Innovation ECHO Network

Session 5: A New Approach to Commissioning

25 May 2022
Network Recording Declaration

During this ECHO session discussions will be recorded so that people who cannot attend will be able to benefit at another time. Filming is regarded as ‘personal data’ under the Data Protection Act 2018 General Data Protection Regulations (GDPR), under that law we need you to be aware that:

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• This Data will be available for as long as your network continues to meet and will then be taken down from the internet and either stored securely at the Superhub or deleted.

Your ongoing participation in this ECHO session is assumed to imply your agreement to the use of your data in this way.

If you are NOT willing for your data to be used in this way, please LEAVE the session at this point.
# Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Presenters</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:30</td>
<td><strong>Introduction</strong></td>
<td>Jonathan Ellis, Director of Policy, Advocacy and Clinical Programmes, Hospice UK</td>
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<tr>
<td>10:35</td>
<td><strong>NHS England Commissioning Framework</strong></td>
<td>Sue Bottomley, National Head of Palliative and End of Life Care, NHS England</td>
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<tr>
<td>10:55</td>
<td><strong>Questions &amp; Group Discussion</strong></td>
<td>All</td>
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<tr>
<td>11:00</td>
<td><strong>Lincolnshire ICS: A ‘Change Management’ Approach</strong></td>
<td>Lisa Foyster, Senior Programme Manager for Palliative and End of Life Care for NHS Lincolnshire</td>
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<tr>
<td>11:20</td>
<td><strong>Questions and Group Discussion</strong></td>
<td>All</td>
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<tr>
<td>11:30</td>
<td><strong>Close</strong></td>
<td>Jonathan Ellis, Director of Policy, Advocacy and Clinical Programmes, Hospice UK</td>
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Palliative and End of Life Care Sustainability

Overview of the approach
Changing commissioning landscape

Health and Care Act
• New legal requirement to commission PEOlC
• Strategic guidance
• Technical guidance

ICBs
• Partnership working strengthened
• Opportunities for shared models, improved access to specialist care and cost efficiencies
Commissioning & Investment Framework

- Who Pays guide
- Co-produced
- Not mandatory but recommendations agreed by system leader representatives
- Likely to take time to implement
- Not provider specific
- Support ICBs as they examine commissioning arrangements for PEOiLC (to meet new legal duties)

AIM: To classify palliative and end of life key services into commissioning categories with the intention of simplifying the process of agreeing commissioning responsibilities at a local level, and as a result, progress service transformation to improve access, quality, and sustainability of PEOiLC services.
Commissioning & Investment Framework

**Core**
- Form the majority of services. They are key activities that should be commissioned and funded by ICBs, local authorities or a combination of both.

**Specialist**
- The needs of this group cannot be met by core services alone. This care requires a workforce with specialist skills and experience. They should be commissioned and funded by ICBs, local authorities or a combination of both.

**Enhanced**
- These are services which provide support to patients with PEOlC needs, and their families and carers, which are neither health nor social care. They are most frequently funded by charities and not commissioned by the NHS nor local authorities.
Service Specifications

• Adult and CYP
• Based on ambitions framework and NICE guidance
• Co-produced
• Intention is that they are varied locally and specific activities are extracted for each individual arrangement – unlikely the full spec will be provided by a single provider
• To be published on NHS public webpages early summer
The PEOlC Funding Guidance

Aims to:
• Provide guidance on achieving a fair and sustainable funding model
Predominantly aimed at ICBs – partnership approach absolutely vital

The vision:
• There is likely to be a mixture of approaches, but where partnerships and maturity of systems allow, the blended payment model will be introduced
• Shared efficiencies and closer integrated working
• Informal grants with the charitable providers will likely disappear as more robust arrangements are put into place
• Provider-led partnerships will strengthen the voice of hospices and ensure that, in exchange for improved accountability and intelligence, hospices will have opportunities to increase the funding they receive for services which are core or specialist
• ICBs will have an increasing blended payment approach as tariff systems disappear
• Patients may exercise choice using indicative personal budgets. Specific care provided will be paid for within clear structures that uphold quality standards and renumerate core or specialist PEOlC activity at fair prices
• SCN’s may lead with delegated authority to manage change, or they will be active partners around the table of an engaged ICB board.
Lincolnshire ICS: A ‘Change Management’ Approach

