Item No: 16

Meeting Date: **Wednesday 23rd March 2022**

Glasgow City Integration Joint Board

Report By: **Stephen Fitzpatrick, Assistant Chief Officer, Older People's Services & South Operations**

Contact: **Karen Lockhart, Head of Service Older People and Primary Care**

Phone: **07917521150**

Palliative Care Strategy Update

Purpose of Report:	To inform the Integration Joint Board of progress towards the actions set out in the 5 year plan that was adopted by the IJB Performance Scrutiny Committee in February 2018

Background/Engagement:	The HSCPs Palliative & End of Life Plan can be accessed at the following link: https://www.yoursupportglasgow.org/media/23104/glasgow-hscp-palliative-care-plan-2018-23.pdf The plan provides the definition of palliative care for adults and children (defined by the World Health Organisation-WHO) and sets out the 28 actions as a framework for service delivery over the period 2018-23. The vehicle for translating those actions into locality work plans is the three locality palliative care implementation groups. The three groups report to the HSCPs palliative care steering group. Membership of the palliative care groups consists of HSCP staff plus key partners in palliative care delivery across housing, 3rd and independent sectors.

Recommendations:	The Integration Joint Board is asked to: a) note the progress to date.

Relevance to Integration Joint Board Strategic Plan:

Palliative care is identified in the HSCPs 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:	Good (palliative) care can be reflected in all 9 national health and wellbeing outcomes as experienced by service users, carers and staff
Personnel:	Glasgow will continue to 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 in other community settings. As a consequence, there is a requirement to consider future workforce requirements and associated funding implications.
Carers:	Carer engagement will form a key part of the work plans in keeping with the requirements of the Carers (Scotland) Act 2016 and ongoing feedback will feature throughout the life of the strategy 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 commissioned care homes where good generalist (palliative) care should be available to those that require it. The care at home function delivered by Glasgow City HSCP Homecare and other providers will also feature prominently in the delivery of generalist (palliative) care as will the local authority residential day care units.
Equalities:	The palliative care EQIA can be accessed at: https://glasgowcity.hscp.scot/publication/eqia-palliative-and-end-of-life-care-plan
Fairer Scotland Compliance:	The Palliative and End of Life Plan has considered the impact on those facing socioeconomic disadvantage through the EQIA and the activity within will contribute to reducing such disadvantage.
Financial:	The financial challenges faced by the organisation impact on our directly provided health and social care supports and our partner agencies. There will be a requirement to further invest in generalist and specialist palliative care if

	the objective of managing more care in community settings and reducing the time spent in hospital during the last 6 months of life is to be realised.

Legal:	No legal implications

Economic Impact:	Good palliative care can reduce the health burden by 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 offering choice which has potential to reduce unnecessary investigations or minimally effective interventions.

Sustainability:	Sustainability will rely on an ongoing review of outcomes, continuous improvement programmes, reliable communication networks and regular reference to the associated financial and workforce adjustments required to meet the demand.

Sustainable Procurement and Article 19:	N/A

Risk Implications:	An aging 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 demand.

Implications for Glasgow City Council:	None.

Implications for NHS Greater Glasgow & Clyde:	None.

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. Purpose

1.1. This report reflects the actions completed to end of year 4 of the 5 year plan which was implemented in April 2018.

1.2. It highlights a variety of priorities that have been identified across the 3 Glasgow localities relative to the needs of local populations.

2. Background

2.1. After a period of public consultation, the amended 5 year plan was presented to the IJB Performance Scrutiny Committee in February 2018. The Committee endorsed the plan for implementation from April 2018.

2.2. The HSCPs plan reflects the intentions of the Scottish Government's Strategic Framework for Action and the Scottish Partnership for Palliative Care by 2021, in that everyone in Glasgow City who needs palliative care will have access to it regardless of age, diagnosis or circumstance and that care provided will be safe, effective and person centred.

3. Progress to Date in relation to Actions to end of 2021 and Priorities for 2022

3.1 HSCP Locality Updates

3.1.1 Through effective partnership working the HSCP strives to ensure equitable access to Palliative and End of Life Care (PEoLC) to individuals and their families living in our local communities and across the City.

