MACMILLAN CANCER SUPPORT

NHS South West Yorkshire Partnership NHS Foundation Trust

Katie Yockney

Macmillan Advanced Palliative Care Practitioner (care homes)

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The purpose of the post:

Is to facilitate the earlier recognition of **palliative care** needs of those living in care homes, undertake holistic needs assessments, advance care planning and anticipatory medical care planning.

The overall aim is to enhance the provision of palliative care for people living within a care home setting.

Funded by Macmillan Cancer Support for 3 years.

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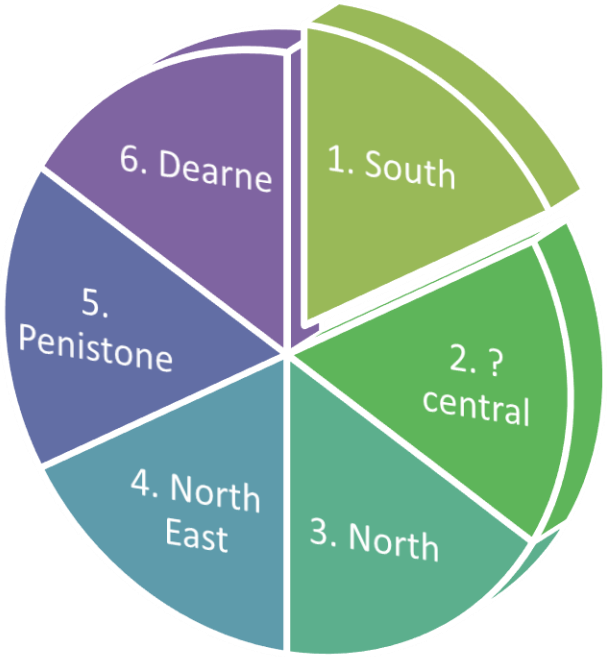
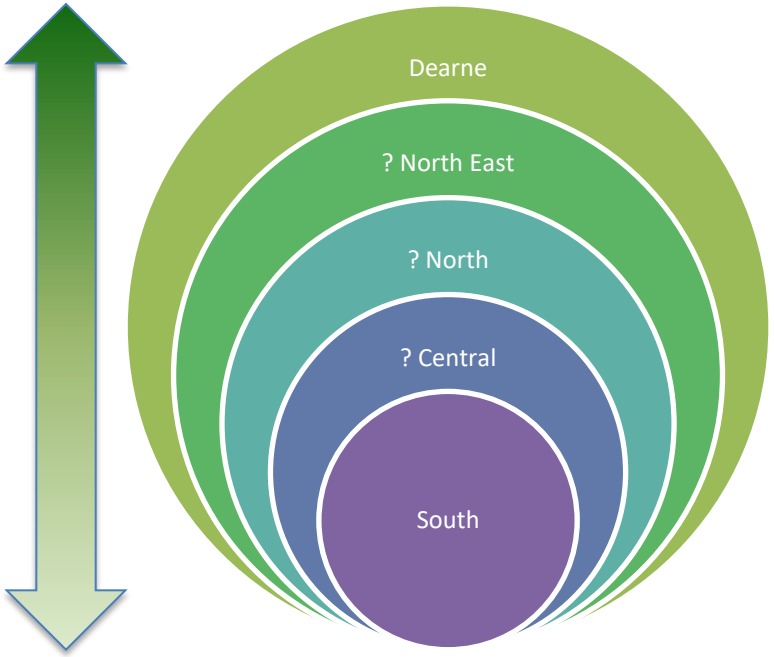
Working neighbourhood by neighbourhood

South West Yorkshire Partnership NHS Foundation Trust





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Aims of the project: 3 main aspects

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- Pro-actively identify people within care home settings who are living with palliative needs
- To undertake holistic needs assessment, then develop and implement robust individualised care plans.
- Use palliative care knowledge and advanced clinical assessment skills to undertake responsive assessments to support care home resident

- Work collaboratively with all health and social care professionals supporting recognition of palliative care needs
- creation of care pathways to support transfer of care
- Build effective working relationships and care pathways with primary care, secondary care, care home staff and existing community teams

- To provide and deliver education to care homes through coaching and being a role model.
- To support and increase confidence of care home staff to effectively manage those with palliative care needs within their preferred place of care, avoiding any unnecessary hospital admissions

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THIS POST COMPLEMENTS EXISTING MACMILLAN SPECIALIST PALLIATIVE CARE SERVICES, IT DOES NOT REPLACE – REFER AS NORMAL

This new post is based collectively around the questions:

- **Does the person live in a care home?**
- **Does the person have palliative care needs?**
- **What palliative care needs have been identified?**
- **Would they benefit from a holistic assessment and advance care planning/anticipatory medical management plan?**

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Which patients?

