

Renfrewshire IJB Palliative and End of Life Care Strategy 2022-25



Renfrewshire
Health & Social Care
Partnership

Contents

What we cover within our Strategy

Section	Page
1 – Introduction to Our Strategy	3
2 – Our Vision	16
3 – Our Priorities	19
4 – Our Actions – “How will we do this?”	24
5 – Monitoring and Evaluating Our Progress	34
Appendix 1 – Our Year One 2022-2023 Action Plan	36

1.1 Introduction to Our Strategy

Background

This three-year strategy sets out the vision and future direction for palliative and end of life care in Renfrewshire. It has been developed as the area emerges from the Covid-19 pandemic where Scotland as a whole is witnessing a growing need for palliative care alongside a rising number of people choosing to die at home. The pandemic accelerated these trends, but even as the death toll from Covid-19 recedes, its impact will remain for years to come.

There is a growing recognition in government and national policy organisations that palliative care, end of life care and bereavement support requires investment, a more visible infrastructure, and support for local areas to grow and develop in a more sustainable way. Throughout the pandemic, many organisations in Renfrewshire stepped up to provide vital palliative and end of life support to the NHS and work collaboratively with community health and social care services to reach people in need. This model of joined-up working, with hospices and others as equal partners in the system, sets the tone in Renfrewshire for the way forward and provides an excellent foundation of person-centred care and services.

This strategy describes how we will endeavour to improve the quality of life of patients and their families in Renfrewshire who are living and dealing with a life limiting illness, ensuring everyone receives person-centred, dignified and compassionate care which reflects individual choices. It has been developed with the national priorities in mind and is complementary to Renfrewshire Health and Social Care Partnership's Strategic Plan 2022 – 2025.

We have considered the evidence base locally, nationally and beyond to inform our thinking as well as considering feedback from those people who have used services and their families.

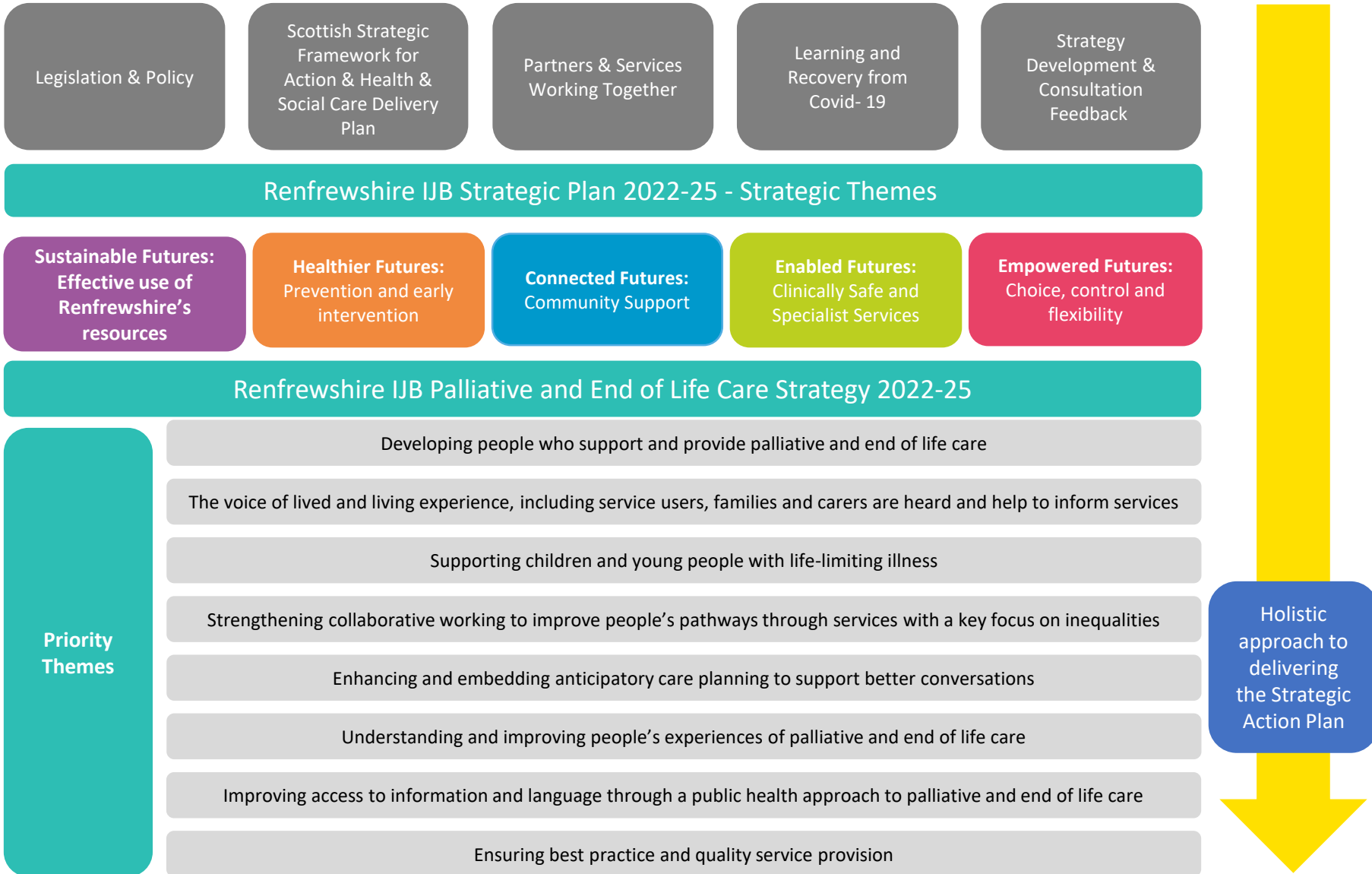
We have considered data on need, met and unmet. We have looked at local and national research depicting future likely need and demand and have focussed our strategy to support that demand as much as possible. We continue to seek and use feedback from people and their families as a key indicator of the quality of our services and to focus areas of improvement.

