Ref: FOI/00050/CMICB
05 September 2022

Your Request:

As the Palliative and End of Life Care Statutory Guidance for Integrated Care Boards (ICBs) (20 July 2022) has been published, we'd like to hear from ICBs on whether they have actioned the Palliative and End of Life Care self-assessment, to identify progress and gaps against the six Ambitions commitments (involving people with lived experience), please.

Is it possible to receive a copy of your self-assessment, if this is public, or be put into contact with someone who is able to assist with this.

Our Response:

1) The Ambitions self-assessment framework was developed by the Cheshire & Merseyside Palliative & End of Life Care Clinical Network in 2016 following the publication of the AMBITIONS framework 2015-2020. The National Palliative and End of Life Care programme adopted the assessment framework and refreshed it with the assistance of the clinical network; this is acknowledged in the introduction to assessment framework and accompanying guidance

'*NHS England & Improvement National End of Life team would like to thank the Cheshire & Merseyside Palliative & End of Life Care Clinical Network for their kind permission to use the tool which originated in the North West, their support in updating the tool and contribution to developing the technical and good practice guidance*.'

Clinical Commissioning Groups (CCGs) across Cheshire & Merseyside undertook self -assessment between 2016-2018 using the information to develop local improvement plans. With the introduction of the Health and Care Bill, CCGs are no longer in existence from 01 July 2022 and Place Based Partnerships have been introduced.

It is the intention, through the Cheshire & Merseyside Place areas, to revisit and repeat the AMBITIONS self-assessment. Cheshire and Merseyside Public Health Collaborative (CHAMPS) has also been commissioned to undertake a Population Based Needs Assessment for end-of-life care across Cheshire & Merseyside, by Place based area, to support service planning.

The current '*Cheshire & Merseyside ICS Palliative & End of Life Care (PEOLC) Programme Delivery Plan 2022-23* (enclosed), was crafted prior to the publication of the ICB guidance but aligns to it.

Enc: *Cheshire & Merseyside ICS Palliative & End of Life Care (PEOLC) Programme Delivery Plan 2022-23*

NHS
North West Coast
Clinical Networks

NHS
Cheshire and Merseyside

Cheshire & Merseyside ICS Palliative & End of Life Care (PEOLC) Programme Delivery Plan 2022-23

SRO - [redacted]
ICS Executive Sponsor – [redacted]
Programme Director - [redacted]
Clinical Leads- [redacted] **SPC Clinical Lead**
[redacted] **GP/Primary Care PEOLC Clinical Lead**
[redacted] **EPaCCS Clinical Lead**
[redacted] **Education Clinical Lead**
[redacted] **CYP PEOL Clinical Lead**
Personalised Care Lead – [redacted]

Programme Descriptions

For the adults, children and young people of Cheshire & Merseyside coming towards the end of their lives to live well, before dying with peace and dignity, in the place where they would like to die, supported by the people important to them. The access to care should be equitable across the Integrated Care System with no post code lottery

Identify patients who are probably in the last 12 months of life enabling their care to be coordinated and supported through anticipatory care planning influencing avoidable hospital admission with care and death in the place of choice

Support the upskilling of health and care staff to be able to recognise when people are approaching the end of life and to work together to co-ordinate and manage their care enabling patients, and those important to them to be assured of care through a confident capable and sustainable workforce

Understand population health need and define an outstanding patient journey to inform a commissioning framework for Cheshire & Merseyside which reflects the National Ambitions framework, NICE Quality Standard and National Service specification to support the consistent provision and commissioning of end-of- life care

Enable timely end of life care supported by information readily available electronically in all care settings

Strengthen the PEOLC infrastructure across Place Based Partnerships

The Aim of the PEOLC programme is to enable access to good quality end of life care equitably Cheshire & Merseyside. The programme will support…

Place Based Partnership areas to;

1. Increase the identification of adults who are probably in the last year of life leading them to be offered a personalised care support plan and coordinated care enabling care and death in the place of choice
2. Upskill health and care staff to be able to recognise when adults, children & young peoples are approaching the end of life and how to work together to co-ordinate and provide high quality PEOLC to them and those important to them.
3. Enable timely and responsive end of life care supported by information which is transferred electronically across all care settings (EPaCCS)

The Integrated Care Board to;

