Updates in Palliative Care

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Outcomes of Barnsley Palliative care survey 2021

64% felt there was sufficient support in primary care for palliative patients

91% confidence in recognising cancer patients versus 72% in non cancer patients approaching end of life

82% felt pandemic not changed their confidence on recognition of palliative patients

75% felt palliative recognition is/should be part of longterm condition reviews with 64% feeling more training would be needed to aid this

72% felt confidence in which person in MDT to contact

50/50 response for the current level of communication within the MDT being sufficient

How to improve things…

Improved EMIS/Systemone communication

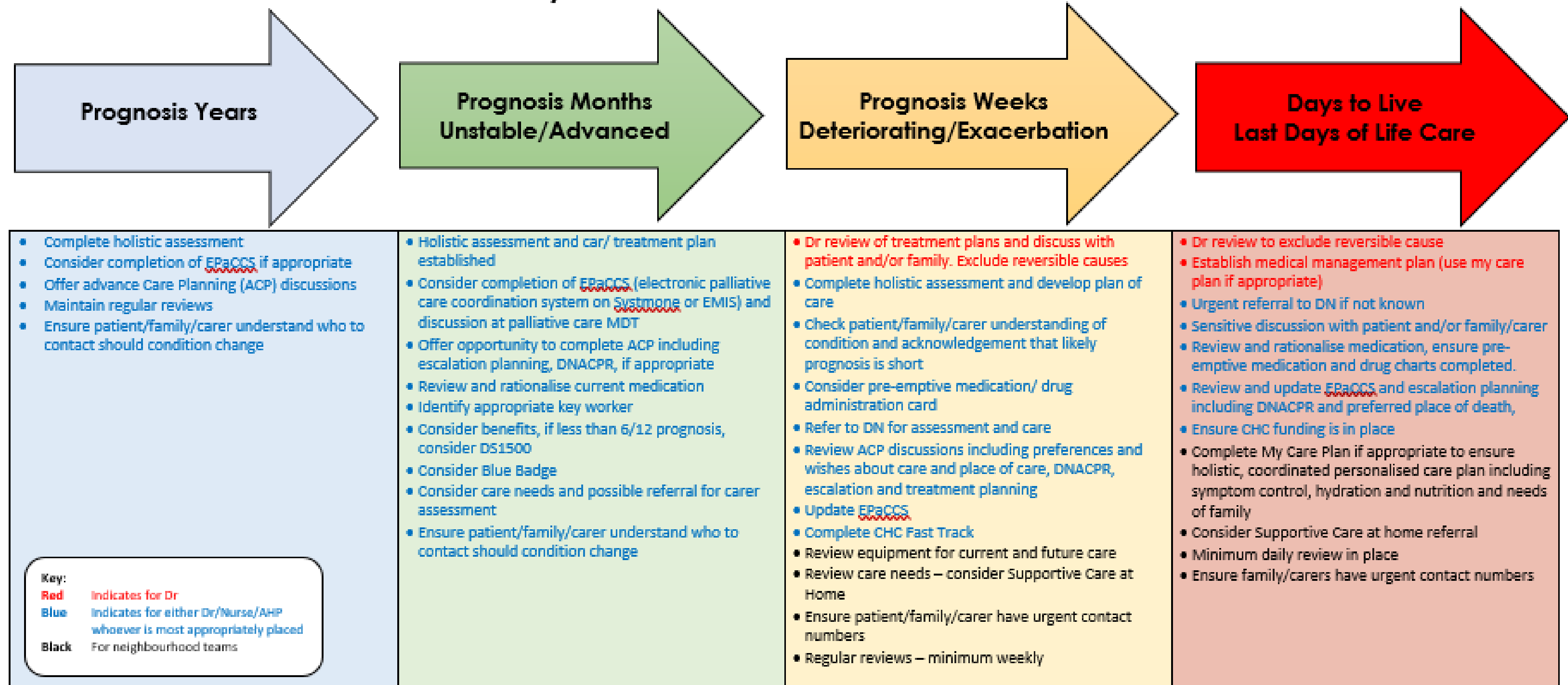
LTC template updates with training for staff