Lisa Foyster, Senior Programme Manager for Palliative and End of Life Care for NHS Lincolnshire
LINCOLNSHIRE’s PALLIATIVE and END of LIFE PROGRAMME

A Change Management Approach

25th May 2022
Lincolnshire Strategic Context

Changing patterns of demand
The current population in Lincolnshire is 751,200, but this figure is predicted to grow by 10% by 2041, with 30% of the population expected to be over 65. Our population is on average older than the population of England. It also has a higher proportion of adults over the age of 75 and the number in this age range is expected to double over the next 20 years. By 2026 it is estimated that the number of people dying each year who could have benefited from PEOL care will have risen by 6.3%. But those who have more complex care needs will have increased by 7.5%

Variation in wealth and deprivation
Urban areas and particularly the coast suffer higher deprivation, although there are pockets of deprivation across the county, including in rural areas which frequently suffer from issues of accessibility.

Geography of Lincolnshire
Lincolnshire is predominately rural, with no motorways, little dual carriageway and 80km of North Sea coastline. 48% of people live in rural areas - compared with the national average of 18%. It has poorly developed road networks, mainly of single carriage A and B roads - impacting on ability of people to access services including healthcare. The coast has the largest concentration of static caravans in Europe leading to large seasonal variations in population.

Population Demographics
‘In’ migration of older people and ‘out’ migration of younger people is causing a significant imbalance. The East coast is a destination for retirees - often with lower income employment and reduced access to social and family networks. In East Lindsey, 28% are over 65 - whereas the national average is 16%

Public Expectations
There are increasing expectations about the support that should be offered to people at the end of life - as set out in the National ‘Ambitions for Palliative and End of Life care”. We want to put people and those who matter to them (family, friends and carers) at the heart of everything that we do.

Economic pressures
Lincolnshire has strong agriculture, manufacturing, food and tourism sectors, however these tend to provide lower paid and lower skilled employment than the national average. Unemployment in Lincolnshire is below national rates, however there is significant seasonal employment in relation to the strong horticulture and tourism sectors, particularly in the east and south of the county.

Advancing technology
With internet, telephone, and video consultations up and running in all of our PCNs, our G Tech is evolving. Some GP practices are dealing with about 80-90% of all patient contacts remotely without patients having to attend a face to face assessment.

The combination of an ageing population, a rural geography and areas of high socioeconomic deprivation defines the specific challenge of delivering high-quality and effective services in Lincolnshire.
Collaborative Working

1.1 Building relationships with partners

1.7 Implementing or strengthening clinical networks.
1.4 Assess provision against the Ambitions Framework and the national service specifications
Collaborative Working

Our Vision

Vision

We will improve the quality of palliative and end of life care in Lincolnshire and make better use of all health, social care, neighbourhood and voluntary sector resources to support these improvements.

Health and Care agencies will work together with communities, to identify all patients deteriorating a life-limiting condition at the earliest possible stage. They will then provide the highest quality of communication and support to those patients and those who are important to them.

Palliative care services will be co-ordinated and delivered within Primary Care Networks, at Locality County levels to provide the best possible support for patients and their families. These services will operate within a consistent framework and at the most appropriate level and setting to meet people’s health needs and provide equity of access to high quality care across all parts of the County.

The provision of Palliative and End of Life care will form an important part of a wider framework of person-centred, integrated care across Lincolnshire, designed to meet the needs of the local population.

The changes in palliative and end of life care will have been delivered in a way that engages, involves and builds the confidence of staff and communities across the County. This will pave the way for future change across the health and care system.

Our Objectives

Objectives

A. To increase our recognition of people deteriorating from a life limiting condition
B. To increase the proportion of those on the Palliative register who have had high quality and timely conversations about dying
C. To increase the proportion of patents who have had advance care planning and robust care assessments
D. To increase the proportion of people who have had high quality care in the last days of their lives
E. To increase the quality of our patient centred care
F. To increase the resilience and sustainability of Palliative and End of Life services
Collaborative Working

1.1 Building relationships with partners

1.6 Strategic planning across ICS or wider for addressing gaps in provision against service specifications

1.7 Implementing or strengthening clinical networks.

• Delivery Group
• Core Programme Team
• Business Partners
• Project Delivery Team
• Clinical Leadership
• Developmental Resources
• SROs - Senior Leaders Group
Strategic Development Plan

Tranche 1: Design and Scoping (October 2021 to December (March) 2022)
Building on baseline work, establish the high level design, scoping and service specifications by January 2022 to support new service models.

