Item No: 12

Meeting Date: **Wednesday 20th September 2017**

Glasgow City Integration Joint Board

Report By: **Alex MacKenzie, Chief Officer, Operations**

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DRAFT PALLIATIVE AND END OF LIFE CARE PLAN

Purpose of Report:	1. To outline the HSCP's key actions and priorities in relation to the Scottish Government's Strategic Framework on Palliative and End of Life Care. 2. To describe a draft plan that aligns to National Integration Indicators and compliments other strategies for implementation by January 2018.

Recommendations:	The Integration Joint Board is asked to: a) note the key priority areas to be incorporated in the plan; b) agree the HSCP's Palliative Care draft Plan; and, c) direct the Council and Health Board to implement the plan

Relevance to Integration Joint Board Strategic Plan:

Palliative Care is identified in the HSCP's Strategic Plan as a function delegated by Glasgow City Council and NHS Greater Glasgow & Clyde. Effective and accessible palliative care is key to supporting people, their families and their carers. It enables people to remain safely at home, it helps to avoid hospital admissions and minimises delays in hospital.

Implications for Health and Social Care Partnership:

Reference to National Health & Wellbeing Outcome:	Sensitive and effective Palliative Care can be reflected in all 9 National Health & Wellbeing Outcomes as experienced by service users, carers and staff.

Personnel:	Glasgow will experience a rising demand for this type of care across the age range of its population as a result of people living longer with long term conditions and the drive to deliver care at home or other community settings. As a consequence, there will be a requirement to consider future workforce requirements and associated funding implications.

Carers:	Carer engagement will form a key part of the consultation process on the draft plan and ongoing feedback will feature throughout in order to obtain a measure of our success and to guide ongoing developments.

Provider Organisations:	The HSCP has commissioning responsibility for the 2 Glasgow Hospices (specialist palliative care) as well as its responsibility for commissioning care homes where good generalist (palliative) care should be available to those that require it. The homecare function delivered by Cordia and other providers will also feature prominently in the delivery of generalist (palliative) care.

Equalities:	The draft plan will be tested against the HSCP's Equalities monitoring process for new policies or strategic documents.

Financial:	The HSCP has secured funding from HIS for a 2 year period commencing June 2017 to support an Improvement Advisor post. This person will work with services to address identified areas of improvement. The financial challenges faced by the organisation will apply to our directly provided health and social care supports, to our partner services including Cordia. There will be a requirement to further invest in palliative care if the objective of managing more care in community settings is to be realised.

Legal:	There are no legal implications from this paper.

Economic Impact:	Good palliative care can reduce the health burden by reducing hospital admissions and reducing lengths of stay in hospital. By using the principles set out in "Realising Realistic Medicine" (http://www.gov.scot/Resource/0051/00514513.pdf), it can also impact on cost by creating co-produced care plans and choice which has potential to reduce unnecessary investigations or minimally effective interventions.

Sustainability:	Sustainability will rely on reliable data collection of outcomes of care that demonstrate demand and the associated financial and workforce adjustments required to meet that demand.

Sustainable Procurement and Article 19:	None

Risk Implications:	An ageing population will see a rising requirement for palliative care while advances in treatment options will mean people live with their condition longer than in the past. The financial climate could constrain the organisation's ability to meet this rising need.

Implications for Glasgow City Council:	Requirement to implement the plan

Implications for NHS Greater Glasgow & Clyde:	Requirement to implement the plan

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	
	2. Glasgow City Council	
	3. NHS Greater Glasgow & Clyde	
	4. Glasgow City Council and NHS Greater Glasgow & Clyde	✓

1. Background to Strategy Development

1.1 Following the launch of the Scottish Government's Strategic Framework for Action on Palliative and End of Life Care in December 2015 (http://www.gov.scot/Resource/0049/00491388.pdf), the HSCP carried out a self-assessment of current provision in the City. This exercise, supported by Healthcare Improvement Scotland (HIS), included a mapping exercise to depict existing service provision through a service-user journey. It included a survey of staff providing care across a range of services and professions and it included a review of the organisation's strategic documents to test the extent to which palliative and end of life care was identified as a priority.

1.2 The self-assessment also looked at mechanisms in place across the City for discussing and agreeing priority areas of work in relation to monitoring and improving palliative and end of life care.

1.3 The self-assessment was presented as a report to the HSCP's Senior Management Team in April 2017. (https://glasgowcity.hscp.scot/publication/draft-palliative-and-end-life-care-plan) The report noted that the exercise had looked only at the provision of supports for the adult population and that the people and their carers to whom palliative care is directed, had not been part of the review.

1.4 The report recommended that these areas be included when translating the self-assessment into a HSCP plan for the delivery of this type of care.

1.5 Glasgow University carried out a study, published in the July 2017 BMJ Supportive & palliative Care (http://spcare.bmj.com/content/early/2017/08/02/bmjspcare-2016-001301) This study focuses on Scotland's provision of specialist palliative care delivered within inpatient settings, by hospital support teams and by home care

teams. The results show that Scotland is consistently in the top 10 for this type of provision across Europe; however it notes that the level of coverage of specialist home care teams shows room for improvement. The plan needs to identify the intention of close collaboration between the HSCP and its partners in acute and hospice care as well as across its primary care services and community teams.

2. Glasgow's Self-assessment Results

2.1 The self-assessment report contains the assessment results, including a map of services which gives a snapshot of the Glasgow position at a point in time, acknowledging the complexity of care provision and the possibility that not all providers are identified.

