Palliative Care: New Approaches

January 2017
Palliative and End of Life Care

- Palliative and end of life care is the active, holistic care of people with advanced progressive, non-curative illness.
- Focuses on the person rather than the disease and aims to ensure the best possible quality of life.
- An integral part of the care delivered by all health and social professionals, and by families and carers, to those living with and dying from any advanced, progressive incurable condition.

...is the responsibility of all health and social care staff ... involves both generalist and specialist professionals and support staff.
Strategic Context

- Living Matters, Dying Matters 2010
- Transforming Your Palliative & End of Life Care Programme 2012
- RQIA Review 2016
- Let’s Talk About Survey 2013 - 2016
Key themes from Strategic Drivers

- Provision of high quality palliative care for all patients with palliative care needs regardless of diagnosis or care setting.

- Provision of a patient centred service to enable the person to be cared for in their preferred place of care.

- Access to multidisciplinary specialist palliative care for those patients/ carers with complex needs should be available.

- Better integration between specialist and generalist services and closer working with the voluntary and community sector.
Regional Palliative Care Programme

Palliative Care in Partnership

- One structure
- One agenda
- One clear direction for palliative care in N. Ireland

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Regional Palliative Care Work Plan

**Aim:** that everyone *identified* as possibly in their last year of life (regardless of their condition) is:

- Allocated a **keyworker**
- Have the opportunity to discuss and record their **advance care planning** decisions
- Be supported with appropriate generalist and **specialist palliative care services**
- Underpinned by **good practice tools, guidance and education**

**Priorities for 2016/7**

- Identification
- Keyworker
- Advance Care Planning
- Specialist Palliative Care Services

**Good practice tools and guidance**
Identification

Why?

- Predict need for support for all patients at the end of life
- Enable earlier discussion of wishes and facilitate appropriate care

How?

- Tools to support identification example: Gold Standards Framework (GSF) and SPICT
Keyworker

- Act as a main contact for patient/carer
- Facilitate decision making and end of life care planning
- Ensure appropriate discussions take place at the patient’s pace
- Provide information and guidance to other professionals relating to the patient and their carer.
- Co-ordinate assessments, referrals and care planning
- Ensure symptoms managed and physical, emotional and spiritual needs met
- Co-ordinate and share information

....‘typically’ the District Nurse
Advance Care Planning

WHAT is advance care planning?

- Advance care planning is an umbrella term covering legal, personal and clinical planning to prepare for a person’s future care.
- Advance care planning is an on-going process of discussion between the person, those close to them and their health care professionals focusing on the person’s wishes and preferences for their care as they approach the end of their life.

WHY is advance care planning important?

- Advance care planning is an important part of routine clinical practice to ensure that people have the opportunity to have realistic and practical discussions about where and how they would like to be cared for at the end of their life.
Specialist Palliative Care

Why?
Regional scoping highlighted variations in the provision of specialist palliative care services across Northern Ireland including:

– Access to SPC Nurses at weekends
– Access to Palliative Medicine Consultants at home and OOH
– Access to SPC Allied Health Professionals in the community
– SPC workforce nearing retirement age

How?
Specialist Palliative Care Workforce review underway – medical, nursing, AHP, social work and pharmacy
Community MD Specialist Team

- Social Worker (1wte)
- Occupational Therapist (1wte)
- Physiotherapist (1wte) (job share)
- Speech & Language Therapist (1wte)
- Dietitian (1wte)
- Clinical Nurse Specialist 10.6wte (band 7 &6)
- Specialist Palliative Care Practice Facilitator (0.4wte)
- Palliative Medicine Consultant (0.8wte)

Community Multidisciplinary Specialist Palliative Care Team

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Other Regional Work Programmes

- Macmillan Palliative Care Pharmacy Project
- Project ECHO: Nursing Homes, Carers, Domiciliary Care
- Monitoring & Measures
- Care of the Dying Adult Guidelines (NICE NG31)
- SPC Day Service model
- Hospital Discharge
- Ambulance Service
Ongoing Local Work

- Raising Awareness
- Education & Development of Staff
- Palliative Care Patient Experience Group
- Engagement & Partnership working
- Embracing the Public Health Approach
Public Health Approach

- Expanding our approach to health care to include the community as genuine partners - not simply as targets of our service provision
- Reminding ourselves and our community that end of life care – like all health care – is everyone’s responsibility
- Re-engage the community whilst recognizing the limits to professional care and service provision
- Dying, loss and grief are not medical matters but rather social relationship matters with medical dimensions.
- The longer part of dying and grieving occurs outside of institutional care and episodes of professional care (95% rule)
Further Information


- Your life and your choices: plan ahead
  Macmillan Cancer Support and the Public Health Agency 2016 Available from be.macmillan.org.uk (MAC14376)

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