person and those important to them, including bereavement support

Enablers and Responsibilities

Enabler	Commissioner Levers	Provider Levers
Early identification tools are in use e.g., EARLY Tool, Gold Standards Framework, SHADOW tool for Care Homes, Amber Care Bundle, other digital tools that support early identification	Underpinning guidance detailed on page 1[1-4] National Specialist Level Palliative & End of Life Care Services Specification (Adults)[5] Enhanced Health in Care Homes Framework[6] NHS Continuing Health Care Fast-Track Pathway[18] Universal Principles for Advance Care Planning[7] NHS Virtual ward guidance[19] NHS Chaplaincy Guidance[20] Clinical Leadership and peer leadership throughout ICS, ICP and place-based partnerships Joint Strategic Needs Assessment The Well Pathway- Dementia Care [22]	Named Clinical & Board Executive Lead Organisational Palliative & End of Life Care Strategy Place Based Partnership Groups Annual Audits Incident reviews Job Roles and Responsibilities Data Sharing Agreements Education & Training Clinical Appointment Scheduling Universal Principles of Advance Care Planning[7] Information Standard for End of Life Care[8] North West Anticipatory Clinical Management Planning Guidance [9] Local Public Information Portals Single Point of Referral/Care The Well Pathway- Dementia Care [22]
Public health approaches are being taken towards death, dying & bereavement e.g., compassionate communities, dying matters,		
There is dedicated private space and opportunity for sensitive conversations e.g., dedicated consulting rooms, longer appointment times		
Personalised Care & Support Planning is being proactively offered and regularly reviewed e.g., concerns checklist, holistic needs assessment, Advance Care Planning **and** understanding peoples wishes - for example preferred place of care, organ and tissue donation, DNACPR, Escalation Plans, Anticipatory Clinical Management Planning, Future Life Planning, ICD deactivation, Mental Capacity Assessment/Best Interests, processes in place for regular review		
Patient and public information on palliative & end of life care is accessible setting out what patients and carers can expect, available in different formats & languages, signposting across statutory and voluntary services and Care Homes		
Personal Health Budgets specifically to support end-of-life		
Electronic Palliative Care Coordination Systems (EPaCCS) includes platforms for patients to share or to view their own plans		

Palliative & End of Life Care Pathways at Place are integrated to meet individual needs e.g. across health, social, third sector, through Joint MDT's, trusted assessment processes, integrated discharge summaries,	Dying Well in Custody Charter [23] Care committed to me [24] UK Commission on Bereavement[26] **Standard KPI's across provider contracts** Primary Care Contracts Care Home Contracts Community Service Contracts Hospital Contracts Hospice (Including Children's Hospice) Grants 3rd Sector contracts/grants IT Contracts Domiciliary Care Contracts Lead/Joint Provider Contracts	
Pre & Post Bereavement Support helping people to prepare for loss, grief, and bereavement, e.g. in Care Homes, across maternity, children's and adult's services, Inc. Sudden & traumatic death		
Patient and Public Engagement – gaining service user and carer feedback and involving them in service evaluation and design		
Equality and diversity strategy to deliver palliative and end of life care services and support that meet the needs of marginalised groups working within best practice when supporting individuals that may feel marginalised e.g. LGBTQ+, homeless people, prisoners, immigrants, travelling community		

Measurements of success

0.6% of the practice population will be on a palliative care register

60% of people that die will have been on the Palliative Care Register (include breakdown of cancer, non-cancer and dementia)

60% of people identified as palliative will have been given the opportunity to discuss a personalised care and support plan before they die

% of people that die will have a CPR decision or discussion recorded

Number of organisations having robust systems in place to share advance care/anticipatory care plans electronically

% Achieving their preferred place of death

Survey of service users and bereaved people (consider Place or ICS wide approach)

National Audit for Care at the End of Life (NACEL)

Patient case studies

Audit of standards of Advance Care Planning against Northwest Anticipatory Clinical Management Planning Guidance [9]

NB: Baseline data should consider skewed data arising due to COVID

Best Practice Examples

St Johns Hospice Forget me not centre bereavement support

Coverage: South lakes, North Lancashire, and West Yorkshire

Lead Contact: maddy.bass@sjhospice.org.uk

Brief Description: Bereavement support at psychological levels 2 to 4. – whole family (4 yrs +). Pre and post bereavement, individual or groups or families. Work with schools to train them to support bereaved children. In the last quarter of 2022 this team have supported 138 individuals.

Outcomes: Enabling children, young people and families cared for by St Johns Hospice to stay together in grief- not to be separated in grief and supporting them to work as social unit through grief. Improving health and education outcomes for children and young peopleEnabling schools to support bereaved children and young people

Advance Care Plan for the Homeless - What if document

Coverage: Burnley, Pendle, Rossendale. People who attend Church on the Street (CoTS)

Lead Contact: Alison Lucas - alison.lucas@pendleside/org.uk

Brief Description: Partnership working with CoTS to develop and promote advance care planning for the Homeless / vulnerable groups. The document asks:

- What preferences are if they cannot be made better?
- Who would they like to be contacted?

- Where would they like to be cared for?

Outcomes: A pathway has been developed to share the document with GP, Out of Hours Medical Services, Pendleside Hospice and E.D. Flags have been added to the individual organisations systems to alert to the existence of the What if document. NWAS are aware of the document but cannot flag as their system flag an addresses

Swan Model End of Life & Bereavement Care Fylde Coast

Scope of Coverage: Patients in Blackpool Teaching Hospitals with life limiting illnesses, last days & their families, including bereavement and carer support.

Lead Contact: Jackie Brunton- Lead Nurse EOL & Bereavement Care, Blackpool Teaching Hospitals.

Brief Description: SWAN End of Life and Bereavement Care Team | Blackpool Teaching Hospitals NHS Foundation Trust (bfwh.nhs.uk)

The Swan model of care is about providing excellent, individualised end of life and bereavement care for every patient and every family, every time. It is patient and family focussed and centres on meeting the unique needs of each individual and their loved ones.

The Swan model is instigated at the point of recognition of dying and is used to support care throughout end of life, into bereavement and beyond. Staff inform the family wherever possible of what the Swan model means and swan signage will be used throughout the Trust included on documentation, information, comfort packs, swan sign is placed on the door or curtain of the area in which the dying person is being cared for. It acts as a visual reminder for all staff to employ the principes of the Swan model in their care for that person and their loved ones, and reminds everyone, including other visitors, to be mindful of maintaining as peaceful an environment as possible.

The Swan is an enabling model which supports generalists to be specialists in end of life and bereavement care. It's ethos is about empowering staff and giving them permission to care and to break the rules that don't exist. We will maintain standards that we would expect for our own loved ones, find out to know what matters most and support making this happen.

Outcomes: Impact is monitored through bereaved experience in national and local audit.

