Palliative & End of Life Care Delivery Group +

The Studio Glasgow, 8th November 2018

Michelle Church, Improvement Advisor
Living Well in Communities, iHub
Healthcare Improvement Scotland

Enabling health and
social care improvement

WiFi:
Twitter: @LWiC_QI #peolcdg

Are you sitting comfortably?

- Website: Menti.com
- Code: 99 85 95
- How is the temperature in the room?
- Where have you travelled from today?

Who’s here today?

Healthcare Improvement Scotland | ihub
Enabling health and social care improvement

The Scottish Government

MACMILLAN CANCER SUPPORT

NHS Lothian

East Ayrshire COUNCIL

NHS Ayrshire & Arran

Alzheimer Scotland
Action on Dementia

Glasgow CITY COUNCIL

Scottish Social Services Council

NHS Greater Glasgow and Clyde

Marie Curie
Care and support through terminal illness

RAMH
recovery across mental health

NHS Fife

NHS Tayside

Renfrewshire Health & Social Care Partnership

EAST AYRSHIRE Health & Social Care Partnership

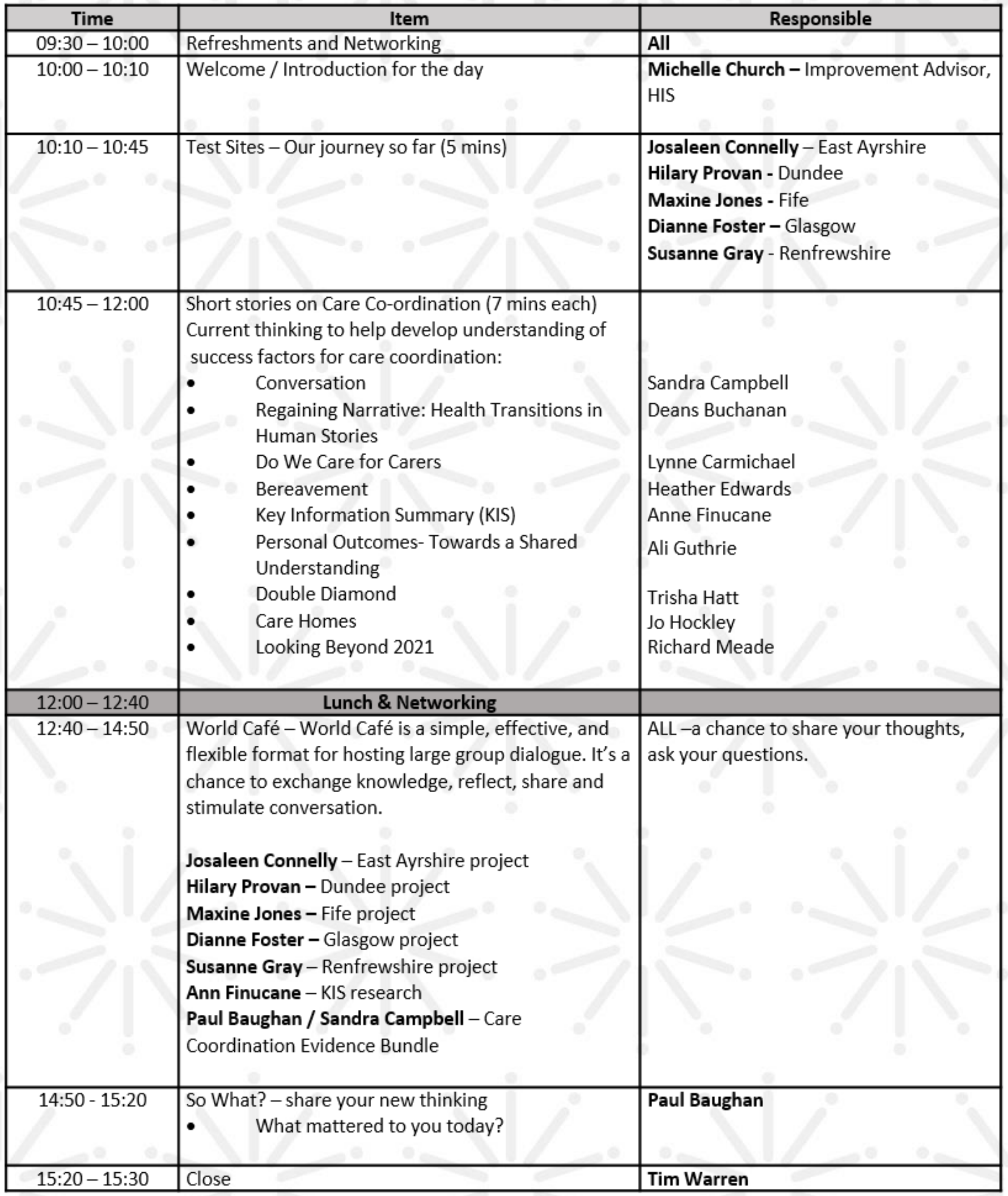
University of Glasgow

University of Dundee

Today – Focus on Care Coordination

- Gain an understanding of what is going on in the test sites
- Current thinking on care coordination to develop an understanding of factors for success
- Knowledge exchange: Reflect, share and stimulate conversation that will mobilise change ideas.

Agenda:



Time	Item	Responsible
09:30 – 10:00	Refreshments and Networking	**All**
10:00 – 10:10	Welcome / Introduction for the day	**Michelle Church –** Improvement Advisor, HIS
10:10 – 10:45	Test Sites – Our journey so far (5 mins)	**Josaleen Connelly** – East Ayrshire **Hilary Provan -** Dundee **Maxine Jones -** Fife **Dianne Foster –** Glasgow **Susanne Gray** - Renfrewshire
10:45 – 12:00	Short stories on Care Co-ordination (7 mins each) Current thinking to help develop understanding of success factors for care coordination:	
	• Conversation	Sandra Campbell
	• Regaining Narrative: Health Transitions in Human Stories	Deans Buchanan
	• Do We Care for Carers	Lynne Carmichael
	• Bereavement	Heather Edwards
	• Key Information Summary (KIS)	Anne Finucane
	• Personal Outcomes- Towards a Shared Understanding	Ali Guthrie
	• Double Diamond	Trisha Hatt
	• Care Homes	Jo Hockley
	• Looking Beyond 2021	Richard Meade
12:00 – 12:40	**Lunch & Networking**	
12:40 – 14:50	World Café – World Café is a simple, effective, and flexible format for hosting large group dialogue. It's a chance to exchange knowledge, reflect, share and stimulate conversation. **Josaleen Connelly** – East Ayrshire project **Hilary Provan –** Dundee project **Maxine Jones –** Fife project **Dianne Foster –** Glasgow project **Susanne Gray** – Renfrewshire project **Ann Finucane** – KIS research **Paul Baughan / Sandra Campbell** – Care Coordination Evidence Bundle	ALL –a chance to share your thoughts, ask your questions.
14:50 - 15:20	So What? – share your new thinking • What mattered to you today?	**Paul Baughan**
15:20 – 15:30	Close	**Tim Warren**

Living Well in Communities

IMPROVEMENT SUCCESS! (?)

Michelle Church, Improvement Advisor

Plan
Do
Study
Act

Courage

Curiosity

Resilience

Determination

What’s success?

- Safe space
- Courageous thinking
- Become your leader

Test site journey’s on care co-ordination so far…..

Josaleen Connolly – East Ayrshire
Hilary Provan - Dundee
Maxine Jones - Fife
Carol Ann Duffy – Glasgow
Susanne Gray - Renfrewshire

East Ayrshire - Josaleen Connolly

Palliative care bed in a care home setting

Identifying COPD for palliative care

ACP in the community

MAGICE Model

MAGICE Model – getting palliative care right every time

EAST AYRSHIRE
Health & Social Care
Partnership

NHS
Ayrshire
& Arran

M Mindful that good quality palliative care needs
A Assessment and
G Great conversations that are
I Important to identify people early so that they have a
C Care plan and know how to communicate with their care co-ordinator to
E Enable excellence in end of life care & support in bereavement

Holistic Assessment & early identification

- Use SPICT to identify people with palliative care needs
- Assess assets already in place and what matters now
- Initiate ACP conversation
- Assess main carer needs
- Consider Realistic Medicine
- Prepare and plan for future changes
- Communicate all findings with all involved
- Early warning sent to services of changing needs

Communication & Information sharing with person and services involved

- Phone call to community team(s) involved – have knowledge of person's home situation- follow up with written information
- All teams involved need to know diagnosis/prognosis, current situation, person's preferences for care & their closest family understanding
- Clear, concise and honest communication- acknowledge uncertainty
- Explain in full, care needed during admission/significant conversations
- Care services – need informed in full of current situation/prognosis
- Timely recognition – Consider person's preferred place of care
- Prompt assessment of environment / order of equipment
- Assess needs in the present and future
- Medicines- order in advance and send 5 day supply home

Recognise symptoms

- Engage in conversation with the person and those closest to them always
- Assess and review need & outcomes with the person /with their carer
- Use Scottish palliative care guidelines (booklet, app & web site)
- Provide person with access details for help 24/7
- Access specialist support for complex issues
- Plan for pain – analgesia available always
- Symptom management – Communicate handover to teams what's current & been tried and alternative suggestions for the future

Medicines

- Assess compliance and ability to take medicines orally
- Good medicine management – prioritise most important medicines.
- Proactively anticipate Just in case medicines needed – include pain relief.
- Involve community pharmacist
- Provide/ signpost to training for social carers to give 'as required' medicines
- Assess literacy – what do people understand about their medicines?
- Improve access to anticipatory medicines

Assess/ review of Finances

- DS 1500
- Make sure income is maximised
- Share updates with those who have knowledge of person's situation ie Care Co-ordinator

Care Coordinator

- Who is key person and has most input
- Known to family
- Knowledge of referrals
- Put on Key Information Summary who Care Coordinator is
- Family/Services must know who Care Coordinator is

Role

- Keep all services up to date including ACP's
- Needs to be right person at right time
- Care Coordinator needs role to be clear
- Identify key Care Coordinator at MDT
- Document centrally

Getting it right for people with palliative care needs in East Ayrshire

Fundamental Principles

- Easy access to information and services
- Respect/caring/safe/compassion/trust at all times
- Recognise and respond to education and training needs
- Proactive planning
- Agree right person/right place/right time
- Ownership /governance/accountability
- Assess risks

Support for Carer/ Family

- Carers Assessment completed/reviewed/shared
- Provide details for a Key person contact directly 24/7
- Understanding & clear information what NHS and Social Care can/can't do.
- Involve the main carer in all planning – listen to their views
- Provide /signpost to education ie moving and handling, medicines management
- Offer information/plan respite breaks with person and their carer
- Provide time for emotional support/discussion with Carer
- Help carer build resilience/coping strategy
- Assess need for overnight care/break for carer
- Provide/signpost to social/therapeutic groups for additional support/care ie Community Connector

Utilise Community Groups

Involve support in the local area:

- Neighbours
- Volunteers i.e. foodbank, Community Connectors, compassionate communities to support people at home
- Sacred Care
- Support groups
- Spiritual care

Equipment

- Assess need and liaise with key care co-ordinator
- Risk assess area
- Order equipment promptly
- Keep family informed and consider appropriateness
- Prompt removal of equipment and aids no longer required

Transport must be

- Accessible
- Reliable
- Consistent
- booked promptly for transfer of person to another setting

Education in Palliative care

- Provide/signpost to education for all staff
- Provide/signpost to education for family, public, volunteers i.e. Moving & Handling, Medicines, Reporting symptoms, Knowing what to do and who to contact when needed

Recognising Dying

- Provide/signpost to education and communication skills for all staff
- Ensure the main carer and the person is aware of the reasons for deterioration – open and honest conversations
- Ensure additional medication/JIC meds are readily available on site
- If wanted, prepare the person/main carer for the person dying and how this is likely to be/look like
- Provide verbal and written information so that the main carer knows what to do and who to contact when death occurs

Bereavement & Loss Support

- Respect cultural differences
- Provide/signpost to appropriate support if requested/needed
- Provide written information
- Communicate to ALL services when death occurs
- Arrange a bereavement visit from most appropriate person and inform other services

MI S18-003-CC

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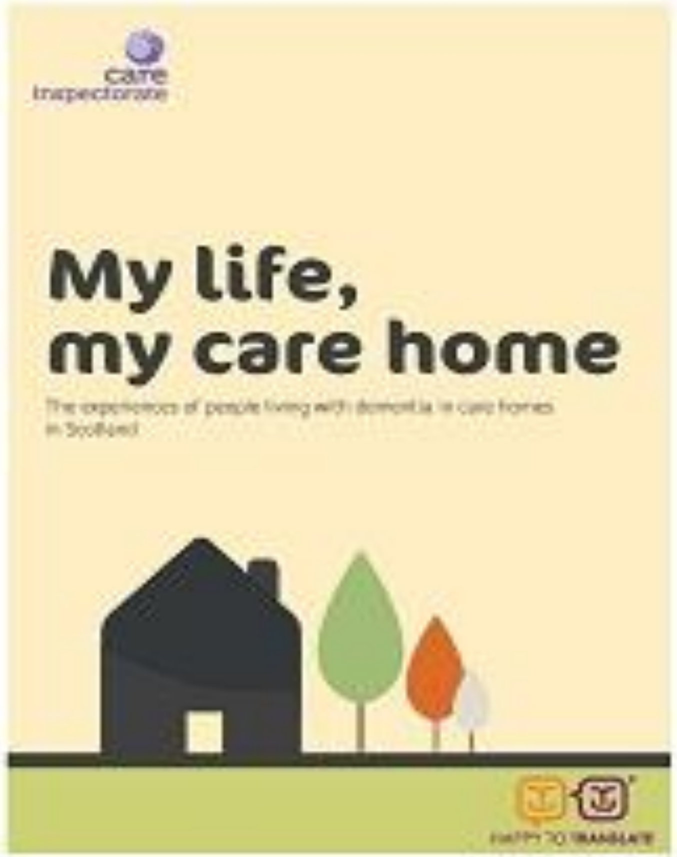
Dundee – Hilary Provan

Standards of Care for Dementia in Scotland

I have the right to end of life care that respects my wishes



care inspectorate

My life,
my care home

Improvement is needed in respect of meeting the “I have the right to end of life care that respects my wishes” standard, with 42% of care homes found to be adequate or lower. We expect to see staff who are confident and skilled in understanding their roles and responsibilities in palliative and end of life care.

Building Knowledge

Carer experience of families care and care coordination

Peoples pathways and experiences of care

Understand current practice, culture and barriers

4 Care Homes within Dundee

Building knowledge and skills of teams

PDSA Learning

Staff Focus Groups

Planning for Improvement

Project Charter ☑

Logic Model ☑

Driver Diagram ☑

Model for Improvement and PDSA ☑

Measurement Plan ☑

Change Ideas

Trial use of FAST Tool to identify deterioration and support decision making

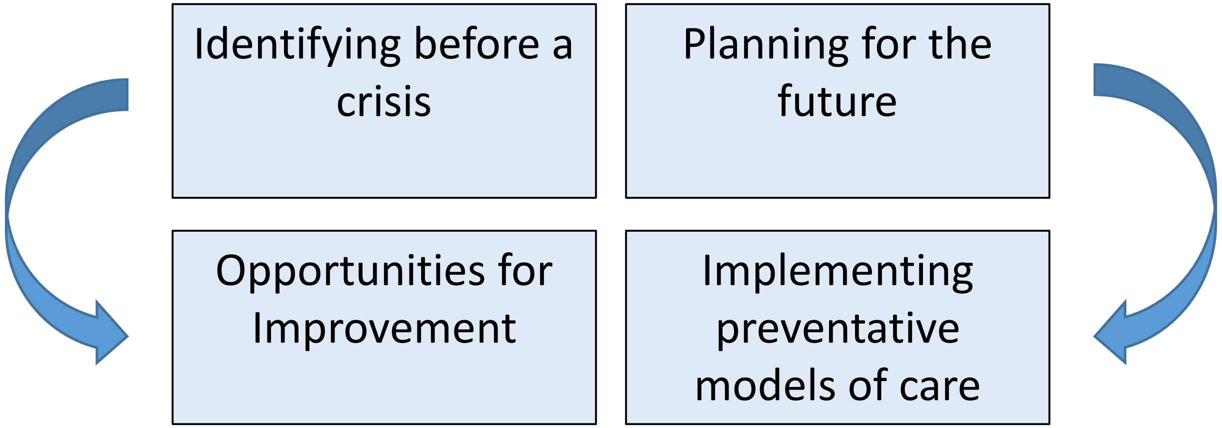
Enhance Multidisciplinary Review processes by implementing structured review document

Incorporate Care Home Team Pathway to support coordination of care

Trial use of PPP Tool to identify deterioration and support decision making

ACP thinking ahead - Preferences for care

Doing Improvement



Identifying before a crisis

Planning for the future

Implementing preventative models of care

Opportunities for Improvement

Pay attention to...

- Organisational context, culture and capacities
- Care home setting
- Staff engagement and relationships
- Learning

Thank you

Hilary Provan
Improvement Advisor
NHS Tayside
hprovan@nhs.net

Fife – Maxine Jones

NHS Fife
Day Service Coordination Initiative

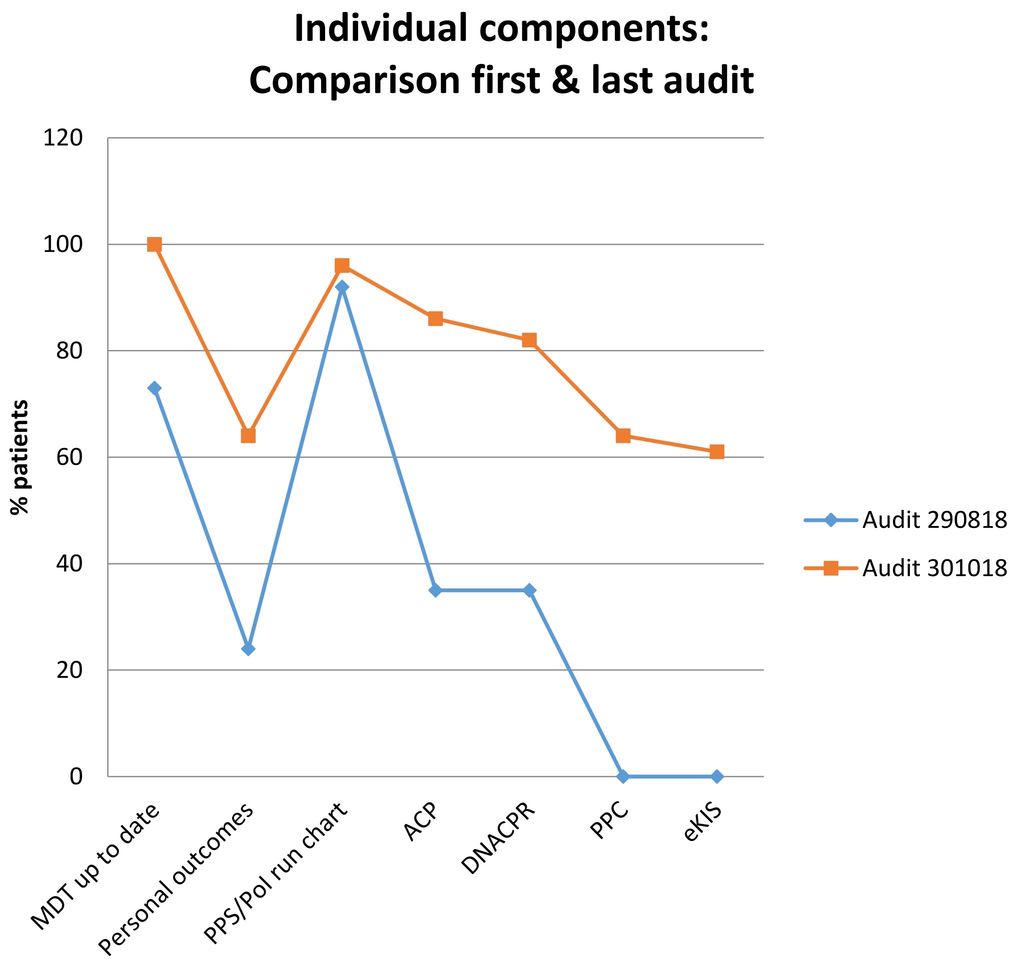
Maxine Jones
Programme Manager
Fife Specialist Palliative Care Service
maxine.jones9@nhs.net

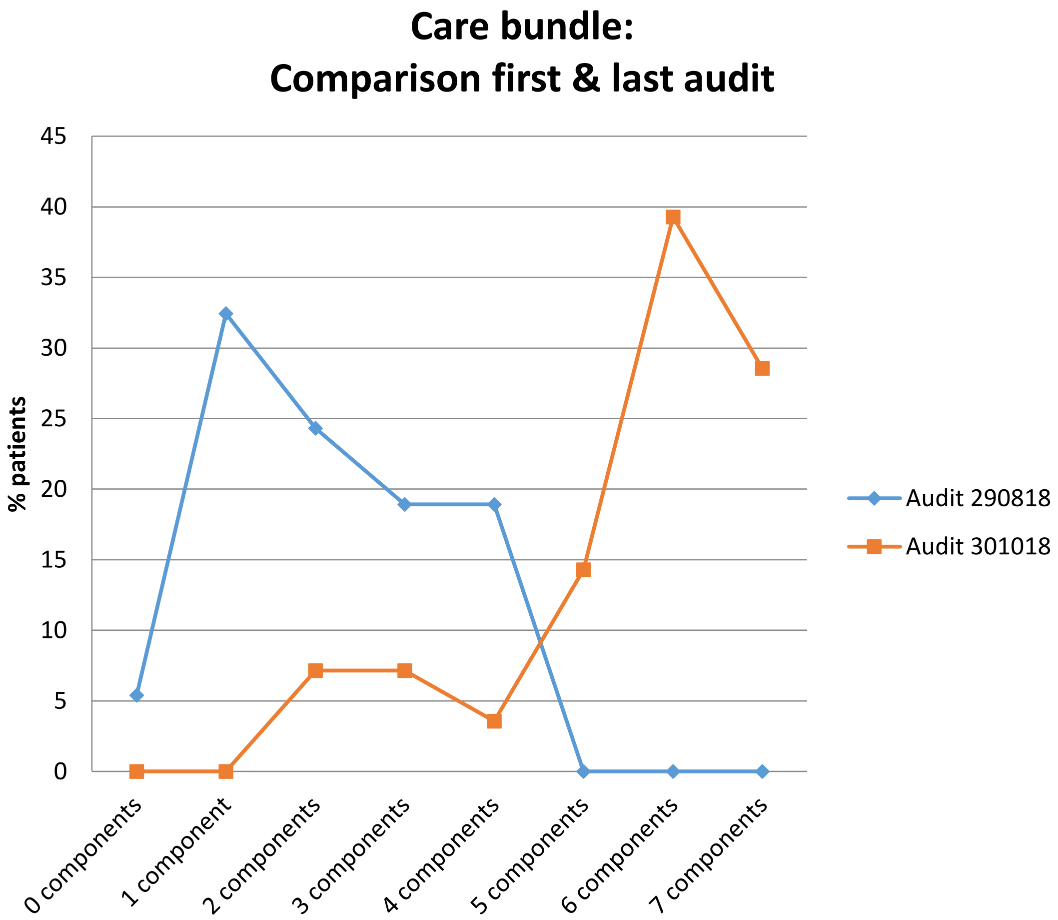
Driver diagram: NHS Fife, Day service coordination initiative