Tranche 2: Establishing Integrated Palliative and End of life Care service models (January 2022 to June 2022)
This Tranche will focus on agreeing the operating models for each Palliative & End of Life Care priority and the required business change needed to support this model.
1. Service Models
2. Workforce and Implementation Plans
3. Commissioning and contracting approaches
4. Agreed investment framework and implementation plan (Exemplar site)

Tranche 3: Delivery and Stabilisation (July 2022 - March 2025)
This Tranche will focus on implementation of commissioning arrangements from July 2022, embedding the new service models integrating Palliative and End of Life Care within a wider framework for integrated health provision in Lincolnshire. This will include creating the right conditions to establish a system which has “continuous improvement” at its heart
Delivery will be monitored against an agreed performance and benefits framework.
Services

1. **SPECIALIST**: Establishing a single specialist palliative care service;

2. **PLANNED**: Ensuring effective home based support services; To simplify access to PEOL services and to identify opportunities to improve recognition of palliative needs

3. **UNPLANNED**: Developing effective rapid response in the community with a 24/7 SPA and integration of PEOL rapid response services

4. **INPATIENT STRATEGY**
1.3 Develop data collection methodologies
Transformation Capability

Co-Production

1. Collaboration is getting things done in groups...
2. Collaborate on the right ‘stuff’ - don’t collaborate on everything or with everyone...
3. Collaboration needs ownership and order.

OD

Voices

Tell us your experience

Are we doing enough for you?
We’re keen to hear from palliative and end of life patients or relatives of loved ones, who have recently had a hospital stay in the last 12 months

Tell us your experience in our online survey at: tinyurl.com/hwlincspeol

Closing date: 6th April 2022

All provided answers remain anonymous and will never identify you or your family to your community care team or practice.

Support and funded by:
Our Current Operating Model

Key features (as at Jan 21)
- Organisation: Primary Care
- Organisation: Lincolnshire County Council
- Organisation: Lincolnshire Community Health Services
- Organisation: St Barnabas
- Organisation: Marie Curie
- Organisation: United Lincolnshire Hospitals Trust

Operating model operates through individual organisations and is coupled with variation developed through different processes and approaches to co-ordination in different localities (both by practice and PCN).

Each organisation provides several services with different pathways connecting services within individual organisations to others.

The Lincolnshire CCG provides formal oversight of individual organisations and service provision - but there is no similar formal operational co-ordination across Lincolnshire.

1.5 Assess existing funding against the commissioning & investment framework

1.8 Workforce mapping
### Our Current Operating Model

#### Palliative & End of Life: demand flow through services (As Is)

<table>
<thead>
<tr>
<th>Unplanned Care</th>
<th>Planned Care</th>
<th>Inpatient Care</th>
<th>Specialist Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Predicted no of deaths, based on 1% of Pem, who may have benefitted from PEOLC 898.3</strong>&lt;br&gt;Registered PEOL Patients: 5401&lt;br&gt;Prevalence: 0.67&lt;br&gt;(10374 patients provided with PEOL in a 12-month period)**</td>
<td>On Palliative Register (Jan 22): 4940 (73 s1)</td>
<td>ULHT Attendances at A&amp;E: 3961&lt;br&gt;Emergency Admissions: 3945&lt;br&gt;Total LOS: 36397 bed days&lt;br&gt;ALOS: 10.96</td>
<td>Specialist Caseload&lt;br&gt;St Barnabas 360&lt;br&gt;MacMillan 462</td>
</tr>
</tbody>
</table>
| **GSF stage (Jan 22): 4002**<br>Blue – 1561 (32%)
Green – 1702 (35%)
Yellow – 308 (6.2%)
Red 92 (2%)
Other: 392 (8%) | Advance Planning | High level analysis indicates that only 54% of IDEE patients admitted to hospital had been previously identified as palliative. In Dec 2021, 50% of those admitted, who hadn’t been recognised as palliative, died within the same month. | Packages of Care<br>Requests made: 1719<br>Care Sourced: 1269 (74%)
RIP: 523 (16%)
Not Sourced: 61 (6%)
Admitted to Hospice: 65 (3%) |
| **Advance Planning**<br>ACP in place: 1162 (34%)
ACP or offer made: 1758 (56%)
RtSPECT in place: 2349 (47%)
Anticipated: in place: 770 (16%) | **Caseload Community Nursing 529**<br>**Preferred Place of Death**<br>PPOD Recorded: 1820 (38%)
PPOD Home: 1820 (31%)<br>ADA 2021 | **Hospices**:<br>St Barnabas 12<br>Butterfly Hospice 5 | **Delays in Packages (FYTD)**<br>Same day: 312 (23%)
1-2 Days: 503 (37%)
3-5 Days: 238 (16%)
6-10 Days: 111 (7%)
> 10 Days: 7 (6%) |
| **Palliative SPA (in Hour C 3000 calls)** | **MC Out of Hours**<br>10501 calls<br>6987 home visits<br>2615 new patients | **MC RRS Reporting**<br>PSPA Reporting | **PEOL Operational Dashboard**<br>**After Death Audit**