National Ambition 2: I have fair access to care

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

- What the citizens of Lancashire & South Cumbria say this means for them
- Lancashire & South Cumbria commitments towards making this happen
- Enablers and Responsibilities
- Measurements of success
- Best Practice Examples

National Ambition 2: I have fair access to care

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

What the citizens of Lancashire & South Cumbria say this means for them

Everyone should be entitled to the same standard of care no matter who or what the circumstances

I need to know that care is available and how to access it when I need it, particularly overnight and at weekends as well as at different stages of my illness

I think every person is an individual and deserves the same care regardless of age, religion, sex, financial, personal circumstances etc

We all die, so being able to access the right care, at the right time and place although unique to me, should be equitable to anyone else.

Lancashire & South Cumbria commitments towards making this happen

- We will seek to understanding the palliative, end of life and bereavement care needs of the local population
- We will provide accessible services that respond to the diverse palliative, end of life and bereavement care needs of our communities
- We will continuously improve the quality of palliative, end of life, and bereavement services by evaluating their impact on the people that use them
- We will seek to understand the reasons why people might not access palliative, end of life care and bereavement services
- We will actively involve people/ organisations representing, different age groups, disabilities, illnesses and cultures in future service design and strategy development
- We will help people that are finding it difficult, for whatever reason, to navigate their way around palliative and end of life services more easily
- We will ensure that you have the care you need in the place where you would like to be cared for
- We will ensure that your family and those important to you have access to support and care, including bereavement support after you have died
- We will ensure that you have 24/7 access to someone that can help if you are struggling

Enablers and Responsibilities

Enabler	Commissioner Levers	Provider Levers
An all-conditions approach to palliative and end of life care- e.g. Specialist Palliative Care representation at specific MDT's e.g. neurology, respiratory, cross sector referral to GP Palliative Care Registers, collaborations between palliative care and disease/population specific services	Underpinning guidance detailed on page 1[1-4] Joint Strategic Needs Assessment Specialist Level Palliative & End of Life Care Services Specification (Adults)[5] Enhanced Health in Care Homes Framework[6] NHS Continuing Health Care Fast-Track Pathway[18] Universal Principles for Advance Care Planning[7] NHS Virtual ward guidance[19] NHS Chaplaincy Guidance[20] Clinical Leadership and peer leadership throughout ICS, ICP and place-based partnerships Joint Strategic Needs Assessment	Named Clinical & Board Executive Lead Organisational Palliative & End of Life Care Strategy Place Based Partnership Groups Annual Audits Incident reviews Job Roles and Responsibilities Data Sharing Agreements Education & Training MDT coordination Business Intelligence Equality and Diversity Monitoring Co-work with Children's Services Patient & Public User Groups Information Standard for End of Life Care[8] The Well Pathway- Dementia Care [22] Dying Well in Custody Charter [23]
Data dashboards are being used to collate, benchmark and inform priorities – e.g. representing a system wide response, used to set priorities, to understand and to remedy the reach of current services, use of standardised outcome measures/core metrics in service contracts		
Equalities and health inequalities impact assessment and action plan- e.g., addressing improved equity of access to services, reducing inequity of outcomes and experience, reflected in clinical pathway design e.g. homeless, prisons, mental health units, supported living, LGBTQ+		
All ages approach to palliative and end of life care- e.g. adults and children strategy, inclusive of services supporting the transition between childhood and adulthood. Standardised outcomes for children with life-limiting illness		
Service co-design and evaluation- e.g. involving people and organisations representing faith groups, cultural communities, all ages, and those with life limiting illness,		

strategy for seeking service user feedback to inform service development & improvement	The Well Pathway- Dementia Care [22]	
Electronic Palliative Care Coordination Systems (EPaCCS)-e.g., to provide consistent data that can be benchmarked across localities and regions	Dying Well in Custody Charter [23]	
Published list of providers of palliative & end of life care and bereavement support- readily available to the public and across the health economy to support future commissioning of services, and to facilitate partner collaborations	Care committed to me [24]	
	UK Commission on Bereavement[26]	
	Standard KPI's across provider contracts	
	Primary Care Contracts	
	Care Home Contracts	
	Community Service Contracts	
	Hospital Contracts	
	Hospice (Including Children's Hospice)	
	Grants	
	VCFSE contracts/grants	
	IT/BI Contracts	
	Domiciliary Care Contracts	
	Lead/Joint Provider Contracts	

Measurements of success

Improved % of people on the Palliative Care Register with a non-cancer diagnosis

Evidence of increased diversity of people accessing specialist palliative care services e.g., age, ethnicity, geographical areas, primary diagnosis

Reduction in hospital admissions in the last 90 days of life

Reduction in hospital admissions from Care Homes in the last 90 days of life

Survey of service users and bereaved people (consider Place or ICS wide approach)

National Audit for Care at the End of Life (NACEL)

Patient case studies

Achievement of Preferred Place of Death

Place of Death by ethnic group

NHS Continuing Health Care provision – who is receiving it, how soon before death,

Delays in transfers of care/discharges including to Care Homes

NB: Baseline measurements should consider skewed data arising due to COVID

Best Practice Examples

Admiral Nursing Service-Fylde Coast

Scope of Coverage: Based at Trinity Hospice

Lead Contact: Admiral Nurse: Maxine.emslie@nhs.net

Brief Description: Admiral Nurse at Trinity Hospice will help people access dementia care - Dementia UK Admiral Nurses are Registered Nurses who specialise in dementia care, working with families and people affected by dementia, particularly during complex periods of transition.

Outcomes: Are achieved through casework, coordination, groups and/or clinics to;

- Promote physical, social and psychological health of family carers and people with dementia
- Improve well-being and quality of life for people with dementia and their family carers
- Enhance adjustment and coping strategies for people affected by dementia and their families

Advanced Dementia Support Team- Cheshire

Scope of Coverage: Cheshire West & Cheshire East Place

Lead Contact: Jenny Casson- Team Leader Tel 01270 310260 jenny.casson@eolp.org.uk

Brief Description: Advanced Dementia Consultancy | The End of Life Partnership (eolp.co.uk) The Advanced Dementia Support Team (ADST) are a small multi-disciplinary team of specialist professionals working across Cheshire East and Cheshire West and Chester. ADST provide consultancy to professionals

or family carers caring for someone with advanced dementia who requires 24/7 supervision, either at home or in a care setting. The service aims to guide and educate professionals and informal caregivers in the delivery of best practice for people with advanced dementia.

Outcomes: Respond to referrals from professionals and informal carers who are caring for people with advanced dementia and seek guidance or education Deliver education and information to clinical teams, care services and informal carers on the nature of advanced dementia and likely deterioration Support clinical teams and care services through the delivery of care home clinics & by attending multidisciplinary meetings. Support clinical teams, care services and informal carers to identify the possible causes of behavioural and psychological symptoms of dementia. Support clinical teams, care services and informal carers to implement Best Interests Advance Care Plans

National Ambition 3: Maximising Comfort & Wellbeing

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.

- What the citizens of Lancashire & South Cumbria say this means for them
- Lancashire & South Cumbria commitments towards making this happen
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National Ambition 3: Maximising Comfort & Wellbeing

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.