(maxine.jones9@nhs.net)

Aim	Primary Drivers	Secondary Drivers	Change Ideas	Measures (care bundle components)
By April 2019, to improve care coordination for **all** people attending day service, through introduction of a care bundle, to better support people with "what really matters" to them in their palliative journey	Conversations The right conversations with patients	Capability Staff use a personal outcomes approach	Bespoke personal outcomes training	% staff trained
		What really matters Personal outcomes are established	Personal outcomes are established at first visit and reviewed at MDT	% with personal outcomes
	Information The right information is shared	Information capture The right information is captured	PPS/PoI is introduced at first visit and updated at each attendance	% with PPS/PoI run chart
			ACP is recorded within 4 weeks of first visit	% with ACP
			DNACPR is recorded within 4 weeks of first visit	% with DNACPR
			PPC is recorded within 4 weeks of first visit	% with PPC
	Coordination The right coordination mechanisms	MDT review People receive timely MDT review	MDT triggers are introduced: – PPS 10-50% – PPS drop of 20% in 3 consecutive weeks – PoI unstable, deteriorating, dying – Due monthly review – New patient – No eKIS	% with triggers reviewed at next MDT
			Standardised letter is sent to GP following MDT: – Where eKIS update is needed – Where there is no eKIS	% with eKIS

NHS Fife, Day service coordination initiative: Results as at 30 October 2018





Glasgow City – Carol-Ann Duffy

Renfrewshire – Susanne Gray

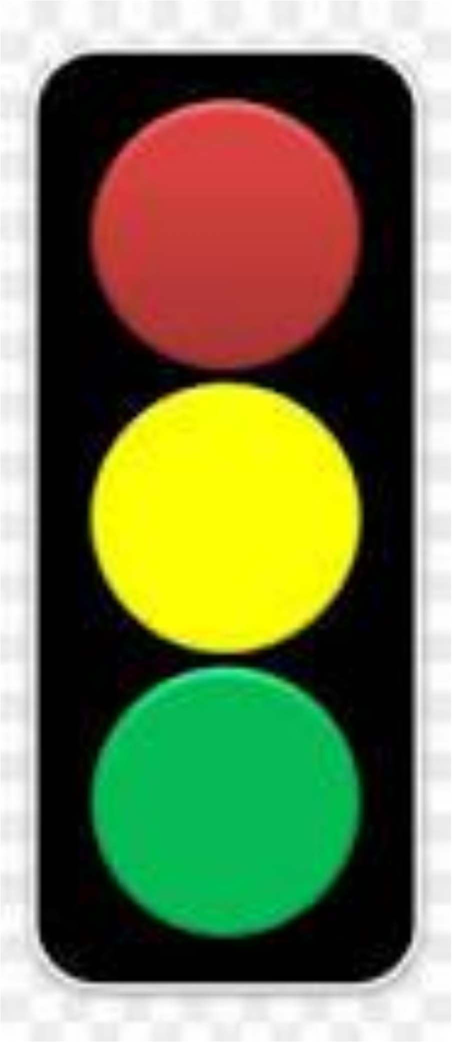
Testing a holistic system for community palliative care

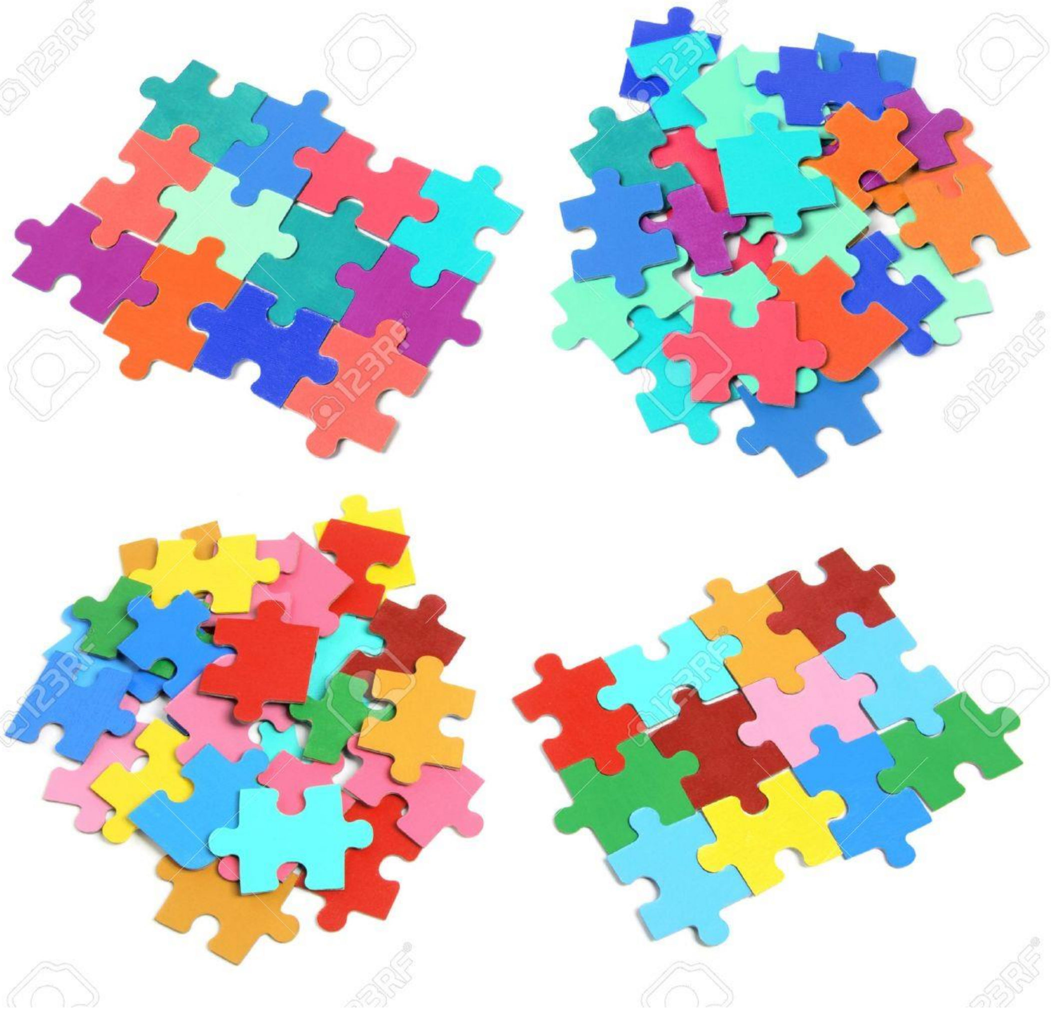
- Renfrewshire Health and Social Care Partnership
- November 2018

"The services offered were almost a given, whether they were right for us or not. We tweaked the edges but were not given much flexibility."

"Finding information and services is one of the most difficult parts of caring."

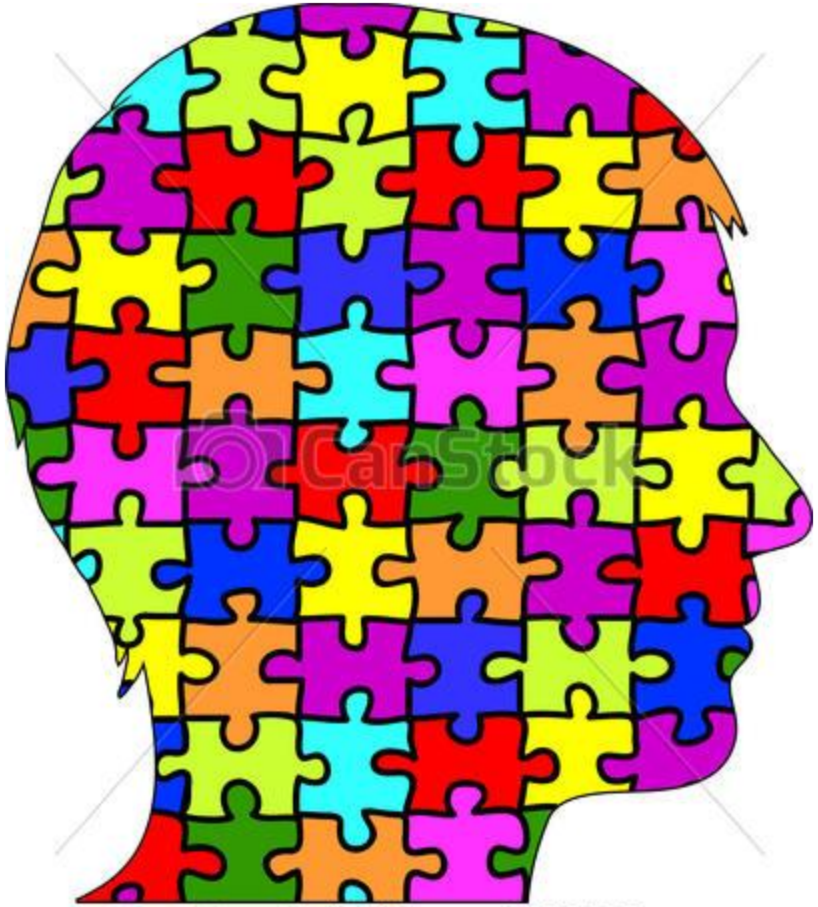
"It was always up to us to ensure everyone knew what was happening, tell the DN what the GP said, tell the GP what the consultant said. It never felt like anyone other than us had the full picture."





It's always the **small pieces** that make the **big picture.**


KEEP
CALM
AND
SOLVE
PUZZLES



Short stories on Care Co-ordination

Inter-professional and interpersonal conversations

Sandra Campbell

Care Co-ordination in PEOLC

- **WHAT is *care coordination in PEOLC*?**
- **WHY is it important?**
- **WHEN should it be done?**
- **WHO by?**
- **WHERE?**
- **HOW?**

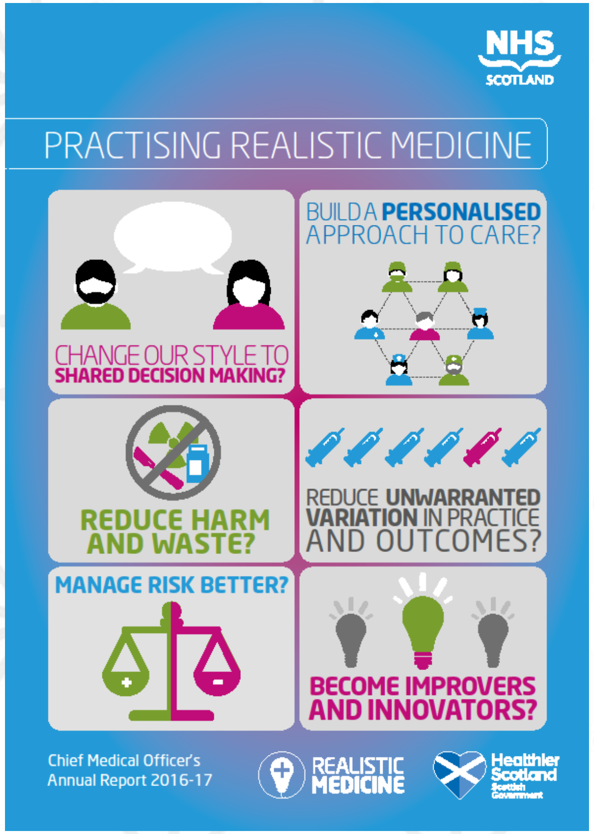
- **Communication about planning of care**
- **To obtain optimum outcome**
- **Commence at point of identification of need/Transitions**
- **Begins with whoever identifies need**
- **Central point/ may vary**
- **Through good communication/conversations and systems**

Cs of Communication in Care Co-ordination in PEOLC

- Care planning following holistic assessment, including practical components of care & comfort
- Common language
- Consistency in approach
- Collaboration
- Clear understanding of roles
- Critical and central to PPC
- Compassion
- Correct
- Challenges addressed
- Creative & credible
- Continuity
- Culture
- Confidence
- Complete the circle of communication
- Consequences...

Conversations in care Co-ordination in PEOLC

What do I need to know about you as a person to give you the best care possible ?
Patient Dignity Question (PDQ) by Prof. Harvey Chochinov



NHS SCOTLAND

PRACTISING REALISTIC MEDICINE

CHANGE OUR STYLE TO SHARED DECISION MAKING?

BUILD A PERSONALISED APPROACH TO CARE?

REDUCE HARM AND WASTE?

REDUCE UNWARRANTED VARIATION IN PRACTICE AND OUTCOMES?

MANAGE RISK BETTER?

BECOME IMPROVERS AND INNOVATORS?

Chief Medical Officer's
Annual Report 2016-17

REALISTIC MEDICINE

Healthier Scotland
Scottish Government

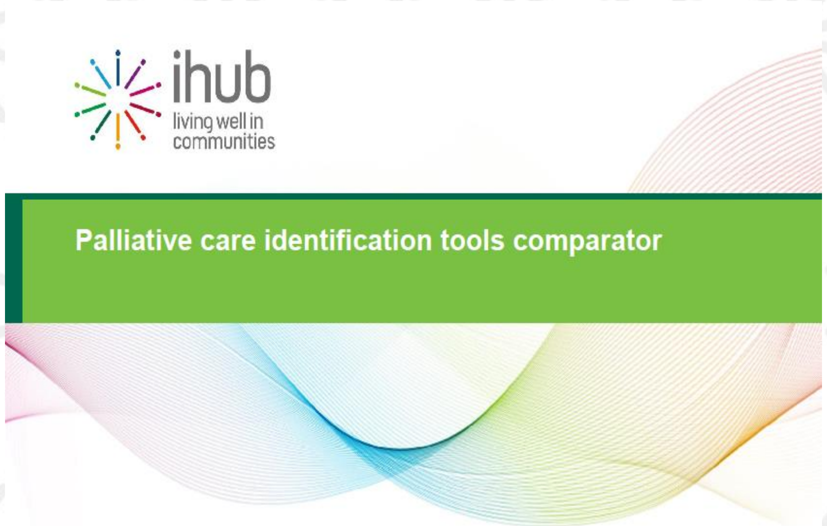
Organisational Processes & Arrangements

Engaged, Informed, Empowered Individuals & those that matter to them (Carers)

Timely focused conversation, to plan - 'What matters to you'

Health & Care professional team committed to partnership working

'MORE THAN MEDICINE'
Informal and formal sources of support and care
Sustained by the responsive allocation of resources



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Palliative care identification tools comparator

Combination of skills and tools!!

FIRST IMPRESSIONS

HUMAN THERAPEUTIC ENCOUNTER

LEADERSHIP

SAGE &THYME

5Ps

GOOD CONVERSATION

Organisational Processes & Arrangements

Engaged, Informed, Empowered Individuals & those that matter to them (Carers)

Timely focused conversation, to plan - 'What matters to you'

Health & Care professional team committed to partnership working

'MORE THAN MEDICINE'
Informal and formal sources of support and care
Sustained by the responsive allocation of resources

COACHING

10 MINUTE CBT

EC4H

SPIKES

RAPPORT

SBAR

MOTIVATIONAL INTERVIEWING

KIND MODEL

What do I need to know about you as a person to give you the best care possible ?

Patient Dignity Question (PDQ) by Prof. Harvey Chochinov

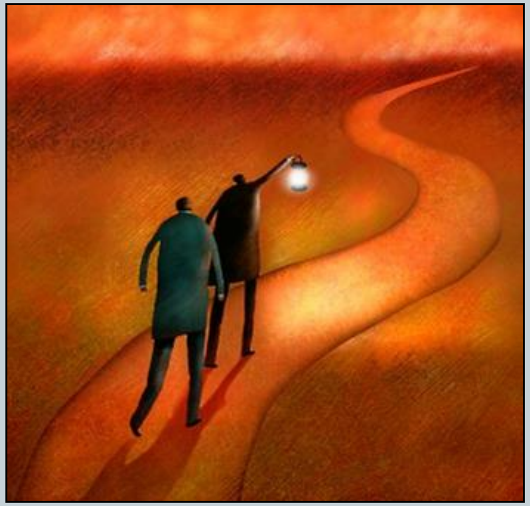
Short stories on Care Co-ordination

Transitions

Dr Deans Buchanan

Regaining narrative: health transitions in human stories

DEANS BUCHANAN



'WE LIVE BY STORIES, AND THEY'RE WHAT GIVE SENSE TO OUR LIVES.'

Narrative

- “*Stories* or *narratives* are at the centre of human understanding, memory systems, and communication. Memories and information are not just **stored**; they are ***storied”***
- “But patients’ stories will have been **disrupted** by their illness; this experience of **discontinuity**, of not feeling settled in the story of their lives exacerbates the illness experience and can affect their attitude and response to treatment.”
- Why do people attend doctors?

‘My story is broken, can you help me fix it?’

Shared decision making: co-authorship

- Who's is sharing with who?
- What is the context for the decision?
  - Relationship
  - Shared humanity and common mortality
  - Knowledge of who and knowledge of what
  - Reality-perception-reality
- What is the story, how is it broken and how will it proceed

Knowledge building,"the **social activity** by which communities create new knowledge through a process of collaborative, iterative idea improvement"

The story begins…..?

Some info

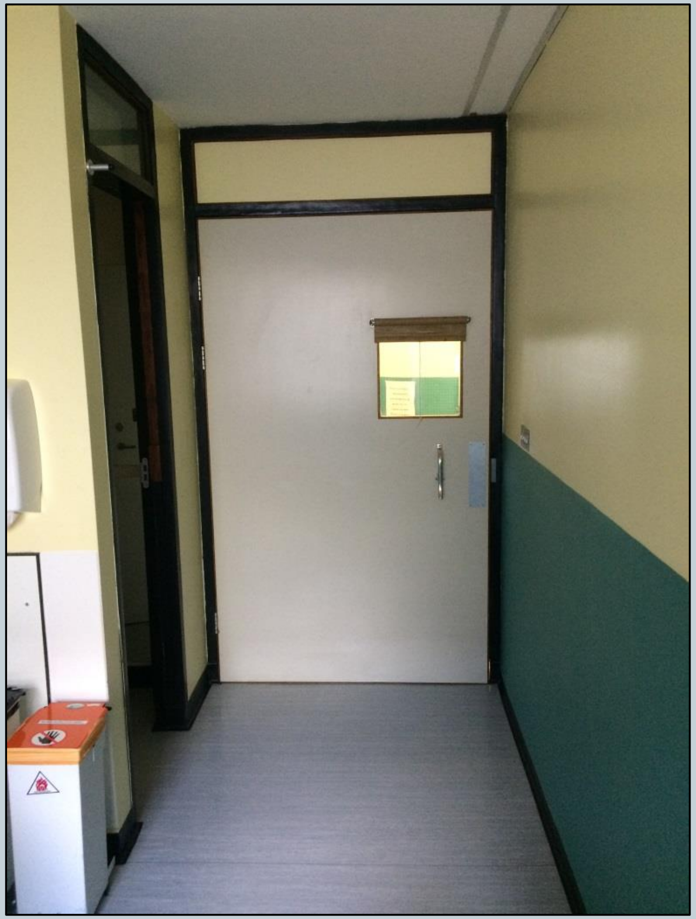
- Distressed person who may not be aware of surroundings….but might be
  - Family present - distressed
  - Risk of dying at that moment, in that hour, or that night is high
- Professionals: thinking, acting, speaking professional
- Approach….
  - A - Attitudes
  - B - Behaviour
  - C - Compassion
  - D- Dialogue

Dignity and the essence of medicine: the A, B, C, and D of dignity conserving care

Kindness, humanity, and respect—the core values of medical professionalism—are too often being overlooked in the time pressured culture of modern health care, says **Harvey Chochinov**, and the A, B, C, and D of dignity conserving care can reinstate them

An abrupt end to a story?

A new chapter, kind of




EMPATHY
JOURNEYS
OUTCOMES

From

Identification

to

Co-ordination

From

I

to

Co

From

Alone

to

Together

Short Stories on Care Co-ordination

Do we care for Carers?

Lynne Carmichael

DO WE CARE FOR “CARERS”???

Lynne Carmichael

Respite and Response Team Manager

Ayrshire Hospice

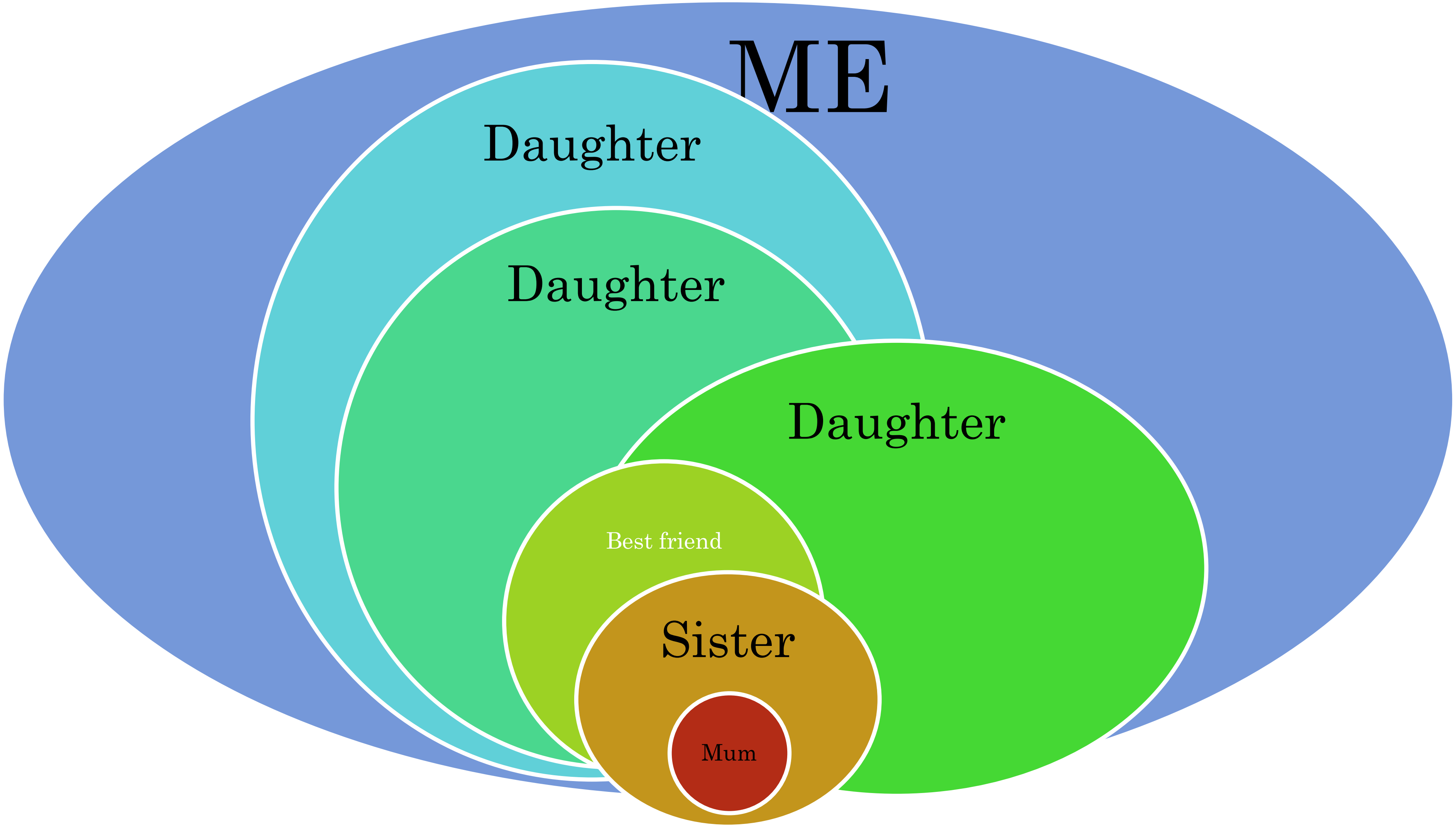
“CARERS/FAMILIES ANXIETY IS RATED ALONGSIDE PATIENTS SYMPTOMS AS THE MOST SEVERE PROBLEMS TO BE EXPERIENCED BY BOTH PATIENTS AND THEIR FAMILIES"

THE 1ST BARRIER????