1. Understand population need for PEOLC to enable service planning and reduce inequity
2. Strengthen the PEOLC strategic infrastructure across Place Based Partnerships to steer and embed service improvement
3. Define an outstanding PEOLC patient journey to inform a C&M PEOLC commissioning framework to enable consistent service provision
4. Understand the gap in the Specialist Palliative Care workforce and develop a workforce plan

The Integrated Care System to;

1. Support equitable access to high quality palliative and end of life care for all irrespective of condition , diagnosis or where they live.
2. Raise public awareness of death and dying so the people of Cheshire & Merseyside are willing and confident enough to support each other in times of crisis and loss and build compassionate communities
3. Understand and enable equitable access for the people of Cheshire & Merseyside to bereavement care, including children and young people, and those affected by sudden or traumatic death
4. Be confident in Anticipatory Clinical Management Planning including DNACPR clinical decision making, record keeping, communication with patients, relatives and fellow health and care professionals; in line with CQC recommendations

IMPROVING ACCESS			
Programme Priority	**Outcomes 2022-2023**	**ICS Programme will .. 2022-23**	**Place Based Partnership will .. 2022-23**
<u>Early identification</u>: People are identified as likely to be in the last 12 months of life and are offered personalised care and support planning (PCSP)	**By March 2023 each GP practice will have a minimum of 0.6% of their population included on a GP palliative care register using an electronic record (EPaCCS)** **60% of those patients included on the GP Palliative Care Register to have had a PCP conversation by the time they have died coded and included on the electronic record/ EPaCCS**	**Establish the ability to collect the required data** **Gather and report baseline data for actual numbers of adult patients on a GP register by Place Based Partnership/PCN/GP practice** **Gather and report by Place Based Partnership/PCN/GP practice baseline data for:** **%/number patients at the end of life identified as being in the last 12 months of life and**	**Develop a service improvement plan building on the baseline** **Build the Place Based Service Improvement Plan on the enablers** • **EARLY clinical search tool and toolkit** • **MAYFLY ACP/COMMS training** • **EPaCCS Template** • **PEOLC Clinical Leadership**

		included on a GP register using nationally agreed codes **%/number who had a care plan in place by the time they died using nationally agreed codes** **%/number who had a CPR discussion/decision recorded using nationally agreed codes**	**Service Improvement Plan progress to be managed and monitored through Place Based PEOLC Strategy group or equivalent and reported into the PEOLC Programme Board**
		Agree a service improvement plan with each Place Based Partnership	
		Monitor progress against the service improvement plan through the ICS PEOLC programme	
		Report to the ICS Transformation Programme Board	
		Gather and report by ICS/ Place Based Partnership/PCN data on:	

Enhanced (PEOLC) Health in Care Homes: Prevent unplanned admissions for those residents in care homes identified as probably being in the last 12 months of life	**By March 2023 each Place Based Partnership Area will have an improvement action plan to support** - **early identification of those care home residents likely to be within the last 12 months of life** - **care home residents to have a personalised care support plan (PCSP)** - **care home staff education and training**	**%/number of emergency admissions for care home residents in the last 90 days** **number of PCSP for residents identified as being at end of life** **Agree a service improvement plan with each Place Based Partnership** **Report to the ICS Transformation Programme Board** **Monitor progress against the service improvement plan through the ICS PEOLC programme**	**Develop a service improvement plan building on the baseline** **Build the Place Based Service Improvement Plan on the enablers** • **SHADOW tool** • **EHCH standards** • **MAYFLY ACP/COMMS training** • **Six Steps training** • **EPaCCS Template** • **PEOLC Clinical Leadership** **Service Improvement Plan progress to be managed and monitored through Place Based PEOLC Strategy group or equivalent**
<u>Specialist Advice</u>: Staff, patients and carers can access the care and advice they need, whatever time of day.	**By March 2023 each Place Based Partnership in C&M will have an improvement action plan building on the C&M baseline of specialist PEoLC services available 24/7 for adults**	**Summary report of access in C&M for adults to 24/7** - **specialist advice** - **assessment**	

		- **admission to a Hospice IPU** - **hospice at home** - **formulary meds** **Agree adult C&M ICS specification for access to 24/7 specialist palliative care advice for professionals** **Agree adult C&M ICS specification for access to 24/7 specialist palliative care advice for public** **Agree C&M ICS specification for access to 7day face to face specialist palliative care assessment** **Map Place Based Partnership compliance with the specifications**	**Develop a service improvement plan building on the PBP mapping managed and monitored through Place Based PEOLC Strategy group or equivalent**

