Glasgow City HSCP
Health and Social Care Partnership

Draft Palliative Care Plan

2018-2021

Contents

1. Our Vision

1.1 The HSCP's vision for good palliative and end of life care reflects the intentions of the Scottish Government's Strategic Framework for Action and the Scottish Partnership for Palliative Care. That is that by 2021, everyone in Glasgow who needs palliative care will have access to it regardless of age, diagnosis or circumstance and that the care provided will be safe, effective and person-centred.

1.2 Staff delivering care will be supported via learning and education opportunities to understand how best to make a significant difference to a person's wellbeing, even in the last months, weeks, days and hours of that person's life.

1.3 Glasgow will be a place where people die well, are supported throughout bereavement and communities and individuals are able to help each other through declining health, death, dying and bereavement.

2 Key Aims

2.1 People and their families and carers have timely and focussed conversations with appropriately skilled professionals to plan their care and support toward the end of life. The National Anticipatory Care Plan will be used to support this process and capture people's needs and preferences.
http://ihub.scot/anticipatory-care-planning-toolkit/

2.2 The HSCP's Palliative Care plan will not be used in isolation but as part of a suite of material aimed at engaging people in their care and improving quality of life and wellbeing. This includes for example some of the material in the Scottish Government's 3rd Dementia Strategy (http://www.gov.scot/Publications/2017/06/7735/downloads), in Realising Realistic Medicine (http://www.gov.scot/Resource/0051/00514513.pdf), in the Carers Act 2016 (http://www.legislation.gov.uk/asp/2016/9/contents/enacted) and the HSCP's Carer Strategy.

3 Summary of Actions – "What will we do"

3.1 Following the review of Glasgow HSCP palliative Care Services for Adults we will

- Work with our staff and with partners to identify learning and education needs and will use the NES National Palliative Care Educational Framework "Enriching & Improving Experience" (http://elearning.scot.nhs.uk:8080/intralibrary/open_virtual_file_path/i2564n4083939t/Palliative%20framework%20interactive_p2.pdf) to achieve a consistent approach.

- Establish Locality Palliative Care groups and structures to focus on specific population needs in relation to palliative and end of life care and ensure that these

Locality groups are representative of a full range of partners, including e.g. Improving Cancer Journey (ICJ), Hospices, 3rd & Independent Sector Providers, Health & Social Care staff , Macmillan Facilitators and Carer Services/Organisations.

- Develop a more detailed understanding of Palliative Care services for Children and Young People.

- Be an active participant in the wider Glasgow & Clyde Palliative Care Network which will provide a platform for shared learning.

- Ensure the pathways between general care and specialist palliative and end of life care are clear and easily understood by all stakeholders.

- Embed Anticipatory Care approaches and ensure staff are equipped to facilitate conversations about death, dying and bereavement; including the potential benefits or side effects of various care and treatment options.

- Establish, in collaboration with patients, carers and Carer Groups, an ongoing feedback mechanism that informs the HSCP about people's experience and areas where further development might be required.

- Work within Locality groups to ensure that service provision is equitable and consideration is given to identifying and engaging with "harder to reach" minority groups.

- Embed Marie Curie (North) and Prince and Princess of Wales (South) as central providers to the overall provision in the city and using their expertise, take forward new and innovative approaches to delivering palliative care in the community and avoiding admissions to hospital as appropriate. We will also work closely with other hospices, particularly St. Margaret's of Scotland (and their associated HSCP, West Dunbartonshire) who care for many Glasgow residents and provide nurse/carer education.

- Continue to work with Macmillan Cancer support in delivering information, education and testing new developments.

- Develop our relationship with secondary and tertiary specialist palliative care services to ensure effective and timely transitions between places of care

- Maximise the totality of financial and personnel resource currently deployed in the city in order to develop a coherent and connected approach to the provision of good palliative and end of life care in the city and substantially reduce the numbers of people who die in acute hospital settings

4 Priorities

4.1 The following table sets out our priorities in developing the draft plan into a final working document and provides an estimated timescale for implementation over the next short period in order to ensure effective delivery over the period of the plan to 2021.

4.2 The draft plan will be refined over the next 4 months in consultation and collaboration with Glasgow citizens and partners in care delivery. When launched in January 2018, it will be accompanied by an implementation plan that will describe the key areas of work associated with the priorities; it will identify lead officers and it will describe intended outcomes, methods for monitoring progress and for measuring outcomes.

4.3 Table of Priorities

Priority	Timescale
Policy & Planning	
1. Consult on the draft Palliative & End of Life Care Plan for Glasgow HSCP, moving from draft to working document following a period of consultation.	September to December 2017
2. Review data sources and identify appropriate performance monitoring arrangements and outcome measurement. This will include what we currently collect, what we need to collect and how we can utilise electronic systems to extract data and translate that into informative reports.	November 2017
3. Link with the Glasgow Hospices to embed their provision into the totality of provision and	December 2017
4. develop and agree innovative approaches to delivering palliative care	March 2018
5. Develop a forecast of workforce implications in collaboration with partners in order to establish commissioning intentions.	Jan 2018
Education	
1. Introduce and use NES Palliative Care Education Framework “Enriching & Improving Experience” across our services	April 2018

Communication & Collaboration	
1. Test Palliative Care Plan with groups of carers in keeping with the Carer Scotland Act 2016. 2. Establish a mechanism for regular engagement with Carers groups in order to use this feedback to refine service delivery. 3. Establish closer working with acute based palliative care services to address transitions. 4. Develop a clear understanding of Palliative Care for Children by understanding provision elsewhere and benchmark against current GCHSCP provision.	September – December 2017 December 2017 November 2017 April 2018
Practice	
1. Transition from using the Glasgow Anticipatory Care Planning documentation to testing the National suite of material and using this as the standard ACP/Personal Plan across the range of HSCP services. 2. Evaluate the extent to which the HSCP's directly provided services (Residential & Day Care Services) utilise identification tools, e.g. "Supportive Palliative Action Register" (SPAR) and work to achieve a consistent approach across Residential Units. 3. Ensure the HIS funded Associate Improvement Advisor is developing and delivering much of the actions outlined in this priority list.	January 2018 January 2018 January 2018

Structure	
1. Establish an HSCP Palliative Care structure. 2. Establish links with wider Palliative Care Network. 3. Establish a web-based mechanism for sharing outputs of Palliative Care forums.	August 2017 September 2017 October 2017