'You matter because you are you. You matter to the last moment of your life and we will do all we can, not only to help you die peacefully, but also live until you die'

Dame Cicely Saunders

1.2 Our Palliative and End of Life Care Strategy on a Page

How the elements of our Strategy fit together








1.3 Links with Renfrewshire IJB's Strategic Plan

Supporting palliative and end of life care through our Strategic Plan

The Renfrewshire IJB Strategic Plan 2022-25 was approved by the Integration Joint Board in March 2022. The Plan sets out how services will be shaped around individuals and communities to support everyone in Renfrewshire to live meaningful lives and achieve their hopes and aspirations. The IJB Strategic Plan has a focus on delivering within five key themes, and the table below sets out how this Strategy's Vision links with them.

The Palliative Care Planning Group contributed to the development of the Strategic Plan and developed the Palliative Care Strategies priorities to ensure ongoing alignment with this separate but complementary plan. The Plan on the Page shown previously shows how these elements fit together.

Strategic Plan Themes	Palliative and End of Life Care Strategy Priorities	
 <p>Healthier futures</p>	<p>People experience reduced inequalities and improved health and wellbeing through early action and prevention of more complex need.</p>	<p>Everyone in Renfrewshire who needs palliative care will have access to it regardless of age, diagnosis or circumstance. Support will be identified and accessible as early as possible.</p>
 <p>Connected futures</p>	<p>People are supported to recover, or manage disabilities and long-term conditions, and to live as safely and independently in their own home or community as possible.</p>	<p>The Strategy aims to improve the quality of life of patients and their families. Ensuring everyone receives person-centred compassionate care which reflects individual choices.</p>
 <p>Enabled futures</p>	<p>Our services are clinically safe, and people have access to the appropriate specialist support to aid them in their recovery and rehabilitation, where possible.</p>	<p>Aims to support the workforce to promote person-centred discussions with people and families and which identifies and plans for resources to be available to support choice.</p>
 <p>Empowered futures</p>	<p>People access the right care at the right time and place and are empowered to shape their support at every stage of life.</p>	<p>A future where all people, their families and carers, living with a life limiting illness, have the support they need to live the best possible life and to experience the best possible death.</p>
 <p>Sustainable futures</p>	<p>We maximise the impact of our people and resources by working collaboratively across sectors to deliver integrated services.</p>	<p>Our workforce will have reliable access to appropriate palliative care education and training, and we will work to improve access and pathways between our services.</p>

1.4 Informing the Strategy

How we consulted on the Strategy

This strategy has been developed through extensive collaboration and partnership engagement involving service users, carers, staff, providers and partners. The visual below demonstrates the breadth of stakeholder involvement in determining the content for the plan.



1.5 Reflecting on People's Experiences

What people shared with us

Through our robust and extensive consultation and engagement, a number of people have shared with us their own personal experiences of supporting someone in need of palliative or end of life care. This includes family members, carers and people supporting others as part of their job. These experiences are very powerful and emotive and help us to understand how everyone involved is impacted. It also provides us with the opportunity to reflect and learn from both positive and negative experiences.

"My dad was only in the centre for 3 days before he died but all staff were friendly and they looked after dad well."

"Sometimes there were too many people in at the one time. I think all teams are great, maybe just sort timings out."

"Very positive experience. Able to provide maximum care and carry out the person's wishes."

"From a personal experience it was negative, task orientated, not looking at the patient needs."

"There is lack of reflective work together. The eKIS can be better shared there is lack of mechanisms in place for sharing."

"I only wish he could have got in sooner as the hospital was not the right place for him, he was better looked after in the hospice."

"Having cared for my husband during Covid at home it was one of the most traumatic times of both my husband's and my children's life. We went through an emotional journey beyond what we could have imagined, my husband's wishes that he was with his family and didn't want to die alone in hospital and being able to do this gave me comfort when he passed away."

1.5 Reflecting on People's Experiences

What people shared with us

The two anonymous case studies below provide both a positive, rewarding experience and a more challenging experience within a care home from the perspective of a member of staff. They emphasise the impact palliative and end of life care can have on those providing it and reiterates the importance of supporting people to live and die where they wish to.

"This lady had been a resident in our care home for 18 years. As she had been with us for such a long-time staff were very close to her and her family. This lady became very frail quickly, staff got all the input they could from outside agencies and worked really well together to make sure there was always someone there. In the latter few days staff ensured there was someone at her bedside if family were unable to be there as we didn't want her to pass away on her own.

After this lady finally passed, it was a big loss for staff as they had attended to her every day for 18 years, it was a weird feeling her not being in the house she had lived for so long. Not seeing family regularly is a loss as they were part of staff lives for 18 years. "

"This person arrived at our care home. He was a quiet but friendly man, he appeared quite frail but was fully independent and was cancer recovered. He didn't have any family but had a friend who visited. He became very frail and ill very quickly, staff got outside agencies involved and cared for him, all the while getting to know as much as they could about him until he was admitted to hospital.

Unfortunately, the cancer had returned and he was taken away to hospital and died in hospital with no one around him. Staff felt he and they had not had a choice as it was very quick when he was taken into hospital once a diagnosis was given. They were concerned however he was starting to settle in at home for the time he was with us, and would have been really nice if he could have spent his last days at "Home" with the staff where he would have got that tender loving care around faces he knew."