Its all in a name…………..

What is a “CARER”…………..do I see myself as a carer?????

WHO IS IN MY INNER CIRCLE?



ME

Daughter

Daughter

Daughter

Best friend

Sister

Mum

- A CARER IS A PERSON – with their own lives and aspirations

- Often slipping away
- Often not their choice
- Often because there is no-one else to do it

JOB ADVERT: FAMILY/CARER

Length of contract: unknown Hours:

24hrs/day, 7 days/wk

An unexpected opportunity has arisen for a job caring for your relative who has a life-limiting condition.

This will be in addition to all other aspects of your current life responsibilities. You must be able to multi-task and have a multitude of skills including:

- **Household tasks** – cooking, cleaning, laundry, gardening
- **Caring** – nursing, bathing, dressing, lifting, using medical equipment
- **Pharmacy** – administering meds, ordering/collecting prescriptions
- **Co-ordinator / PR / Secretary** – organise, co-ordinate medical appointments
- **Counselling** – emotional support, listening, advice, confidante
- **Taxi driving** – or transport organiser
- **Financial Management** – managing bills when income may have stopped
- **Create memories** – spend quality time with your loved one

You may need to be able to do some or all of these skills, however this is what can be expected from you.
You need to manage your own emotions and at times, go without sleep.
The terms and conditions for this role are ever fluctuating and you have to manage that accordingly.

A job description is not available as this role is too big and the individual nature of each situation would make this impossible to create.

DO YOU ASSESS CARERS NEEDS?

- How do you do that?
  - On the doorstep?
  - At the bedside?
  - In the corridor?
- Does the carer know you are assessing their needs?
- How is the carer considered when we think “care coordination”?

CARERS ASSESSMENT?

- Should be considered equally to the needs of the patient?
- Consistent?
- Co-ordinated?
- Consent?
- Everyone's role? How do the team know who has assessed the carers needs?

- The CSNAT - Carer Support Needs Assessment Tool – A consistent Approach?

SUPPORTING THE NEEDS OF CARERS OF THOSE WITH A TERMINAL ILLNESS
RESEARCH STUDY MARIE CURIE

- **Not knowing who to call**

'And I don't know why I had got it into my head that, you know, it was the[hospital] now and the doctors and staff there and not my surgery. So I sort

of, went for several days, floundering I suppose. Not knowing what to do.' *[Glioma Interview]*

- **Seeking information**

'They advise you to take a notepad when you're talking to the consultant. But you don't even, when I looked at what I'd wrote , it wasn't even legible…It was like shorthand. And she was saying, "What did they say?" and I'm saying, "Aye well it's okay, you've got to go"…I hadn't a clue.' *[Primary Focus Group]*

- **What to expect in the future**

'…I was told he had a tumour, a glioblastoma or whatever it was, aggressive, blah, blah, blah. But nobody ever sat me down and said, you can expect this to happen or you can expect that to happen.' *[Glioma Interview]*

- **Crisis**

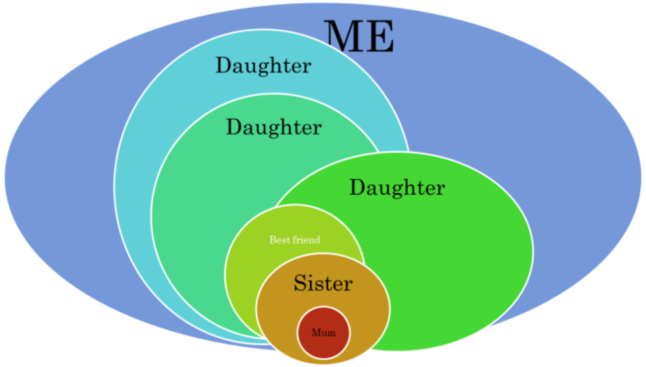
'It's the bashing your head against a brick wall, it's going from crisis, to crisis, to crisis. And knowing, not knowing when the next crisis is coming, not knowing what that crisis is going to be, but knowing that it's coming. And just expectations are high that it's gonna be there.' *[Primary Focus Group]*

- **Failures**

'…just slipped through the system three times, they hadn't even a record of her name. That's how important she was.' *[Primary Focus Group]*

CARE CO-ORDINATION

Truly person centred – inner circle ?



Research

- The Real-World Problem of Care Coordination: A Longitudinal Qualitative Study with Patients Living with Advanced Progressive Illness and Their Unpaid Caregivers **Barbara A. Daveson et al**
- **Providing comprehensive, person-centred assessment and support for family carers towards the end of life -** 10 recommendations for achieving organisational change **Gail Ewing, University of Cambridge, Gunn Grande, University of Manchester**
- **Who cares for the carers at hospital discharge at the end of life? A qualitative study of current practice in discharge planning and the potential value of using The Carer Support Needs Assessment Tool (CSNAT) Approach Gail Ewing , Lynn Austin, Debra Jones and Gunn Grande**

ONE CHANCE TO GET IT RIGHT?

Sometimes we need someone
to simply be there...
Not to fix anything
or do anything
in particular,
but just to let
us feel we are
supported and cared about

Fb.com/MinionQuote

The CSNAT Approach
Training and Implementation Toolkit

CSNAT | Carer Support Needs Assessment Tool

Plan → Pilot → Train → Sustain

Two learning units

Learning Unit 1

Individual level: training for practitioners to use the CSNAT intervention

Learning Unit 2

Organisational level: assistance for a project facilitation team to plan, pilot and sustain implementation

[Further details on csnat.org](https://csnat.org)

Bereavement

Heather Edwards

Dementia Consultant

Care Inspectorate

Short Stories on Care Co-ordination

Key Information Summary (KIS)

Anne Finucane

Key Information Summary generation for people who died in Scotland in 2017

Dr Anne Finucane
Research Lead, Marie Curie Hospice Edinburgh
Honorary Fellow, University of Edinburgh

Care and support
through terminal illness

Healthcare Improvement Scotland

Marie Curie

Study team

Anne Finucane – Research Lead, Marie Curie Hospice Edinburgh

Scott Murray – Chair of Primary Palliative Care, University of Edinburgh

Deborah Davydaitis – Palliative Care Speciality Doctor and Researcher

Zoe Horseman – Nurse Researcher

Emma Carduff -Research Lead, Marie Curie Hospice Edinburgh

Paul Baughan – GP and National Clinical Lead for Palliative Care

Sandra Campbell - National Clinical Lead for Palliative Care - Nursing

Richard Meade – Head of Policy for Scotland - Marie Curie

Tim Warren – Palliative Care Lead - Scottish Government

Julia Tapsfield – GP, NHS Lothian (led previous KIS study in 2014)

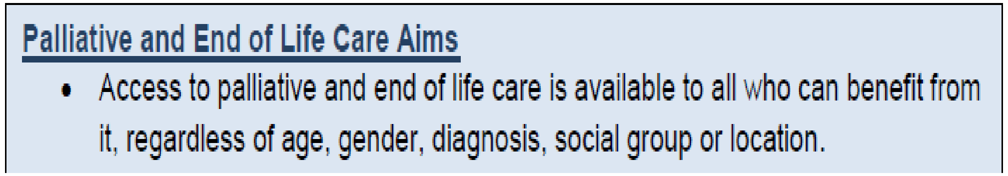
Juliet Spiller – Consultant in Palliative Medicine, Marie Curie Hospice Edinburgh

Ian Thompson – Primary Care Clinical Lead in Digital Health and Care, Infrastructure and Digital Division, Scottish Government

Background

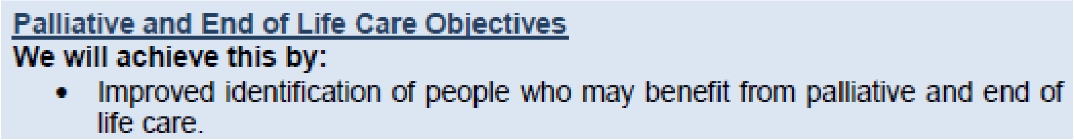
Vision

By 2021, everyone in Scotland who needs palliative care will have access to it.



Palliative and End of Life Care Aims

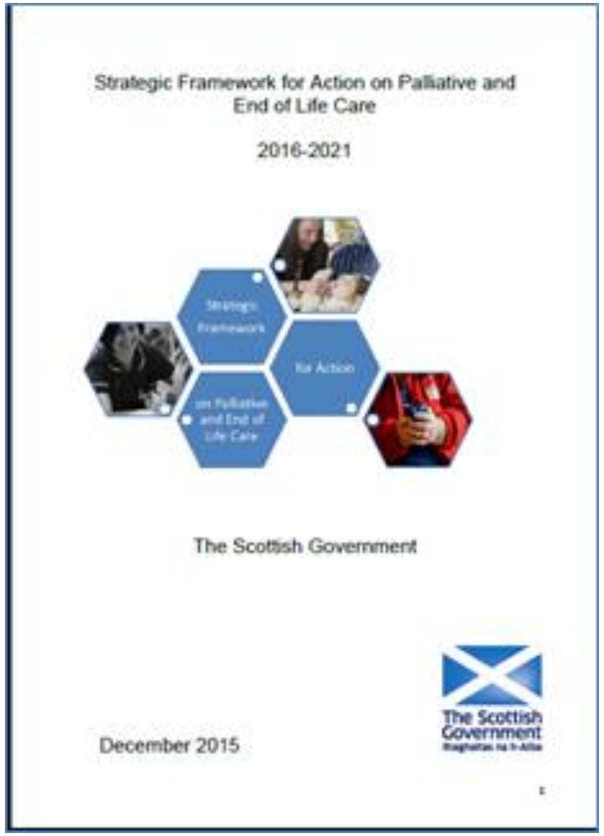
- Access to palliative and end of life care is available to all who can benefit from it, regardless of age, gender, diagnosis, social group or location.



Palliative and End of Life Care Objectives

We will achieve this by:

- Improved identification of people who may benefit from palliative and end of life care.



Strategic Framework for Action on Palliative and End of Life Care

2016-2021

The Scottish Government

December 2015

The Scottish Government

Riaghaltas na h-Alba

1

Strategic Framework for Action on Palliative and End of Life Care 2016-2021

Background

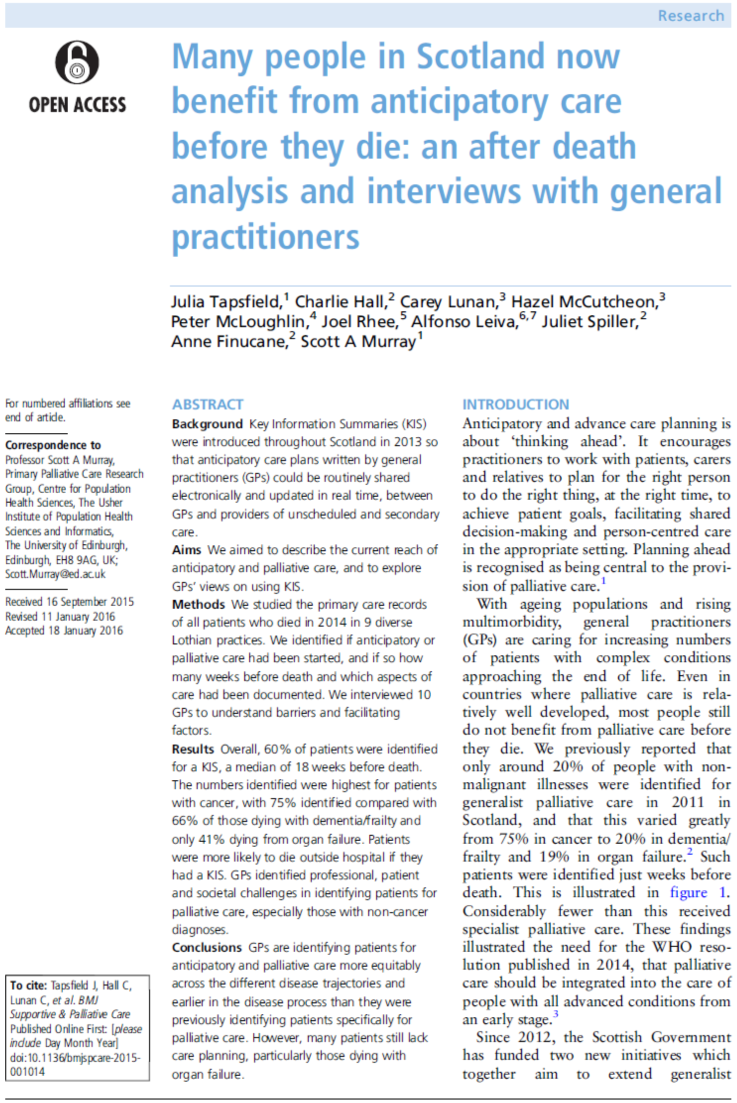
Tapsfield et al (2016)

Data collection in 2014

- 9 general practices in Lothian
- 605 patient records

Findings

- 60% had a KIS
- 18 weeks before death
- Only 41% with organ failure had KIS
- Overall improvements compared with 2011 (Zheng et al. 2013)



OPEN ACCESS

Many people in Scotland now benefit from anticipatory care before they die: an after death analysis and interviews with general practitioners

Julia Tapsfield,[1] Charlie Hall,[2] Carey Lunan,[3] Hazel McCutcheon,[3]
Peter McLoughlin,[4] Joel Rhee,[5] Alfonso Leiva,[6,7] Juliet Spiller,[2]
Anne Finucane,[2] Scott A Murray[1]

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ABSTRACT

Background Key Information Summaries (KIS) were introduced throughout Scotland in 2013 so that anticipatory care plans written by general practitioners (GPs) could be routinely shared electronically and updated in real time, between GPs and providers of unscheduled and secondary care.

Aims We aimed to describe the current reach of anticipatory and palliative care, and to explore GPs' views on using KIS.

Methods We studied the primary care records of all patients who died in 2014 in 9 diverse Lothian practices. We identified if anticipatory or palliative care had been started, and if so how many weeks before death and which aspects of care had been documented. We interviewed 10 GPs to understand barriers and facilitating factors.

Results Overall, 60% of patients were identified for a KIS, a median of 18 weeks before death. The numbers identified were highest for patients with cancer, with 75% identified compared with 66% of those dying with dementia/frailty and only 41% dying from organ failure. Patients were more likely to die outside hospital if they had a KIS. GPs identified professional, patient and societal challenges in identifying patients for palliative care, especially those with non-cancer diagnoses.

Conclusions GPs are identifying patients for anticipatory and palliative care more equitably across the different disease trajectories and earlier in the disease process than they were previously identifying patients specifically for palliative care. However, many patients still lack care planning, particularly those dying with organ failure.

INTRODUCTION

Anticipatory and advance care planning is about 'thinking ahead'. It encourages practitioners to work with patients, carers and relatives to plan for the right person to do the right thing, at the right time, to achieve patient goals, facilitating shared decision-making and person-centred care in the appropriate setting. Planning ahead is recognised as being central to the provision of palliative care.[1]

With ageing populations and rising multimorbidity, general practitioners (GPs) are caring for increasing numbers of patients with complex conditions approaching the end of life. Even in countries where palliative care is relatively well developed, most people still do not benefit from palliative care before they die. We previously reported that only around 20% of people with non-malignant illnesses were identified for generalist palliative care in 2011 in Scotland, and that this varied greatly from 75% in cancer to 20% in dementia/frailty and 19% in organ failure.[2] Such patients were identified just weeks before death. This is illustrated in figure 1. Considerably fewer than this received specialist palliative care. These findings illustrated the need for the WHO resolution published in 2014, that palliative care should be integrated into the care of people with all advanced conditions from an early stage.[3]

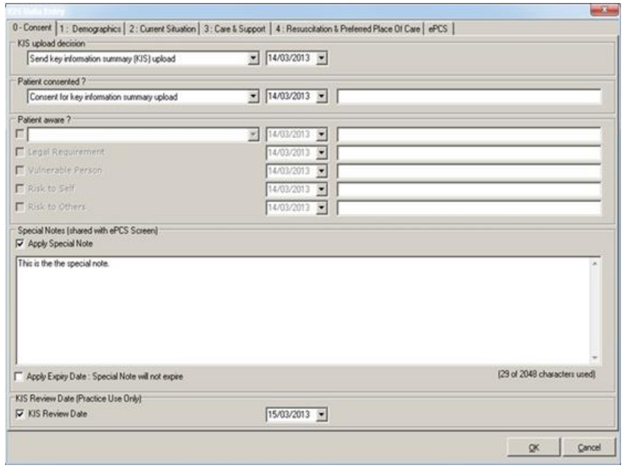
Since 2012, the Scottish Government has funded two new initiatives which together aim to extend generalist

Study Aims

- To estimate the extent of KIS generation for people who died with an advanced progressive condition in **2017**
- To explore GP perspectives of commencing and updating a KIS; what works well and what can be improved.

Methods

Retrospective review of the records of all patients who died in **18** Scottish general practices across four NHS Board areas in 2017



KIS upload decision
Send key information summary (KIS) upload 14/03/2013

Patient consented ?
Consent for key information summary upload 14/03/2013

Patient aware ?
☐ 14/03/2013
☐ Legal Requirement 14/03/2013
☐ Vulnerable Person 14/03/2013
☐ Risk to Self 14/03/2013
☐ Risk to Others 14/03/2013

Special Notes (shared with ePCS Screen)
☑ Apply Special Note
This is the the special note.
☐ Apply Expiry Date : Special Note will not expire
(29 of 2048 characters used)

KIS Review Date (Practice Use Only)
☑ KIS Review Date 15/03/2013

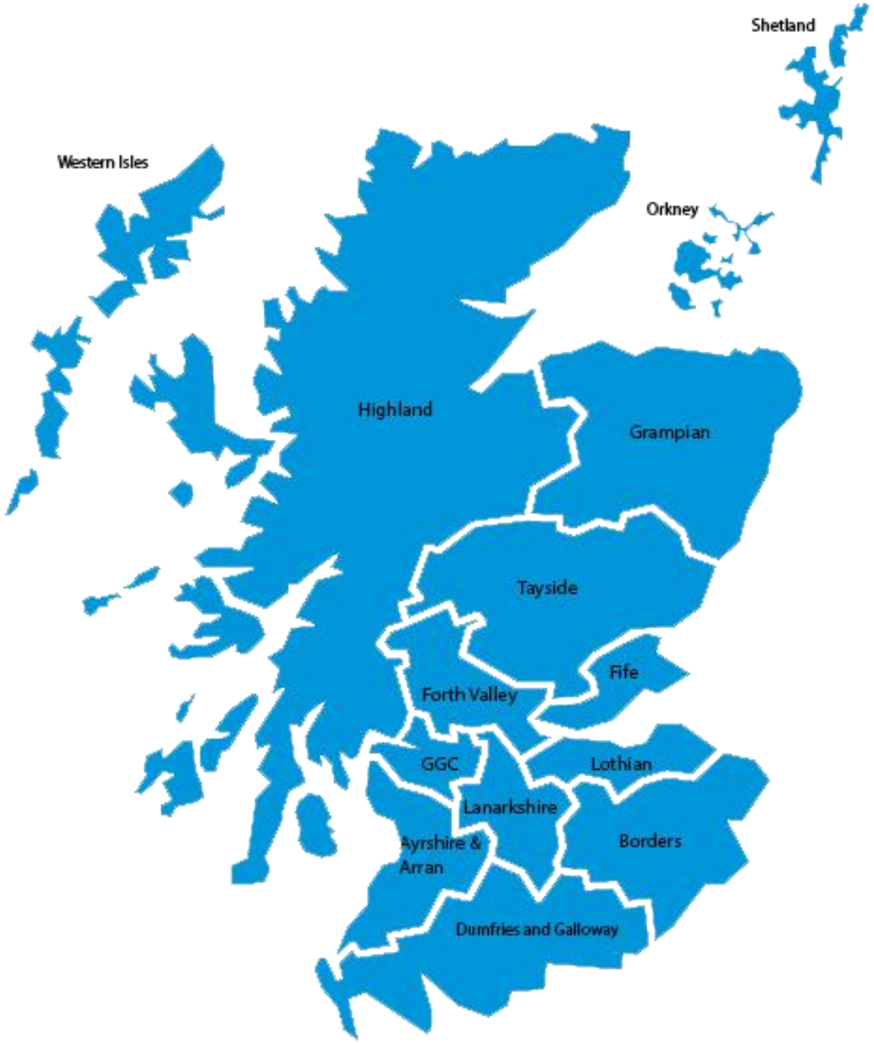
Telephone interviews with one healthcare professional in each general practice.