What the citizens of Lancashire & South Cumbria say this means for them

I need to know my symptoms are being treated and I can access my GP, equipment and medication when I need to

Every time my dad was in pain the staff were very prompt and professional and treated him with dignity and respect.

I want to talk about what is important to me and be involved in making a plan about my comfort and symptoms. I need to know who to contact if I am struggling at any time of day.

The team caring for me help to maintain my comfort and wellbeing at the end of my life so that I can achieve the good death we all hope for.

Having access to timely and skilled pain management delivered with care, compassion, and kindness.

Understanding of the likely process of dying.

Knowing that my loved ones are being supported and that this support will be available after I die.

Lancashire & South Cumbria commitments towards making this happen

- We will provide rapid response services to support people to manage symptoms that are causing them distress e.g., pain, agitation,
- We will provide the right palliative, end of life and bereavement care support services that respond to the common causes of distress
- We will ensure that everyone has access to Specialist Palliative Care advice 24/7
- We will provide 7-day access to face-to-face assessment from Specialist Palliative Care
- We will recognise and respond to the needs and expectations of informal caregivers
- We will provide accessible information about different symptom management options so that people can make informed decisions
- We will maximise comfort and wellbeing by ensuring everyone involved in a person's care has timely access to their individual care and support plan
- We will help people to maximise their independence and social participation to the extent that they want, and for as long as possible
- We will deliver individualised care to the dying person and those important to them

Enablers and Responsibilities

Enabler	Commissioner Levers	Provider Levers
24/7 access to Specialist Palliative Care advice e.g., regardless of setting, available for professionals, patients, and their significant others, advice line with consultant on-call	Underpinning guidance detailed on page 1[1-4] Specialist Level Palliative & End of Life Care Services Specification (Adults)[5] Advice Line Service Specification Enhanced Health in Care Homes Framework[6] NHS Continuing Health Care Fast-Track Pathway[18] Universal Principles for Advance Care Planning[7]	Named Clinical & Board Executive Lead Organisational Palliative & End of Life Care Strategy Place Based Partnership Groups Annual Audits Incident reviews Job Roles and Responsibilities Data Sharing Agreements Education & Training MDT coordination 7 Day working Rapid Response Teams Single Point of Coordination
7-day access to face-to-face assessment from Specialist Palliative Care services – e.g., community and hospital, care homes and specialist units e.g., Learning Disabilities, Prisons, 24/7 availability of hospice admissions		
Single point of referral/care coordination for palliative & end of life care – e.g., regardless of care setting, care coordination & advice, open to health care professionals, patients, & their carers		
Electronic Palliative Care Coordination Systems (EPaCCS)- e.g., includes out of hours & ambulance sharing, last days of life care aligned to the Five Priorities, inclusive of care homes and domiciliary care		

Enabler	Commissioner Levers	Provider Levers
Anticipatory Clinical Management Planning -e.g., treatment escalation plans, anticipatory medications, processes for regular review of medications including within nursing homes	NHS Virtual ward guidance[19] NHS Chaplaincy Guidance[20] Clinical Leadership and peer leadership throughout ICS, ICP and place-based partnerships Joint Strategic Needs Assessment The Well Pathway- Dementia Care [22] Dying Well in Custody Charter [23] Care committed to me [24] UK Commission on Bereavement[26] **Standard KPI's across provider contracts** Primary Care Contracts Care Home Contracts Community Service Contracts Hospital Contracts Hospice (Including Children's Hospice) 3rd Sector contracts/grants IT Contracts Community & Hospital Pharmacy Pharmacy Quality Scheme Patient Transport Contracts Domiciliary Care Contracts Lead/Joint Provider Contracts Equipment contracts	North West Anticipatory Clinical Management Planning Guidance[9] Clinical Practice Summary for Palliative Care Symptoms[11] Administration of Medications Protocols Syringe Pump Coordination & Availability Information Standard for End of Life Care[8] Carer assessments Five Priorities for Care of the Dying[10] The Well Pathway- Dementia Care [22] Dying Well in Custody Charter [23]
Non-Medical Prescribers – e.g., within Palliative Care, education in palliative and end of life care symptoms to nurse prescribers across generalist services		
Palliative Pharmacy Services- e.g. opening hours & access to palliative & end of life drugs, just-in case boxes		
Dedicated Ambulance Service- e.g., end of life transfers, including for Children's Hospice transfers		
Financial Assessment & Support- e.g. DS1500, PIP, CHC, tailored advice		
AHP roles within Palliative Care- Social worker, therapy teams: OT, Physio, & clinical psychology as a minimum		
Rehabilitative Palliative Care Services- dedicated team		
Rapid response services – e.g., regardless of care setting, including for equipment and ambulance conveyancing, access to GP appointments and prescribing for priority patients e.g., gold lines		
Care for Carers – e.g. carer check in, carer breaks, respite, engagement groups		
Care of the Dying Person- e.g., approach is aligned to the five priorities of care,		
Integrated domiciliary care – e.g. dedicated palliative and end of life domiciliary care providers linked to CHC fast track, with appropriate access to patient information, access to specialist services, equipment and medication when required		
Syringe Pumps- availability and coordination across care settings including to nursing homes		

Measurements of success

Service response times

Patient Reported Outcome Measures (PROMS)

Improved carer wellbeing

Survey of service users and bereaved people (consider Place or ICS wide approach)

National Audit for Care at the End of Life (NACEL)

Patient case studies

NB: Baseline data should consider skewed data arising due to COVID

Best Practice Examples

St Johns Hospice Clinical Nurse Specialists

Coverage: South Lakes, North Lancashire, and West Yorkshire

Lead Contact: maddy.bass@sjhospice.org.uk

Brief Description: Set up during COVID, this service allows families to have a break to leave the house for few hours in the day, or to sleep. Or a night sit, to allow the family to sleep overnight. This allows the family to be rested.

Outcomes: Support end of life care at home to meet Preferred Place of Death. Support for the family carer who is vital in ensuring the person who is dying stays at home. Symptom monitoring, with access to DN and H@H, and medical team if required. Advance care planning and supportive discussions.

Psychological Services Trinity Hospice

Coverage: Anyone currently receiving care or support from Trinity's family of services or anyone living with or caring for someone who is being supported by Trinity's family of services. A direct family member who is bereaved after the loss of someone who has been cared for by Trinity's family of services

Lead Contact: Dr Andy Sanderson-Thomas Clinical Psychologist 01253 952567 **dr.sanderson-thomas@nhs.net**

Brief Description: Support for adults - Trinity Hospice Trinity Psychological Services and the Linden Centre accept referrals for patients known to Trinity Hospice and their families for in person 1-1 Counselling/Clinical Psychology support. Bereavement and carer therapy groups are offered for 8 weeks, including a children's group. Art social group for patients. Virtual psychology sessions are available.

Outcomes: The service uses the CORE 10 outcome measure for therapeutic support within the bereavement and carer service. A patient experience questionnaire (including friends and family data) is used for discharged patients within the psychology service.