1.5 Reflecting on People's Experiences

A coordinated, partnership approach to providing care

Improving the Cancer Journey (ICJ) was established in Renfrewshire in January 2020 by Macmillan Cancer Support. The service provides tailored, personal support to individuals with a new cancer diagnosis. This support includes practical advice, understanding of individual circumstances and organising and coordinating the most relevant package of support available. The service has had a significant impact making an invaluable difference to people's lives.

Caroline - Macmillan ICJ Coordinator – Case Study

Caroline has been working as a Macmillan ICJ Co-Ordinator in Renfrewshire since the service started in January 2020. This is a recent case study documenting interventions she made to help a patient in Renfrewshire.

The referral came to ICJ from the Council's neighbourhood hub. The lady is 34 years old and had a brain tumour. She has a 9-month-old daughter and has recently split from her partner. She is receiving daily radiotherapy at the Beatson. The lady is Polish and is not entirely clear on what help is available to her and has concerns about her settled status. The lady has childcare issues, is worried about the future, her housing situation and finances.


Caroline worked with the health visitor and Families First to secure a nursery place for her daughter. She engaged with Community Meals to ensure food is delivered each lunchtime. The client has been referred to counselling and been given a free will through the Macmillan service. She has been supported to submit a housing application which is ongoing and Personal Independence Payment and Macmillan Grant applications which have been successful. The client was referred to Citizens Advice Bureau who arranged for an Immigration Officer meeting to start the process of securing her and her daughter's settled status.

"Thank you, so much, to Caroline and the ICJ service"

ICJ Renfrewshire Service User

1.5 Reflecting on People's Experiences

Highlighting the impact our local hospices have on people's lives




"I am so grateful to the team for coming to our home and supporting Peter and I to make the decision for him to be admitted to the hospice. He had a good death and I was next to him. I can't imagine what would have happened to us if the hospice team had not come to our house that day. He would not have died peacefully and I would have had to live with that. I have peace in my heart that it was the right decision and will always treasure that. I can't express how grateful I am to the hospice, thank you for everything you have done and continue to do to support me."

Peter's wife, Margaret on his time at St Vincent's Hospice

The Primary Care Team contacted St Vincent's Hospice (SVH) Community Team to urgently review Peter at home. Peter had cancer of his throat and had a tracheostomy in place to help him breathe, his cancer was causing him breathing difficulties.

When the team assessed Peter it was evident he was approaching the end of his life and that this would be best managed at the hospice. The team explained this to Peter and his wife. An ambulance was called to take Peter to SVH – when it arrived he was given the time to say goodbye to his four dogs who shared their home.

Peter sadly died the following day with Margaret lying beside him. SVH team supported Margaret throughout and continue to do so.



"For Colin and myself, home was always where we were together anywhere in the world and not a physical building in any location or country, our last home together was the Accord Hospice in Paisley, we were immediately made to feel at home and part of a large caring family, we were instantly cocooned by a selfless, caring, loving group of people, to ensure Colin had exactly what he needed when he needed during the final chapter of his life."

Colin's partner, Malcolm on his time at Accord Hospice

After moving back to the UK, Colin was diagnosed with two brainstem tumours. After a gruelling battle with cancer and the side effects of the treatment, it was sadly decided that there were no more clinical, medical or surgical options available to him to fight the disease. He had a very brave hard fight.

Throughout his entire cancer journey he was treated with dignity and care by the oncology team at the Beatson West of Scotland Cancer Centre and in the final stages of his life he had three weeks at the ACCORD Hospice in Paisley.

When the doors of the hospice were opened for Colin, he had begun the last heart-breaking chapter of his life's journey. The team welcomed him with caring open arms as one of their family to make the hospice his final home.

1.6 Partners Supporting Palliative Care in Renfrewshire

A partnership approach to supporting people with a life-limiting illness

This Strategy recognises the important support that each of our partner organisations and services in Renfrewshire provide to those with a life limiting illness, and their families and carers.

This includes both generalist and specialist services provided by Renfrewshire Health and Social Care Partnership and Renfrewshire Council, as well as services provided by third sector partners such as our local hospices for adults and Children's Hospices Across Scotland (CHAS) for our children and young people.

The aim of our Strategy is to build on this system of strong partnership working already in place, to develop a robust structure of person-centred care and services.

We highlight, on the right, some examples of the partners working closely together locally.

Beyond the examples provided, partners engage and work with a wider range of further organisations to deliver palliative and end of life care in Renfrewshire.



1.7 Partners Supporting Palliative Care in Renfrewshire

Supporting the Bereaved in Renfrewshire

Bereavement support is one of our key priorities. We will commit to ensuring our Strategy aligns with the recommendations for Scotland in the UK Bereavement Commission read due to be published in September 2022 and builds on the support we already have in place locally. This will focus on inclusion and accessible services, partner collaboration for seamless pathways, support and access to statutory services.

Renfrewshire Bereavement Network

Renfrewshire Bereavement Network provides support to people who are experiencing difficulties with loss or dealing with grief – by offering access to the most appropriate advice, guidance and counselling available.

Led by Accord Hospice, in partnership with Renfrewshire Health and Social Care Partnership, the Bereavement Network is made up of other local organisations including Renfrewshire Council and RAMH.

Children and Young People's Service

The Children and Young People's service at St Vincent's Hospice supports children and young people from the ages of 2-18 years old who have been bereaved or have a special person with a life limiting illness. The team work in a person-centered way and meet the individual in a space that is comfortable to them either in school, home, hospice or community. This service is unique as it is not time limited and tailored around each child or young person in order to give them the very best support on a one-to-one level.