More support / training on medications in palliative care

MDT learning and working

? Structure of MDT meetings and knowing who to contact

Barnsley End of Life Care Guidance – What to Do



Prognosis Years	Prognosis Months Unstable/Advanced	Prognosis Weeks Deteriorating/Exacerbation	Days to Live Last Days of Life Care
• Complete holistic assessment • Consider completion of EPaCCS if appropriate • Offer advance Care Planning (ACP) discussions • Maintain regular reviews • Ensure patient/family/carer understand who to contact should condition change	• Holistic assessment and car/ treatment plan established • Consider completion of EPaCCS (electronic palliative care coordination system on Systmone or EMIS) and discussion at palliative care MDT • Offer opportunity to complete ACP including escalation planning, DNACPR, if appropriate • Review and rationalise current medication • Identify appropriate key worker • Consider benefits, if less than 6/12 prognosis, consider DS1500 • Consider Blue Badge • Consider care needs and possible referral for carer assessment • Ensure patient/family/carer understand who to contact should condition change	• Dr review of treatment plans and discuss with patient and/or family. Exclude reversible causes • Complete holistic assessment and develop plan of care • Check patient/family/carer understanding of condition and acknowledgement that likely prognosis is short • Consider pre-emptive medication/ drug administration card • Refer to DN for assessment and care • Review ACP discussions including preferences and wishes about care and place of care, DNACPR, escalation and treatment planning • Update EPaCCS • Complete CHC Fast Track • Review equipment for current and future care • Review care needs – consider Supportive Care at Home • Ensure patient/family/carer have urgent contact numbers • Regular reviews – minimum weekly	• Dr review to exclude reversible cause • Establish medical management plan (use my care plan if appropriate) • Urgent referral to DN if not known • Sensitive discussion with patient and/or family/carer • Review and rationalise medication, ensure pre-emptive medication and drug charts completed. • Review and update EPaCCS and escalation planning including DNACPR and preferred place of death, • Ensure CHC funding is in place • Complete My Care Plan if appropriate to ensure holistic, coordinated personalised care plan including symptom control, hydration and nutrition and needs of family • Consider Supportive Care at home referral • Minimum daily review in place • Ensure family/carers have urgent contact numbers

Key:

Red	Indicates for Dr
Blue	Indicates for either Dr/Nurse/AHP whoever is most appropriately placed
Black	For neighbourhood teams

Key Community Teams Who May Be Involved Contact Right Care SPA on 01226 644575

- **Neighbourhood Teams:** including District Nursing to provide support and care – referral in last weeks and days of life is usually required
- **Community Matron:** consider referral for those who need support with long term condition management
- **Consider referral to Community Macmillan Specialist Palliative Care:** if patient has advanced life limiting illness and complex palliative care needs requiring additional specialist support. Needs can be emotional, physical, social, complex symptom management. Includes medical consultant, physio, OT dietitian, specialist nursing and social worker (advice line or to discuss referral Contact 9am – 4.45 pm)
- **Breathe Team:** Specialist Respiratory support / home oxygen referral via SPA
- **Out of Hours Crisis Response Team:** Contact via SPA or number to contact will be provided if SPA closed
- **Out of Hours Palliative Care Advice:** via Pall Call advice line via Barnsley Hospice contact **01226 244244**
- **Supportive Care at Home:** provides individualised packages of care for carer support and respite, consider referral in last weeks and days of life **01226 645281**

Barnsley Hospice Provision Contact 01226 244244

Consider referral to Hospice services when a patient has advanced life-limiting illness and complex palliative care needs requiring specialist input for needs that may be psychosocial, spiritual or physical and are often a combination of all of these. Hospice services are for these patients and their families and carers.

Services include:

- Inpatient unit stay for assessment and management of holistic needs and may include care in the last days of life for some patients.
- Outpatient medical review, counselling and bereavement support, lymphoedema management, complementary therapy, and day therapy support.
- Outpatient services have both virtual and face to face elements and include provision for individuals and groups.

Barnsley End of Life Care - Our Vision 2021 - 2023

Our Vision

For everyone at the end of their lives, and those important to them, to receive high quality care which respects their personal preferences and choices, and is supported by a workforce which is consistent, honest, skilled and confident.

Our Mission

- Your end of life care is provided in the last year(s) of life and includes months, weeks, days, hours and bereavement care.
- Your care is equitable irrespective of diagnosis
- Your care is personalised with your own individual
  plan of care, led by your choices and preferences
- All care planning and delivery always considers the needs of those important to you

What We Will Ensure

- We have a shared approach across all partners in Barnsley to support seamless and coordinated, high quality services.
- Have a workforce with the required skills and competency, with sufficient capacity to deliver care to the standards we expect.
- We recognise end of life care needs.
- Once recognised, we offer open and honest conversations.
- You, and those most important to you, are at the centre of your plans and decision making.
- All service developments will be informed by feedback from you and those important to you.

