# Renfrewshire Macmillan Palliative Care Project
# Jan 2014 – March 2017

Redesigning palliative care in the community

Renfrewshire Health & Social Care Partnership

WE ARE MACMILLAN. CANCER SUPPORT

# Aim

**“Redesign delivery of palliative care services through integration of supportive and palliative care approaches into mainstream primary & community care service provision”.**

# Engagement

| Methods used: |
| --- |
| Logic model |
| Palliative patient timeline |
| Public climate survey |
| Staff climate Survey |
| Operational group |
| Open space |
| Before I Die Wall |

# 4 key themes-Local Drivers for Change

| **Lack of consistency and equity** | **Patients and their families are often the informal coordinators of care** |
| --- | --- |
| Health and social care services have become difficult to navigate due to size and complexity | Staff have difficulties finding and accessing palliative care training locally and across the health board |

# So what?

| Key decisions and rationale |
| --- |
| Community based |
| Integrated- across health, social care and third sector |
| Trigger/s |
| Person centred and holistic (Concerns Checklist) |
| Proactive not reactive |
| Work with existing resources (GSFS) and existing staff |
| GP led but not GP centred |

# GP led but not GP centred- What we learned from our first test of change

| | |
|---|---|
| **Time**<br>**•Assessments and care planning were taking extra time**<br>**•Holistic assessment for patient and carer (Concerns Checklist and Carers Support Needs Assessment Tool)**<br>**•The new process felt slow and stilted** | **Ownership**<br>**•GPs fed back that they were not the best discipline to care plan or sign posting around social concerns**<br>**•On the whole new process only happens because we are in the room prompting it**<br>**•The MDT think that they already do this** |
| **Change/Project Processes**<br>•Patient selection is happening- process not seen as for everyone<br>•Teams not seeing outcomes<br>•Complex pilot processes- PATIENT CONSENT FOR INTERVIEWS<br>•Scattered experience-most professionals only trying the new process once or twice | **Primary Care landscape**<br>• Barriers to MDT Working – consistent attendance, referral processes, individuals unsure of their role in palliative care<br>•Purpose of the GSFS meeting - information sharing<br>•In current primary care landscape new process was translated as a series of tasks rather than a process |