The team use a range of tools including talking therapy, play and creative ways to help build relationships and support them with their grief. The team have close relationships with schools who are our biggest referrers and offer them guidance and support when required. The hospice also offers bereavement support to those who have a loved one die within the service.



Helping you
cope when you
need us most

“Good to have someone to talk to and give me support out with my family. Also, let me cry a lot and understood”

Renfrewshire Bereavement Network client feedback

1.8 What Palliative and End of Life Care Means to People

The meaning of palliative and end of life care in people's own words

As part of our Strategy consultation, we asked people to share with us what palliative care means to them.

Throughout the Strategy we frequently refer to both palliative and end of life care, and we provide a detailed definition of both on the following pages. However, we understand that these terms can mean different things to different people based on their own experiences as shown in the quotes shared with us. We also recognise that conversations relating to palliative or end of life care can be misunderstood or misinterpreted.

Our Strategy aims to be reflective of this, ensuring the voices of our communities and people who need our support are listened to and understood.

"A positive and not something to be feared"

"Help, support and comfort given to someone who is suffering and is near death"

"To be able to be looked after, surrounded by family and be as pain free as possible"

"Giving the person, the best of care before they die"

"Caring for someone nearing the end of their life, keeping them comfortable and pain free as possible"

"It meant not dealing with things on our own. We would not have got through my husband's illness if it was not for the great Palliative Team"

1.9 Definition of Palliative and End of Life Care

The definitions of Palliative and End of Life Care

National definition

The Scottish Government adopted the World Health Organisation (WHO) definition for palliative care in its Strategic Framework for Action on Palliative and End of Life Care:

“Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.”

Language within the Strategy

When we refer to palliative and end of life care within this document, we are describing the care provided to people whose health is declining and whose lives are coming to an inevitable close.

Palliative care is treatment, care and support for people with a life-limiting illness, and their family, friends and carers. Its aim is to help people in these circumstances to

have the best possible quality of life. Palliative care can be provided at any stage of illness, therefore the length of time people receive care can vary from days and weeks to several years.

Palliative care

Palliative care can be provided by both generalist professionals and specialist palliative care professionals. Generalist palliative care is provided to patients / clients / service users and families by all point of care health and social care professionals in a variety of settings. Specialist palliative care is provided to people with more complex palliative care needs by specially trained teams who are generally based in a hospice, a specialist palliative care unit or as part of a hospital palliative care team.

Specialist palliative care professionals provide care and support direct to patients / clients / service users and also provide support and advice to other health professionals like GPs, hospital clinical teams and district nurses, to name a few. They provide education to general teams and often initiate research or quality improvement projects that allow the continual development and improvement of palliative care and services.

1.9 Definition of Palliative and End of Life Care

The definitions of Palliative and End of Life Care

End of Life Care

End of life care provides treatment, care and support for people who are nearing the end of their life. It aims to help people to live as comfortably as possible in the time that they have left. This care can involve managing physical symptom, providing emotional and practical support for everyone. A major part of end of life care is discussing the future, ensuring people's needs and wishes are considered and reflected in the care that they receive.

Palliative and end of life care, regardless of type, should be available to anyone in Renfrewshire with a life-limiting or chronic illness regardless of age, culture, background, belief or location. This strategy focuses on the delivery of that aim by describing specific, measurable, actions that will be taken.

Children and Young People

Palliative care for children represents a specialist, albeit closely related field to adult palliative care. The World Health Organisation's (WHO) definition of palliative care appropriate for children and their families is as follows; the principles apply to other paediatric chronic disorders (WHO; 1998a):

- Palliative care for children is the active total care of the child's body, mind and spirit, and also involves giving support to the family.
- It begins when illness is diagnosed and continues regardless of whether or not a child receives treatment directed at the disease.
- Health providers must evaluate and alleviate a child's physical, psychological, and social distress.
- Effective palliative care requires a broad multidisciplinary approach that includes the family and makes use of available community resources; it can be successfully implemented even if resources are limited.
- It can be provided in tertiary care facilities, in community health centres and in children's homes.

'Palliative care for children and young people is an active and total approach to care, from the point of diagnosis, throughout the child's life, death and beyond. It embraces physical, emotional, social and spiritual elements and focuses on the enhancement of quality of life for the child or young person and support for the whole family. It includes the management of distressing symptoms, provision of short breaks, and care at the end of life and bereavement support.'

Together for Short Lives



Renfrewshire
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Our Vision

2. Our Vision

2.1 The national position

Supporting the national ambition

We support the national ambition that describes a future where all people, their families and carers, living with a life limiting illness, have the support they need to live the best possible life and to experience the best possible death.

Renfrewshire Health and Social Care Partnership's (HSCP) strategic vision reflects the intentions of the Scottish Government's Strategic Framework for Action on Palliative and End of Life Care as well as those of the Scottish Partnership for Palliative Care. The ambition being to ensure that everyone in Renfrewshire who needs palliative care will have access to it regardless of age, diagnosis or circumstance and that the care provided will be safe, effective, person-centred and person-led.

Our Aim

Our aim was to achieve this by 2021 however the impact of the pandemic in 2020 and beyond delayed progress in some areas of agreed development. This did however allow a greater focus on other areas including palliative support in the community and in care homes where a number of new and emerging services have shown great success for people and their families. Renfrewshire has a distance to go to deliver on the aim stated above but research currently underway will help us to accurately measure impact, unmet need and will support actions that reduce the gap further.