Emergency Department (ED) Project: in-reach into ED and Acute Medical Unit

Scope of Coverage: Patients presenting to ED or AMU at Blackpool Victoria Hospital with a life limiting diagnosis

Lead Contact: Dr Harriet Preston Harriet (BFWH) Blackpool teaching hospitals Harriet.preston@nhs.net

Brief Description: Pilot providing timely & responsive targeted palliative care assessment at the 'front door'. Trialling the use of Specialist Palliative Care Trainee Advanced Practitioners working alongside HPCT providing daily in-reach into ED aiming to:

- reduce unnecessary hospital admissions and GP contacts
- increase the numbers seen achieving their preferred place of care and death
- enhance patient agreed advance care planning including the establishment of ceilings of treatment.

Outcomes: Between 01/02/21-31/1/22 69 patients were supported. Of these 19 (28%) were either discharged appropriately back to their place of residence or to the local hospice on the same day, saving 78 bed days. A high proportion of patients attending without a DNACPR/EPACCS highlights the need for further work to promote anticipatory advance care planning

Trinity Living Well Services

Coverage: Fylde Coast

Lead Contact: Rick Fisher - Richard.fisher9@nhs.net

Brief Description: Through the employment of rehabilitative approaches, the Trinity Living Well Service provides professional and social support, information, and empowerment to 'live well' for those people with a progressive, life limiting condition and those close to them.

Outcomes: The Living Well Service has offered choice to patients who wish to attend an OPA clinic as opposed to being seen in their home. This has on occasion been the only time a person left their home and has led on to sign up at our art group and interaction with others in a similar situation through continuing attendance. We have also been able to support a return to sport, running, community gym access. From a bereavement perspective, we have seen the social support group enable friendships to form for peer support after loss.

Trinity Hospice Spiritual Care Assessment

Scope of Coverage: All patients at Trinity Hospice services – Inpatient, Community and Hospital teams

Lead Contact: David Melvin, Trainee Advanced Clinical Practitioner , Community Palliative Care Team, David.melvin1@nhs.net

Brief Description: Following self-reflection and discussions with peers of all grades in the hospice I recognised there was a lack of confidence and competence in assessing spiritual care needs of patients across hospice services.

The project set out to establish if there is a standardised assessment tool used to assess/address spiritual care concerns of patients as part of a holistic model of care encompassing the four main components of holistic palliative care – physical pain, psychological pain, social pain (broken relationships) and spiritual pain.

Following a staff survey and audit it was clear there is no standardised model of assessment in use and staff confidence in engaging patients/families in spiritual care conversations is low throughout the organisation. This suggests patients may have unmet spiritual needs, this could result in patients continuing to experience some ongoing distress as their health deteriorates.

Outcomes: The project has seen the implementation of our own model to assess spiritual pain or distress – the Just ASK model.

The model is based on 4 open questions that are aimed at engaging patients in conversations about thoughts/feelings and what is important to them. Staff are encouraged to engage patients in conversation and if they are unable to answer any concerns, this is the route to explore referral to the spiritual care team.

To enable the implementation of the model and to address the common themes that were evident from the staff survey spiritual care assessment training sessions are now mandatory for all staff at the hospice. This commenced for clinical staff in September 2022 and will be rolled out for all staff in the hospice to maintain the inclusivity of our organisation.

Just Ask

- When you've faced difficult times what has kept you going?
- What matters to you if time is short?
- What would peaceful mean to you?
- *Do you have any beliefs that bring meaning/purpose to your life*

National Ambition 4: Care is Coordinated

I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of the day or night

- What the citizens of Lancashire & South Cumbria say this means for them
- Lancashire & South Cumbria commitments towards making this happen
- Enablers and Responsibilities
- Measurements of success
- Best Practice Examples

National Ambition 4: Care is Coordinated

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What the citizens of Lancashire & South Cumbria say this means for them

When decisions are made, they are shared with all the relevant healthcare teams, preventing repetition and delays

I have one contact number to someone who can help me find the support or answers I need so I don't have to ring around different services to get help.

Everyone that can help me works together to make things easier for me and my family.

I need to know my family are looked after and supported.

Timely interventions from a familiar person.

I need to tell to tell my story only once

I have a great team around me. 24hour access to care from a team of people who know me and my needs

I need consistency of care from people who know me

I need to know my care can be provided 24 hours a day 7 days a week.

Everyone helping me knows my needs and my plans and works together to look after me.

I need to know that the people who look after me can access up to date information about me.

I'd like to have one point of contact who can coordinate all my care, saving me the worry.

Psycho-social support for those dying and those around them. Multi-agency, multi-professional teams supported by pooled funding working effectively with the 3rd sector

Lancashire & South Cumbria commitments towards making this happen

- We will commission joined up palliative, end of life and bereavement care services across health, social and the VCFSE sector so that services understand how they fit together and where to signpost or refer onto
- We will coordinate multi-disciplinary team working across palliative and end of life care services
- We will meet the needs of diverse groups by establishing integrated care and support pathways e.g. the homeless, learning disabilities, dementia, frailty and old age, children and young people
- We will enable the sharing of care records across services so that the right information is available at the point of care
- We will ensure that people at the end of life, and those important to them always have a point of contact, day, or night where their care and support can be coordinated
- We will empower people to access palliative and end of life services by providing up to date service directories
- We will ensure that your palliative and end of life care is coordinated by a named person

Enablers and Responsibilities

Enabler	Commissioner Levers	Provider Levers
Electronic Palliative Care Coordination Systems (EPaCCS)- e.g. shared across health, social and third sector organisations, shared with the Ambulance Service and Out of Hours, including clinical management planning documentation e.g. DNACPR, Escalation Plans	Underpinning guidance detailed on page 1[1-4] Specialist Level Palliative & End of Life Care Services Specification (Adults)[5] Advice Line Service Specification Enhanced Health in Care Homes Framework[6] NHS Continuing Health Care Fast-Track Pathway[18]	Named Clinical & Board Executive Lead Organisational Palliative & End of Life Care Strategy Place Based Partnership Groups Annual Audits Incident reviews Job Roles and Responsibilities Data Sharing Agreements Education & Training MDT coordination 7 Day working Single Point of Coordination
Key worker/named person – responsible for reviewing the overarching care plan, named GP		
Single point of contact/coordination for palliative & end of life care services – e.g., from triage**,** care coordination and advice, open to health and social care professionals, patients, carers 24/7,		
24/7 Specialist Palliative Care advice to include hospice advice and admissions where clinically appropriate,		