Results

Practices	No.	Records
Ayrshire & Arran:	4	**300**
Lothian:	4	**304**
Tayside:	4	**368**
Fife:	6	**332**
Total	**18**	**1304**

Telephone Interviews

- 17 GPs and 2 practice nurses

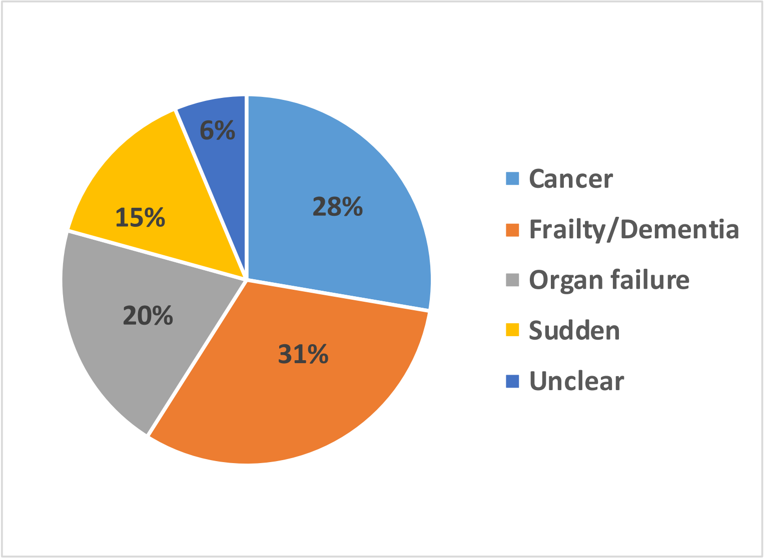


Results

Sample

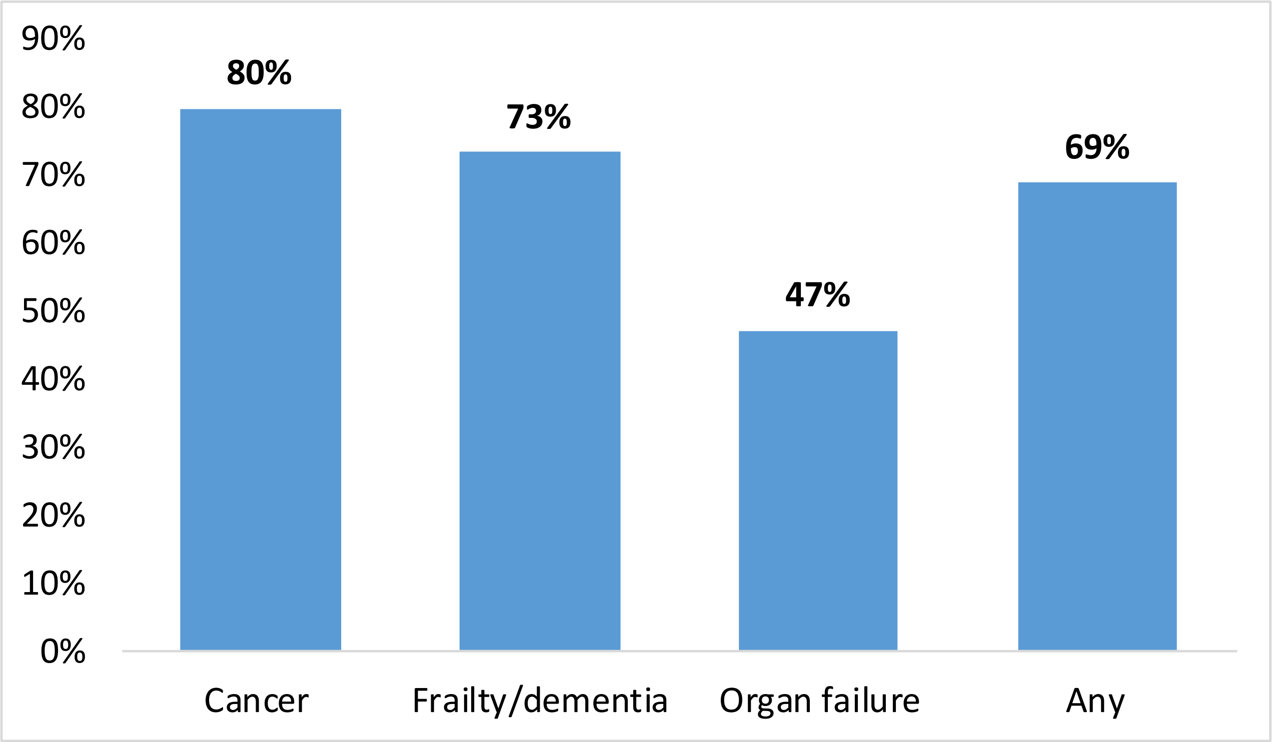
- 1304 patients
- 49% female, 51% male
- Median: 79 years
- 1,034 had an advanced progressive condition at time of death (79%)

Illness trajectory (n=1304)



Results

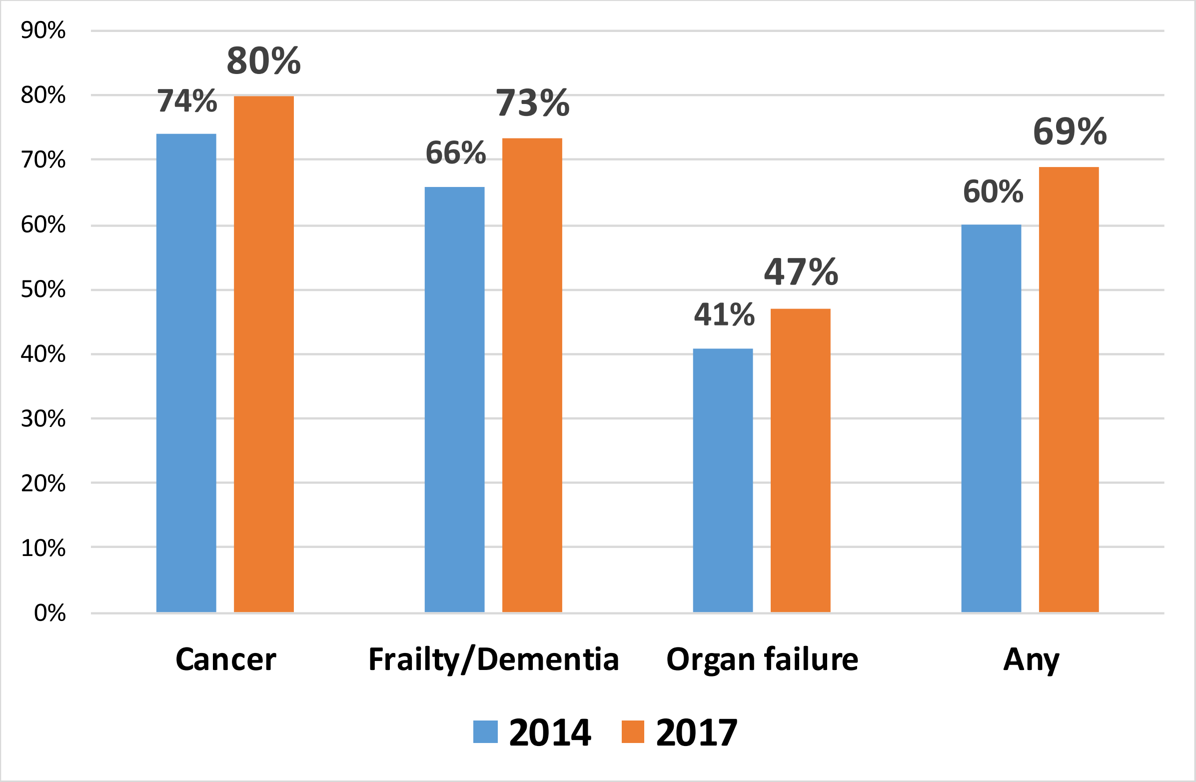
Proportion of patients with a KIS at the time of death (n=1034)



Results

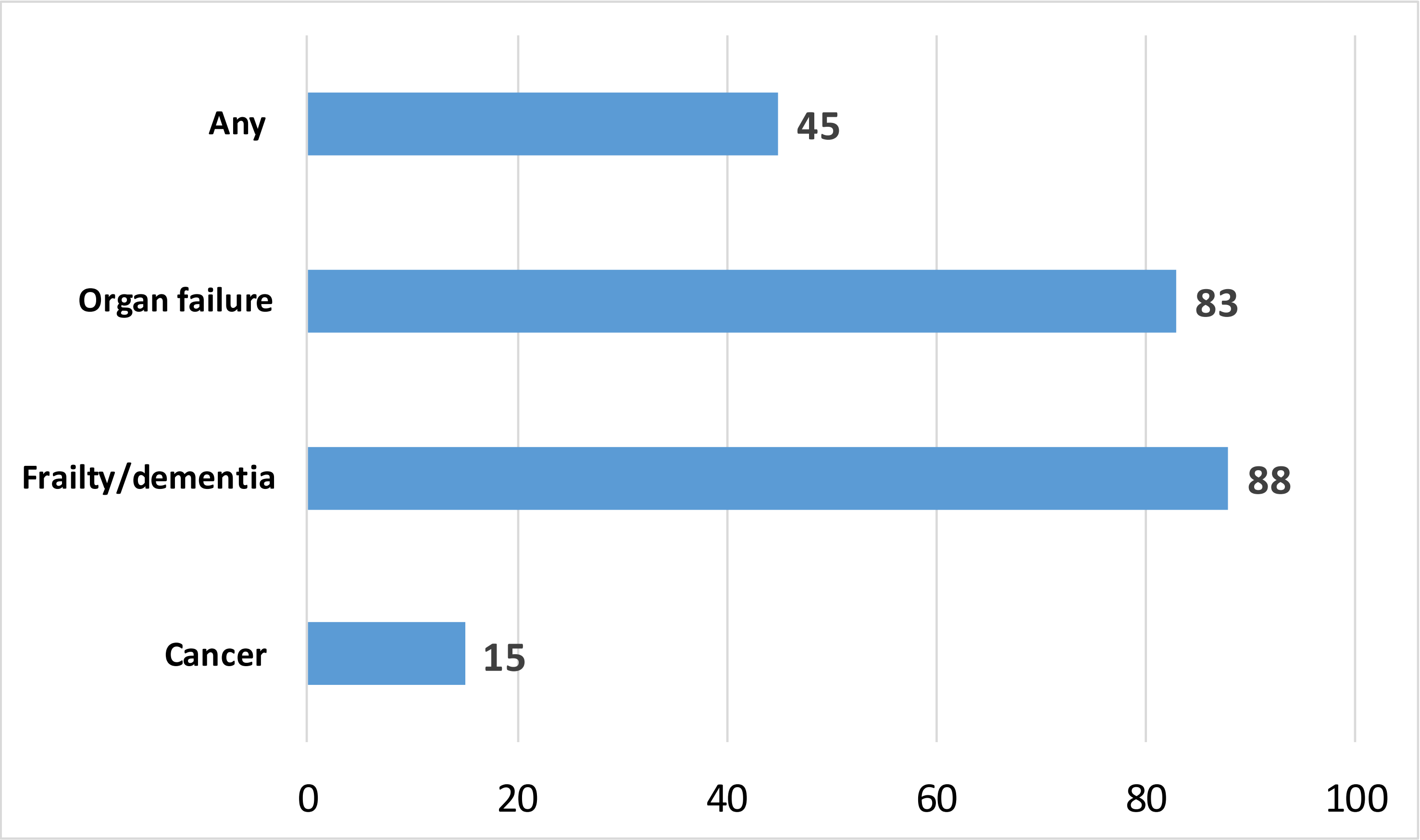
Proportion of patients with a KIS at the time of death

2014 versus 2017 (%)



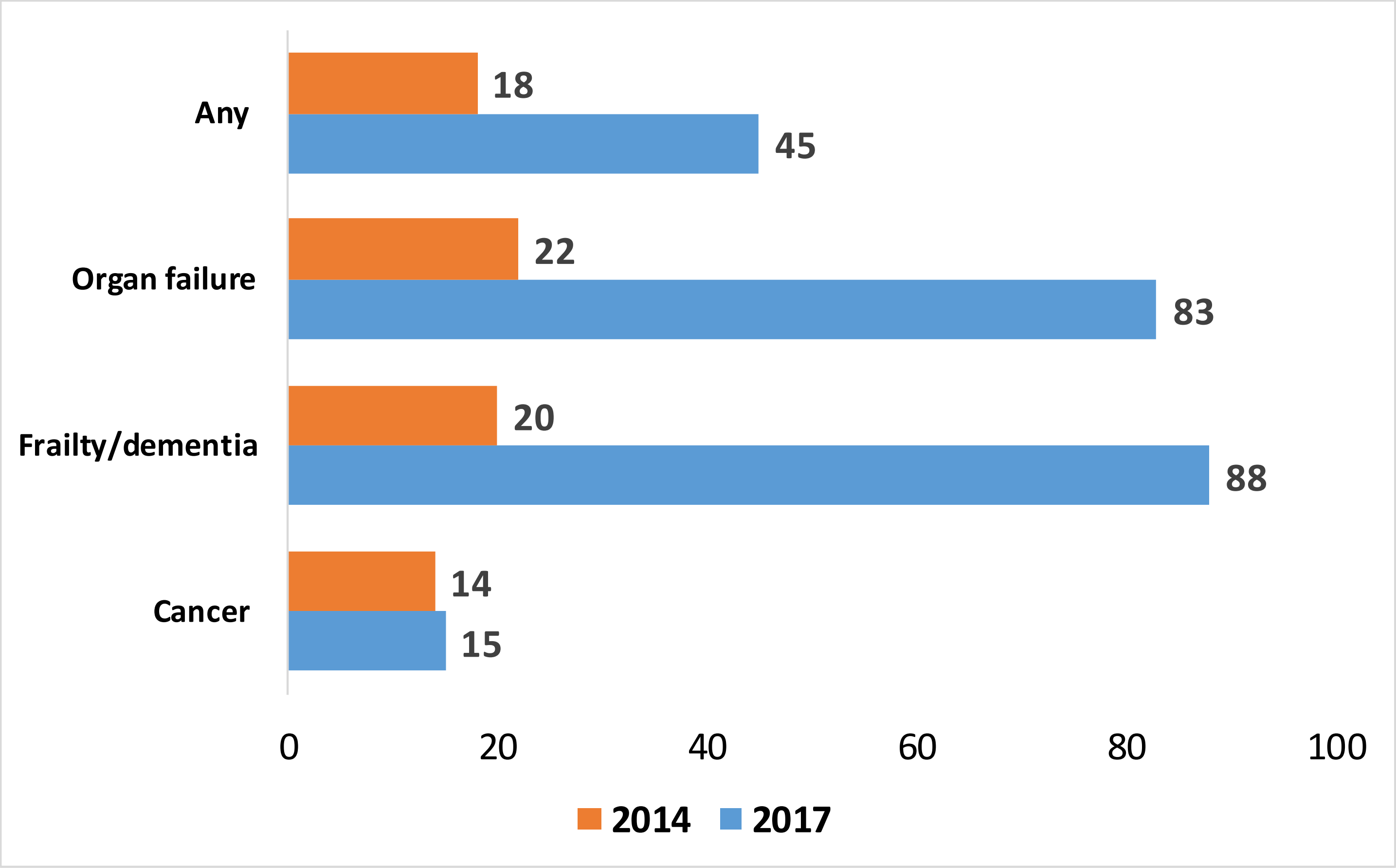
Results

Timing of KIS generation (median weeks before death)



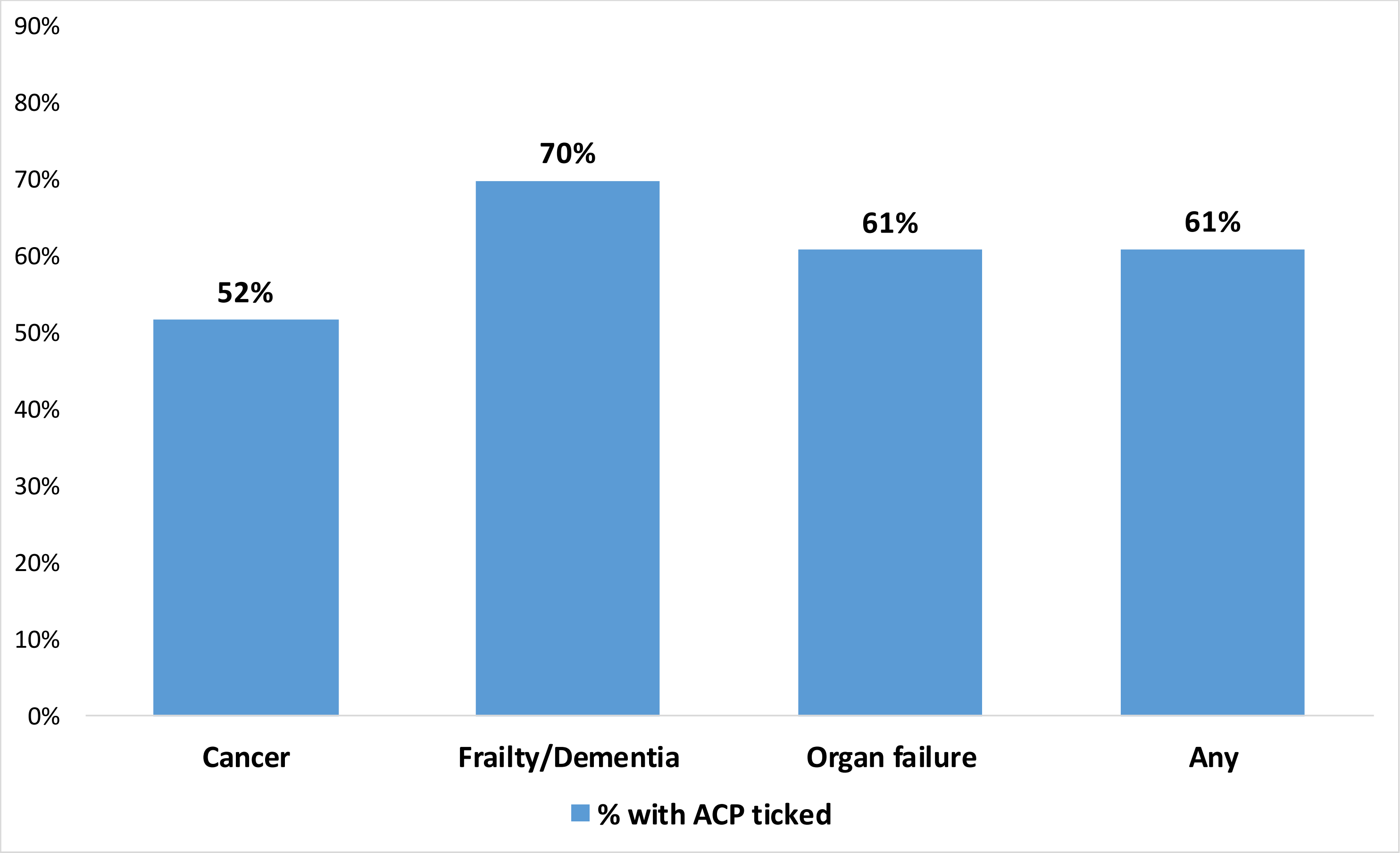
Results

Timing of KIS generation (median weeks before death)



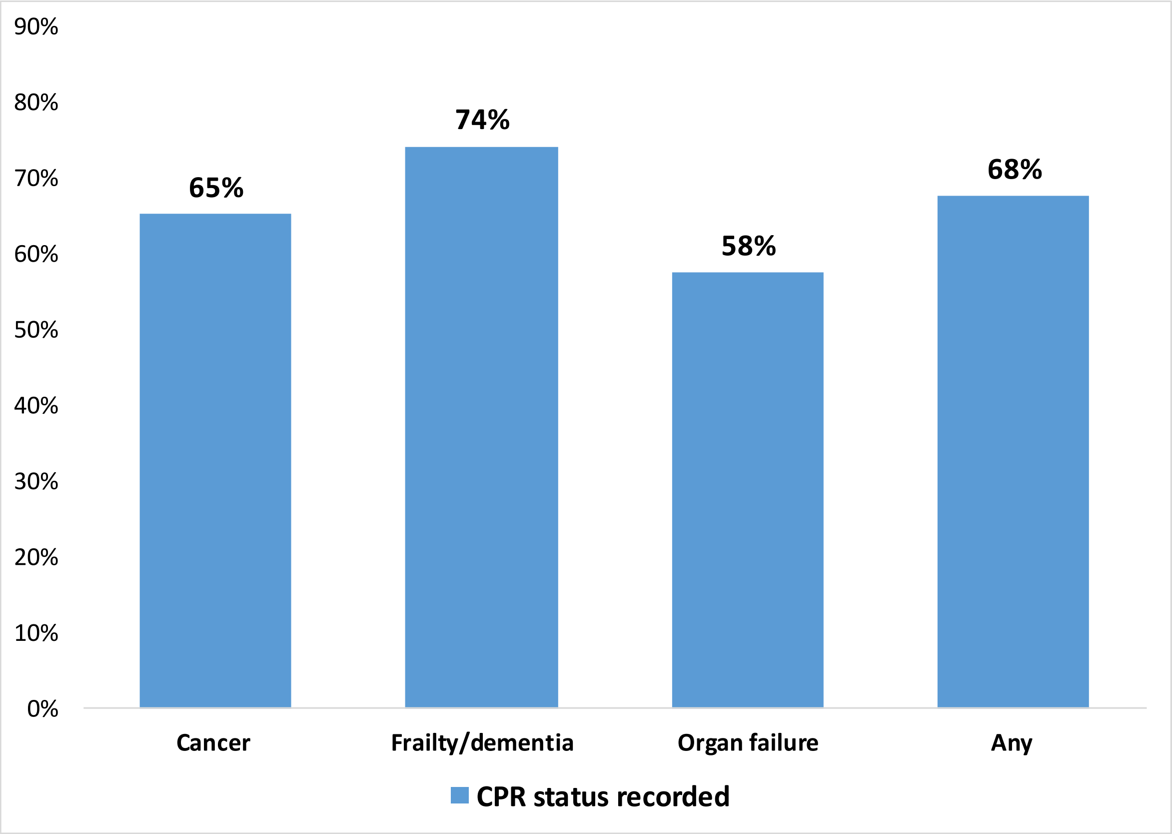
Results

Proportion of patients with ACP box ticked



Results

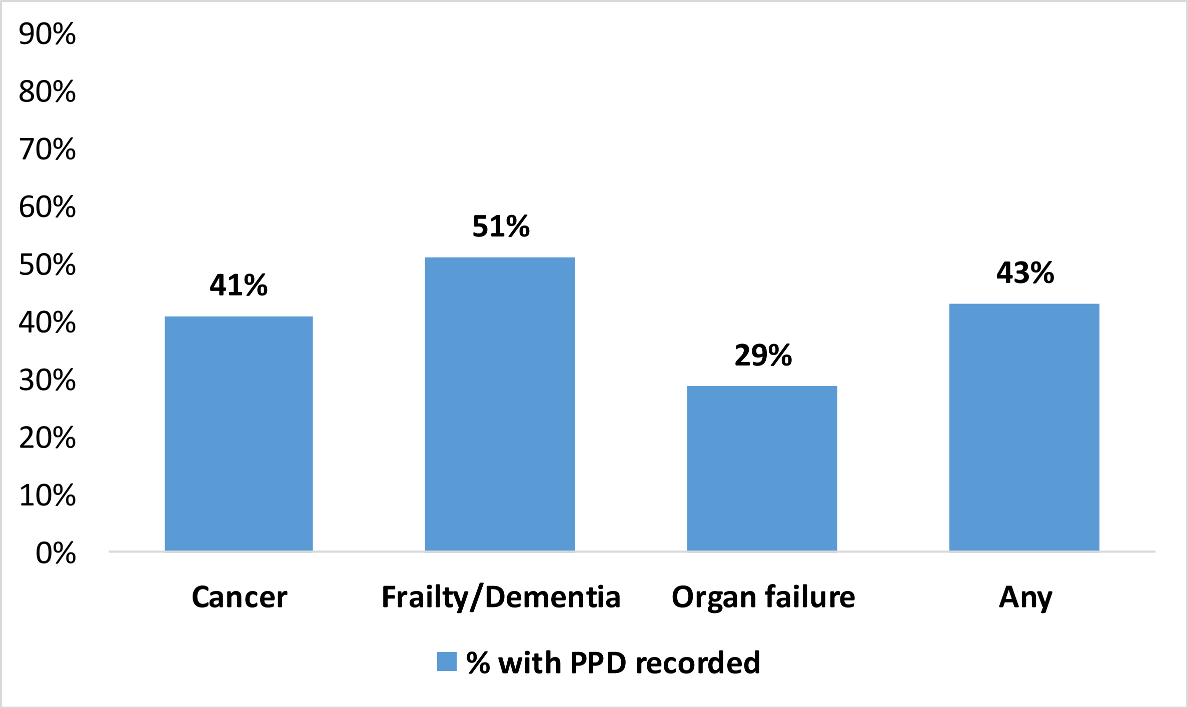
Proportion of patients with resuscitation status recorded in KIS (n=712)