A new National Strategy and Action Plan for Palliative Care is expected to be published by Scottish Government in 2023. The Strategy for Renfrewshire will be reviewed and adjusted, where appropriate, to ensure alignment with a national vision and supporting objectives.

2. Our Vision

2.2 Our vision for Renfrewshire

Everyone's business

Renfrewshire will be a place where people live and die well

- We shall support and enable communities and individuals to help each other through declining health and ensure the best supportive care throughout their illness and end of life.
- We will harness the compassion and capability in our population to support our aim.
- We shall continue to care for their families and carers into bereavement.
- We recognise this is a population-wide aim and will address it as such. The Compassionate Communities Programme piloted in other areas in Scotland is one example of an approach aimed at harnessing support across entire communities.

Support for health and care staff

Our staff and volunteers will have reliable access to appropriate palliative care education and training and to the emotional wellbeing support they need

- Staff delivering care will be supported via learning and education opportunities
- To understand how best to make a significant difference to a person's wellbeing, even in the last months, weeks, days and hours of that person's life.
- Maintaining staff wellbeing and providing emotional support will be a key priority.
- We will work with partners across all sectors to understand needs and agree and develop delivery mechanisms and capacity.
- We recognise that this is a key area for increasing staff confidence, competence and wellbeing which will in turn support the delivery of high-quality care to those we serve.



Our Priorities

3. Our Priorities

Our priority areas for palliative and end of life care in Renfrewshire

Understanding local evidence and data

In Renfrewshire we will continue to build the evidence base for quality of care and service planning, commissioning and delivery. This will involve continuing to collect, analyse and report on data that shows current activity and we will complete research that helps us to understand the access to services that people need in that last year of life. We will commission a system-wide palliative care needs assessment during the life of this strategy that will allow us to evolve and improve in response to need.

Early identification and assessment of people who need care

In Renfrewshire, we aim to introduce a process and tools across GP practices that will support early identification and assessment of people who would benefit from a palliative approach to care. This will ensure those identified will have the opportunity to have a holistic needs assessment with a support/care plan. Support can then be delivered in various ways depending on the needs of the individual and drawing on the wide variety of services across the Partnership.

Integrated community care coordination

We will work to develop, roll out and sustain an integrated community palliative care multi-disciplinary team for people who would benefit from care coordination.

3. Our Priorities

Our priority areas for palliative and end of life care in Renfrewshire

Bereavement support

We will reflect on the recent pandemic and beyond to help us understand the demand and need for different types of bereavement support. We will make sure this informs service planning and commissioning. We will work in partnership with current and new providers of bereavement support to widen access and increase choice in bereavement care services available for adults and children/young people in Renfrewshire. This will ensure bereavement services are offered on an equitable basis across the area regardless of age, faith, belief or the location of death of the loved one.

Person centred discussions and care

At the end of this strategy, we will have a clear framework for the health and social care workforce that promotes person-centred discussions with people and families and which identifies and plans for resources to be available to support choice.

Anticipatory care planning

We will ensure that people and their families and carers have timely and focused conversations with appropriately skilled professionals to capture their goals and wishes, plan their care and agree the support they may need toward the end of life.

As reflected in our strategic plan priority activities, we will aim to achieve year on year increases in our use of anticipatory care plans. The National Anticipatory Care Planning tool, and local adaptations, will be used to support this process and capture people's needs and preferences, but whatever format is used it must be able to be shared across services with the permission of the person it relates to.

<http://ihub.scot/anticipatory-care-planning-toolkit/>

3. Our Priorities

Our priority areas for palliative and end of life care in Renfrewshire

Education and Wellbeing

We will agree and deliver an educational and wellbeing plan that supports all staff providing palliative and end of life care in Renfrewshire.

Accessible information for improved transitions

We will work to understand options that are available to improve the accessibility of patient / client / service user information to health and care teams, currently impeded by the barriers between sectors and organisations. This will enable care planning needs and wishes to be understood and transitions of care to be seamless for people through the palliative period and towards the end of their lives.

Supporting policy

The plan will not be used in isolation but as part of a suite of material aimed at engaging people in their care and improving quality of life and wellbeing. This includes for example:

- Scottish Government's third Dementia Strategy which is expected to be updated in 2022 (<http://www.gov.scot/Publications/2017/06/7735/downloads>)
- Realising Realistic Medicine (<http://www.gov.scot/Resource/0051/00514513.pdf>)
- The Carers Act 2016 (<http://www.legislation.gov.uk/asp/2016/9/contents/enacted>)
- HSCP's Carer Strategy www.renfrewshire.hscp.scot/CarersStrategy .
- NHS Recovery Plan 2021-2026 [NHS recovery plan - gov.scot \(www.gov.scot\)](http://www.gov.scot)

3. Our Priorities

Our priority areas for palliative and end of life care in Renfrewshire

National Health and Social Care Delivery Plan

The Palliative & End of Life Care Plan will align with the aims set out in the Scottish Government's Health & Social Care Delivery Plan (<http://www.gov.scot/Resource/0051/00511950.pdf>), in particular the aim that (originally planned by 2021) everyone who needs palliative end of life care will have access to care that meets their individual needs and that "all who would benefit from a Key Information Summary (KIS) will receive one". The plan also indicates that people will receive more sensitive end of life care with the aim of supporting them in the setting that they wish. These objectives remain hugely important five years on from the publication of the delivery plan.

Supporting and working with our colleagues in NHSGGC, charities and the independent sector to develop a framework for identifying and resourcing the needs of those with life shortening/limiting illness will be vital for success of the wider strategy.