USEFUL LINKS AND NUMBERS

- **Gold Standard Framework:** Aims to clarify the triggers that help identify those patients who are in the last year of life. Once identified then patients can receive proactive support. www.goldstandardsframework.org.uk
- **SPICT Tools:** Prognostic indicator guidance to identify when a person is approaching the last year of life. www.spict.org.uk
- EPaCCS (Electronic Palliative Care Coordination System) available on SystmOne and EMIS – provide links to medication advice, referrals EPaCCS Electronic Palliative Care Coordination System Local guideline or pathway (barnsleyccg.nhs.uk)
- **My Care Plan:** Personalised care plan developed to support and guide last days of life care in all settings across Barnsley.
  - A paper document that stays with the patient
  - Commenced following multi-disciplinary agreement and communication with the patient and / or their family / carers.
  - Used when a person is thought to be approaching last few days to hours or life. (Access link via live EPaCCS template)
- **Barnsley Palliative Care Formulary:** Guide for palliative care symptom management. Palliative Care Formulary Local guideline or pathway (barnsleyccg.nhs.uk)
- **Last Days of Life Symptom Management Guidance:** Guidance to symptom management in the last days of life including prescribing pre-emptive medication, syringe drivers. Pre-emptive Drugs Local guideline or pathway (barnsleyccg.nhs.uk)
- **List of Palliative Care Pharmacy Stockist:** List of pharmacies who stock additional palliative care medication to ensure available as required. Pre-emptive Drugs Local guideline or pathway (barnsleyccg.nhs.uk)

LINKS to CHC forms, medication prescribing advice, MY Care Plan, DNACPR forms and leaflets are available on the EPaCCS template

Service	Number
Adult Social Services	01226 773300
Community Equipment Store	01226 645400
Barnsley Right Care SPA	01226 644575
Welfare Rights Barnsley	07809 103254 or 07741 168743
Continuing Health Care	01226 433634
Barnsley Hospice	01226 244244
Supportive Care at Home	01226 645281
Barnsley Hospital	01226 730000
Pallcall	01226 244244
iHeart (Out of Hours GP)	01226 242419

Palliative Care MDTs

Generate patient list for discussion
(see Guide for how to do this)

Care-Coordinator / Palliative Coordinator to review list and highlight those without appropriate stage action (refer to EoLC model / poster)

- To complete grid prior to MDT
- Coordinate with professionals for any concern patients or those not there to complete proforma for patients they need discussing

Patients to discuss

Deaths

- Any issues
- Complete place of death and where achieved preferred if not why not?
- ? bereavement support offered / needed

Red Category Patients

- Any urgent issues
- ? seen within 28 days
- Will this patient require the coroner?

Amber Category Patients

- Any issues? needing referral to DN (have they been fasttracked)
- DNACPR status
- ACP sections completed
- Anticipatory drugs prescribed? Indicated
- Symptoms and management

New Patients to the List

- Have they had palliative review?
- Category – review what needed based on this
- Any concerns / people needing to be involved

Other

Any other patients in blue or green that are of concern, or patients changing colour categories

MDT Proforma

Patient Name:			
Primary Diagnosis:			
Category			
Red	Amber	Green	Blue

Please tick	Yes	No
DNACPR in place		
Does DNACPR need to be reviewed		
ACP / Emergency care plan (transfer from EPaCCs)		

Please tick	Yes	No
Anticipatory medications in place? (if not ensure done after MDT if indicated)		
Will this patient require referral to coroner?		
Date last seen GP: (within 28 days? If Red / Amber)		
Any recent changes / reason for discussion:		

After Death Pathway

Data input team:

After receiving confirmation from relative or letter of confirmation, add to all clinical staff screen to notify them of death.

Date input team:

Where appropriate added to Doctor who has seen most recently to complete certificate – once completed given to allocated admin team to ensure registrar receives, also family can collect if wishes.

Reception Staff:

- Collect bereavement card and booklet and give to clinician (not only GP) who has most input / relationship with patient and relative to complete card and send out *within 1 week of notification of death*.
- Offer of bereavement support appointment in this also.
- Clinicians often contact relatives offering support and condolences via telephone at same time.

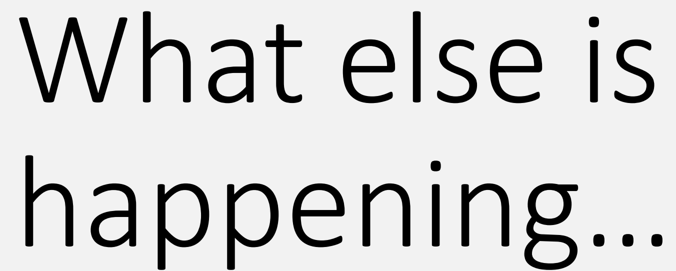
Clinicians:

Deaths discussed in the weekly clinical meeting and audit template completed:

- Whether palliative patient / expected
- Place of death and whether met ACP
- Learning from case / debrief

Clinicians:

After discussion in clinical meeting where appropriate admin team tasked with offering a telephone / face to face bereavement review with NoK / family with clinician best known to relative.



What else is happening…

Educational programme from End of life team 2022

ECHO – including a trial in Wombwell for MDT approach learning

CCG commissioner taking templates to development team for LTC / EPaCCs integration

BHNFT information sharing

Planning to review EPaCCs template 2022

Proposal to expand palliative consultant support