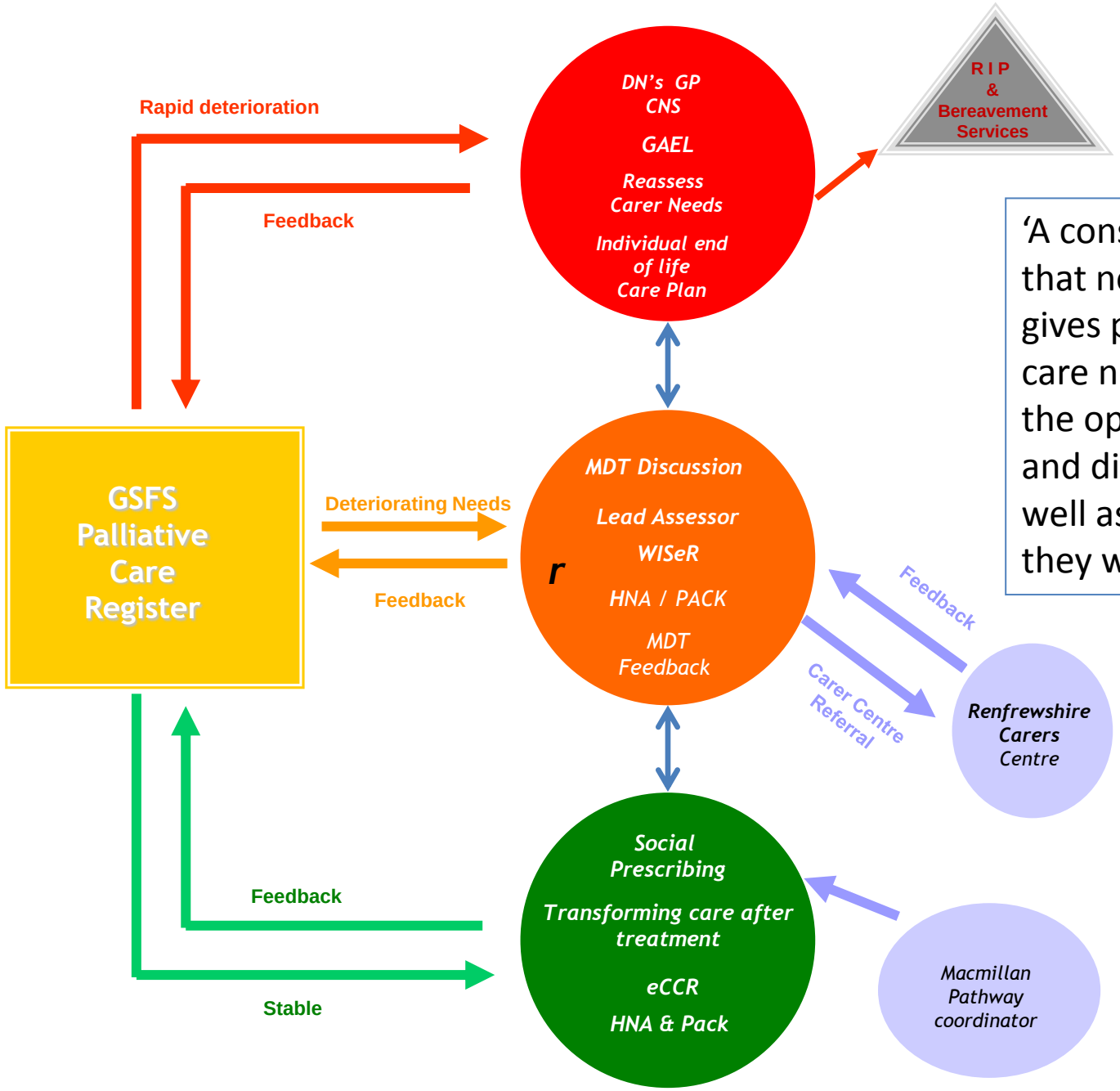
# Can services respond consistently?

## Need for consistency and equity

- We don't know who is involved in care
- We need equity in care for all
- Approach should be person centred
- There is variation in prescribing

There is difficulty meeting the needs of complex patients with multimorbidity – it needs coordination