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1. **Around 43% of people have been placed on the palliative register in the last 4 weeks of their life – this late recognition is higher in areas of higher deprivation.**

2. **Across all ages, locally around 54.9% of females are being identified as palliative, compared to 45.1% males, whilst the population distribution is 50.5% and 49.5% respectively. This suggests inequality in the services received by men.**

3. **“White other” - disproportionately low recognition compared to White British – 2% only whilst constituting 6% of the population. This picture is similar across other ethnicities.**
Design Principles: Palliative and End of Life Care in Lincolnshire

By 2025, across Lincolnshire, there will be:

1. A PEOL care service that will focus, above all else, on delivering what is important to the person, their family and carers.

2. Proactive recognition of all those who would benefit from palliative support - with holistic care for people from the first point of recognition to the end of their life. For families and carers this support will continue post bereavement.

3. A Palliative Care Service (PCS) that works as a multi-disciplinary team, 24/7, to ensure patients receive the care and treatment required irrespective of their care setting.

4. A Palliative Care Service that adopts an integrated place based approach to provide competent, confident and compassionate care.

5. Palliative care packages that are delivered in a person’s preferred place of care within 24 hours.

6. A single Specialist Palliative Care Service (SPCS) that directly supports people and their families with complex needs and that provides advice and guidance plus education and training for all other core palliative and end of life care services.

7. Standard referral processes for palliative care – linking local teams to Specialist Palliative MDTs and system level support.

8. A digital health record of each palliative person accessible by all organisations providing palliative and end of life care.

9. A culture of continuous improvement driving ongoing improvement and efficiency in palliative and end of life care.

Design Principles: A Single Specialist Service

1. There will be a single process across Lincolnshire to refer any palliative patient to a Specialist MDT meeting.

2. All referrals to Specialist Services are to be triaged to enable patients to be appropriately prioritised and allocate.

3. The Specialist service will provide 24/7 cover across all care settings.

4. Specialist medical and clinical nursing roles will be capable of operating across all care settings.

5. Specialist services will deal with both clinical and non-clinical complexity - and on the basis that there is “no wrong door”.

Design Principles: Planned Care

1. Where any patient, carer or health and social care professional believes that an individual requires palliative care, they should refer to the relevant GP to ensure that the patient is reviewed and placed on the palliative register.

2. When recognised as palliative by his/her GP, every patient will be provided with a named case manager and a holistic assessment of their personal needs.

3. Every palliative patient and their care plan will be monitored by their GP Practice using the Gold Standards Framework.

4. There will be a single referral pathway for health and social care packages.

5. When being discharged from an inpatient setting, the patient and package of care will be reviewed by the case manager within 24 hours of a return home.

Design Principles: Unplanned Care

1. A single point of contact, 24/7, for Lincolnshire patients, carers and professionals.

2. A 24/7 service that provides support for unplanned need and provides advice and guidance for patients, carers and professionals.

3. A response within 2 hours for urgent unplanned palliative and end of life need.

4. Re-assessment and triage within 24 hours of all patients (who have had unplanned needs) to confirm appropriate planned care and support is in place.

