Lunch & Learn

NHS
North East & Yorkshire
Palliative and End of Life Care Strategic Clinical Network

## Wed. 19 October 2022 12.30-1.30

# Topic: ICB Statutory Guidance PEoL, Commissioning and contracting approaches PEoL, national service specifications PEoL adults and children.

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NHSE National Programme Director Palliative and End of Life care

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# Palliative and End of Life Care Sustainability

Overview of the approach

# National update

- National update and priorities
- Going further faster for winter
- Fuller stocktake and implementation
- Government Health priorities
- Health and Care Act (2022) update
- Moving to a new NHS England
- Programme risks and issues

# Palliative and End of Life Care

## What this should look like for people?

01 Each person is seen as an individual

02 Each person gets fair access to care

03 Maximising comfort and wellbeing

04 Care is coordinated

05 All staff are prepared to care

06 Each community is prepared to help

*"I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s)."*

# Universal Palliative and End of Life Care

## Interventions

### Personalised Approaches

Shared decision making; identification of people likely to be in their last year of life; personalised care and support planning; social prescribing, self management; personal health budgets; compassionate communities, including wellbeing interventions and bereavement support.

### Specialist (plus targeted and universal)

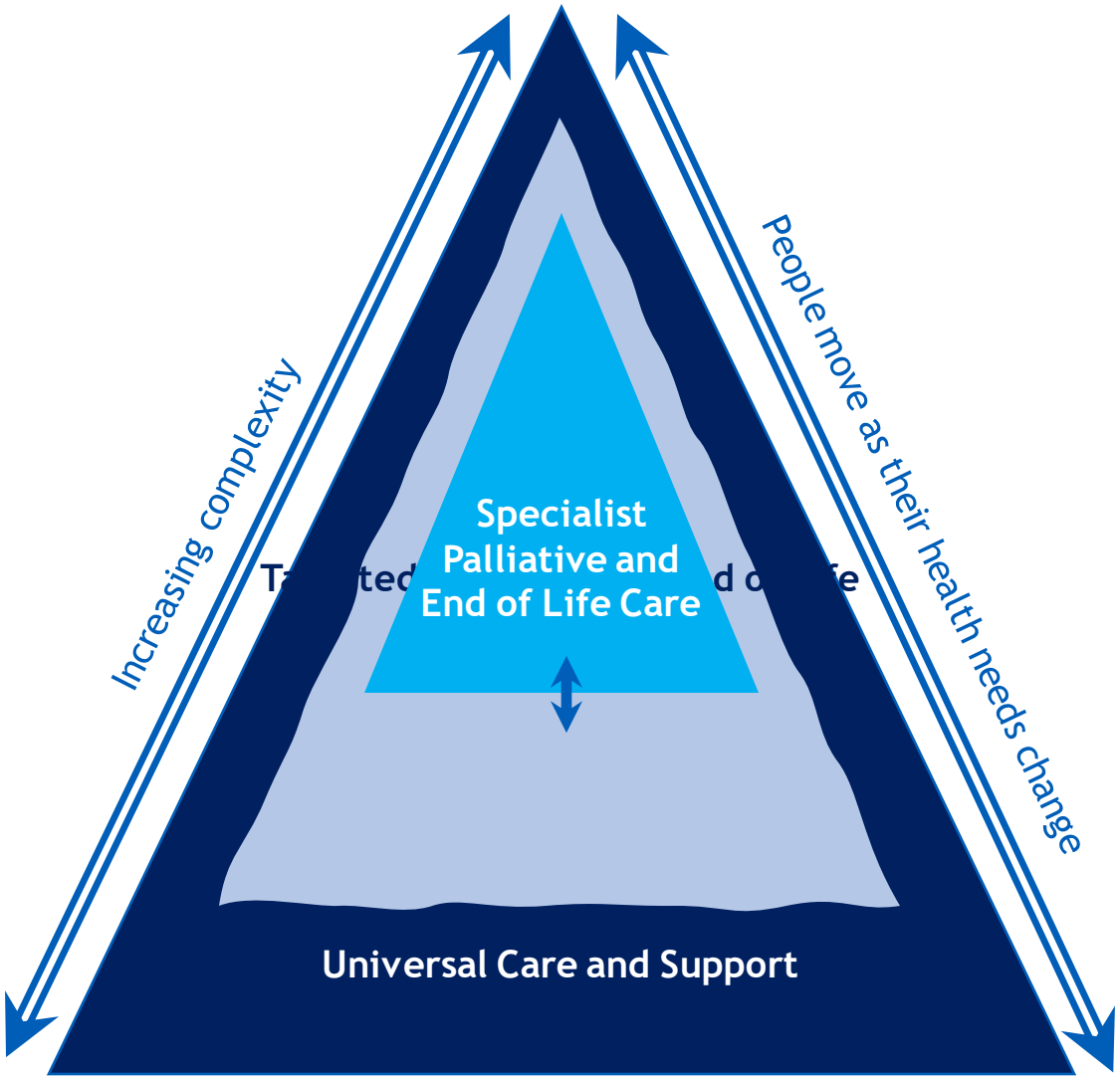
Tertiary or specialist palliative care services in hospices, community and hospital: 24/7 advice or care, complex symptom management and specialist equipment