→ Increase from 42% in 2014

Results

Proportion of patients with preferred place of death recorded in the KIS (n=712)

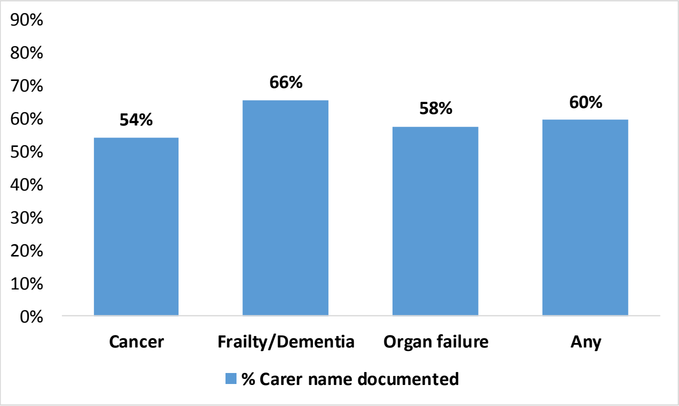


Increase from 29% in 2014

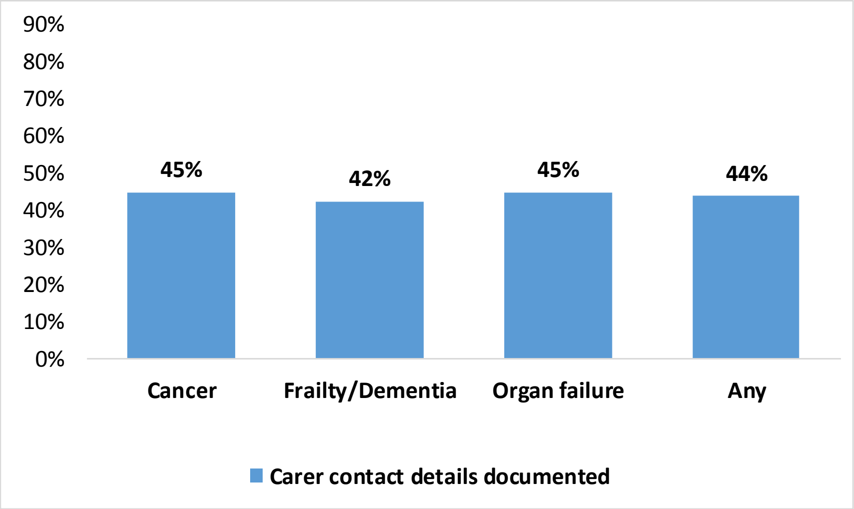
Results

Proportion of patients carer details documented in the KIS (n=712)

Carer name documented (%)



Carer contact details documented (%)



Results

KIS Usefulness

Highly useful

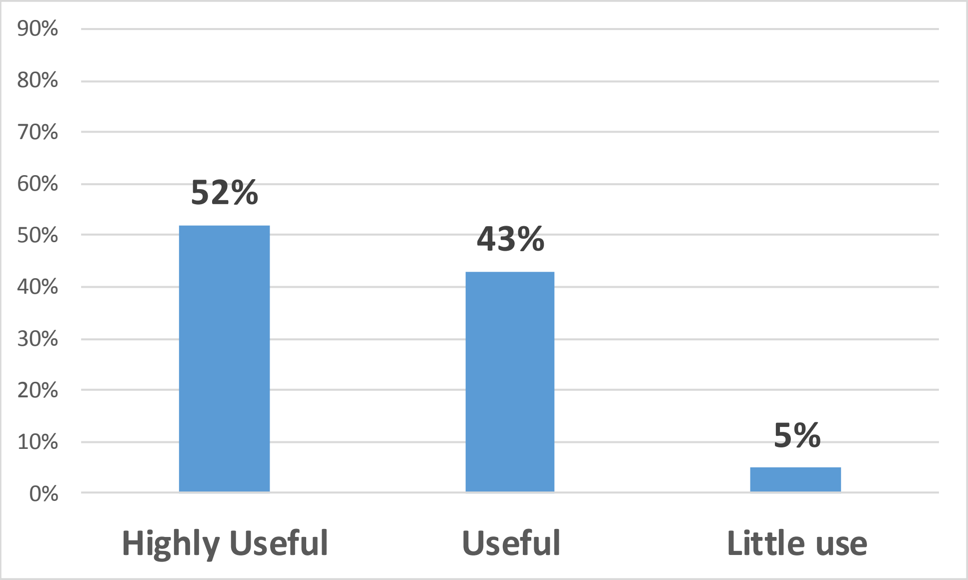
- Clear plan regarding patient (and ideally family) wishes regarding current care and future planning.

Useful

- Some additional useful clinical information, but no clear wishes regarding current care or future planning.

Little use

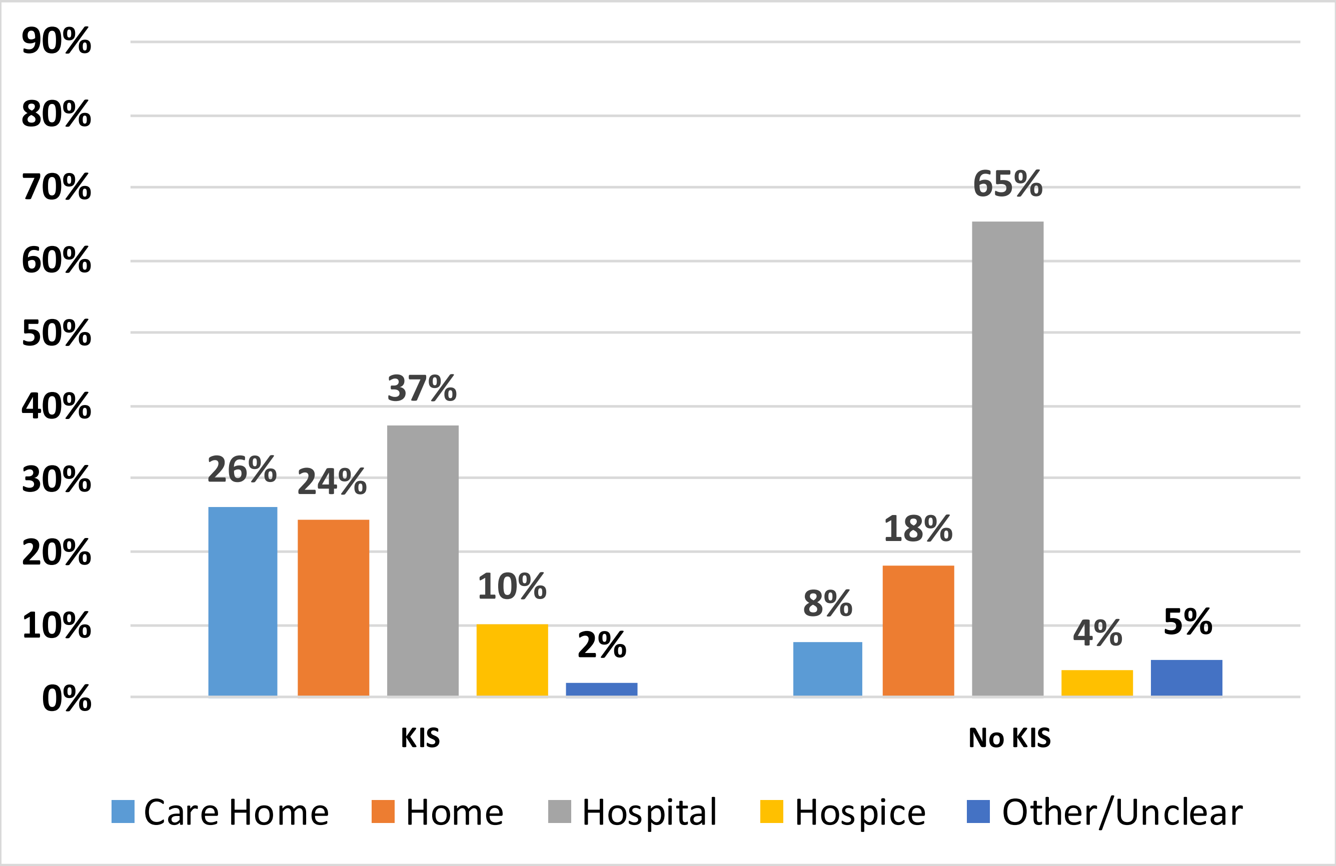
- KIS present but no additional information added, no relevant boxes ticked, no special note.



Marie Curie

Results

KIS and place of death (n=712)



Qualitative findings

Special note is considered most useful section

> …out-of-hours [it’s] the special notes box that I go for, the most useful bit because of clinical information and ceiling of care…really useful information.

> And one of the things I think the KIS has been useful for , and does appear to get read by the out-of-hours service, is where the patients ceiling of care is set at staying in the nursing home.. I’ve seen that …that has swayed the out-of-hours services

Qualitative findings

Perception that NHS24 don’t access the KIS

> NHS24 are dire at noticing they are in place and it has a negative impact on patient care if they fail to notice that.

Patients and carers could ask for a KIS

> [Patients and carers] should come and ask ‘I need a KIS’.. do people know [to ask]

Conclusions

- The proportion of people with an advanced progressive illness who have a KIS has increased significantly since 2014.
- KISs are being generated earlier, and over half of all KISs are generated at least a year before the person dies.
- The ACP tick box has limited value.
- The vast majority of KISs are useful or highly useful and KIS completion is regarded as important by GPs.
- Renewed focus on triggers for KIS completion for people with organ failure is warranted
- Better information regarding carers/next of kin is recommended

Conclusions

- Consider how to ensure greater use of KIS by NHS 24 to enhance clinical decision-making out-of-hours.
- Could we rebrand the KIS to make it so that it is easier for patients to understand, and empower people to request a KIS?
- Strong and sustained progress towards improved identification of patients for a supportive and palliative approach, and sharing of key patient information across settings in Scotland.

Thank you

Personal outcomes – Towards a shared understanding

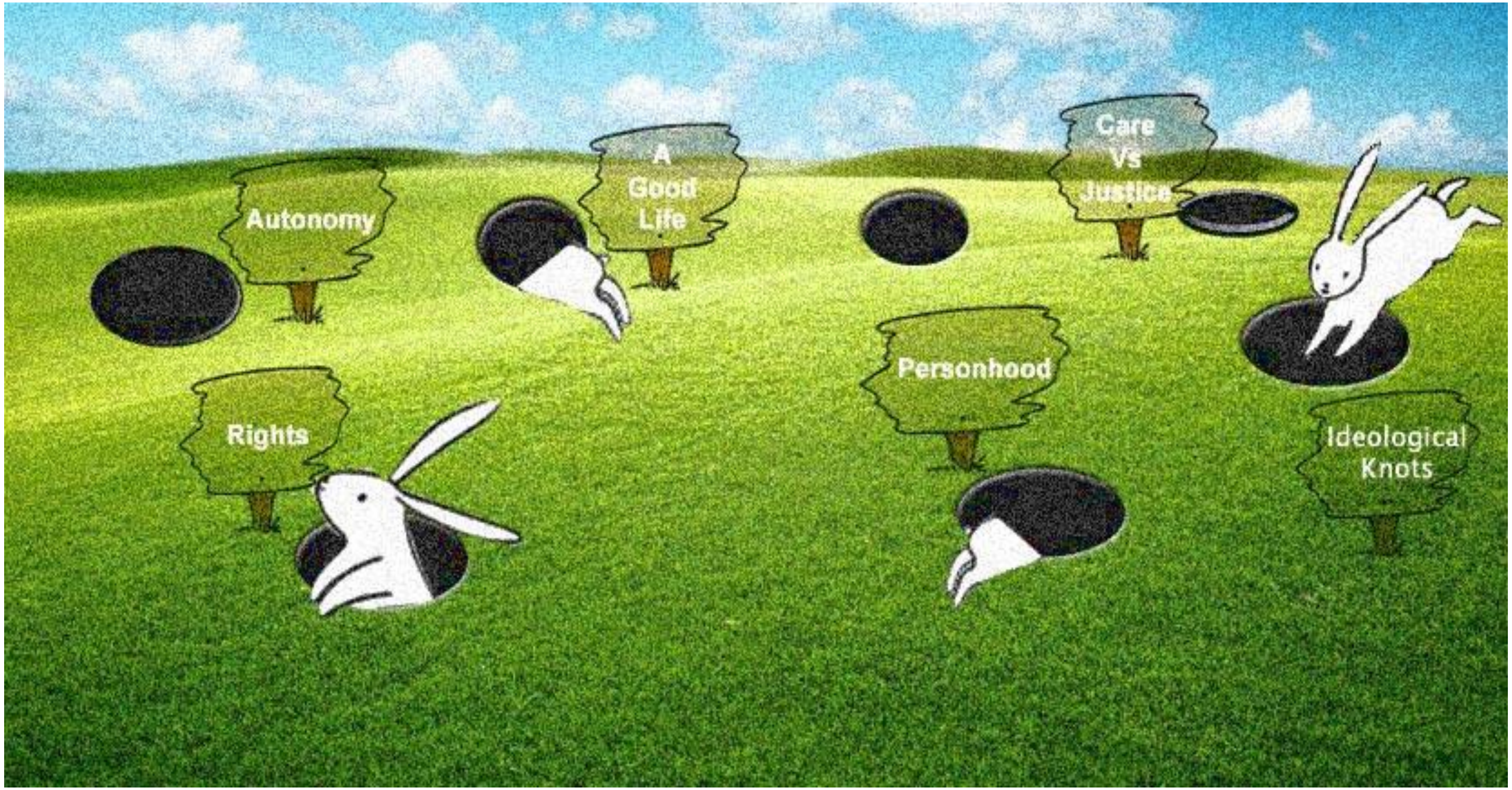
Ali Guthrie

Scottish Social Services Council

Personal Outcomes: Towards a shared understanding – Personal Outcomes Resources for you and your role

Healthcare Improvement Scotland 08/11/18

Alison Guthrie Learning & Development Adviser, SSSC


Autonomy
A Good Life
Care Vs Justice
Rights
Personhood
Ideological Knots

- The Christie report on public service reform in Scotland in 2011 highlighted the need to work closely with individuals to understand their needs, maximise their talents and resources, support self-reliance and build resilience.

- Since then, focusing on what matters to people by adopting personal outcomes approaches has moved beyond the 'nice to do' category of service improvement to being understood as fundamental to transforming and sustaining public services in Scotland.

- Many services across health, social care, housing and beyond have now developed good practice around personal outcomes.

- Evidence shows this approach leads to better outcomes for the individuals being supported and for organisations adopting this approach.

- Workers across all sectors have identified the need to raise awareness of personal outcomes approaches and to share experience and evidence.

Personal outcomes approaches in a nutshell

A wide range of policy areas in Scotland are underpinned by personal outcome approaches.

The individual and their personal outcomes

- Person-centred practice
- Recovery/rehabilitation/reablement
- Personalisation
- Health and social care integration
- Dementia
- Palliative and end of life care
- Active and independent living
- Autism
- Self-directed support
- GIRFEC
- National Health and Wellbeing outcomes
- Carers

What are personal outcomes?

When we talk about personal outcomes we mean the things that are important to people in their lives.

> “I want help with getting my confidence back in the kitchen. Home cooking makes a house into a home and the smell of soup on the stove makes me feel I am making a home for my husband and me.”

Iris, 82
Home from hospital after
breaking her leg in a fall

Personal outcomes often relate to maintaining or improving wellbeing.

- Seeing family friend and other people
- Being listened to
- Improved morale
- Having control in daily life
- Staying as well as can be
- Improved mobility
- Making a contribution
- Feeling safe
- Reduced/ managed symptoms
- Being treated as individual
- Being valued and respected
- Having things to do
- Belonging to a community
- Having people to rely on
- (Re)gaining confidence/skills

What does a personal outcomes approach mean for you?

For you as a worker, a personal outcomes approach involves **active listening, good conversations and engagement; recording personal outcomes in a meaningful way; reviewing and monitoring progress towards achieving personal outcomes.**

> “What I like about this way of working is that we are engaging with people about what is important to them, instead of processing them through the system.”

Eileen, 37
Social worker

The Health and Social Care Standards

Health and Social Care Standards

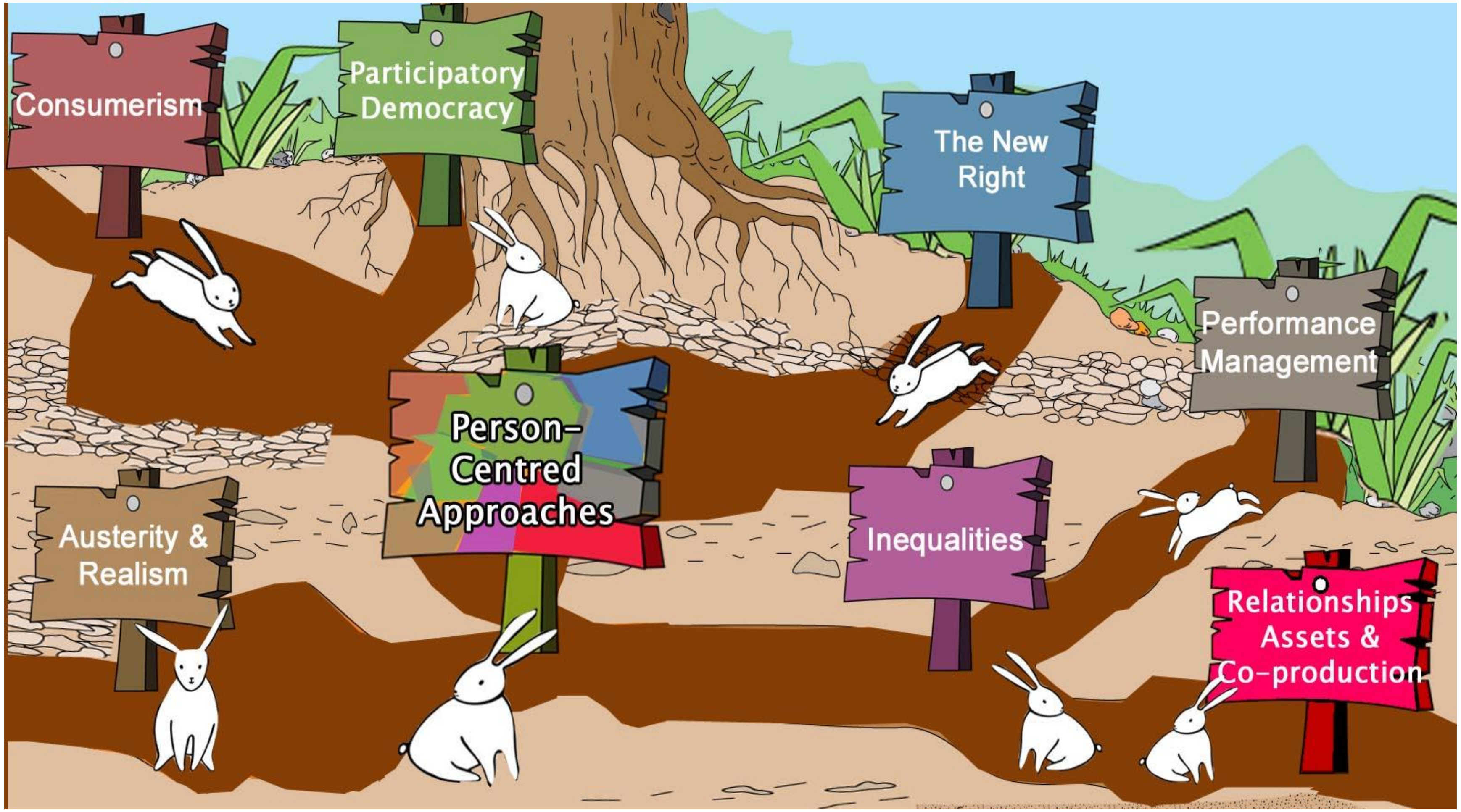
My support, my life.

Principles

- Dignity and respect
- Compassion
- Be included
- Responsive care and support
- Wellbeing

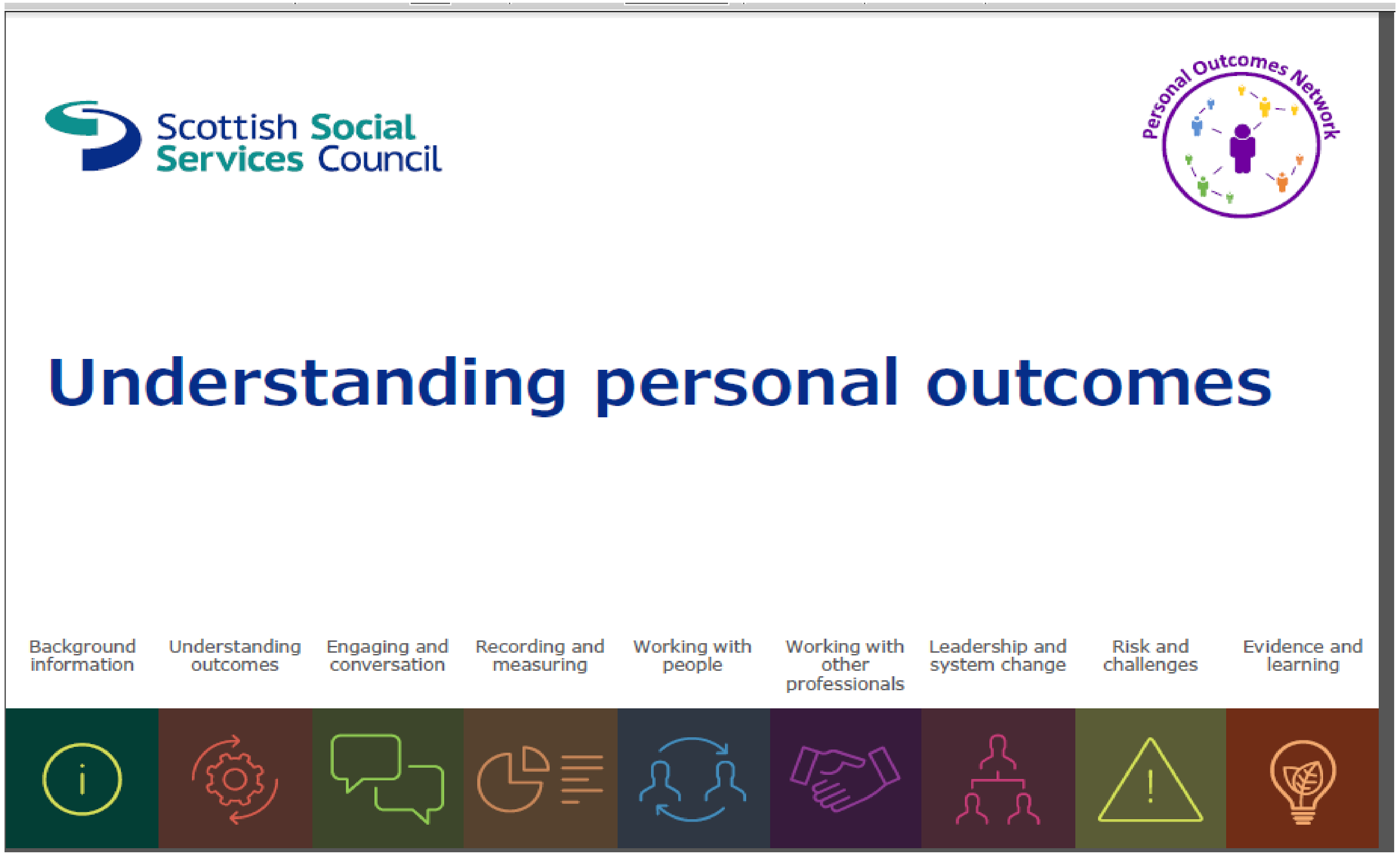
Standards

1. I experience high quality care and support that is right for me.
2. I am fully involved in all decisions about my care and support.
3. I have confidence in the people who support and care for me.
4. I have confidence in the organisation providing my care and support.
5. I experience a high quality environment if the organisations provides the premises.