5. A culture of continuous improvement driving ongoing improvement and efficiency in palliative and end of life care.
### Patient Journey

#### John’s journey

<table>
<thead>
<tr>
<th>Background and role</th>
<th>Goals and motivations</th>
</tr>
</thead>
<tbody>
<tr>
<td>John is 62 yrs old and lives with his wife Norma. He took early retirement due to worsening of his chronic obstructive airways disease (COPD).</td>
<td>Prefers to be treated at home and avoid hospital. Wants to put some future plans in place for himself and Norma.</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Physical</th>
<th>Social</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breathless on exertion and uses intermittent oxygen.</td>
<td>Norma has arthritis. John helps her with her personal care.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychological</th>
</tr>
</thead>
<tbody>
<tr>
<td>John is worried about his increasing breathlessness is getting worse and Norma will manage. He does not want to “let Norma burden Peter.”</td>
</tr>
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</table>

#### Gosia’s journey

<table>
<thead>
<tr>
<th>Background</th>
<th>Concerns/ worries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gosia is 35yrs old and has breast cancer with bone metastases in her spine. Polish is her first language but she speaks good English. She is having palliative chemotherapy.</td>
<td>Gosia does worry that in the future her cancer may spread further but does not want to worry Bartek or her children.</td>
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<table>
<thead>
<tr>
<th>Social</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norma</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Social</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peter</td>
</tr>
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</table>

#### Jean’s journey

<table>
<thead>
<tr>
<th>Jean</th>
<th>Goals and motivations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jean is 84yrs old. She is a retired teacher. Jean is diagnosed with vascular dementia and moves into a residential care home.</td>
<td>Jean appointed her daughter as attorney for finances a few years ago, after she had a TIA (mini stroke). It has always been important to Jean to be independent and an active member of the community.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical</th>
<th>Social</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jean is prone to falls but can walk around her home. She is eating and drinking well. She needs some prompting and assistance with personal care.</td>
<td>Jean’s husband Ted died a year ago. They have 3 adult children. Their daughter Jenny arranged for Jean to come to a care home near to her.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychological</th>
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<tbody>
<tr>
<td>Jean is often confused and disorientated. She doesn’t understand why she is living here.</td>
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</tbody>
</table>

<table>
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<tr>
<th>Spiritual</th>
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<tbody>
<tr>
<td>Jean worries about her “young children who are back at home on their own”. As a mother she is distressed not to be looking after them.</td>
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</table>

#### Jenny

<table>
<thead>
<tr>
<th>Jenny</th>
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<tbody>
<tr>
<td>Jenny has power of attorney for financial affairs only. Jenny worries that she doesn’t always agree with her brother Greg about what is in their mother’s best interests.</td>
</tr>
</tbody>
</table>

### Detailed Analysis

- **Jean**
  - **Background**: 84yrs old, retired teacher, diagnosed with vascular dementia.
  - **Goals and motivations**: Appointed daughter as attorney for finances, wants to remain independent.
  - **Physical**: Prone to falls, needs prompting and assistance.
  - **Psychological**: Confused and disorientated.
  - **Social**: Husband deceased, 3 adult children.

- **Gosia**
  - **Background**: 35yrs old, breast cancer with bone metastases.
  - **Concerns/ worries**: Cancer may spread further, wishes to avoid worrying children.

- **John**
  - **Background**: 62yrs old, COPD, early retirement.
  - **Goals and motivations**: Treat at home, future planning.
  - **Physical**: Breathless on exertion.
  - **Social**: Wife Norma has arthritis, personal care assistance.

- **Norma**
  - **Concerns**: Husband Jean’s condition.

- **Jenny**
  - **Role**: Power of attorney, family dynamics.

- **Jean’s family**
  - **Social**: Family support, decision making.

**Note**: The table structure and analysis cover the key aspects of each individual’s journey, focusing on critical health, personal, and social details.
Design and Scoping

(October 2021 to January 2022)

Building on baseline work, establish the high level design, scoping and service specifications by Jan 2021 to support new service models.

### Design Principles

<table>
<thead>
<tr>
<th>Prime Settings</th>
<th>Service Delivery</th>
<th>Co-ord</th>
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</thead>
<tbody>
<tr>
<td>Hospice</td>
<td>PCN</td>
<td>PCN Cluster</td>
</tr>
<tr>
<td>Community Hospital</td>
<td>PCN</td>
<td>PCN Cluster</td>
</tr>
<tr>
<td>Acute</td>
<td>Countywide</td>
<td>Countywide</td>
</tr>
<tr>
<td>Own Home</td>
<td>PCN Cluster</td>
<td>Countywide</td>
</tr>
<tr>
<td>Own Home</td>
<td>GP/PCN</td>
<td>PCN</td>
</tr>
</tbody>
</table>