### Targeted (plus universal)

Non-specialist palliative care delivered in hospitals; hospice at home, respite care and hospice day services (may be generalist and/or specialist level)

### Universal

Non-specialist palliative care delivered by primary, community, acute and urgent care services




## Outcomes

*I am treated with dignity and respect*

*I have a personalised care and support plan that records my preferences, wants and needs*

*My pain and symptoms are proactively managed*

*I am seen as an individual*

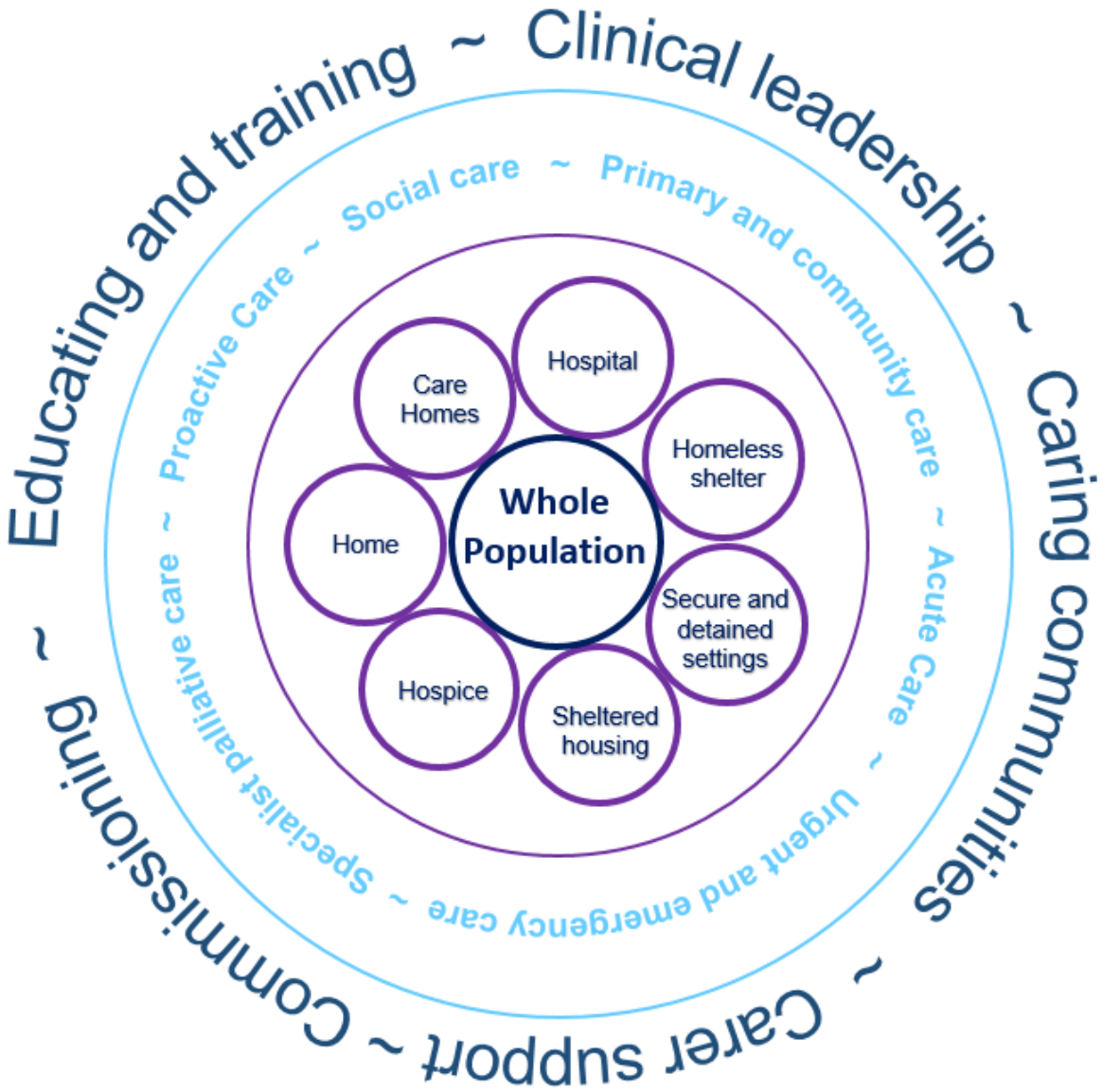
*I have fair access to care*

*My care is coordinated and seamless*

*I can expect my carer/family have their needs recognised and are given the support they need*