Quality of assessments should not be personality dependent

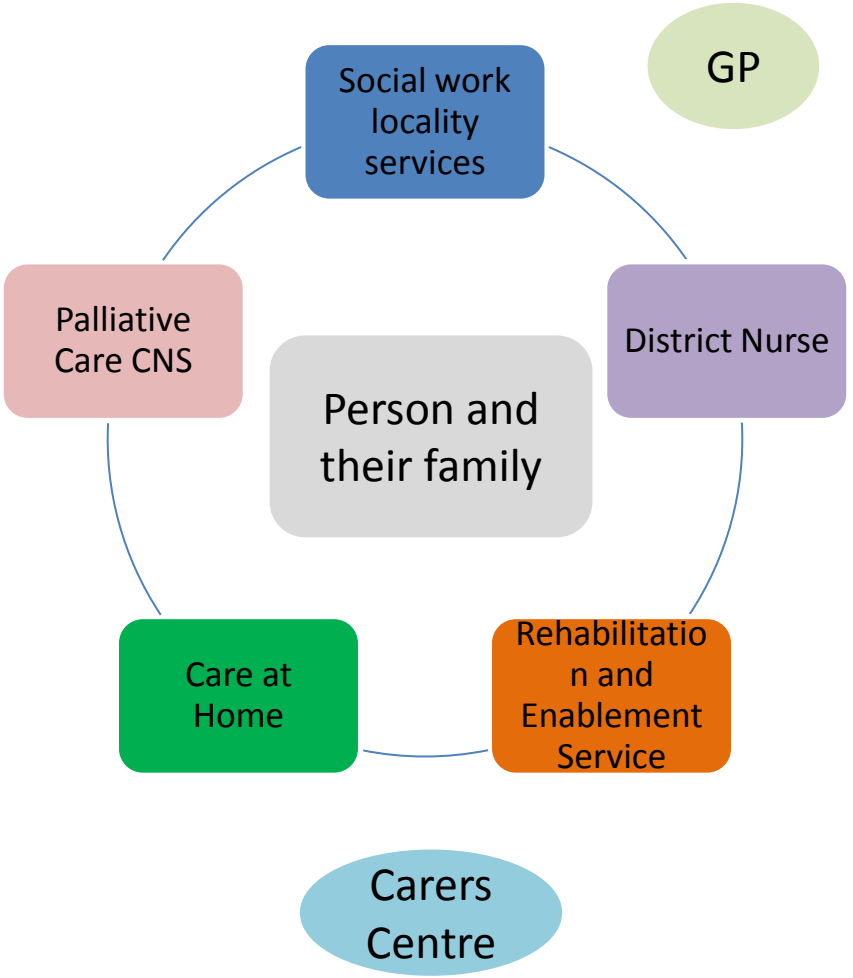



'A consistent response, so that no-one is missed, that gives people with palliative care needs and their families, the opportunity to identify and discuss their concerns as well as plan ahead, should they wish to do so'

# WISeR palliative care

## (Weekly Integrated Standard e Response)

- Weekly meeting
- Lasting 1 hour (at the longest)
- Named, consistent service representative
- Gateway to the service they represent (recognising referral processes and service capacity)
- “Passing the baton” based on changing needs



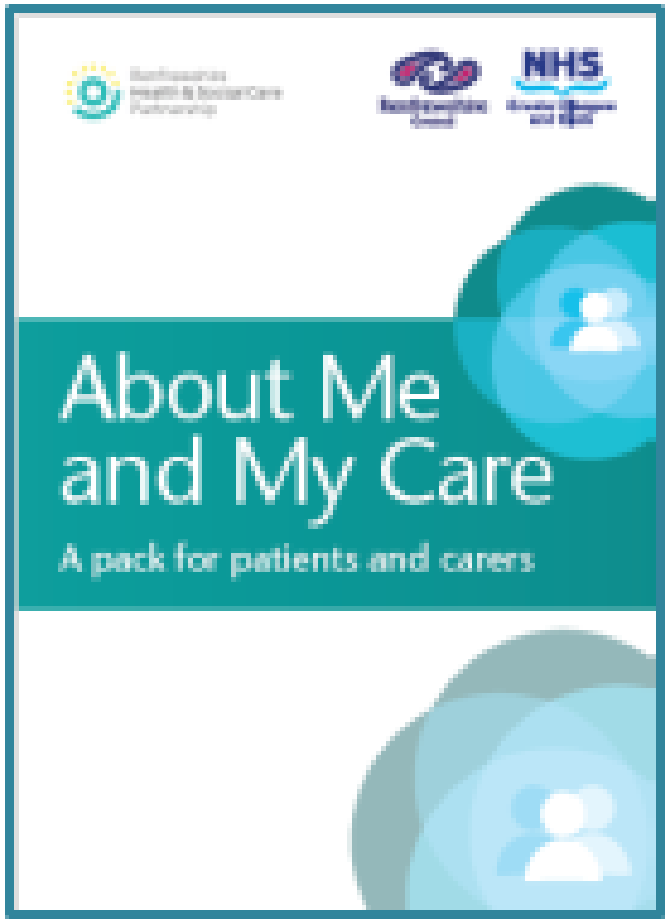
# Palliative care everybody's business

| **To support the patient , their families and a generalist workforce we introduced:** | |
|---|---|
| Families are informal coordinators of care: | About Me and My Care |
| Staff can struggle to access training: | The Palliative Care Training Calendar |
| Services difficult to navigate: | electronic Concerns Checklist Resource (eCCR) |
| Lack of consistency and equity: | WISeR Palliative Care (Re design) |

# ‘About Me and My Care’ Pack

**Helping with the informal coordination of care.**

- PACK
- Produced LEAFLETS – information about roles, carer information, finances, going into and out of hospital, useful contacts
- Includes advance care planning opportunities- My Thinking Ahead and Making Plans
- Space to record details of questions, what matter to me, people involved in care, keeping track of appointments



# Training Calendar

## Integrated palliative care training calendar

- Realised that a lot of training available but people not aware

- Approached education providers and pulled together what they offer into one calendar which is located online but with reminders and prompts sent out quarterly

- We plugged local gaps: DNACPR, Nurse Verification of Expected Death (VoED), Sage and Thyme Communication Training, Syringe Driver Competencies and palliative care induction for care at home staff

# electronic Concerns Checklist Resource (eCCR)

**Electronic signposting and information tool**

- Created a resource based around an established and validated concerns checklist – a holistic needs assessment.