Coordinated Palliative Consultant cover across Place or ICS	EPaCCS digital roadmap Universal Principles for Advance Care Planning[7] NHS Virtual ward guidance[19] NHS Chaplaincy Guidance[20] Clinical Leadership and peer leadership throughout ICS, ICP and place-based partnerships Joint Strategic Needs Assessment The Well Pathway- Dementia Care [22] Dying Well in Custody Charter [23] Care committed to me [24] UK Commission on Bereavement[26] **Standard KPI's across provider contracts** Primary Care Contracts Community Service Contracts Care Home Contracts Hospital Contracts Hospice (Including Children's Hospice) Grants 3rd Sector contracts/grants	North West Anticipatory Clinical Management Planning Guidance[9] Palliative and end of life care virtual ward guidance[12] Information Standard for End of Life Care[8] Rapid Discharge Pathways Care After Death: Registered Nurse Verification of Expected Adult Death Guidance[13] Out of Hours Notifications Joint working with Children's and Young Peoples Services The Well Pathway- Dementia Care [22] Dying Well in Custody Charter [23]
7-day working – e.g., across all core services involved in palliative and end of life care incl. equipment & transport		
Integrated Commissioning – e.g., active partnerships that bring together providers and commissioners to collectively plan services, responding as a whole system approach to locally identified needs		
Multi-Disciplinary Approach – e.g., cross sector MDT meetings incl. social care, hospital integrated discharge summaries, Integrated Care Pathways (incl. for diverse needs), neighbourhood teams,		
Virtual Wards- specifically for palliative and end of life care and involving the GP		
Transition Pathways- between children & young people, and adult palliative & end of life care services		
Care of the Dying- Rapid Discharge/Transfers, Nurse Verification, expected death notifications for OOH,		
Out of Area coordination- local pathways take into consideration cross boundary working including transportation and admission and discharge for people with palliative and end of life care needs, medication, and syringe pumps		

	IT Contracts Domiciliary Care Contracts Lead/Joint Provider Contracts Children's and Young Peoples Service Contacts	

Measurements of success

% Reduction in hospital admissions during the last 90 days of life

% Reduction in hospital admissions from Care Homes for those identified as palliative

% Reduction in hospital admissions for people with a dementia diagnosis that are identified as palliative

% Increase in achievement of preferred place of care/death

Survey of service users and bereaved people (consider Place or ICS wide approach)

National Audit for Care at the End of Life (NACEL)

Patient case studies

Reduction in the number of end of life care related incident reports

Reduction in the number of end of life care related complaints

Number of GP Practices holding at least 10 GSF meetings per annum

Increased % of patients on the Palliative Care Register

Increased % of people on the Palliative Care Register that have an EPaCCS

NB: Baseline data should consider skewed data arising due to COVID

Best Practice Examples

Enhanced Integrated System Partner Working for End of Life Care on Fylde Coast

Scope of Coverage: Fylde Coast population footprint

Lead Contacts: Dr Gillian Au, Medical Director Trinity Hospice g.au@nhs.net & Jackie Brunton, EOL Lead Blackpool Teaching Hospitals NHS Trust j.brunton@nhs.net

Brief Description: From the well-established integrated Fylde Coast EOLC Strategic group (running since 2010) we set up a Fylde Coast System Partners End of Life Care working Group at the start of the pandemic. Meets monthly, virtually, with engagement from hospice, community, hospital, OOHs service, Care Homes, Social Care, Public Health, primary care and NWAS – to:

- Share situational awareness of areas on the Fylde Coast recognising that there are challenges
- To ensure and agree that issues are appropriately understood and escalated to the ICS
- To be responsive to changing requirements/direction
- To update the End of Life Pathways action log
- To discuss case studies and share learning experiences for shared understanding and problem solving.

Outcomes: Clinical symptom management guidelines for community, hospital, and care homes. Specific Covid advance care planning guidance for care homes. Sufficient supplies of end-of-life care anticipatory drugs and key documentation. End of life care training and support for all Fylde Coast care homes. EPaCCS, ACP and Ceilings of Treatment. End of life care training and support for local peripheral hospitals, primary and community care. Commissioning of a private ambulance service to ensure timely end of life care discharges and transfers. Promotion of our 24/7 SPC advice line to all system partners. Established daily morning system palliative and end of life care "Safety Huddles" virtually with key partners sharing daily EOLC "SitRep" reports. Used learning from case studies to identify gaps in co-ordination or continuity of care, understand and address these collaboratively. Launched "Our Compassionate Fylde Coast Communities" May 2022. Escalated gap for social care packages for EOL fast track discharges – Bid gone to ICS to commission specific service for this. Development of policy for Carer administration of s/c EOLC meds in community pilot. EOLC Virtual Wards service development updates

EPaCCS Quality Improvement Project

Scope of Coverage: Blackpool Teaching Hospitals, Fylde Coast

Lead Contact: Lorraine Tymon Lorraine.tymon@nhs.net

Brief Description: Increased awareness, understanding, usage and development of patient EPaCCS records. Associated projects looking at engagement with specific staff groups (e.g CNS') to promote timely ACP conversations that are then developed into EPaCCS records.

Regular and accessible training and support available to staff to ensure they are aware of and know how to access EPaCCs records, aim to support patients being cared for in their preferred place of care.

TNA completed to ascertain levels of knowledge pre project – will be repeated post project with aim of seeing improvement.

Outcomes Maintenance of the number of EPaCCS records in existence across the Fylde Coast. Longer term measurement to look for reduction in inappropriate ED presentations for people who are at end of life. Empowering staff to advocate for their patients as they know their wishes in advance.

Single Point of Access Fast Track Palliative and EOLC Care

Scope of Coverage: Pennine Lancashire

Lead Contacts: Anne Huntley, Pendleside Hospice, Carol Evans, East Lancashire Hospice, Jayne Lothian, Commissioner ICB Pennine

Brief Description: All continuing care fast track referrals for palliative and end of life care are now sent to either Pendleside Hospice or East Lancashire Hospice dependent on where the patient lives. The Hospice then coordinate hospice at home, Marie Curie and domiciliary care night sits to patients in these localities. Fast track day referrals are sent to continuing health care for allocation Hospice at home provide RN support into patients including syringe drivers, just in case drugs etc. supporting district nurses with their caseload

Outcomes: Response time is usually less than 2 hours from referral for night sits if referral received between 7.30am and 10pm Monday until Sunday.

- Patients who wish to stay at home for end of life care have are able to do so
- Admissions to hospital are prevented
- Patients receive better continuity of care
- Domiciliary care agencies feel better supported by hospice services and are provided with the necessary information to care for patients
- Patients received their preferred place of care
- More patients receive hospice at home in the community

Enhanced Supportive Care for Cancer Services

Scope of Coverage: At present the service provides early palliative care input for patients in Central Lancashire with UGI, CUP, Lung or Stage 3 (first relapse) & 4 ovarian cancer alongside their active oncology treatment (but hoping this will expand to other cancer sites over the next year with the recruitment of an ACP)

Lead Contact: Dr Kate Stewart and Tomoko Lewis (LTHTR) Katherine.stewart@lthtr.nhs.uk & Tomoko.lewis@lthtr.nhs.uk

Brief Description: Early palliative care input provided alongside active oncology treatment. The service has specialist medical and nursing input, with access to other hospital-based services (e.g., dieticians, clinical psychology). The service is predominantly delivered through:

- outpatient clinics
- inpatient support.

Palliative care input into cancer MDTs to identify patients who may benefit from early palliative care support.