### Prime Settings
- **Hospice**: PCN
- **Community Hospital**: PCN Cluster
- **Acute**: Countywide
- **Own Home**: PCN Cluster
- **Own Home**: GP/PCN

### Service Delivery
- **Hospice**: PCN
- **Community Hospital**: PCN Cluster
- **Acute**: Countywide
- **Own Home**: PCN Cluster
- **Own Home**: GP/PCN

### Co-ord
- **Hospice**: PCN Cluster
- **Community Hospital**: PCN Cluster
- **Acute**: Countywide
- **Own Home**: PCN Cluster
- **Own Home**: GP/PCN

### Design Principles - A Single Specialist Service

1. There will be a single process across Lucrative to refer any palliative patient to a Specialist MDT meeting.
2. Every patient requiring specialist palliative services will be provided with a holistic assessment to incorporate the 5 pillars of palliative care.
3. Specialist medical and clinical nursing roles will be capable of operating in all care settings.
4. Specialist services will deal with both clinical and non-clinical complexity - one that there is “no wrong door.”
5. Specialist services will ensure continuity of care and effective transfer of care across information across care settings.

### Design Principles - Planned Care

1. Where any person believes that an individual requires palliative care, they should refer to the relevant GP to ensure that the patient is reviewed and if appropriate, referred on to the palliative care service.
2. When recognised as palliative by their GP, every patient will be provided with a point of contact for the co-ordination of their care, and a holistic assessment of their personal needs.
3. Every palliative patient and their care plan will be monitored by their GP Practice or PCN using the Gold Standards Framework.
4. There will be a single referral pathway for health and social care packages.
5. When being discharged from an inpatient setting, the patient and package of care will be reviewed within 24 hours of a return home.

### Design Principles - Unplanned Care

1. A single point of contact, 24/7, for inpatient patients, carers, and professionals.
2. A 24/7 service that provides support for unplanned need and provides advice and guidance for patients, carers, and professionals.
3. A response within 2 hours for urgent unplanned palliative end-of-life need.
4. Assessment and triage within 20 hours of all patients who have been reviewed and needs to confirm appropriate planned care and support is in place.
5. Co-ordination of all unplanned responses, re-assessment and triage with the relevant GP and point of care co-ordination for that patient.

### Skill mix level

<table>
<thead>
<tr>
<th>Skill mix level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foundation</td>
<td>This level of skill requires staff to have an understanding and awareness of work procedures which staff would be expected to have after induction + on-the-job training</td>
</tr>
<tr>
<td>Core</td>
<td>An understanding and knowledge of work procedures that requires a level of theoretical knowledge normally acquired through formal training or equivalent experience</td>
</tr>
<tr>
<td>Enhanced</td>
<td>Understanding a range of work procedures and practices that require a higher level of theoretical knowledge and practical experience normally acquired through formal training or equivalent experience applied in a specific area of need such as a single health condition</td>
</tr>
<tr>
<td>Advanced</td>
<td>Knowledge across a range of work procedures underpinned by advanced theoretical knowledge acquired through extended formal education, training and practical experience</td>
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### CARE FUNCTION: WORKFORCE

**Recognition**: the process of recognizing those who are in the last year or phase of life. Including but not limited to Edmonton SPICT RNT AKPS Phase of Illness; PC&SP and SPICT4ALL (including domiciliary care)

**Assessment**: the process of assessing, actioning, sharing and reviewing the needs of all individuals and those important to them who are entering the last year of life

**Planning Ahead**: provide ongoing opportunities and clear process for all individuals if / when they wish to discuss what’s important to them enabling them to document their preferences including Advance Care Planning, ReSPECT which includes Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR), Advanced Decisions to Refuse Treatment (ADRT) and share as they wish

**Enhanced care and support**: The provision of the necessary services and support for those who are in the last year of life and those important to them to help meet their informational, emotional, spiritual, social, and physical needs

**Care closer to death** to recognise that an individual is in the last days or hours, to communicate and provide the care and support needed including immediate care after death.

**Bereavement**: to assess need and provide care and support to bereaved individuals
Our “To Be” Operating Model

Key features

- Service: Unplanned Care
- Service: Planned Care
- Service: Inpatient Care
- Service: Specialist Care

To deliver our Vision, and in line with our Design Principles and the Palliative Pledge, we will move from an approach based on the capability of individual organisations to a Population Health Management approach. This re-orientates PEOL service delivery to provide individualised care at scale through the different PEOL services.