- **GP practices**
    - EPaCCs/palliative care registers
    - eFI
    - eCGA
    - Practice/GP knowledge
- Long Term condition nurse in-reach service BHNFT
- Frailty Team BHNFT
- Health care professionals including Neighbourhood Nursing Service colleagues and Memory Team
- Yorkshire Ambulance Service
- Right Care

Referral pathway

South West Yorkshire Partnership NHS Foundation Trust

Referral to community specialist palliative care team

Referral form, E-referral via S1 or

01226 645280

Referral reviewed by Community Macmillan CNS Palliative (care home) + Macmillan Advanced Palliative Care Practitioner (care home)

Referral taken by community Macmillan CNS Palliative Care (Care Homes) – Tracy Forde and Kerry Hewitt

If they have specialist palliative care Needs

Referral taken by Macmillan Advanced Palliative Care Practitioner (Katie)

If they have general palliative care needs

Referral for End of life care facilitator

For educational support

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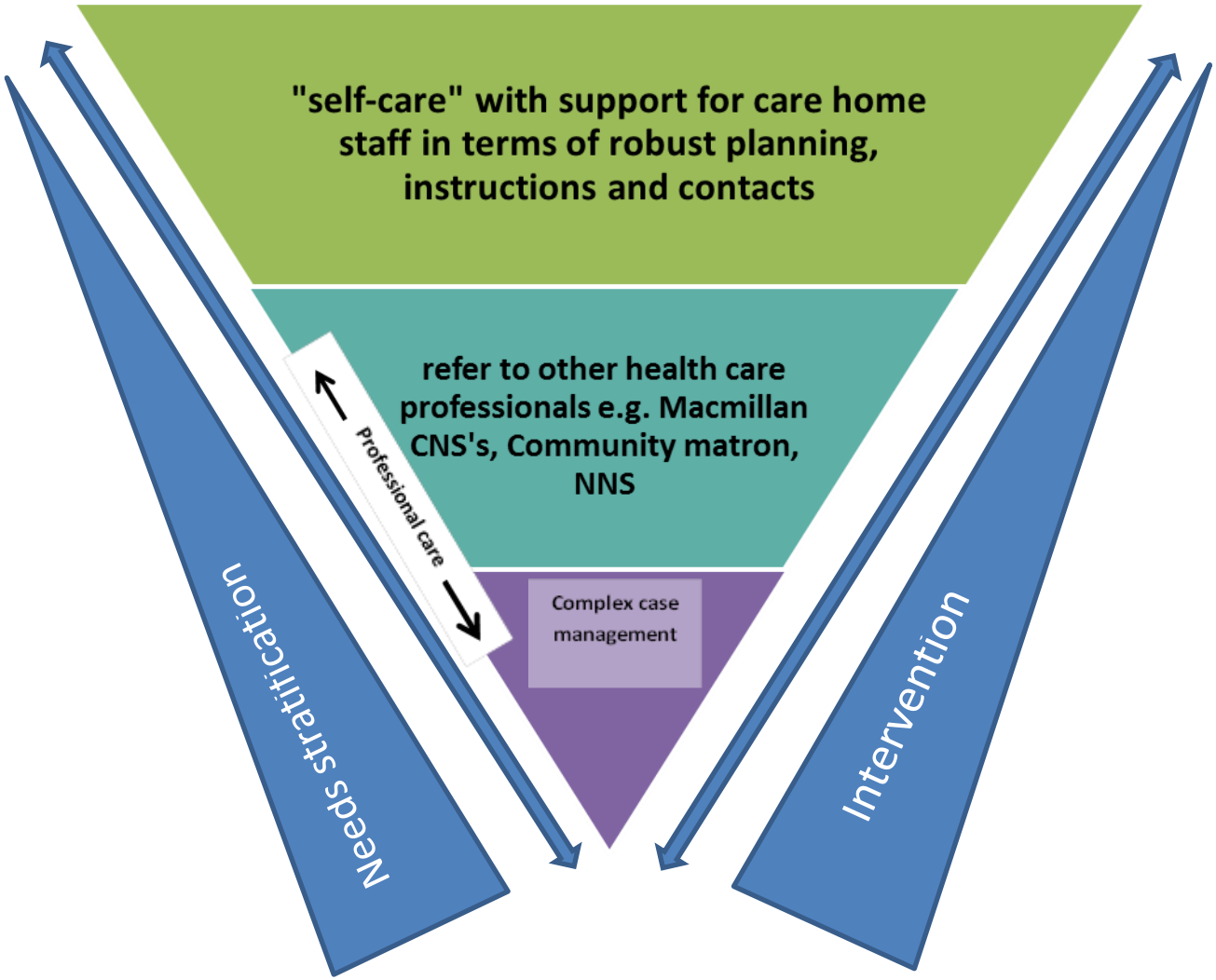
Risk stratification tool



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The project will be independently evaluated from quantitative and qualitative data collated over the 3 year period.

The independent evaluator will be sourced by Macmillan Cancer Support

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