Outcomes: Improved patient experience / quality of life

- Reduction in overall healthcare costs (primarily through reduction in emergency/unplanned admissions to hospital and reduction in length of stay)
- Reduction in the need for aggressive interventions and promoting in better care in the last days / weeks of life.

Care Home Support Service- Cheshire

Scope of Coverage: Cheshire East & Cheshire West Places

Lead Contact: Karen Finch-Burke kare.finch-burke@eolp.org.uk

Brief Description: Care Home Support Services: Home Page | The End of Life Partnership (eolp.co.uk). The Care Home Support Service provides a responsive service offering dedicated advice, training, and education to support proactive care, centred on the needs of residents, including enabling residents to live well and plan for end of life.

Working together with residential, nursing, learning disability, mental health and dementia care homes we will help you to identify areas for development. This maybe specific to the care of individual residents, opportunities for staff development and/or your leadership team within the home. Each home will then have a co-designed individual Support Plan that reflects your priorities. The Care Home Support Service is a fully funded NHS commissioned service provided to all residential and nursing care homes within Cheshire West and East Place

Outcomes: This service launched in 2022 is being monitored and reported for quarterly outcomes via a dedicated data dashboard

National Ambition 5: All Staff are Prepared to Care

Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident, and compassionate care

- What the citizens of Lancashire & South Cumbria say this means for them
- Lancashire & South Cumbria commitments towards making this happen
- Enablers and Responsibilities
- Measurements of success
- Best Practice Examples

National Ambition 5: All Staff are Prepared to Care

Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident, and compassionate care

What the citizens of Lancashire & South Cumbria say this means for them

I need the people who look after me to communicate properly with me and have open and honest conversations.

I need to know that staff who look after me have the training they need to be able to care for me properly

I need to know that people recognise when I am less well and care for me appropriately

Everyone helping and supporting me respects me and treats me with care and compassion.

I have empathic and compassionate staff around me who are confident to talk openly about death and dying. They take a non-judgmental approach and are sensitive to differing cultural and religious practices.

Lancashire & South Cumbria commitments towards making this happen

- We will include the provision of funded education and training into service contracts to ensure that patients and those important to them are being cared for by appropriately trained staff and volunteers
- We will identify and respond to the palliative and end of life care education and training needs for informal carers & for health and social care staff and volunteers

- We will invest in the leadership, development and succession planning of the palliative and end of life care workforce
- We will deliver engaging, diverse, and dynamic education and training to the workforce, making the best use of advancing technology
- We will assure the quality of our education and training provision against Quality Assurance Frameworks and Education Standards
- We will develop champions in palliative and end of life care that advocate for best practice and have the courage to challenge poor care
- We will prioritise the health and wellbeing of the workforce
- We will ensure care is more inclusive by raising staff and volunteer awareness of equality and diversity issues at the end of life
- We will include legislation within our education and training to improve safe practice at the end of life
- We will evaluate education and training so that we can evidence that this is making a difference for patients, families, and carers

Enablers and Responsibilities

Enabler	Commissioner Levers	Provider Levers
Education Standards –e.g., workforce education is provided in accordance with the L&SC End of Life Care Education Standards[14]	Underpinning guidance detailed on page 1[1-4]	Named Clinical & Board Executive Lead Champion at exec level for Learning & Development of staff Organisational Palliative & End of Life Education Strategy Place Based Partnership Groups Annual Audits Incident reviews Job Roles and Responsibilities Education & Training End of Life Care Facilitators North West Anticipatory Clinical Management Planning Guidance[9] Clinical Practice Summary for Palliative Care Symptoms[11]
Quality Assured Education – education is delivered by skilled and competent clinicians, facilitators, and educators, **e.g.,** aligned to the Standards and guidelines for end of life care facilitators and educators[15]	National Specialist Level Palliative & End of Life Care Services Specification (Adults)[5]	
Coordination of Education - Palliative/end of life training centrally coordinated & monitored to ensure accessibility & applicability to all incl. informal carers and volunteers, e.g., Palliative Education Hubs or Hospice Education Centres	Enhanced Health in Care Homes Framework[6]	
Sustainable Provision- Palliative and end of life care education is specifically commissioned, included in service contracts, and seen as a core component of Place provision	End of Life Care Education Standards for L&SC[14]	
Impact on practice- Education is evaluated to monitor effectiveness and impact on quality of care, evaluations are used as part of continuous improvement processes	Standards and guidelines for end of life care facilitators and educators[15]	
	NHS Continuing Health Care Fast-Track Pathway[18]	

Enabler	Commissioner Levers	Provider Levers
Mentorship, Supervision & Coaching – e.g. Staff forums focusing on sharing experiences & enablers/ barriers to putting things into practice, clinical & management supervision, access to mentorship and coaching	Universal Principles for Advance Care Planning[7] NHS Virtual ward guidance[19] NHS Chaplaincy Guidance[20] Clinical Leadership and peer leadership throughout ICS, ICP and place-based partnerships Joint Strategic Needs Assessment Dementia Training Standards Framework [21] Dying Well in Custody Charter [23] Care committed to me [24] UK Commission on Bereavement[26] **Standard KPI's across provider contracts** Community Service Contracts Primary Care Contracts Care Home Contracts Hospital Contracts Hospice (Including Children's Hospice) Grants 3rd Sector contracts/grants IT Contracts	L&SC End of life Care Education Standards[14] Standards and guidelines for end of life care facilitators and educators[15] Standards & Guidelines for the provision of Advanced & Key Level Communication Skills Training Programmes[16] Training & Development Framework for SAS Doctors working in Specialist Palliative Care [17] Dementia Training Standards Framework [21] Dying Well in Custody Charter [23] Care committed to me [24] EELCA (elearning)
Schwartz Rounds- or similar models available that facilitate a safe space and time for staff reflection		
Induction & annual updates – Palliative/end of life care training included on staff induction and annual updates with communication skills, Equality & Diversity and Advance Care Planning being taught to all roles and disciplines		
Release of Staff – staff are paid & released to attend palliative/end of life care training that is considered core to their role **e.g.** as defined by the L&SC educ. standards		
Staff Appraisals – mechanisms in place to identify gaps in knowledge, skills & confidence, signposting to available training aligned to core competencies		
Specialist Palliative Care –delivery of education to generalists is part of their job plan, specialist level education is accessible to support team development		
Palliative Care Workforce Plan- e.g., covering succession planning, recruitment & retention, staff wellbeing & education & training		
Palliative Care Leadership e.g. developing leaders education & training, coaching and mentorship, workplace experience, end of life care champions to cascade best practice and inspire and influence the practice of others		
Dementia Education- e.g. specific to meeting palliative and end of life care needs, raising awareness of dementia being a life-limiting condition, Mental Capacity training		

Enabler	Commissioner Levers	Provider Levers
	Domiciliary Care Contracts Lead/Joint Provider Contracts Children's and Young Peoples Service Contacts L&SC Palliative Education Strategy Group North West Coast Learning Collaborative	
Bereavement support training- to staff and volunteers in recognising and responding to grief and loss and signposting to local support		