**Living and dying well**

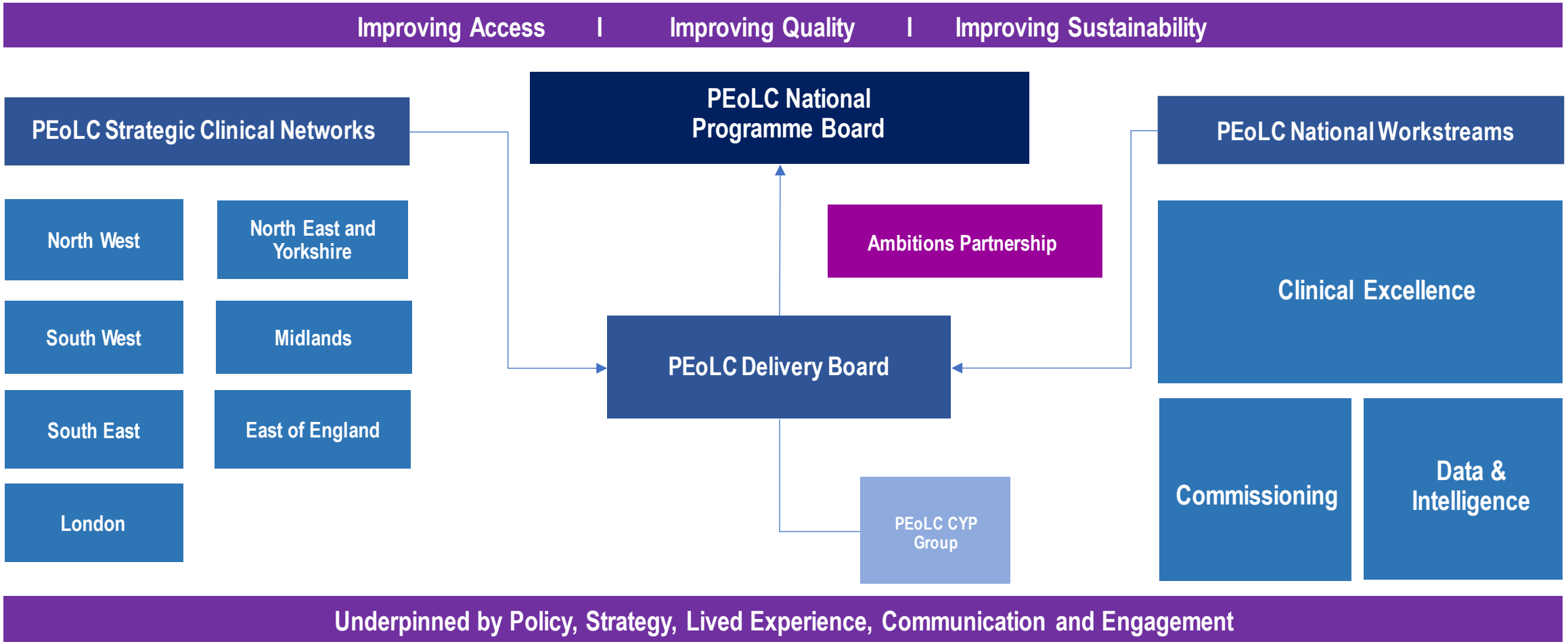
# PEoLC Population Approach




- All settings
- Services

# National PEoLC Structure

***High Quality Personalised PEoLC for All in All settings***



# PEoLC Delivery Plan

## Our NHSE contribution into transforming PEoLC

| Priority | Outcomes |
|---|---|
| **1. Improving Access** | 1.1. People are identified as likely to be in the last 12 months of life and are offered personalised care and support planning<br><br>1.2. Staff, patients and carers can access the care and advice they need, whatever time of day<br><br>1.3. Equitable access to PEoLC for all, focussing on locally identified under-served populations |
| **2. Improving Quality** | 2.1. High quality palliative and end of life care for all, irrespective of condition or diagnosis<br><br>2.2. A confident workforce with the knowledge, skills and capability to deliver high quality PEoLC<br><br>2.3. High quality PEoLC across all systems |
| **3. Improving Sustainability** | 3.1 PEoLC is sustainably commissioned<br><br>3.2 The PEoLC workforce is fit-for-purpose, now and in the future<br><br>3.3. Personalised and community focused approaches are fundamental to improving the PEOLC experience |

# PEoLC Delivery Plan

## Our NHSE contribution into transforming PEoLC

| Priority | Outcomes | Outputs and Measures 2024/25 |
|---|---|---|
| **1. Improving Access** | 1.1. People are identified as likely to be in the last 12 months of life and are offered personalised care and support planning<br><br>1.2. Staff, patients and carers can access the care and advice they need, whatever time of day<br><br>1.3. Equitable access to PEoLC for all, focussing on locally identified under-served populations | 1.1. There will be X% increase in those identified and X% of people offered PCSP compared to baseline<br><br>1.2.1. Phase 1: 24/7 generalist