Effective use of people and resources

Renfrewshire HSCP will aim to maximise the impact of palliative and end of life care in Renfrewshire through the most effective use of our people and resources. This will support us to develop a coherent and connected approach to the provision of good palliative and end of life care by:

- Working with ACCORD and St Vincent's Hospices in the provision of care, using their specialist expertise to take forward new and innovative approaches to delivering palliative care in the community.
- Developing our relationship with charities and independent organisations in the planning and delivery of effective and sustainable service provision

By doing so, we will endeavour to meet patient preferences that may reduce the numbers of people who die in acute hospital settings and/or reduce the number of days people spend in hospital in the last 6 months of life.



Our Actions – How will we do this?

4. Our Actions – “How will we do this?”

Our identified action themes to deliver on our priorities

1.

Development of people that support and provide palliative and end of life care.

2.

Establishing our Palliative Care Planning Group leadership and governance.

3.

Supporting children and young adults.

4.

Strengthening collaborative working to improve people’s pathways through services.

5.

Enhancing and embedding Anticipatory Care Planning.

6.

Understanding and improving people’s experiences of palliative and end of life care.

7.

Public health approach to palliative and end of life care.

8.

Ensuring best practice and quality service provision.

4. Our Actions – “How will we do this?”

Our identified actions to deliver on our priorities

Theme 1: Development of people that support and provide palliative and end of life care

To improve outcomes for people who would benefit from a palliative approach to care we will work with our workforce and our partners to identify learning and education needs. We will use the NHS Education Scotland National Palliative Care Educational Framework "[Enriching & Improving Experience](#)" achieve a consistent approach.

To do this we will:

- Consider the education, training and support needs of families, carers and communities of people who need palliative care. Aim to ensure they feel sufficiently enabled to provide the best possible support and care.
- Understand the increased need for emotional support for families and carers following the pandemic, utilising the rich and informative feedback we have received through our consultation. We will ensure the Carers Centre is represented on our Care Planning Group and we work towards establishing a lived and living experience forum where families and carers have a voice.
- Continue to support ACCORD Hospice and St Vincent’s Hospice in delivering palliative and end of life care training to Health and Social Care staff who work in community settings. The scope of this will be widened with the utilisation of ECHO.
- Consider the workforce and financial implications of meeting the increasing demand for palliative and end of life care in community settings, and work with partners to maximise resource utilisation while identifying future funding opportunities. This will need to link to the HSCP’s Workforce Strategy 2022-25 and to the Scottish Government’s National HSC Workforce Plan.
- Consider the psychosocial and health impact on everyone who works with and supports the very ill, the dying and the bereaved on a daily basis and explore ways of supporting them, aiming to alleviate work related stress and increase their resilience. Ensure the increased emotional impact of the Covid-19 pandemic is considered and suitable support is provided through e.g.
 - Clinical debrief sessions
 - Clinical and management supervision
 - Utilising National and local health and wellbeing resources including the National Wellbeing Hub.

4. Our Actions – “How will we do this?”

Our identified actions to deliver on our priorities

Theme 2: Establishing Our Palliative Care Planning Group Leadership and Governance

Renfrewshire HSCP has tasked us – the Palliative Care Planning Group - with implementing the Plan and ensuring implementation reflects an understanding of specific population needs in relation to palliative and end of life care.

To do this we will:

- Ensure our Palliative Care Planning Group includes a full range of partners, including e.g. Improving the Cancer Journey (ICJ), Hospices, charities and private care providers, Health & Social Care staff across all services, and Carer services or organisations. We will bring the voice of service users and families into the group.
- Ensure the outputs and outcomes from the group are able to influence the HSCP’s Senior Management Team and Integrated Joint Board and are shared with the wider palliative care community via the HSCP’s website and the NHSGGC palliative care website.
- Continually review data sources and agree a suite of measures that can be used to determine the impact of the strategy over its lifespan. This will include provision for ongoing monitoring and development of measures including new initiatives such as Excellence in Care.
- Continue to be closely aligned with the wider Glasgow and Clyde Palliative Care Network which will provide a platform for shared communication and learning.
- Continue to work with Scottish Government departments and related bodies to share practice innovation and to refine reporting and feedback mechanisms to give greater clarity on the impact of good palliative care e.g.
 - Emerging National Palliative Care Network and new Clinical Lead once appointed
 - HIS frailty collaborative
 - HIS collaborative testing approaches to meet Commitment 1 of the Strategic Framework for Action
 - Working with NES to influence national approaches to Confirmation of Death.

4. Our Actions – “How will we do this?”

Our identified actions to deliver on our priorities

Theme 3: Supporting children and young people who require palliative care

To do this we will:

- Work in partnership with individuals and organisations to develop and implement reliable systems that allow the voices of children and young people to shape and influence care and service provision in Renfrewshire and to develop a more detailed understanding of the availability of palliative care services for them.
- This will complement the work undertaken for adult services. It will involve work with HSCP children’s services staff, children’s hospice representatives, paediatric/acute hospital services and charity and private care providers.
- Children and Young People who have life limiting conditions or have a terminal diagnosis, along with their families and carers, will be known to Renfrewshire HSCP Specialist Children’s Services. The services include Community Paediatric Nurses, Occupational Therapist, Physiotherapists, Speech and Language Therapist and Community Paediatricians, who will work in partnership with colleagues from Royal Hospital for Sick Children and the child’s GP. Support may also include services being provided by the Children’s Hospice, Rachel House base in Balloch.
- Recognising each individual child is unique, they will have an individualised care plan, which is developed in partnership with them and their families and carers. This will detail how their individual needs will be met, anticipatory care planning making sure their hopes and wishes for end of life care are known and clearly communicated to key members of the care team. The care team will offer bereavement support to the family following the loss of their child.