Measurements of success

Improvement in knowledge, skills, and confidence

Number and diversity of people reached by training e.g. organisations, roles, ethnicity,

Staff attrition pre and post education and training investment

Core evaluation from education

Post event follow-up to evidence changes to practice

National Audit for Care at the End of Life (NACEL)

Learner case studies e.g., reflective practice and revalidation

Staff training passports

Role specific competency frameworks

Annual Training Needs Analysis

NB: Baseline measurements should consider skewed data arising due to COVID

Best Practice Examples

Fylde Coast Daily Safety Huddles for Palliative Care, End of Life & Bereavement Care Services

Scope of Coverage: Fylde Coast Hospital, community, and hospice

Lead Contact: Jackie Brunton Lead Nurse EOL Bereavement Care Blackpool Teaching Hospitals J.Brunton@nhs.net

Brief Description: During the challenging times of the pandemic with all its uncertainty and anxiety, we established a daily morning safety support huddle for all teams involved in end of life and bereavement care. The huddle has been sustained and is attended by palliative care teams across the hospital, community and hospice, end of life and bereavement teams in the acute and community, district nurse lead and chaplaincy.

The huddle provides peer support and a mutually supportive culture with an opportunity to share and concerns and seek any operational support that may be needed for example to assist individual discharge plans, case discussion re shared care etc.

We share good practice, feedback on patients, and have discussions about any system pressures and mutual support that could be provided. The huddle is documented and fed back to all system partners and feeds into the Fylde Coast system meetings including escalating within the operational wider system if required. The rounds are held daily on Microsoft Teams for 15- 30 minutes with a chair who acts as the management lead for the day

Outcomes: Teams have found this mutually supportive from a wellbeing perspective and offering mutual aid and different ways of working for example DN support to cover community hospice short falls, weekend admissions and planning IPU / out of areas transfers/discharges. More effective use of resources for e.g staff cross cover, discussions. Timely response to escalations and incidents. Opportunity for shared learning and any service improvement / actions needed. Learning and educational opportunity. Clinical supervision.

GP & Advanced Clinical Practitioner Workforce Development Trinity Hospice

Scope of Coverage: Fylde Coast

Lead Contact: Dr Gillian Au -Medical Director g.au@nhs.net

Brief Description: Enhancing the local workforce development in Palliative and EOLC by training future local GPs. Applied to HEENW for accreditation to become a host training organisation for pairs of full time 6-month rotational GPSTs giving them experience of working across IPU and community service at the same time as supporting service delivery. Developed the role of the SPC Advanced Clinical Practitioner (ACP) utilising HEE funding streams to enhance the skill mix of our SPC clinical leadership workforce to bridge the gap between CNS and specialty doctor, support 7 day working across all services, the medical 1st on call rota, teaching, and supervision to meet the projected palliative and end of life care needs of the future workforce.

Outcomes: Approval as host training site for GPST s from August 21. Now welcomed 3rd pair of GPSTs from the Blackpool Program. Ensured experienced and effective Clinical Supervisors. Had excellent feedback and evaluation of the learning experience. Supported the development of their communication skills and EoLC skills and competences. Exposed them to best practice in multidisciplinary patient centred care. GPSTs support direct clinical care and service provision of patients and the 1st on-call rota. Successfully bid for funding to support the training of 6 ACPs across the organisation. One physiotherapist ACP who is now leading on the development of our Living Well Service, one paediatric trainee ACP supporting training and developments in our Brian House Children's hospice services, and 4 ANPs across our adult services (IPU, hospital and community)

Our learning from our pandemic experience has only served to reinforce the considerable value of the ACP role in realising our mission and service goals, enhancing our effectiveness and responsiveness with the ability to work flexibly across our community, hospital and in-patient unit services where needed. All have undertaken valuable QIPs that have enhanced our service and patient experience. The ACPs have supported 7 day working and the medical on-call rota, and in addition to their direct clinical work, our ACPs provide clinical leadership, teaching and supervision to the teams.

Cornea Donation & Advance Care Planning (ACP) Conversation at Trinity Hospice

Scope of Coverage: Starting with Hospice In-patient Unit which admits patients from across the Fylde Coast.

Lead Contact: ACP Alison Jones

Brief Description: Project aim - to normalise conversations with patients within the inpatient unit regarding cornea donation, such discussion to become part of Advanced Care Planning (ACP) with all patients considered medically suitable donors. The aim is not to coerce but merely to inform the patient of the opportunity. Implementation included:

- Staff training
- Networking and advice from National Health Service Blood and Transplant Unit (NHSBT)
- Creation of documentation and referral process
- Coaching and staff peer support in leading such conversations
- Gaining feedback from staff after holding such conversations regarding: how they felt? What went well? What they may do differently in future?
- A patient information leaflet was produced and discussed with patients on admission
- Staff to witness eye retrieval which supported staff in future conversations.

Outcomes: In previous years cornea donation was only carried out at the patient's request, this was not a routine conversation raised by hospice staff, therefore if the patient did not have knowledge that they were suitable for donation, the opportunity would be missed.

After teaching sessions were held, the project was implemented in July 2021. Conversation and referral information was captured between July 2021-November 21. Within this time cornea conversation increased by 24% resulting in 21 referrals being made to NHSBT for cornea retrieval after the death of a patient on IPU which resulted in 15 cornea retrievals.This is a very positive start to the project which now requires further reinforcement to achieve our aim that all patients cared for by our IPU, community and hospital services who are eligible to donate their corneas are made aware of this possibility.

End of Life Core Competency and Skills Framework

Scope of Coverage: Blackpool Teaching Hospitals

Lead Contact: Lead for project, Victoria Dixon Victoria.dixon2@nhs.net

Brief Description: Core competency framework developed to ensure consistent and sufficient level of knowledge and skills in end of life care across all staff groups. Competencies assigned as are relevant to role and scope of practice and attendance at required training recorded on electronic staff record for monitoring of compliance. Training needs analysis and review of educational content reviewed as part of this piece of work

Outcomes Very recently gone live and therefore no outcomes to measure yet. Will achieve consistency and streamline the education that is provided, avoiding duplication, and enabling key EOL/SPC/Bereavement staff to use resources more efficiently while still providing the required training.

Staff will have the knowledge and skills to provide excellent end of life and bereavement care.

The End of Life Partnership (EOLP)

Scope of Coverage: Cheshire West and Cheshire East, North West and National

Lead Contact: Salli Jeynes CEO

Brief Description: The End of Life Partnership (eolp.co.uk) –

Our Vision-Everyone experiences compassionate and personalised end of life care.

Our Mission- To educate, innovate and collaborate so that people are empowered to care with confidence and compassion at end of life. We building confidence to care through delivering End of Life Care Education, Leadership & Innovation, Knowledge & Informatics and Compassionate Communities.

