GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS
in Greater Manchester

DRAFT

Greater Manchester Commitments to Individuals with Palliative Care needs approaching or within the Last Year of Life -

What an individual with Palliative and End of Life Care needs should expect across Greater Manchester

NHS
Greater Manchester
and Eastern Cheshire
Strategic Clinical Networks

1 Identify

If I am likely to be approaching or within the last year of life, health care professionals will recognise this where possible and discuss it with me and those important to me if this is my choice.

Individuals likely to be approaching or within the last year of life should be identified and offered the opportunity to discuss this with an appropriate care provider. Those important to the individual should be included in this discussion, if the individual wants this. Some individuals may be identified with advancing/ progressive diseases or deteriorating with incurable illnesses who may not be in the last year of life, but could benefit from access to supportive care.

2 Assess

An assessment of all my needs will be made – physical, psychological, social, cultural and spiritual.

An holistic assessment of the individual's needs should be undertaken covering physical, psychological, social, cultural and spiritual needs.

3 Plan care

My care will be planned with me and those important to me in a sensitive way. I will be asked about my wishes for future care and an advance care plan will be written, if I want it.

A person centred plan of care, including consideration of advance care planning, should be formulated and agreed with the individual by professionals skilled in communication.

4 Communicate and coordinate

All professionals and services involved in my care, planned or in a crisis, will be able to access the information about me and my conditions electronically, should I choose to give my consent.

All relevant professionals, including those involved in crisis care, should be able to share, read and update electronic records of care plans and advance care plans.

5 Deliver care

I will receive appropriate physical, psychological, social and cultural spiritual care in a timely manner, in the setting of my choice with all the relevant co-ordinated agencies informed of my needs.

Physical, psychological, social and spiritual care should be delivered in the right setting, at the right time for the individual, ensuring all appropriate equipment and relevant co-ordinated agencies are involved.

6 Support carers

My unpaid/informal carers will be identified and offered a carers assessment to appropriately support their needs.

Unpaid/informal carers should be identified, offered a carer’s assessment and their identified needs be considered and supported

7 Review Proactive Care

My care will be reviewed on a regular basis, and the necessary adjustments made to plans when my condition changes.

Individuals should be reviewed regularly to ensure the care being delivered is appropriate and adjustments are made as required, according to the individual's changing condition.

8 Review – Reactive Urgent Care

I will have a named professional who will be my main point of contact and they will inform me of who to contact in a time of crisis or need. My plan of care to support my palliative and end of life care needs will be available to those who require it routinely and in a time of crisis.

Individuals will know who to contact in case of crisis, have plans already in place, where possible, and will receive responsive palliative and end of life care linked to their urgent care needs.

9 Identify dying

If I am likely to die in the coming days, health and care professionals will recognise this and, if I want, discuss it with me and those important to me.

Individuals who are likely to die in the coming days should be diagnosed as dying, reversible causes treated if appropriate and in accordance with the individual's wishes, and this should be discussed with the individual and those important to them.

10 Plan of care for the last days of life

When I am dying, I will be cared for well - physically, psychologically, socially, culturally and spiritually - in accordance with my wishes.

Individuals in the last days of life should be cared for in accordance with their wishes and supported by an holistic plan of care for the last days of life, tailored to that individual.

11 Care after death

When I die, and in the hours after, I and those important to me will be cared for and supported according to our wishes.

Individuals who have died, and those important to them, should be cared for in a sensitive and culturally appropriate way.

12 Bereavement support

Those who are important to me will receive bereavement support in the days, weeks, months and years after my death, if it is required.

Those important to the individual should have access to appropriate bereavement support and be referred on or signposted as necessary.

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System enabling commitments to support individuals approaching or within the Last Year of Life -

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1 System requirements

I should have timely access to Specialists trained in Palliative and End of Life Care across all settings if I need their support, advice and care.

Specialist Palliative Care Services

- Specialist palliative Care services should be available for face to face contact seven days a week and advice should be available 24 hours a day
- In patient specialist palliative care provision should be available to those requiring it, with admissions seven days a week. Provision should be sustainable and equitable

2 Services

Systems are in place to ensure that I will receive the right care, at the right time, delivered by a skilled workforce

Services should be available, accessible and responsive so that individuals can access appropriate services including:

- Adequate provision of coordinated services, which are able to communicate effectively
- A workforce which is appropriately trained

3 The community

I live within a community that talks about death and dying and supports me, and those close to me, as I deteriorate and die in that community.

The community should be engaged in discussing death and dying and encourage voluntary participation to support those dying in their community.

4 Evaluation

I am able to participate in research and studies to benefit my own and others care, if I wish.

A culture of innovation, evaluation and outcome measurement as well as research should be developed to underpin evidence based, effective and cost efficient service provision and delivery.