2.2 The assessment covered both specialist and generalist palliative care. The differentiation being that specialist care includes that delivered by hospital palliative care teams, hospices and specialist palliative care community teams while generalist palliative care is basic "good care" delivered by a range of staff including hospital staff, GPs, community nurses, residential and nursing homes and home care providers.

2.3 The results also inform service gaps and areas for improvement that are subsequently captured in the draft strategy, including areas of HSCP policy and service practice.

2.4 The absence of a coherent meeting structure to address Palliative and End of Life Care was identified as a priority and new arrangements have been implemented since April 2017.

2.5 The assessment of Children and Young People's services has not been as thorough as that conducted for the Adult population and as such, the plan will commit to addressing this in greater depth.

2.6 Some initial areas for attention have become apparent following engagement with the NHSGGC Specialist Children's Service, Paediatric Oncology, Children's Hospice Association Scotland (CHAS) and the charity Clic Sargent.

2.7 This has highlighted for instance that the majority of child oncology (cancer) patients are able to be supported to die at home whereas most non-oncology children pass away in hospital.

2.8 Currently there are inadequate community nursing services to provide a 24 hour responsive and sustainable service for children and young people who wish to be cared for at home at the end of their life. It is recognised that not all would choose the provision of care at home but currently there is no flexibility of choice. Glasgow compares poorly to other parts of Scotland in relation to this type of care provision. The HSCP needs to further examine the inequity of provision for children with non-malignant, life limiting illness with an end of life prognosis. These children are currently supported by Community Children's Nursing Teams who are seeking to address some of the service gaps in collaboration with CHAS and Paediatric Oncology Outreach Nurses.

2.9 The Government's Strategic Framework for Action commits to support and promote the further development of holistic palliative care for the 0-25 age group. This is an area where the HSCP will need to monitor Government direction and collaborate with partners in order to determine how this will be achieved.

3. Financial Implications

3.1 The HSCP assumed commissioning and contract monitoring responsibility for Glasgow based Hospices in 2016/17 and budget transfer from Acute services was concluded in 2017. The budget is in excess of £4M and provides inpatient specialist beds as well as outpatient services.

3.2 The HSCP also commissions services from hospice providers, including Fast Track and Managed Care to the value of approximately £0.5M

3.3 Mainstream services also manage palliative and end of life care in the Community. A review of the Clinical Nurse Information System (CNIS), identifies that across all inputs, (i.e. In Hours, Out of Hours & Weekend) the workforce deliver an average of 3000 visits every month with each visit lasting approximately 30 minutes. Of this, 1500 hours per month is identified by CNIS entries logged as "Palliative Care" or "Palliative Care Needs". It excludes work performed by care home liaison nursing staff. A full time nurse is contracted to work 37.5 hours per week, therefore based on the above demand, palliative care currently estimated to require 40 staff. The cost of this service (excluding non-pay cost such as equipment, drugs, consumables and travel), based on a band 6 nurse equates to £1.5M.

3.4 The cost of a hospital bed day is approx £500/day. The average length of stay for people with palliative care needs is difficult to quantify as the recording systems don't always capture admissions as "palliative care" but rather as a diagnosis, e.g. heart failure or COPD. It would be fair to assume however that the provision of joined up palliative and end of life care has the potential to reduce admissions and realise a reduced number of bed days.

3.5 Adopting a "realistic medicine" approach with greater co-production in treatment planning would introduce greater choice and might eliminate less effective interventions and some of the associated prescribing costs.

3.6 The HSCP has also developed Intermediate Care (Complex & Palliative) beds as a response to its changing responsibility for beds previously labelled "Continuing Care" and managed wholly by Acute services. The shift in management of the beds affords the HSCP an opportunity to consider care options and identify alternative care pathways for people who in the past would have remained in a hospital setting.

3.7 National Integration Indicator 15 identifies the proportion of the last 6 months of life spent at home or in a community setting. This has been consistently around 86 days over the last few years. Over the 3 year term of the Palliative & End of Life Care Strategy, the HSCP will seek to increase the time people spend at home towards end of life. This will significantly reduce the burden on Acute services while increasing demand on community provision.

3.8 A variety of data sources suggest a reducing percentage of people are dying in hospital; however the data can be conflicting and as part of the consultation period,

requires to be reviewed. It appears from existing data that Glasgow showed a positive trend in the period 2013-16 and effective Palliative and End of Life Care should impact further on that trend. Measurement is likely to prove challenging due to limitations in IT/recording systems and the complexity of presentations toward end of life.

4. Recommendations

4.1 The Integration Joint Board is asked to:

a) note the key priority areas to be incorporated in the plan;
b) agree the HSCP's Palliative Care draft plan; and
c) direct the Council and Health Board to implement the plan.

DIRECTION FROM THE GLASGOW CITY INTEGRATION JOINT BOARD

1	Reference number	200917-12-a
2	Date direction issued by Integration Joint Board	20 September 2017
3	Date from which direction takes effect	20 September 2017
4	Direction to:	Glasgow City Council and NHS Greater Glasgow and Clyde jointly
5	Does this direction supersede, amend or cancel a previous direction – if yes, include the reference number(s)	No
6	Functions covered by direction	Palliative care and end of life care services
7	Full text of direction	Glasgow City Council and NHS Greater Glasgow and Clyde are directed to implement the Palliative and End of Life Care Plan
8	Budget allocated by Integration Joint Board to carry out direction	As advised by the Chief Officer: Finance and Resources
9	Performance monitoring arrangements	In line with the agreed Performance Management Framework of the Glasgow City Integration Joint Board and the Glasgow City Health and Social Care Partnership.
10	Date direction will be reviewed	September 2018

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