Consumerism
Participatory Democracy
The New Right
Performance Management
Person-Centred Approaches
Austerity & Realism
Inequalities
Relationships Assets & Co-production

Background

- Co-design - Using Appreciative Inquiry principles
- Connecting with existing evidence and personal outcomes materials
- Building on what already exists
- Sharing learning and experience through collaborative development
- Grounded in the everyday realities, complexities. diversity and dynamics of people’s lives
- In recognition that improving personal outcomes is everybody’s business



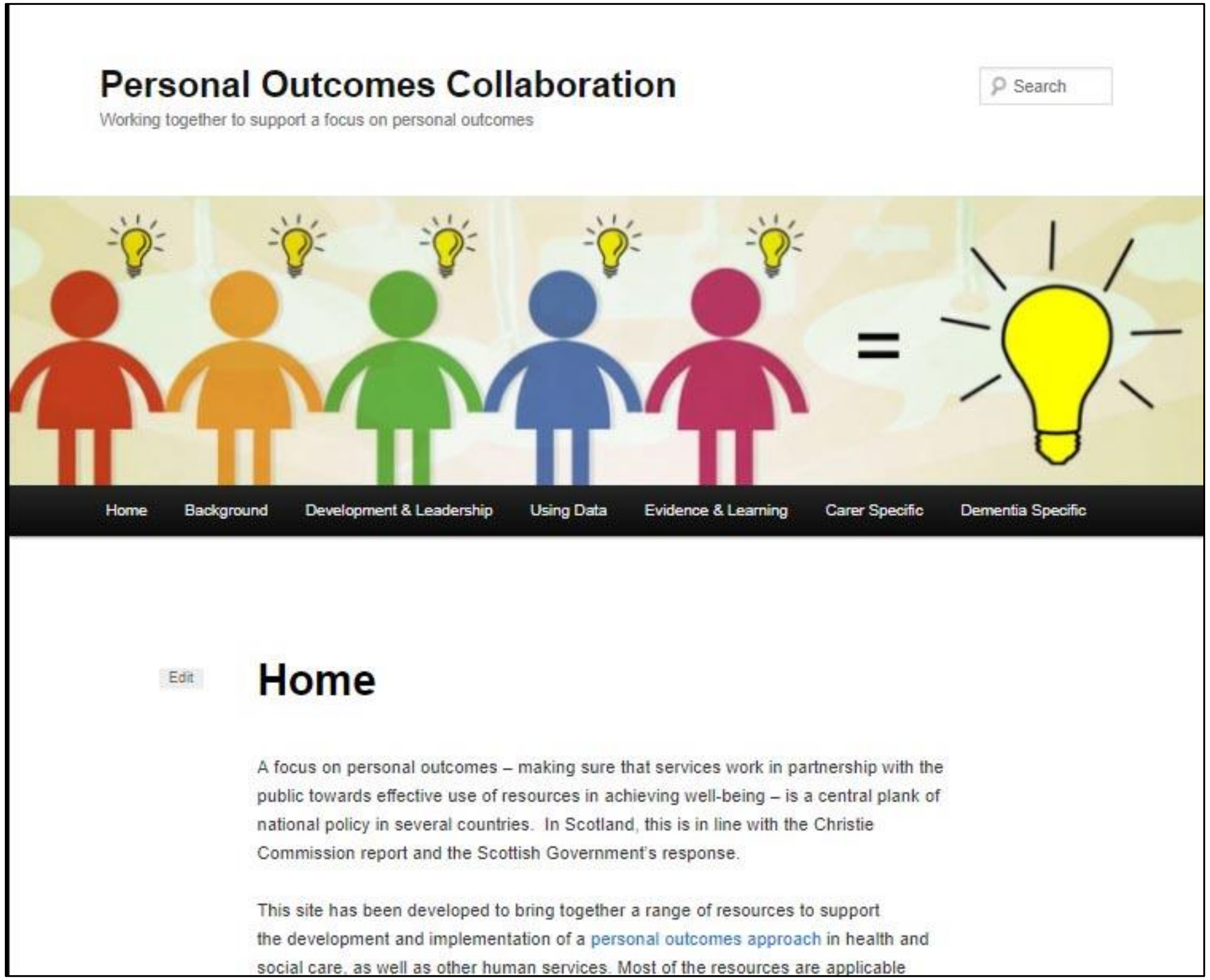
Scottish Social Services Council

Personal Outcomes Network

Understanding personal outcomes

- Background information
- Understanding outcomes
- Engaging and conversation
- Recording and measuring
- Working with people
- Working with other professionals
- Leadership and system change
- Risk and challenges
- Evidence and learning

Updating the Personal Outcomes Collaboration Website
https://personaloutcomescollaboration.org/



Personal Outcomes Collaboration

Working together to support a focus on personal outcomes

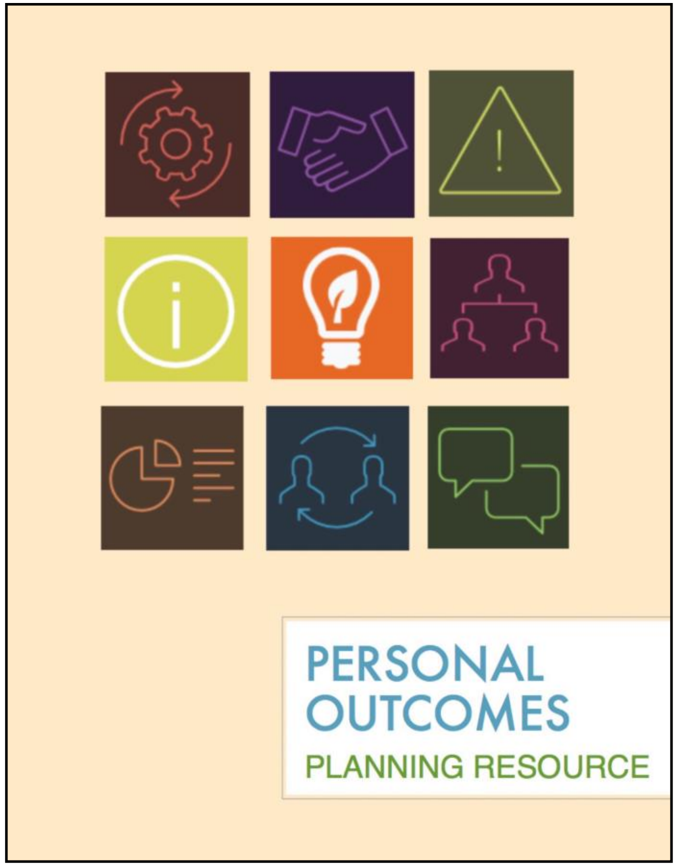
Home

A focus on personal outcomes – making sure that services work in partnership with the public towards effective use of resources in achieving well-being – is a central plank of national policy in several countries. In Scotland, this is in line with the Christie Commission report and the Scottish Government's response.

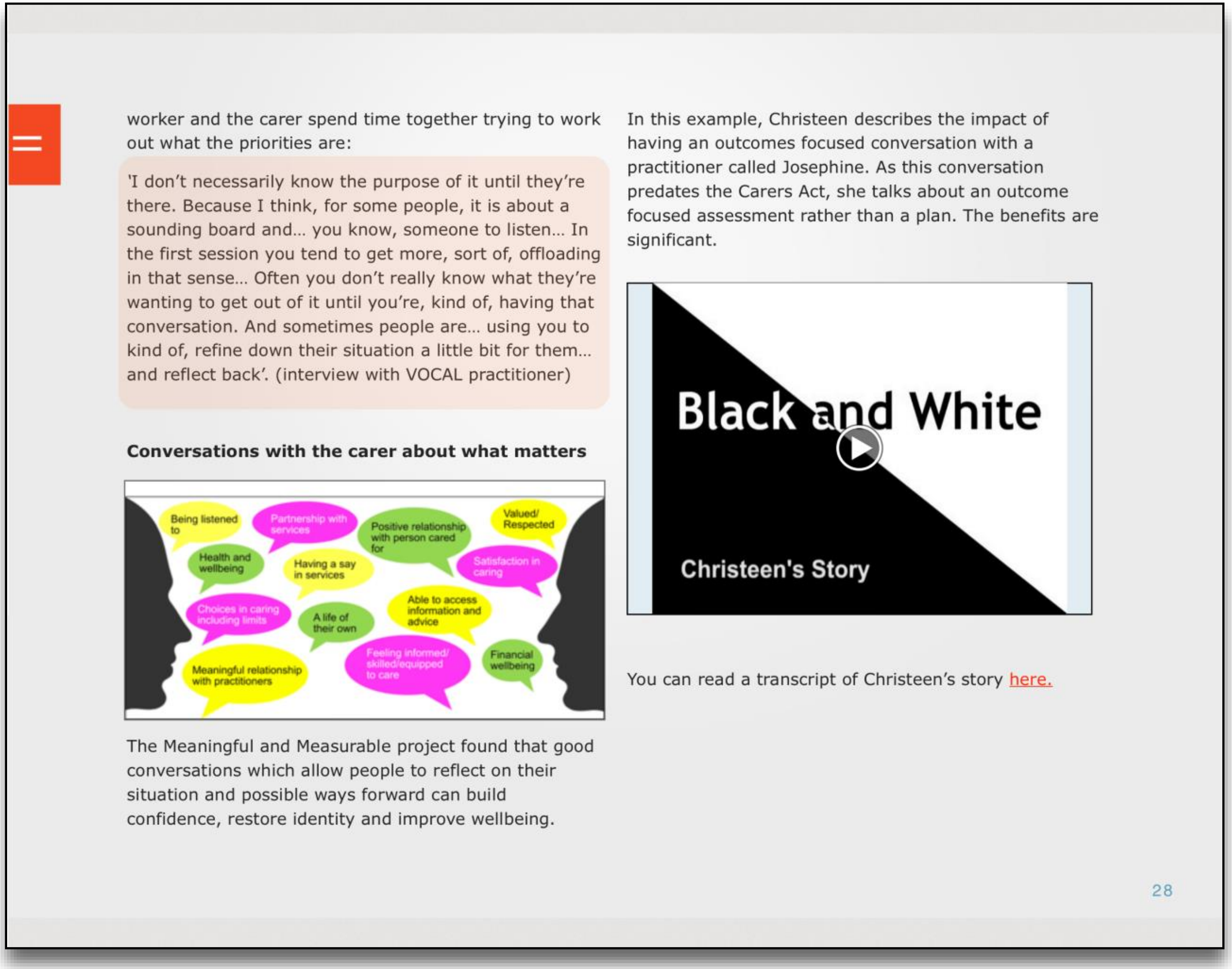
This site has been developed to bring together a range of resources to support the development and implementation of a personal outcomes approach in health and social care, as well as other human services. Most of the resources are applicable

Personal Outcomes E-books

- Interactive learning resource
- Includes videos and internet links
- Also has internal bookmarks to enable easy and quick navigation between sections
- Users are able to write their own notes to develop individualised resource



Personal Outcomes E-books



worker and the carer spend time together trying to work out what the priorities are:

> 'I don't necessarily know the purpose of it until they're there. Because I think, for some people, it is about a sounding board and… you know, someone to listen… In the first session you tend to get more, sort of, offloading in that sense… Often you don't really know what they're wanting to get out of it until you're, kind of, having that conversation. And sometimes people are… using you to kind of, refine down their situation a little bit for them… and reflect back'. (interview with VOCAL practitioner)

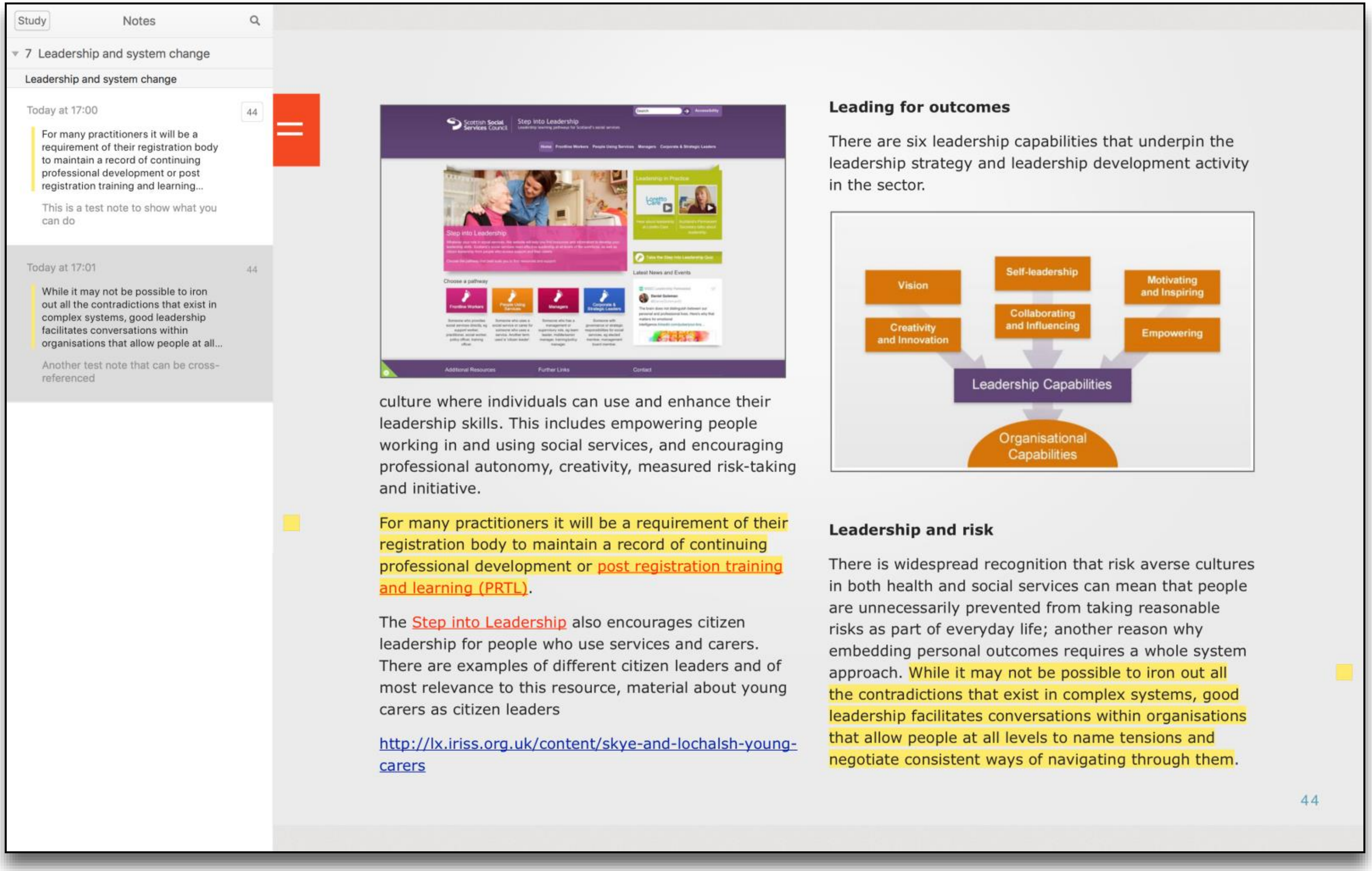
Conversations with the carer about what matters

The Meaningful and Measurable project found that good conversations which allow people to reflect on their situation and possible ways forward can build confidence, restore identity and improve wellbeing.

In this example, Christeen describes the impact of having an outcomes focused conversation with a practitioner called Josephine. As this conversation predates the Carers Act, she talks about an outcome focused assessment rather than a plan. The benefits are significant.

You can read a transcript of Christeen's story here.

Personal Outcomes E-books



Today at 17:00 44

For many practitioners it will be a requirement of their registration body to maintain a record of continuing professional development or post registration training and learning...

This is a test note to show what you can do

Today at 17:01 44

While it may not be possible to iron out all the contradictions that exist in complex systems, good leadership facilitates conversations within organisations that allow people at all...

Another test note that can be cross-referenced

culture where individuals can use and enhance their leadership skills. This includes empowering people working in and using social services, and encouraging professional autonomy, creativity, measured risk-taking and initiative.

For many practitioners it will be a requirement of their registration body to maintain a record of continuing professional development or post registration training and learning (PRTL).

The Step into Leadership also encourages citizen leadership for people who use services and carers. There are examples of different citizen leaders and of most relevance to this resource, material about young carers as citizen leaders

http://lx.iriss.org.uk/content/skye-and-lochalsh-young-carers

Leading for outcomes

There are six leadership capabilities that underpin the leadership strategy and leadership development activity in the sector.

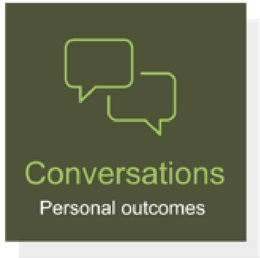
Leadership and risk

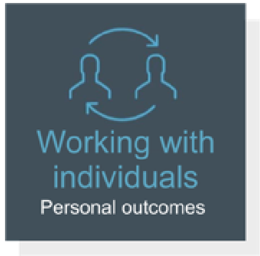
There is widespread recognition that risk averse cultures in both health and social services can mean that people are unnecessarily prevented from taking reasonable risks as part of everyday life; another reason why embedding personal outcomes requires a whole system approach. While it may not be possible to iron out all the contradictions that exist in complex systems, good leadership facilitates conversations within organisations that allow people at all levels to name tensions and negotiate consistent ways of navigating through them.

44

Open Badges

- Open badges available to recognise learning
- Learners will need to write short reflective account
- More badges to be developed including over-arching badge





Personal outcomes page on SSSC Learning Zone: learn.sssc.uk.com/popr

Immediate impact: Reactions, awareness

Do you feel that the resource is useful to your role and practice context? 99% of respondents to local launch events questionnaires to date answered Yes.

‘I am going to introduce the resource in Practitioner training –particularly ‘Carers Act’

‘Will check out with Voluntary sector colleagues and Children’s Services’

‘I plan to look at project group with practitioners and how we can collaboratively use the resources’

Immediate impact: Reactions, awareness

‘Great new book on Personal Outcomes, fantastic resource’

‘Also worth mentioning you can use the approach beyond client/practitioner relationships and include team meetings, student/clinical supervision. Let’s really shift the culture of care!’