	By September 2022 C&M ICS will have an improvement plan against the national CYP PEOLC service specification	**C&M ICS scoping report completed through Together for Short Lives**	
<u>Equitable access to PEoLC :</u> **To support the sustainable funding and delivery of PEOLC across C&M with the ICB including PEoLC as a strategic priority in the ICB delivery plan**	**C&M ICB will continue to include PEOLC as a strategic priority and have an understanding of palliative care need across C&M through undertaking a** - **PBNA for adult PEOLC** - **Points prevalence study for CYP PEOLC**	**Undertake a** - **C&M wide PBNA reported by Place Based Partnership** - **PP study by ICS**	**Develop a service improvement plan building on the PBNA managed and monitored through Place Based PEOLC Strategy group or equivalent**
IMPROVING QUALITY			

<u>Workforce</u>: A confident workforce with the knowledge, skills and capability to deliver high quality PEoLC	**By March 2023 each Place Based Partnership can** - **evidence improved confidence knowledge and skills in Personalised Care Support Planning and Advance Care Planning for staff supporting adult PEOLC patients** - **have a plan to sustain education and training in PCSP/ACP for staff supporting adult PEOLC patients at PLACE** **By March 2023 the C&M PEOLC CYP Clinical Network will have** - **a plan to train CYP PEOLC ACST facilitators** - **a plan to train CYP PEOLC staff in ACP** - **evidence improved confidence knowledge and skills in Advance Care Planning (ACP) and Advance Communication Skills**	**Agree funding for PEOLC PCSP and deliver ACP training through MAYFLY programme targeting the primary care workforce** **Report quarterly by PCN on staff confidence and knowledge post Mayfly attendance** **Agree with each Place Based Area plans to sustain ACP education and training** **Report the** - **number of staff working with CYP EPOLC who have completed ACST** - **number of staff working with CYP PEOLC who have completed ACP training** - **% increase in confidence, knowledge and skills in CYP PEOLC staff**	**Develop local plans to sustain ACP training** **Develop local plans to sustain ACP training**

	Training (ACST) for staff supporting PEOLC C&YP	**completing ACST and ACP**	
IMPROVING SUSTAINABILITY			

<u>Strategy</u>: High quality palliative and end of life care for all, irrespective of condition or diagnosis	**By 2022 Each Place Based Partnership will have infrastructure with appropriate clinical and service representation to advance and implement the C&M ICS PEOLC strategic priorities; this includes representation on the CYP PEOLC clinical network**	**Agree the 22-23 Delivery Plan through the ICS Transformation Programme Board** **Support the development of Place Based Partnership PEOLC Strategy groups** **Support the C&M ICS PEOLC programme Board with ICS SRO and Exec Sponsor roles** **Link CYP PEOLC with the Children's Transformation Board**	**Establish robust Place Based Partnership PEOLC Strategy groups reflecting the PEOLC programme principles for PEOLC partnership groups** **Ensure appropriate Place Based Representation on the ICS PEOLC Programme Board/ CYP PEOLC clinical network**
<u>Workforce</u>: The PEoLC workforce is fit for purpose, now and in the future and specialist palliative care will be sustained with each ICS having a workforce plan which includes specialist palliative care workforce mapping for adults and CYP	**By March 2023 C&M ICB will have an understanding** - **by PLACE of the gaps in the adult specialist palliative care workforce and service delivery to incorporate into the ICB workforce plan**	**By September 2022** - **complete a review of the Adult SPC CNS workforce as recommended in the C&M Specialist Palliative Care workforce survey 2022** - **provide an ICS position update**	**Draft a SPC workforce plan managed and monitored through Place Based PEOLC Strategy group or equivalent**

	- **by ICS of the gaps in the CYP PEOLC workforce to incorporate in the ICB workforce plan**	- **complete C&M CYP SPC workforce survey** - **provide and ICS summary report**	
<u>Sustainably commissioned</u>: Safe specialist palliative care delivered through specialist palliative care hospices is sustainably commissioned across C&M	**By March 2023 each Place Based Partnership has a plan to commission adult hospice specialist palliative care by applying an agreed C&M core service funding model**	**Support NHS Cheshire as lead CCG for developing an agreed SPC funding model for SPC hospices**	**Place Based Partnerships, through CCGJC (or replacement) representation to review and agree the funding model**