3.1.2 Education: On-going delivery of PEoLC education and training to various staff/disciplines within Primary Care and Acute across NHS GGC, 6 HSCPs and private care homes. These sessions will align to the framework and be delivered by the Primary Care Palliative Care Team (Macmillan Nurse Facilitators), various members of the Multi-disciplinary Teams (MDTs) from our local hospices and others depending on the needs identified.

3.1.3 Supportive Palliative Care Action Register (SPAR)

- SPAR is a simple framework to improve recognition of change/ decline or the possible approaching death of a resident. It consists of a traffic light system with associated actions, used with a Palliative Performance Scale Tool (PPSv2).
- The assessment of the resident is undertaken weekly, or daily depending on the assessment. The SPAR process also includes an Anticipatory Care Plan (ACP) and an After Death Analysis (ADA) form.
- SPAR was implemented in Riverside Care Home in 2018-2019. At that time, approximately a third of the 120 residents were supported and cared for through to the end of their life and died within Riverside Care Home, thus achieving their Preferred Place of Care.
- With the introduction of SPAR, additional palliative care training to the Carers and the introduction of Advanced Nurse Practitioner (ANP) input, 85% of residents are now cared for until the end of their life in Riverside. All ACP key information for residents is also uploaded to Clinical Portal by the ANP.

- Since SPAR is now embedded in practice, carers are now more empowered and confident at providing effective end of life care and this is reflected in the statistical analysis. The plan is to roll out SPAR to the remaining Glasgow City local authority older people's residential care homes throughout 2022.

3.1.4 Anticipatory care planning - Embed Anticipatory Care approaches, using National ACP documentation where appropriate but recognising that plans might be available in a variety of formats. Staff will use an ACP summary tool to capture the key elements of people's plans and pass those summaries to GPs to inform the key information summary (KIS). In most cases this will be recorded on the Clinical Portal and will incorporate a frailty score based on the Rockwood scale.

3.1.5 Access to bereavement support - Knowing that access to bereavement support is limited and has long waiting lists. Members of all Palliative Care Implementation Groups (PCIGs) across the city are looking at ways in which they can support various community-led projects wishing to provide support around loss, grief and bereavement. In addition to this, the teams are seeking ways in which they can make staff aware that their loss, grief and bereavement over this time of pandemic is recognised.

3.1.6 Work continues with the Children's Planning & Delivery Group and other relevant service managers and practitioners in adult and physical disability services to ensure PEoLC need is being assessed and appropriate care provided particularly around points of transition.

3.1.7 Children and Families Update – Work has been ongoing with colleagues from acute and community services to develop an options paper to identify what a potential service would look like which addresses the ongoing gap in provision of support to children (0-18 years) who are at end of life to die at home. The next step will be to achieve financial agreement and to identify where this service would be paid from to get it established. This service would be an NHSGGC service and early discussions have taken place with all partner HSCPs. Additionally, further work is required in relation to the creation of a service specification and potential impact on other services such as pharmacology.

3.1.8 A further area of development is a service to support young people aged 14-24 at end of life to enable them to die at home and this is being progressed in 2022. Progress thus far will support young people up to 18 years of age and further work will be developed to look at the older age range, and this will involve discussion with colleagues form adult services.

3.1.9 Prison Healthcare Update – Prison Healthcare Team Nurse Team Leads have attended ECHO training and had the opportunity to learn from and share best practice in relation to pain management and symptom control. Additional ECHO sessions have been arranged for the wider prison healthcare team throughout 2022. Dr Graham White, Palliative Care Consultant from Marie Curie Hospice, continues to make links with the healthcare team to offer additional specialist support and advice required for patients.

3.1.10 Anticipatory Care Planning Update

- Understanding people's priorities, preferences and motivations is crucial to planning and delivering high quality palliative care. Anticipatory Care Planning (ACP) is a useful way to frame these types of conversations and document decisions that have been made in a way that multiple services can access. Whilst ACP conversations should not only be reserved for those receiving palliative care, there should be considerable effort made to ensure that anyone with a terminal diagnosis, or identified as benefiting from palliative care input, should be offered ACP.
- The Anticipatory Care Programme works across all 6 HSCPs within NHS Greater Glasgow and Clyde to support staff to embed ACP conversations into core business through resource creation and training. The programme also aims to raise public awareness regarding all aspects of future planning including Power of Attorney, Carer Support and emotional wellbeing.
- Over the next year, the Glasgow City ACP Implementation Group will continue to work with the Anticipatory Care Programme to identify key staff groups who can promote ACP conversations with the communities they work in. This will include community nursing, community rehabilitation, social work and care home teams. By working alongside the other HSCPs learning and good practice can be easily shared, ensuring joined up working within all parts of the wider health and social care system.