‘I am going to explore further with Children’s Services’

‘Will use to develop further learning resources and to work with staff’

THANK YOU

For more information on the personal outcomes resources and to request copies of the personal outcomes booklet please contact: sdsandintegration@sssc.uk.com

Short Stories on Care Co-ordination

Care homes

Jo Hockley

Care coordination and care homes

Jo Hockley RN PhD
Primary Palliative Care Research Group
Centre for Population Health Sciences
The Usher Institute, University of Edinburgh
Jo.hockley@ed.ac.uk

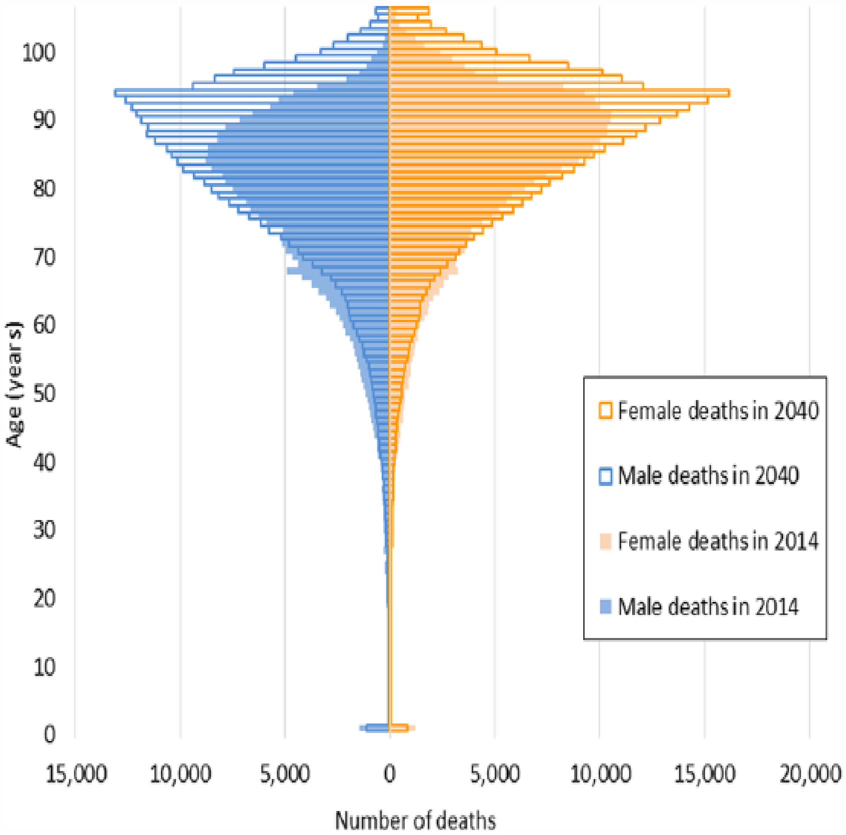
Over the last 10 years:

- People over 80+ years is the fastest segment of our UK population
- **Care home residents now increasingly frail with multiple co-morbidities and increasing dependency**
  - 80% of residents in care homes have diagnosis of dementia or severe memory loss
  - Multiple co-morbidities
  - One fifth of Scottish population die in care homes
- Care home workforce
  - Is overlooked compared with its NHS counterpart – lack of career structure
  - High turnover of staff + difficulties in recruitment
- **Increasing pressure for external healthcare professionals to support to care homes**

Impact of population ageing

- The disabled older population will increase by over 80% and those with dementia by 50% by 2030 (Jagger et al 2009)

- By 2040, it is predicted that 40% UK population will die in care homes (Bone et al, 2017)



Bone et al (2017) What is the impact of population ageing on future provision of end-of-life care. Pall Med https://doi.org/10.1177/0269216317734435
Jagger et al (2009) The effect of dementia trends and treatments on longevity and disability: a simulation model based on the MRC Cognitive Function and Ageing Study (MRC CFAS) *Age and Ageing* 2009; 38: 319–325

Gaining a better hold on palliative care in care homes – what are the main issues

- Lack of recognising dying
- Lack of external healthcare support in relation to palliative care
- Lack of support of staff

- CIRC tool
- Monthly palliative care m/disciplinary meetings in the care home
- Reflective debriefing

Gaining a better hold on palliative care in care homes – what are the main issues

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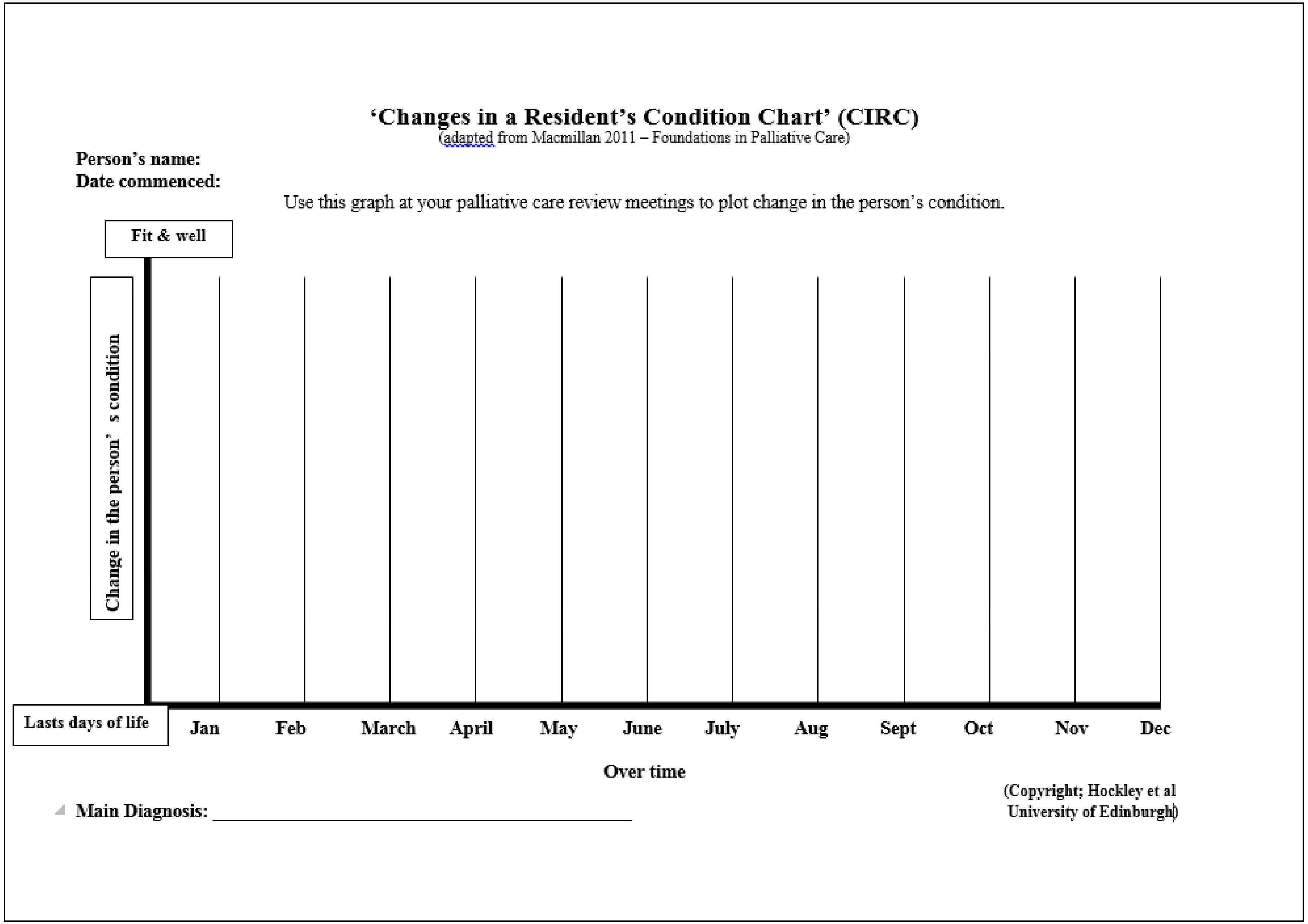


‘Changes in a Resident’s Condition Chart’ (CIRC)

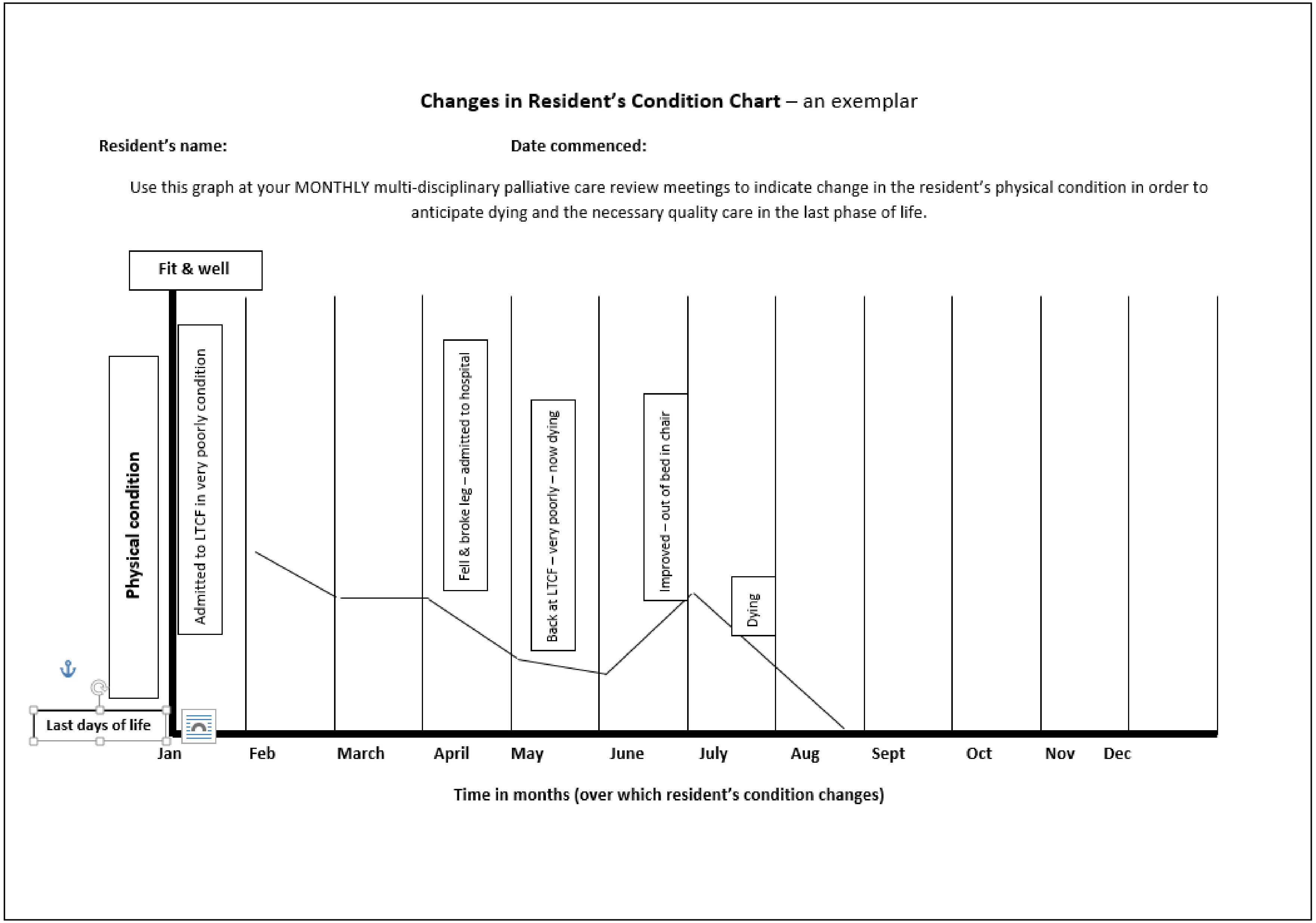
(adapted from Macmillan 2011 – Foundations in Palliative Care)

Person’s name:
Date commenced:

Use this graph at your palliative care review meetings to plot change in the person’s condition.

Main Diagnosis: ____

(Copyright; Hockley et al
University of Edinburgh)



Changes in Resident's Condition Chart – an exemplar

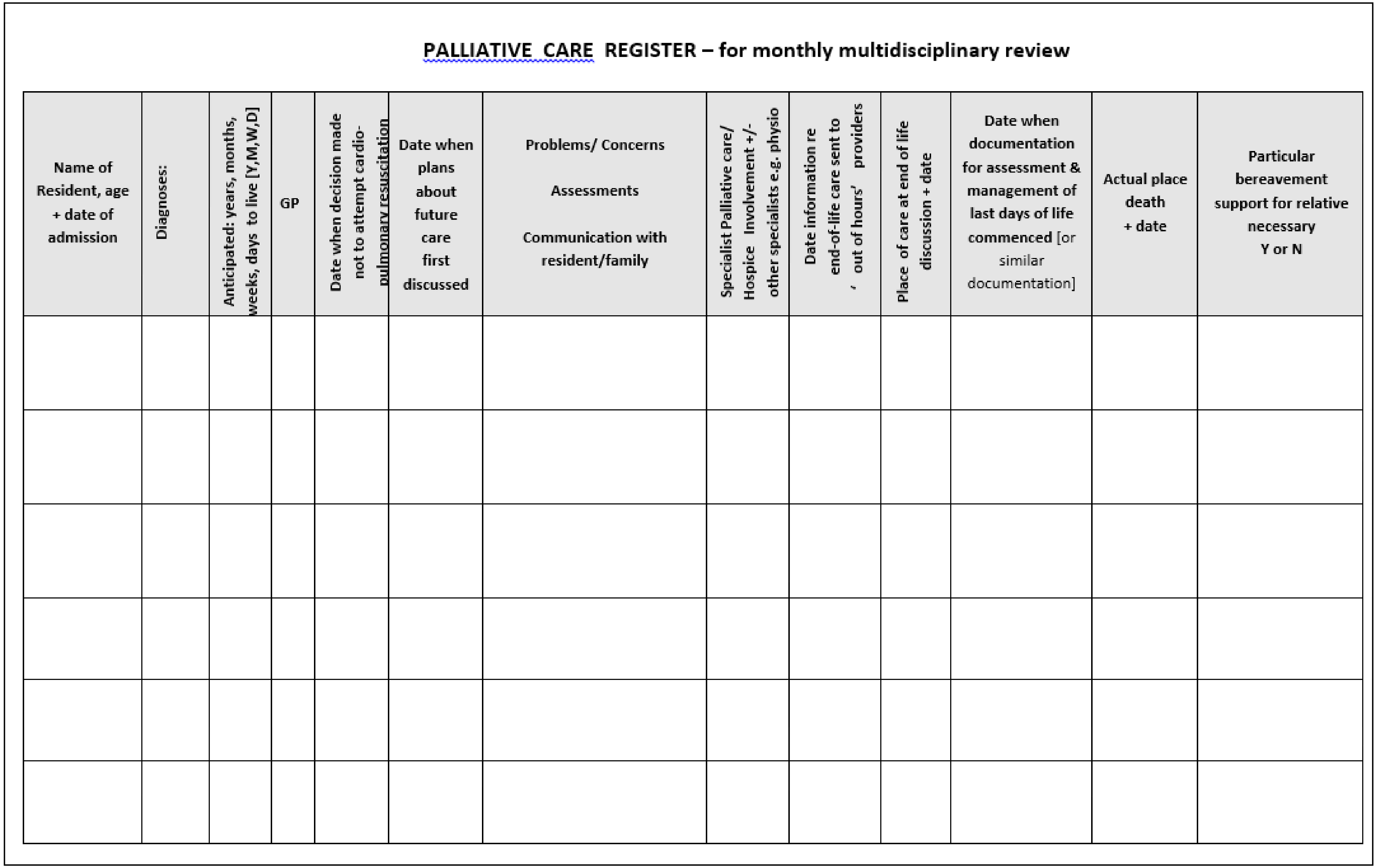
Resident's name: **Date commenced:**

Use this graph at your MONTHLY multi-disciplinary palliative care review meetings to indicate change in the resident's physical condition in order to anticipate dying and the necessary quality care in the last phase of life.

Gaining a better hold on palliative care in care homes – what are the main issues

- Lack of recognising dying
- Lack of external healthcare support in relation to palliative care
- Lack of support of staff

- CIRC tool
- Monthly palliative care m/disciplinary meetings in the care home
- Reflective debriefing



PALLIATIVE CARE REGISTER – for monthly multidisciplinary review

Name of Resident, age + date of admission	Diagnoses:	Anticipated: years, months, weeks, days to live [Y,M,W,D]	GP	Date when decision made not to attempt cardio-pulmonary resuscitation	Date when plans about future care first discussed	Problems/ Concerns Assessments Communication with resident/family	Specialist Palliative care/ Hospice Involvement +/- other specialists e.g. physio	Date information re end-of-life care sent to 'out of hours' providers	Place of care at end of life discussion + date	Date when documentation for assessment & management of last days of life commenced [or similar documentation]	Actual place death + date	Particular bereavement support for relative necessary Y or N

Gaining a better hold on palliative care in care homes – what are the main issues

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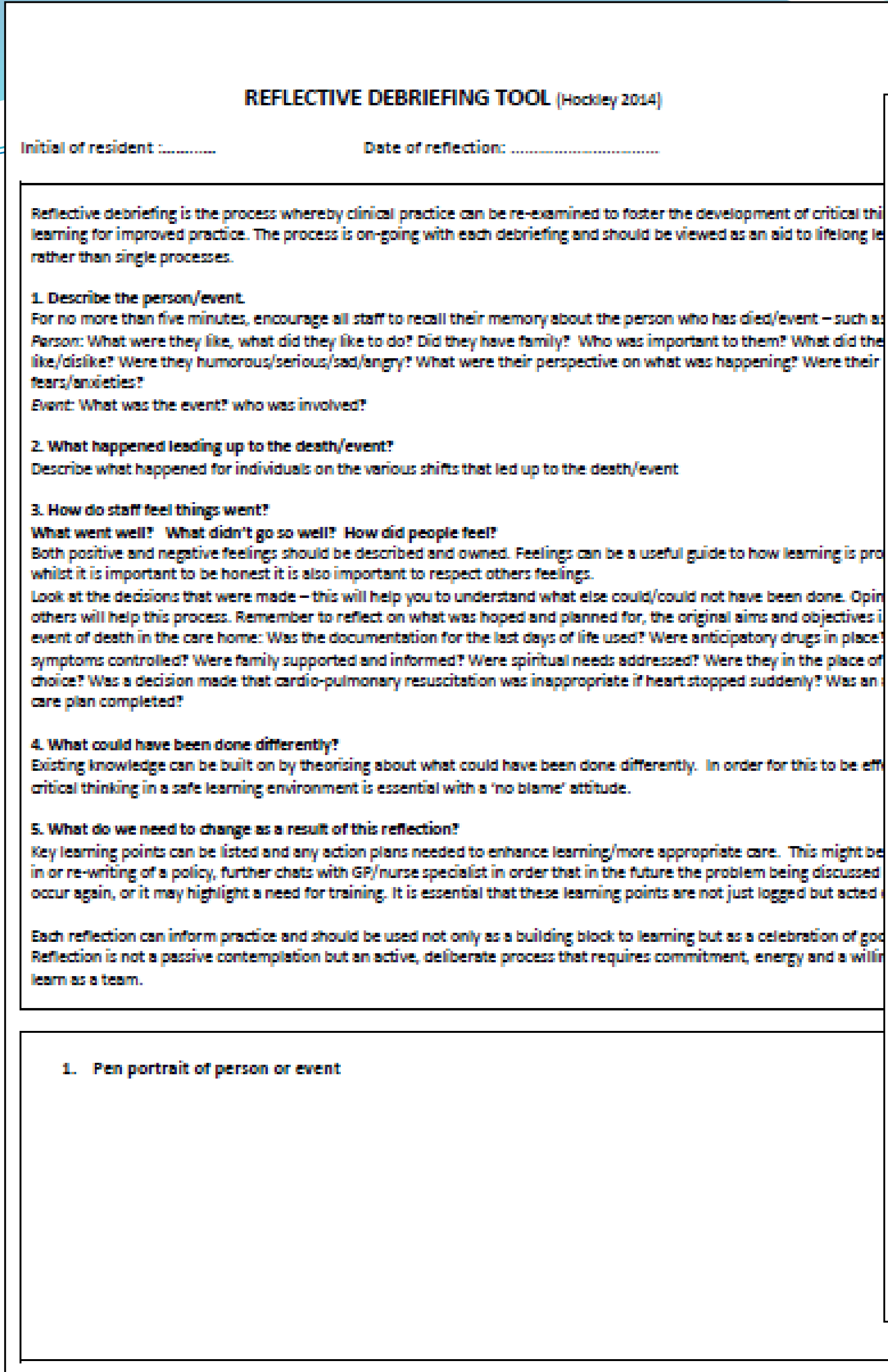


REFLECTIVE DEBRIEFING TOOL (Hockley 2014)

Initial of resident :..........   Date of reflection: ....

Reflective debriefing is the process whereby clinical practice can be re-examined to foster the development of critical thi learning for improved practice. The process is on-going with each debriefing and should be viewed as an aid to lifelong le rather than single processes.

1. Describe the person/event.
For no more than five minutes, encourage all staff to recall their memory about the person who has died/event – such as
Person: What were they like, what did they like to do? Did they have family? Who was important to them? What did the like/dislike? Were they humorous/serious/sad/angry? What were their perspective on what was happening? Were their fears/anxieties?
Event: What was the event? who was involved?

2. What happened leading up to the death/event?
Describe what happened for individuals on the various shifts that led up to the death/event

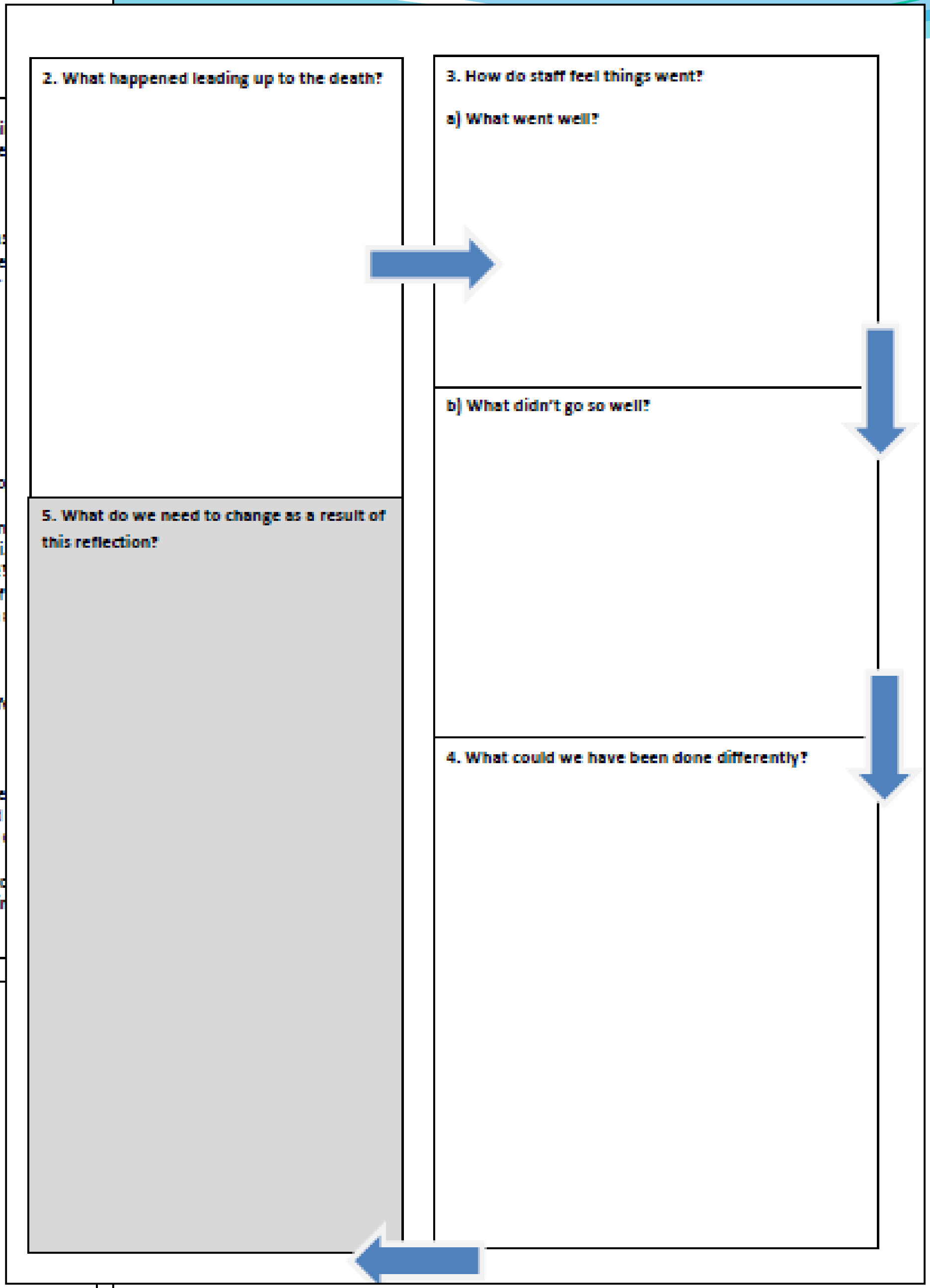
3. How do staff feel things went?
What went well? What didn't go so well? How did people feel?
Both positive and negative feelings should be described and owned. Feelings can be a useful guide to how learning is pro whilst it is important to be honest it is also important to respect others feelings.
Look at the decisions that were made – this will help you to understand what else could/could not have been done. Opin others will help this process. Remember to reflect on what was hoped and planned for, the original aims and objectives i event of death in the care home: Was the documentation for the last days of life used? Were anticipatory drugs in place? symptoms controlled? Were family supported and informed? Were spiritual needs addressed? Were they in the place of choice? Was a decision made that cardio-pulmonary resuscitation was inappropriate if heart stopped suddenly? Was an care plan completed?