4. Our Actions – “How will we do this?”

Our identified actions to deliver on our priorities

Theme 4: Strengthening collaborative working to improve people’s pathways through services

To do this we will:

- Outline the pathways between general and specialist palliative care and end of life care. We will ensure these are clearly communicated at a local level and understood by those requiring or delivering services.
- Develop a greater understanding of the palliative care and palliative service needs of people with progressive terminal illnesses that shorten life like Motor Neurone Disease. We will then agree clearer pathways for people across Renfrewshire.
- Develop our relationships with all partners in these pathways to ensure care delivery is seamless for the people we serve.
- Aim to ensure effective and timely transitions between places of care with particular emphasis on the involvement of families and carers in planning care, and the provision of appropriate patient information at the point of discharge.
- Improve collaborative and seamless ways of working between services by implementing more fluid means of sharing patient information, data and care plans. Aim to ensure this improves people’s care pathways and helps to direct their treatment and care.

4. Our Actions – “How will we do this?”

Our identified actions to deliver on our priorities

Theme 5: Enhancing and embedding anticipatory care planning

Anticipatory care planning (ACP) is a priority for all HSCPs.

To do this we will:

- Work with staff groups across all sectors to promote planning conversations that can be recorded in the most appropriate shareable format. This will support our strategic plan priority to achieve year on year increases in our use of Anticipatory Care Plans.
- Work with primary care governance groups to enhance the quality of ACP and the number of people with an electronic key information summary (eKIS). Ensuring wider completion and accessibility of ACP and eKIS information across all MDT teams and services.
- Work to embed Anticipatory Care approaches, using National ACP documentation where appropriate. We will ensure staff are equipped to take a holistic approach to facilitating conversations about an uncertain future, including:
 - The potential benefits or side effects of various care and treatment options
 - Concerns about social aspects of life i.e., isolation and loneliness
 - Financial concerns
 - ‘Red Bag’ scheme for care home residents.

4. Our Actions – “How will we do this?”

Our identified actions to deliver on our priorities

Theme 6: Understanding and improving people’s experiences of palliative and end of life care

We aim to ensure people’s experiences inform and shape everything that we do including how we deliver, plan and shape services.

To do this we will:

- Ensure the views and experiences shared with us through our Strategy consultation is used to inform our future work to improve service delivery.

“Social care staff excelling in promoting a good death experience involving all relevant parties.”

“We went through an emotional journey beyond what we could have imagined, my husbands wishes that he was with his family and didn’t want to die alone in hospital and being able to do this gave me comfort after he passed away”

- Establish in collaboration with patients, carers and carer groups, an ongoing feedback mechanism that informs the HSCP about people’s experiences and areas where further development might be required. This could include feedback on the care provided or the impact on family/carer wellbeing.
- It will also consider ways in which to reflect on examples where things worked well and to understand and learn from what did not. This includes feedback and reflection on the experience of people who have passed away and ensuring this is a reflective exercise which is shared across services. Validated tools will be used where possible and direction will be sought from key national reports including the ‘Trees that Bend in the Wind report’ by Scottish Care.

4. Our Actions – “How will we do this?”

Our identified actions to deliver on our priorities

Theme 7: Public health approach to palliative and end of life care

To do this we will:

- Continue to promote the wider public health messages around palliative care, with the HSCP and partners supporting initiatives such as ‘Big Conversation’ and ‘Palliative Care is Everyone’s Business’.
- Introduce the Compassionate Community model to maximise the capacity and capability of the people in Renfrewshire’s communities that is available to support people to live and die well at the end of their lives.
- Improve access to information for people requiring palliative care and their carers and families. This will include online and written information and will cover medical/clinical issues as well as non-medical issues such as Power of Attorney and financial advice.
- Work within locality groups to ensure that service provision is equitable and consideration is given to identifying and engaging with harder to reach groups, including e.g. ethnic minorities, people with a learning disability and the homeless.
- Aim to provide agreement on a common language used within palliative care to ensure all staff within all partner organisations, patients and their families are clear what we mean when palliative and end of life care discussions occur. This will be supported by means of written material.

4. Our Actions – “How will we do this?”

Our identified actions to deliver on our priorities

Theme 8: Ensuring best practice and quality service provision

To do this we will:

- Work in partnership with Equipu to monitor the provision of equipment to people with palliative care needs. This will include:
 - identification of commonly used equipment
 - planning of future provision
 - ongoing review of service response particularly to those who require items urgently.
- Explore advances in telecare and telehealth for people with palliative and end of life care needs to enhance monitoring and safety within the community.
- Continue work and development within Local Authority and private provider Care Homes with the implementation of the Supportive Palliative Action Register. This will allow Care Homes to identify residents who are deteriorating and to be supported to assess and manage their care appropriately.
- Continue to roll out and engage with GP Practices to identify patients who have palliative care needs. The aim is to provide access to all to the Community Palliative and Supportive Care MDT to ensure all who would benefit from care coordination have access to it.
- Work towards ensuring best practice around the prescribing, administering, and prompting of medications used in palliative and end of life care in all care settings.
- Continue to learn and build on innovative new ways of working which have been implemented in and around palliative and end of life care services during the pandemic. This includes utilising more flexible, community-based working to provide people with care in the settings most comfortable to them.
- Continue to develop and utilise enhanced digital capabilities for communication and education purposes.