We know that a person’s level of involvement with each service will fluctuate as they move towards death. This is therefore an intentionally flexible model, supported by improved co-ordination, which will respond to changing needs with seamless transitions of care.

This model is a whole system approach in which consistent use of structures, systems and IT will improve co-ordination and communication between service providers and support seamless, high quality care. It will minimise any gaps in service and health inequalities and ensure that specialist care is targeted where needed most.

The foundation for this approach will be a PEOL MDT in every PCN, which will use the Gold Standards Framework (GSF). PCN MDTs will be supported by Specialist services with escalation to Specialist care for more complex cases.

Future care planning, facilitated through the GSF framework, will include personalised care and support planning and supported self management. This will reduce unnecessary Inpatient admissions and Unplanned need.

A specialist service, supporting unplanned community response, to deal with unplanned PEOL and provide a 24/7 safety net for care, advice and support for all patients.
Critical Interventions

To address the challenges identified and to deliver our proposed operating model, we have identified the following critical interventions:

• **To increase our recognition of people deteriorating from a life limiting condition, we will establish**
  1. Proactive risk stratification to identify those with unrecognised palliative need

• **To increase the proportion of those on the palliative register who have had high quality and timely conversations about dying, we will establish**
  2. A specialist and core PEOL workforce with clearly defined competencies and skill levels for their roles
  3. Support for the self-management of palliative care (*including a Self-Management App*)
  4. Specialist roles with the capability and capacity to support ongoing PEOL training and education
  5. A learning network for specialist and core PEOL staff

• **To increase the proportion of patients who have had advance care planning and robust care assessments we will establish**
  6. The capacity to deliver specialist and core care to an agreed standard in all settings (*to include 7 day working in ULHT and integrated teams around PCNs*)

• **To increase the quality of patient-centred care**
  7. Enhanced personalised advance care planning practices and documentation (*including ReSPECT*)
  8. Improve the consistency and access to pre- and post-bereavement services for people, families, carers and professionals

• **To increase the proportion of people who have had high quality care in the last days of their lives, we will establish**
  9. A Palliative Hub, operating 24/7, through which patients, carers and professionals will be able to access support and care can be coordinated
  10. An enhanced 24/7 response and re-ablement provision for PEOL patients with urgent need
  11. Efficient contracting arrangements that provide personal care at the end of life, where necessary, within 24 hours of referral

• **To increase the resilience and sustainability of Palliative and End of life Services, we will establish**
  12. A single Specialist Palliative Care team
  13. A Specialist MDT and operating practices to co-ordinate and manage specialist support
  14. In-patient provision that is accessible, meets demand and admits people 7/7
  15. A Multi-Disciplinary PEOL Team and operating practice in every PCN (*using the Gold Standards Framework*)
  16. The capacity to support the co-ordination and transition of PEOL care in every PCN
  17. A digital infrastructure that supports the co-ordination and transition of PEOL care (*inc shared care records, a care portal, virtual wards and MDT*)
Strategic Development Plan

Tranche 1: Design and Scoping (October 2021 to January 2022)
Building on baseline work, establish the high level design, scoping and service specifications by January 2022 to support new service models.

Tranche 2: Establishing Integrated Palliative and End of Life Care service models (Jan 2022 to June 2022)
This Tranche will focus on agreeing the operating models for each Palliative & End of Life Care priority and the required business change needed to support this model.
1. Service Models
2. Workforce and Implementation Plans
3. Commissioning and contracting approaches
4. Agreed investment framework and implementation plan

Tranche 3: Delivery and Stabilisation (July 2022 - March 2025)
This Tranche will focus on implementation of commissioning arrangements from July 2022, embedding the new service models integrating Palliative and End of Life Care within a wider framework for integrated health provision in Lincolnshire. This will include creating the right conditions to establish a system which has “continuous improvement” at its heart.
Delivery will be monitored against an agreed performance and benefits framework.
Thank you for listening. Any questions?
Next Session:

Topic: Learning from Commissioning Models Across the UK

Date: 29 June 2022
Time: 10:30 – 11:30
Before you go…

https://www.surveymonkey.co.uk/r/Innovation25-05