- Developed into an electronic resource which is hosted online and has self management information as well as support for professionals

- Links with ongoing local and national service directory work

www. palliativecareggc.org.uk/eccr

# Outcomes

**Improved /increased access to assessment and services for patients and carers**

*"knowing you can pass holistic needs over to others and they will be taken care of makes a big difference to us"* ***Participating GP***

**Time savings benefits for GPs initially**

*"Time saving for the doctor as you can feel confident you are passing their (the patient and their family) needs on and these will be dealt with"* ***Participating GP***

*"getting things sorted in an hour saves me time in the long run chasing things up"* ***WISeR member***

**Crisis prevention**

*"we have already proved that this has prevented crisis, it is helpful that we are getting all this information"* ***WISeR member***

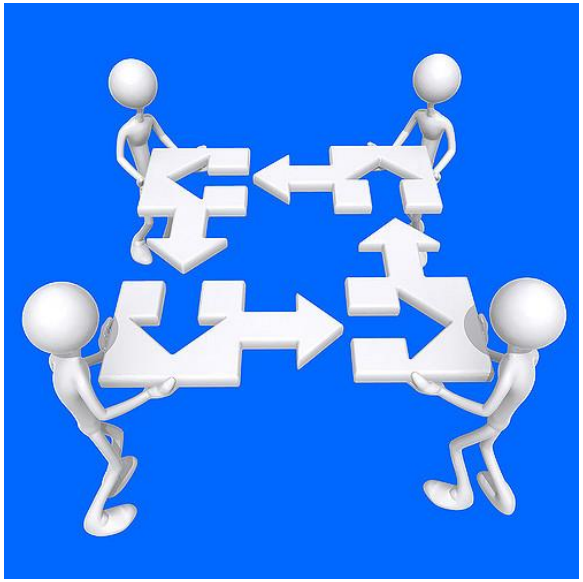
**Improved communication**

*"the big positive is that it is an MDT approach in a service where they don't talk to each other routinely. Getting to know each other and what others do is a huge bonus for staff and patients"* ***WISeR member***

**Improved integrated working and problem solving**

*" I am no longer in a bubble with lots to deal with for this patient, you are all there and its the wider team"* ***WISeR member***

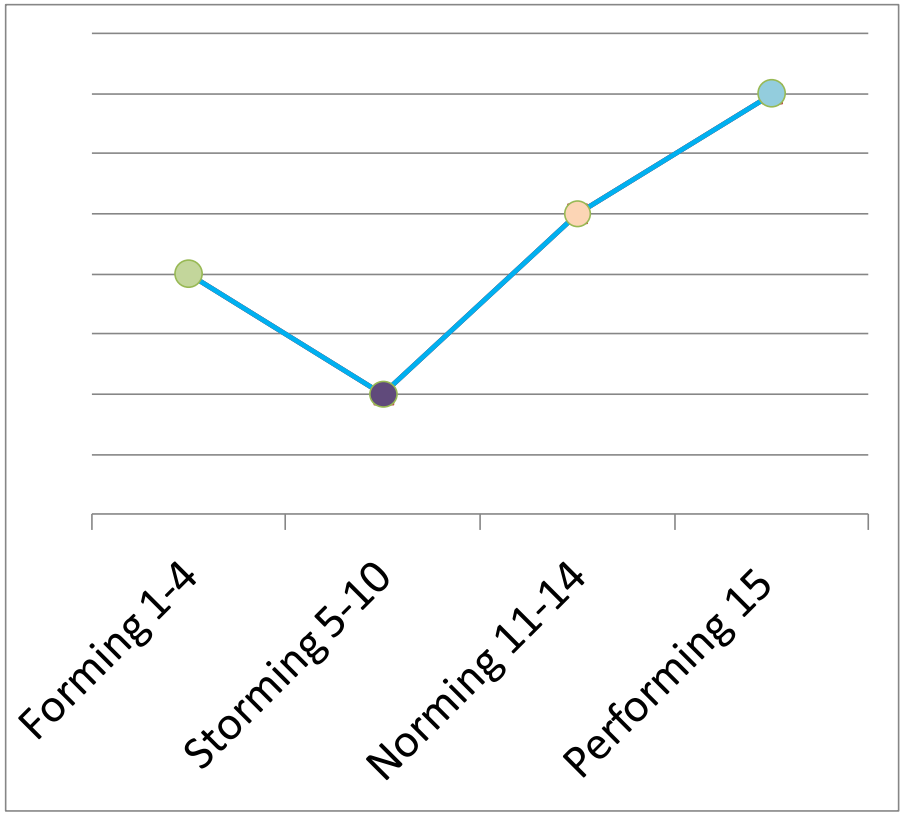
# Patient Experience:



| Immediate Outcomes | Mid-term Outcomes | Long term Strategic Outcomes |
|---|---|---|
| More co-ordination, joint working and problem solving in MDT | Preventing the preventable crisis | Reduction in unscheduled care |
| Consistent opportunities to access care, support and services | More opportunities for equitable care | Preventing inequality |
| More carers identified and linked into carers centre | Improved recognition of carers needs | Support the health and wellbeing of carers |
| Aligning multi disciplinary services around GP practice | Supporting development of GP clusters | Delivery of well co-ordinated care that is timely and appropriate to peoples needs |

| | |
|---|---|
| Week 1 | Questions |
| Week 2 | Good attendance |
| Week 3 | Avoiding patient selection/ informing patients |
| Week 4 | Consistency |
| Week 5 | Sharing |
| Week 6 | Turning Point |
| Week 7 | Feedback to GPs |
| Week 8 | Frustration |
| Week 9 | Staff Barriers |
| Week 10 | Not all reps prepared |
| Week 11 | Breakthrough and Realisation |
| Week 12 | Joint Problem Solving |
| Week 13 | Falling into Place/Professional relationships building |
| Week 14 | Wanting More |
| Week 15 | Ownership/Running with it |

# Observation of the WISeR Team Weeks 1-15




Teamwork Theory: Tuckmans Stages of Group Development

# What Next?

| |
|---|
| Weekly Integrated Standard Response (WISeR) Palliative care |
| About Me and My Care |
| electronic Concerns Checklist Resource (eCCR) |
| Training Calendar |

# New local Intelligence

| You said | We did |
| --- | --- |
| What about the stable GREEN palliative care patients? | Macmillan Pathway coordinator<br>WE ARE MACMILLAN. CANCER SUPPORT |

# Health and Social Care Delivery Plan

| Better Care | Better Health | Better Value |
|---|---|---|
| •Right help at the right time<br>•Individuals at the centre<br>•Everyone should be able to see a wide range of professionals more quickly | •Early intervention<br>•Not just what services can provide, but what individuals themselves want | •Improving outcomes<br>•Doing the right things in different ways<br>•Culture of improvement |

"Not just what services can provide, but what individuals themselves want and what those around them want"

Health and Social Care Delivery Plan Scottish Government 2016

# Strategic framework for action on palliative and end of life care 2016-2021

The Scottish government commits to working with stakeholders to:

| **Commitment 1** |
| --- |
| Support Health Care Improvement Scotland in providing HSCPs with expertise on testing and implementing improvements in the identification and care co-ordination of those who can benefit from palliative and end of life care. |

Scottish Government 2015

# Health Improvement Scotland

- **“it’s the kind of work that the Scottish Government’s Strategic Framework of Action for Palliative and End of Life Care wants others to replicate”**

**(Improvement advisor HIS).**

# Renfrewshire Macmillan Palliative Care Project

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# Thank you

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