Monitoring and Evaluating our Progress

5. Monitoring and Evaluating our Progress

Measuring the impact of our Plan

Measuring the impact of our Plan

- Each year of the Strategy our Palliative Care Planning Group will produce a yearly action plan that outlines our priority actions aligned to the local and national themes that these relate to. The Palliative Care Planning Group will take forward the action plan for implementation, ensuring our commitments are delivered upon and our objectives are met.
- We will look to continually review data sources and agree a suite of measures that can be used to determine the impact of the strategy over its three-year lifespan. This will include provision for ongoing monitoring and development of measures including new initiatives such as Excellence in Care.
- The Palliative Care Planning Group sits within the HSCP's care planning governance structure and will report on the priority activities relating to palliative care within the HSCP's Strategic Plan. This ensures performance against agreed local and national performance indicators are monitored and reported on.

Related Renfrewshire HSCP Strategic Plan Objectives

In Renfrewshire, palliative care is everybody's business. We will deliver Renfrewshire's updated Palliative Care and End of Life Care Strategy in partnership, with a particular focus on (i) improving access for all; (ii) improving pathways between services; and (iii) providing training and information across services to broaden understanding of generalist and specialist forms of palliative and end of life care. We will do this with the aim of meeting the emotional support needs of families and unpaid carers and supporting the wellbeing of staff.

Anticipatory Care Planning (ACP) is a priority. We will work with staff groups across all sectors to promote planning conversations that can be recorded in a shareable format via clinical portal, supported by staff attending training to have the competence and skill to have sensitive discussions with patients. This will also contribute to our objective to achieve year on year increases in our use of Anticipatory Care Plans that are reflective of people's individual wishes, inclusive of times where the individual does not wish to have this conversation. We will work with primary care governance groups to enhance the quality of Anticipatory Care Planning and increase the number of people with an eKIS (electronic key information summary).



Appendices

Appendix 1 – Our Year One 2022-2023 Action Plan

Our identified actions for year one of the Strategy

This action plan identifies specific high level action areas that will support the delivery of the Palliative and End of Life Care Strategy and our vision for Renfrewshire. The Palliative Care Planning Group will be responsible for ensuring these are delivered upon. The plan will be formally reviewed and updated twice per year for the duration of the strategy. The detailed year one actions will help to inform priority actions for years two and three.

Theme	Year 1 Action	To inform years 2 & 3
Development of people that support and provide palliative and end of life care	Continue to identify the education, training and support needs of our workforce, including appropriate sufficient health and wellbeing support, building on the significant work already completed.	Identified gaps from year 1 to inform workforce implications and commissioning needs.
Establishing leadership and governance of our Palliative Care Planning Group	Continue to review and enhance the governance structure of the Palliative Care Planning Group, ensuring appropriate representation of partners, service users and families. Include and engage further with the voices of children and young people and hard to reach groups including ethnic minority communities.	Frequent review of the CPG and its impact. Evidence of service user input influencing service provision and planning.
	Implement the Palliative and End of Life Care Strategy and action plan.	Informing a longer-term year 2 and 3 workplan to be developed in 2023.

Appendix 1 – Our Year One 2022-2023 Action Plan

Our identified actions for year one of the Strategy

Theme	Year 1 Action	To inform years 2 & 3
<p>Identifying best practice and Learning to improve people's pathways through services</p>	<p>Map existing palliative care pathways in Renfrewshire to establish and understand what is currently in place, including the following:</p> <ul style="list-style-type: none"> • Consider the efficiency of respite beds for patients and carers living and dealing with a life limiting illness. • Look to identify and evaluate health inequalities prevalent in Renfrewshire, and related disparities in access to our services. • Continue to roll out and engage with GP Practices to identify patients who have palliative care needs. • Consider as a priority the pathways and interfaces between Primary, Secondary and Community care. 	<p>Develop our pathways based on the mapping exercise completed in year 1.</p>
	<p>Complete a needs analysis desktop exercise to ascertain existing issues and gaps in access and provision of people's needs. This will help to inform people's preferences to care and provide a shared understanding of equalities. This will also include current provision of Palliative Care for children in Renfrewshire.</p>	<p>Year 1 analysis will help to inform specific areas of work to resolve existing issues and gaps in access and provision.</p>

Appendix 1 – Our Year One 2022-2023 Action Plan

Our identified actions for year one of the Strategy

Theme	Year 1 Action	To inform years 2 & 3
Public health approach to palliative and end of life care	Introduce the Compassionate Community model to maximise the capacity and capability of the people available in Renfrewshire’s communities to support people to live and die well at the end of their lives.	
		Utilise the year 1 work around pathways and feedback mechanisms to inform the improvement of access to information for people requiring palliative care and their carers and families. This will include online and written information and will cover medical/clinical issues as well as non-medical issues such as Power of Attorney and financial.
	Aim to provide agreement on a common language used within palliative care to ensure all staff within partner organisations, patients and their families are clear what we mean when palliative and end of life care discussions occur.	

Appendix 1 – Our Year One 2022-2023 Action Plan

Our identified actions for year one of the Strategy

Theme	Year 1 Action	To inform years 2 & 3
Enhancing and Embedding anticipatory care planning	Continue to work with staff groups to promote planning conversations that can be recorded in a shareable format, supported by staff attending training to have the competence and skills to have sensitive discussions with patients.	
	Identify and develop a mechanism for recording and measuring the quality and impact of Anticipatory Care Planning.	Improved recording and measuring to inform the quality of ACP and areas for potential improvement.
	Continue to work with Primary Care governance groups to enhance the quality of Anticipatory Care Planning and increase the number of people with an eKIS.	