PEoLC services provided across all regions<br><br>1.2.2. Phase 1: 24/7 remote access to specialist palliative care advice for staff and carers provided across all regions<br><br>1.2.3. Phase 2: 7-day face to face specialist palliative care services provided across all regions<br><br>1.3.1. PEoLC SCNs can evidence improved access for locally identified under-served populations from a baseline. |
| **2. Improving Quality** | 2.1. High quality palliative and end of life care for all, irrespective of condition or diagnosis<br><br>2.2. A confident workforce with the knowledge, skills and capability to deliver high quality PEoLC<br><br>2.3. High quality PEoLC across all systems | 2.1 PEoLC SCNs can evidence improved quality for locally identified priority groups from a baseline<br><br>2.2.1 PEoLC SCNs can evidence improved staff confidence, knowledge and skills in PEOLC from a baseline<br><br>2.3.1 X% of acute settings rated as good or outstanding in all domains<br><br>2.3.2 0% of acute settings rated as inadequate<br><br>2.3.3 PEoLC SCNs can evidence improved patient/carer experience from a baseline. |
| **3. Improving Sustainability** | 3.1 PEoLC is sustainably commissioned<br><br>3.2 The PEoLC workforce is fit-for-purpose, now and in the future<br><br>3.3. Personalised and community focused approaches are fundamental to improving the PEOLC experience | 3.1 Framework for best practice commissioning and funding for PEoLC embedded in at least 50% of ICSs in each region<br><br>3.2. Each ICS has a workforce plan for PEoLC and demonstrates year on year improvement<br><br>3.3.1 X% increase in referrals to social prescribing for PEoLC from baseline within each PCN<br><br>3.3.2 Each PCN has an identified social prescribing lead for PEoLC<br><br>3.3.3 ICSs evidence improved patient experience in personalised and community focused approaches to PEOLC |