3.2 **Hospice Updates**

3.2.1 Since the last IJB update the Glasgow linked hospices have continued to deliver on a host of agendas:

- Joint work across the three localities to develop greater understanding and accessing palliative care services for all service users/patients.
- Make better use of existing networks across primary, secondary care and acute.
- Support the Public Health Agenda - Good Life Good Death Good Grief (GLGDGG)
- Participate in ACP Design and Implementation group and roll out
- Participate in 6 hospice education group and wider Palliative Care Practice Development
- Hospice Specialist Palliative Care: 24 in patient consultant led unit.
- Community Medical /Clinical Nurse Specialist services
- Day Therapy and Complimentary Therapy Services
- Managed Care Service: Current Model in Glasgow and surrounding areas which include East & West Dunbartonshire, East Renfrewshire, Renfrewshire & Inverclyde
- Fast Track: Fast track (Glasgow City Only) enables the safe and timely discharge of patients who have palliative or end of life care needs from acute services or a hospice setting. It also allows GP's and District Nurses to provide referrals and prevent hospital readmission or re-admission. It provides a model of holistic care that reduces stress and anxiety for patients, families, and carers at end of life.

3.3 **Acute Hospitals Update**

3.3.1 NHSGGC Palliative Care Acute Group continue with quarterly meetings – work plan available: www.palliativecareggc.org.uk

3.3.2 The following highlights some current acute palliative care services activity under headings – service delivery/improvement, education/training and research.

3.3.3 Service Delivery/Improvement

- NHSGGC BD T34 syringe pump SLWG progressing plan to phase out version 2 T34 pumps replacing with newer model Bodyguard T. Replacement Programme will take place throughout 2022. The 1st phase (6 GGC Hospices) completed.
- Community Kardex completion prior to discharge for patients with palliative care needs, now embedded across acute hospitals. Ongoing funding agreed by 6 HSCPs.
- Palliative Care Guidelines (GGC and National) added to the new Right Decision-Making Platform https://clinicalguidelines.nhsggc.org.uk/palliative-care/
- Policy ratification - Primary Care Clinical Governance Group approved – Patient/Informal Carer Administration of Subcutaneous Intermittent Medication in Adult Palliative Care Policy **-** communication and implementation of policy underway.
- Quality Improvement Project led by acute palliative care team at QEUH to improve awareness and use of Rapid Discharge at End of Life Guidance.
- ACP communication prompt cards sent to all community nurse teams. QR code on cards to capture staff feedback. Electronic version of card can be downloaded from Anticipatory Care Planning (ACP) (spict.org.uk)

Education

- Sage and Thyme Foundation level communication skills training sessions delivered virtually throughout 2021, 541 participants across the 37 workshops, over 50% of attendees from community or care home place of work.
- Palliative Care Community Nurse education and training continues through MNFs work plan, this has been alongside the MNFs offering in the region of 40% of their role to clinical duties. (MNFs will give details of their work plan under their sector reports)

Research

- Views of Care at End of Life: An action research study exploring the best ways of eliciting patient and family views of end of life care and giving real-time feedback in acute hospitals. Principle Investigator Prof Bridget Johnston - study commenced.