Outcomes watch our impact video for 2021-22

National Ambition 6: Each Community is Prepared to Help

I live in a community where everybody recognises that we all have a role to play in 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

What the citizens of Lancashire & South Cumbria say this means for them

Lancashire & South Cumbria commitments towards making this happen

Enablers and Responsibilities

Measurements of success

Best Practice Examples

National Ambition 6: Each Community is Prepared to Help

I live in a community where everybody recognises that we all have a role to play in 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

What the citizens of Lancashire & South Cumbria say this means for them

I feel like my community cares about me and my family

This is a great ambition to work towards. Supporting each other and everyone involved in the end-of-life care. Honest and open conversations can be difficult but having people you can approach in the community would be great

Encouraging people in communities to talk about death, to plan and to prepare. Involving funeral directors and others in the community who are often involved around death and dying (clerics, publicans etc.)

Death is the only experience we will all share so encouraging planning, talking about and knowing about our loved ones wishes can reduce so much anguish and anxiety for all.

Lancashire & South Cumbria commitments towards making this happen

- We will build end of life care capacity by developing and nourishing compassionate communities
- We will support the public to have more informed and confident discussions around dying, death & bereavement
- We will ensure practical support, information and training on end of life matters is accessible and relevant to those that need it by working closer with families, neighbours and the community
- We will coordinate the recruitment, connecting and training of volunteers so that their contribution and value can be best utilised
- We will ensure that people know what support they can access from their community

Enablers and Responsibilities

Enabler	Commissioner Levers	Provider Levers
Compassionate Communities- awareness and promotion with the public, dedicated approach and resources to building & maximising the use of community assets, volunteer led models of end of life care & bereavement support	Underpinning guidance detailed on page 1[1-4] NHS Continuing Health Care Fast-Track Pathway[18] Universal Principles for Advance Care Planning[7] NHS Virtual ward guidance[19] NHS Chaplaincy Guidance[20] Clinical Leadership and peer leadership throughout ICS, ICP and place-based partnerships	Named Clinical & Board Executive Lead Organisational Palliative & End of Life Care Strategy Place Based Partnership Groups Annual Audits Incident reviews Job Roles and Responsibilities Education & Training Joint working with Social Care Joint working with VCFSE Groups Dying Matters Universal Principles for Advance Care Planning[7] The Well Pathway- Dementia Care [22]
Public Conversations & Future Life Planning- e.g ongoing public engagement around future life planning, platforms & resources to support members of the public to think about, talk about, record, and share what is important to them		
Public Health Campaigns - e.g., local approaches to National Dying Matters and National Grief Week where all organisations, members of the public and businesses and encouraged to participate, social media is used to communicate public health messages far and wide, joint working with population health and public health to support messaging e.g., organ donation		

Public/Patient representatives- active engagement within palliative and end of life strategic and operational groups across the locality	Joint Strategic Needs Assessment The Well Pathway- Dementia Care [22] Dying Well in Custody Charter [23] Care committed to me [24] UK Commission on Bereavement[26] **Standard KPI's across provider contracts** Primary Care Contracts Care Home Contracts Community Service Contracts Hospital Contracts Hospice (Including Children's Hospice) Grants 3rd Sector contracts/grants VCFSE grants Domiciliary Care Contracts Lead/Joint Provider Contracts Children's and Young Peoples Service Contracts	Dying Well in Custody Charter [23] Care committed to me [24]
Social Prescribing – e.g., social prescribers are trained to be knowledgeable, skilled, and confident to recognise and signpost to palliative and end of life care support and services		
Informal Caregivers- carers of people with palliative and end of life care needs are recognised, education and support packages are available, they have access to bereavement support, collaborations with VCFSE sector		
VCFSE Groups- active and frequent engagement with the VCFSE sector to plan, implement and evaluate palliative, end of life care and bereavement services including services to carers		

Measurements of success

Number of active compassionate communities e.g., measured by number of volunteers or volunteer-led activities over period of time

Number of active VCFSE partnerships involved in end-of-life care

Number of people accessing Future Life Planning education

Improved carer wellbeing

Survey of service users and bereaved people (consider Place or ICS wide approach)

Patient case studies

Number of providers adopting a compassionate communities' approach.

Annual Dying Matters campaign that is coordinated cross boundary.

NB: Baseline measurements should consider skewed data arising due to COVID

Best Practice Examples

Primary Care Network support to develop local bereavement groups

Scope of Coverage: Fylde Coast

Lead Contact: Janet Walsh janet.walsh7@nhs.net

Brief Description: Two of our local Primary Care Networks (PCNs) requested our support for developing local neighbourhood bereavement support services. Recognition of the significant increase in need for bereavement support as a result of the pandemic. Seen as an opportunity to address unmet need and current long waiting lists for the Linden Centre adult service and opportunity to build collaborative working with PCN partners.

- To train, support and enable 2 sets of PCN staff to develop and sustain their own local community bereavement support groups.
- To help PCN staff to recognise and support normal patterns of grief as well as those with red flags, who may need referral for more specialist support.

- To reach out further into our local communities to raise awareness of Trinity services and resources.
- To enable support for more people living with grief and bereavement in our local neighbourhoods promoting compassionate, resilient communities

Outcomes: 2 half days training were delivered to staff from Torentum and LSA PCNs. 11 staff attended and delivery was via Teams. The feedback from the sessions was excellent and participants found it useful. Both PCNs are now running bereavement support groups which are going well. We have also offered, as needed ongoing support/information.

EOLP Compassionate Communities Team - Cheshire

Scope of Coverage: Cheshire East & Cheshire West Place

Lead Contact: Catherine Morgan-Jones Catherine.Morgan-Jones@eolp.org.uk

Brief Description: Prospectus for Public Health training sessions (eolp.co.uk) Helping communities to build their networks and resources to meet the needs of local people. Working across Cheshire covering topics that are based on individual community needs, to support people and their families, who are dying or living with loss. Complimenting local services allowing resources to be used efficiently. Developing communities' knowledge, skills and confidence through a variety of training sessions for a wide ranging audience, such as staff, volunteers, carers and members of the public.

Outcomes: Feedback has shown that those who attend our sessions benefit greatly, in being able to support others through times of crisis such as loss, grief and bereavement, supporting carers through their caring journey and planning for the future.

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7. Universal Principles of Advance Care Planning (2022)[7]
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9. North West Anticipatory Clinical Management Planning Guidance (2018)[9]
10. Five Priorities for Care of the Dying Person (2014) [10]
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12. Palliative and end of life care virtual ward guidance (NHS 2022)[12]
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15. Standards and guidelines for end of life care facilitators and educators[15]
16. Standards & Guidelines for the provision of Advanced & Key Level Communication Skills Training Programmes (2018) [16]
17. Training & Development Framework for SAS Doctors working in Specialist Palliative Care [17]
18. NHS Continuing Health Care fast-track pathway [18]
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20. NHS Chaplaincy Guidance - Promoting Excellence in Pastoral, Spiritual & Religious Care [20]
21. Dementia Training Standards Framework [21]
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23. Dying Well in Custody Charter [23]
24. Care committed to me (Hospice UK 2018) [24]
25. Delivering high quality end of life care for people who have a learning disability [25]
26. UK Commission on Bereavement[26]