# Changing Commissioning Landscape

- NHS Reforms, shifting to provider led model
- Risks
- Opportunities
- Mitigations

# Handbook for the Statutory Guidance

Chapters focussed on the Ambitions Framework:

- Identification and personalised care and support planning
- Shared care records
- Evidence and information
- Involving, supporting and caring for those important to the person
- Workforce, education and training
- 24/7 access
- Co-production
- Leadership
- Integration, quality and sustainability

**Additional resources in Palliative Care Network FutureNHS repository**

# Commissioning & Investment Framework

- Who Pays guide
- Co-produced
- Not mandatory but recommendations agreed by system leader representatives
- Likely to take time to implement
- Not provider specific
- Support ICBs as they examine commissioning arrangements for PEoLC (to meet new legal duties)

AIM: To classify palliative and end of life key services into commissioning categories with the intention of simplifying the process of agreeing commissioning responsibilities at a local level, and as a result, progress service transformation to improve access, quality, and sustainability of PEoLC services.

# Commissioning & Investment Framework

| | |
|---|---|
| Core | • Form the majority of services. They are key activities that should be commissioned and funded by ICBs, local authorities or a combination of both. |
| Specialist | • The needs of this group cannot be met by core services alone. This care requires a workforce with specialist skills and experience. They should be commissioned and funded by ICBs, local authorities or a combination of both. |
| Enhanced | • These are services which provide support to patients with PEoLC needs, and their families and carers, which are neither health nor social care. They are most frequently funded by charities and not commissioned by the NHS nor local authorities. |

# Service Specifications

- Adult and CYP
- Based on ambitions framework and NICE guidance
- Co-produced
- Intention is that they are varied locally and specific activities are extracted for each individual arrangement – unlikely the full spec will be provided by a single provider
- To be published on NHS public webpages early summer

# The PEoLC Funding Guidance

Aims to:

- **Provide guidance on achieving a fair and sustainable funding model**

Predominantly aimed at ICBs – partnership approach absolutely vital

The vision:

- There is likely to be a mixture of approaches, but where partnerships and maturity of systems allow, the blended payment model will be introduced
- Shared efficiencies and closer integrated working
- Informal grants with the charitable providers will likely disappear as more robust arrangements are put into place
- Provider-led partnerships will strengthen the voice of hospices and ensure that, in exchange for improved accountability and intelligence, hospices will have opportunities to increase the funding they receive for services which are core or specialist
- ICBs will have an increasing blended payment approach as tariff systems disappear
- Patients may exercise choice using indicative personal budgets. Specific care provided will be paid for within clear structures that uphold quality standards and renumerate core or specialist PEoLC activity at fair prices
- SCNs may lead with delegated authority to manage change, or they will be active partners around the table of an engaged ICB board.

# Next steps and considerations

- Strengthening partnership
- D is for …..
- Aligning and streamlining
- Opportunity to diversify
- Any questions?