4. Additional Developments During 2022

4.1 Compassionate Glasgow - Potential Avenues for Maximising Independence (MI) Investment

4.1.1. The sub-group of the Communities workstream looking at compassion have been particularly interested in support and care in relation to dying, death and bereavement, and will be making a proposal to the MI Executive Group for resource to coordinate and progress this work. This may include a fixed-term post to explore the systemic support and infrastructure needed to ensure people experience 'a good death' in Glasgow, and the development of a common standard or framework for compassion in Glasgow. However, the sub-group recognise that compassion is a much broader concept and would hope all MI workstreams might consider proposals that embed compassion, build community capacity, and provide support for community organising in health and social care. Such activities might include:

- The commission of a capacity-building service, designed to support and enable community organising around the theme of bereavement and loss. Such a service, providing intensive support over a fixed-term period, would help people to organise and run self-care recovery groups for people dealing with bereavement or experiencing grief or loss. The service could offer connection, advice and safeguards on creating community-led groups and provide 'hand-holding' in getting groups established.
- The commission of a digital compassion campaign to promote behaviours that support mental wellbeing in online engagement in a period of increased uptake/use in the context of health and social care services, developing the on-line markers of kindness (and negative indicators of abuse) that can be adopted and promoted by social media users and partners across the city. In addition, this campaign could produce digital content to challenge abuse or aggression towards those working in health and social care. Such a commission could utilise a co-production design process with third sector organisations, staff and service users to generate the messages, content and approach for a Glasgow-specific campaign.
- A one-off, city-wide event inviting organisations, groups and the wider public to explore Glasgow's understanding of compassion and kindness and their relevance and application in the design of the city's health and social care system. As well as organising costs for staging events (in-person and virtually), funds will be used to award small grants to organisations who wish to lead on an event or provide a provocation or intervention, as part of a festival approach.

- A programme of collaborative leadership development, informed by voices of lived experience of health and social care, and built to further capability and capacity for compassion and kindness in the systemic and strategic design of services.

4.2 Measuring Impact

4.2.1 When considering the impact of any programme-wide approach to compassion and kindness, it is suggested MI could follow the international model of measuring compliance with human rights: using structural indictors to measure commitment or intention to embed compassion and kindness; using process indicators to measure the efforts undertaken to embed compassion and kindness; and, using outcome indicators to measure performance, evaluating the results of embedding compassion and kindness in the design and delivery of health and social care services.

4.3 Palliative Care Clinical Lead Post

4.3.1 As Greater Glasgow and Clyde is the only health board in Scotland without a Palliative Care Primary Care lead, there are plans and funding approved to recruit to this post across the 6 HSCP's.

4.3.2 NHS Greater Glasgow and Clyde is the largest health board in Scotland, as such we should be representing both the health board and a large part of primary care sector at national events. The introduction of this post will contribute to planning the next national strategy that is being worked on currently by Palliative Care leads through the Scottish Partnership for Palliative Care.

4.3.3 A Primary Care Palliative Care lead position for Greater Glasgow and Clyde will provide protected time to work with all involved in improving palliative care locally and to be part of strengthening and developing services in our community as well as providing leadership and representation within national services.

4.3.4 With the introduction of this new post, we can build on existing alliances and partnerships across Health and Social care including housing and carers. In Primary care we are well placed to develop relationships with many others including 3rd sector/voluntary sector, providers of out of hours care, cancer networks, prison service, social care providers, acute providers, health and social care partnership and the health board.

4.4 Managed Care and Fast Track Services

4.4.1 The current Managed Care and Fast Track services are provided exclusively by Marie Curie. Fast Track covers Glasgow City HSCP and the Managed Care Service is available to all six HSCPs.

4.4.2 Approval was given in March 2021/22 for the extension to the current SLA until March 2022 with Glasgow City HSCP contributing 50% of the funding deficit felt by Marie Curie due to increasing costs of the service and the impact the pandemic had due to the reduction in fund raising. The remaining deficit in service costs were met through Mare Curie reserves. There are discussions and negations in place to further extend the current SLA for another year to 2022/23, with a view that a full-service review and tender exercise will take place through 2022. The scoping of managed care, fast track and hospice services will take place within this time frame to bring all

contracts in line with current HSCP contract and procurement arrangements, in addition to having any approved contracts running concurrently. The focus for these contracts will be to provide continued support for timely hospital discharge for palliative/end of life patients to their own homes/homely setting and to continue to support care for patients in their own homes/homely setting thus avoiding preventable hospital admission at end of life and supporting patients to die in their own homes/preferred place of death.

5. Recommendations

5.1 The Integration Joint Board is asked to:

a) note progress to date.