4. What could have been done differently?
Existing knowledge can be built on by theorising about what could have been done differently. In order for this to be eff critical thinking in a safe learning environment is essential with a 'no blame' attitude.

5. What do we need to change as a result of this reflection?
Key learning points can be listed and any action plans needed to enhance learning/more appropriate care. This might be in or re-writing of a policy, further chats with GP/nurse specialist in order that in the future the problem being discussed occur again, or it may highlight a need for training. It is essential that these learning points are not just logged but acted

Each reflection can inform practice and should be used not only as a building block to learning but as a celebration of goo Reflection is not a passive contemplation but an active, deliberate process that requires commitment, energy and a willin learn as a team.

1. Pen portrait of person or event



2. What happened leading up to the death?

3. How do staff feel things went?

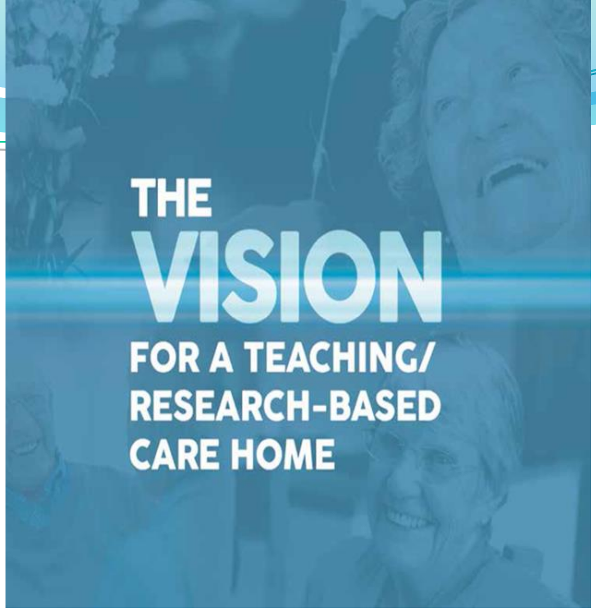
a) What went well?

b) What didn't go so well?

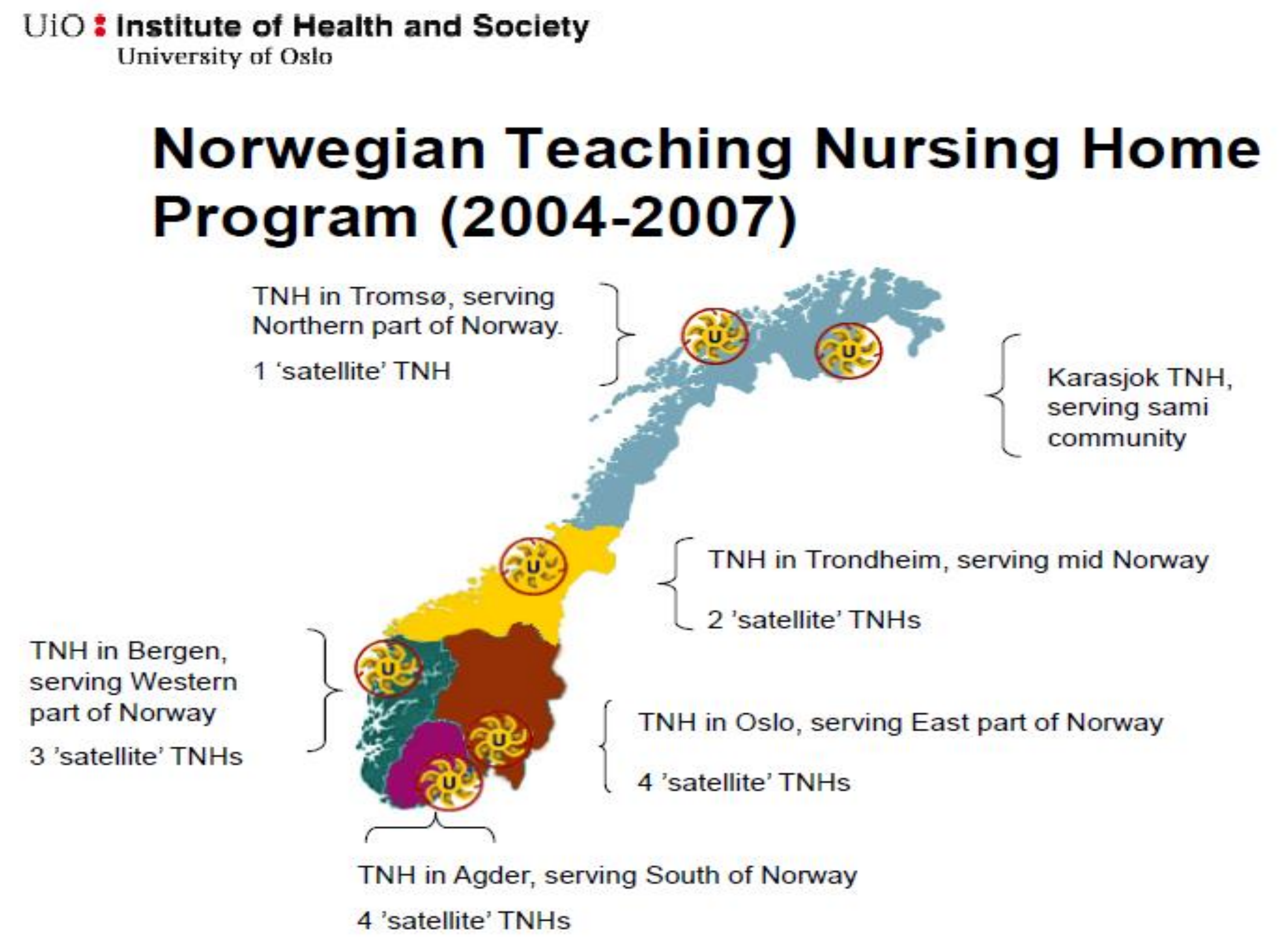
4. What could we have been done differently?

5. What do we need to change as a result of this reflection?

Update [2015-2017]



- 2015-2017
  - Scoping of the international literature + visited TNHs in Norway, the Netherlands & Australia
  - Visioning Day
  - Undertook a FEASIBILITY STUDY
  - Reported to NHS Lothian + local IJBs
- 2018
  - Support
    - all universities in Lothian (QMU, EN, **UoE** & HW) + local 'not-for-profit' care home/housing organisation
    - Scottish Government support



UiO : **Institute of Health and Society**
University of Oslo

Norwegian Teaching Nursing Home Program (2004-2007)

TNH in Tromsø, serving Northern part of Norway.

1 'satellite' TNH

Karasjok TNH, serving sami community

TNH in Trondheim, serving mid Norway

2 'satellite' TNHs

TNH in Bergen, serving Western part of Norway

3 'satellite' TNHs

TNH in Oslo, serving East part of Norway

4 'satellite' TNHs

TNH in Agder, serving South of Norway

4 'satellite' TNHs

Kirkevold, M (2008) The Norwegian teaching home program: developing a model for systematic practice development in the nursing home sector. Journal of Older Peoples Nursing, 3(4):

Linking care homes into the system

- Eight ‘satellite’ care homes:
  - Undertake ‘tests of change’ to inform the Centre
  - Form a relationship together across care home companies
  - Once Centre is built, they will help disseminate to CHs in their region
- Hospital-based ‘older people medicine’
- Hospital-at-home
- Community services

- Linking CHs with each other
  - clusters

In summary – we want to:

- Bring a sea-change in local public/professional perception of care homes
- Be the sustainability initiative behind practice development and quality improvement
- Support/work with 100+ care homes across Lothian in quality improvement initiatives and research
- Encourage a career pathway in care home work for health and social care professionals and so increase the workforce
- Encourage training in CHs for a variety of student interests
- Establish volunteerism and community engagement in care of frail older people

Thank you
jo.hockley@ed.ac.uk

Short Stories on Care Co-ordination

Looking beyond 2021
Richard Meade

Marie
Curie

Care and support
through terminal illness

Beyond 2021: thinking about the future

Richard Meade, Head of Policy and Public Affairs, Scotland

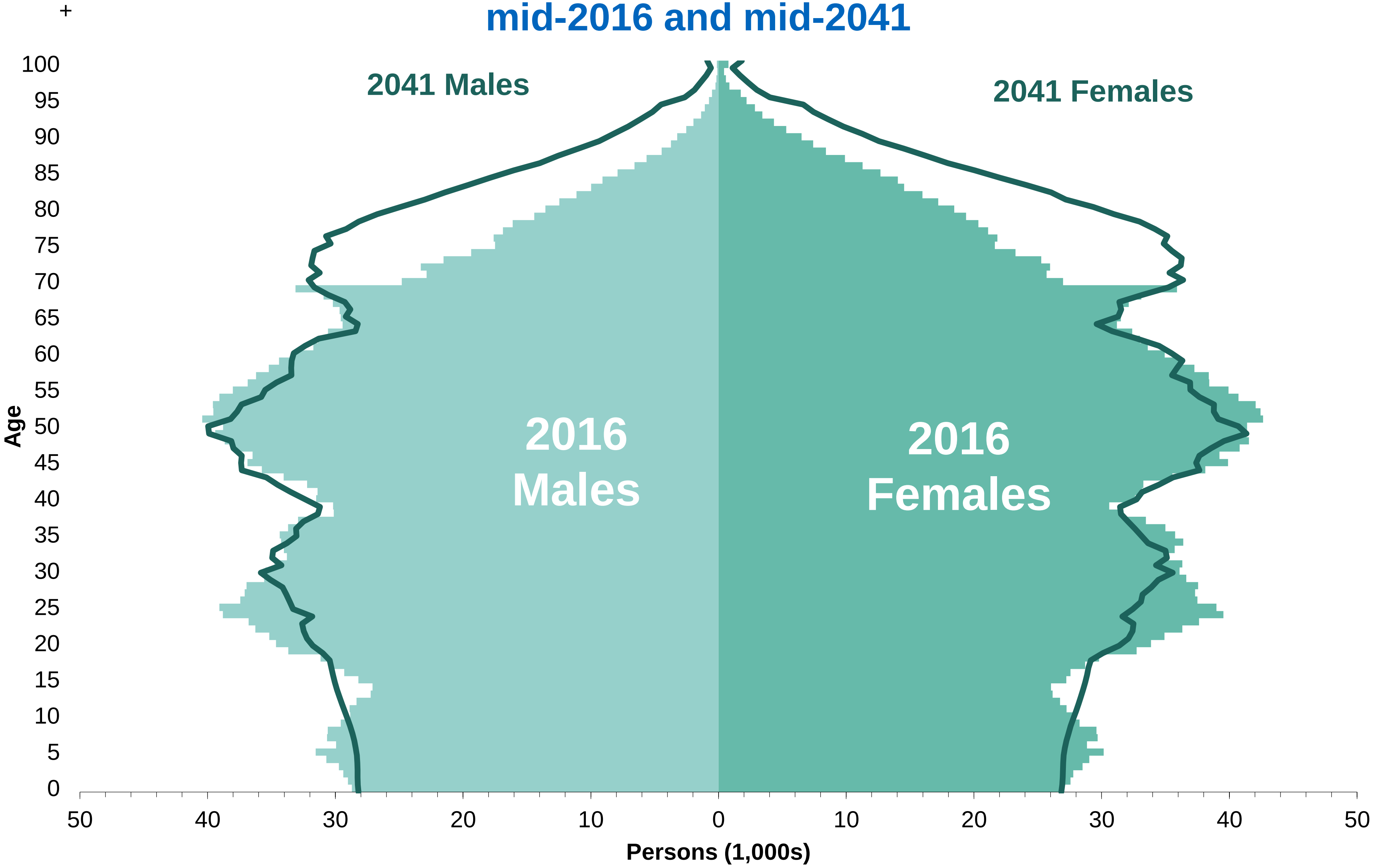
Marie Curie

Care and support through terminal illness

Beyond 2021: thinking about the future

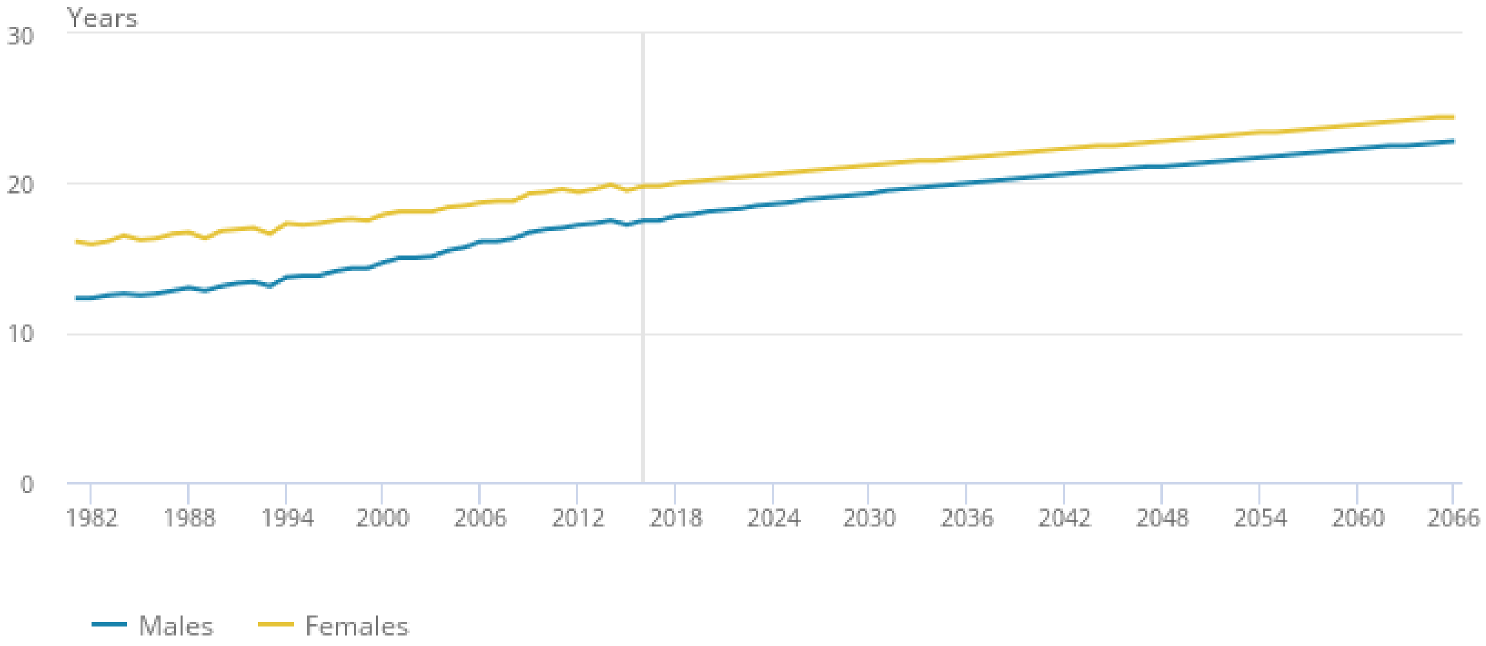
- Are we thinking about tomorrow or just for today?
- What does tomorrow look like?
- What are the challenges we know about?
- What are the challenges we do not know about?
- How can we prepare for the future?

Estimated and projected age structure of the Scottish population, mid-2016 and mid-2041



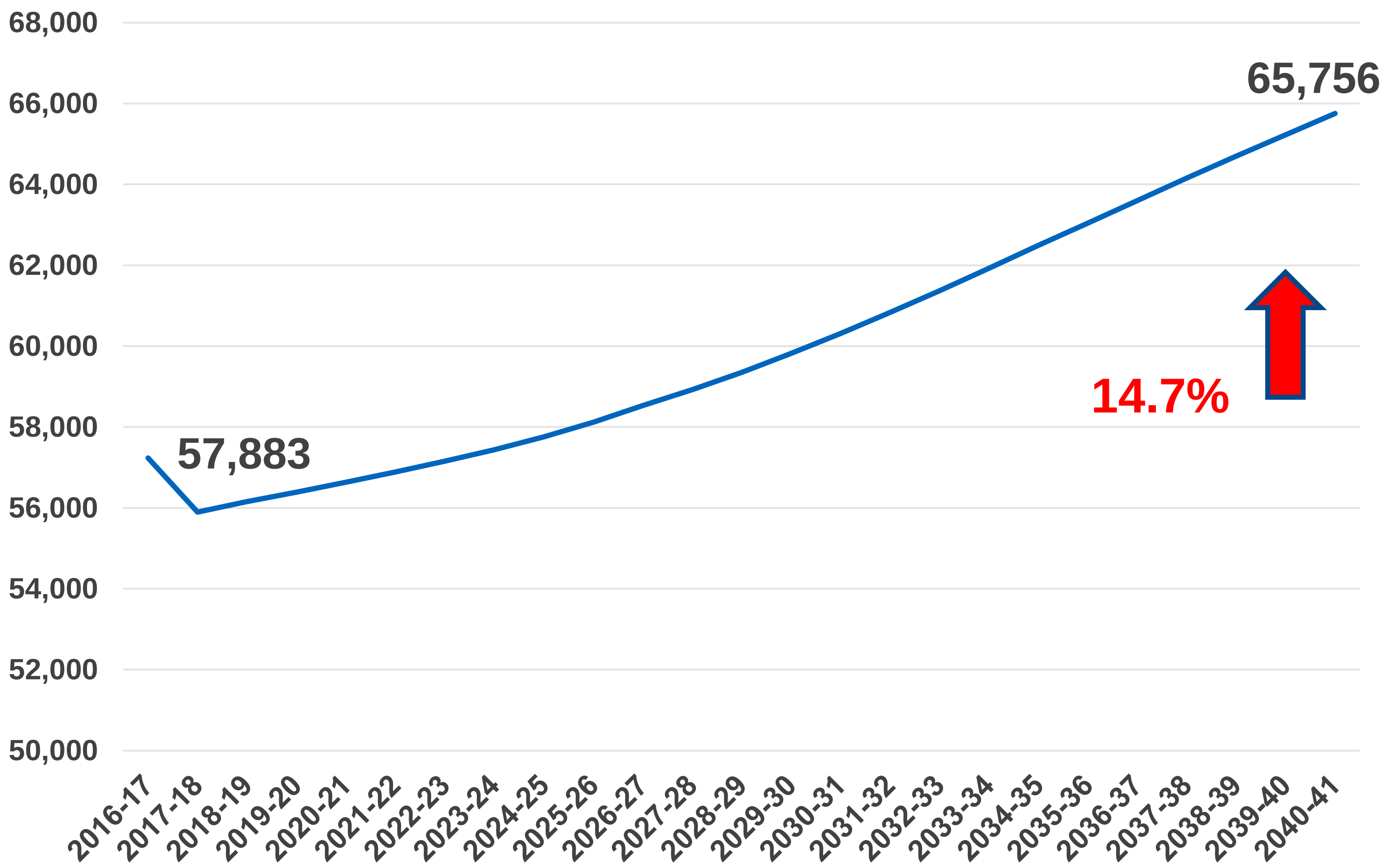
Life Expectancy at 65 – projected forward

Figure 4.8b: Estimated and projected period expectation of life at age 65, Scotland, 1981 to 2066

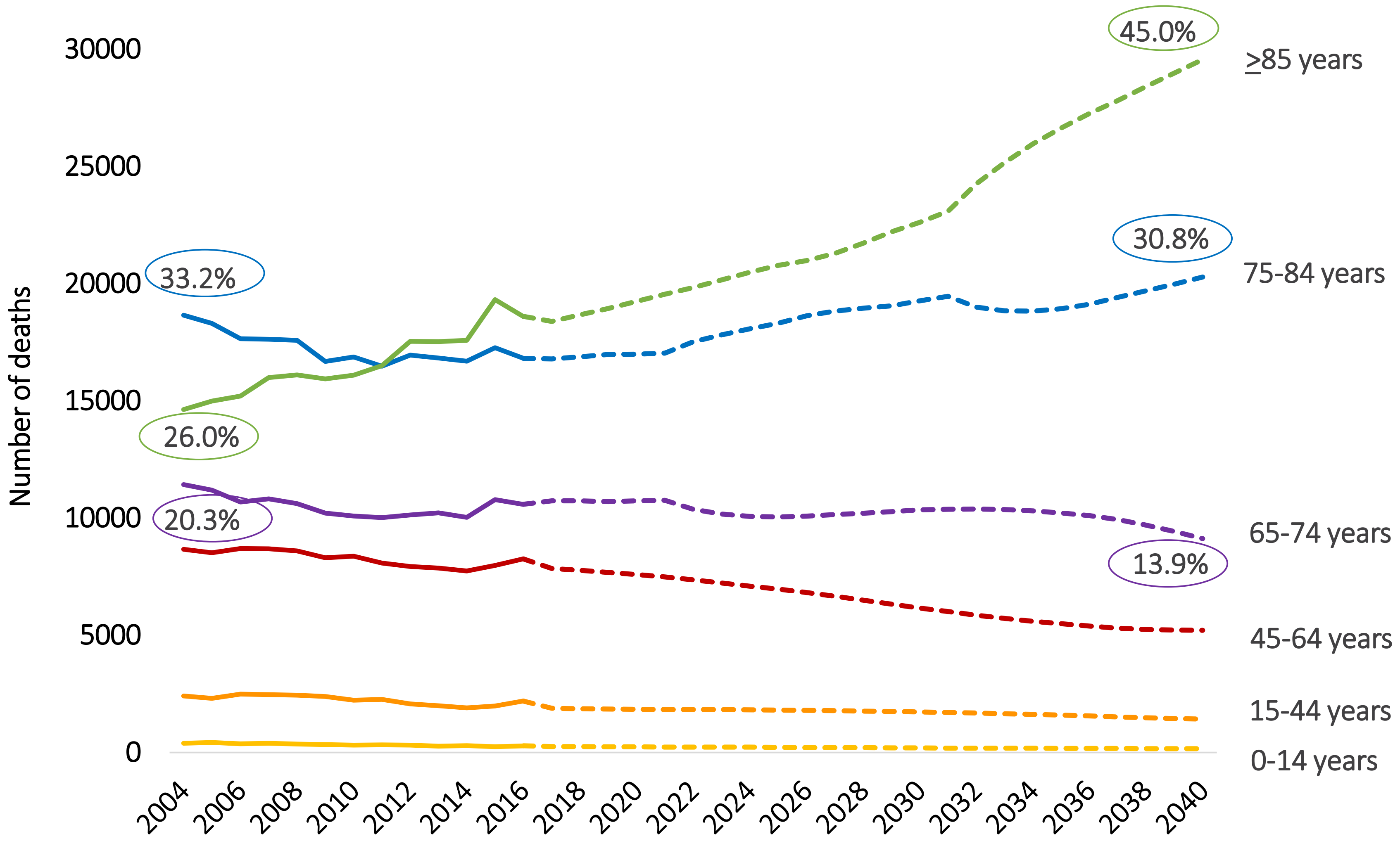


Source: Office for National Statistics

Projected deaths in Scotland 2016-41



Observed and projected deaths in Scotland by age group

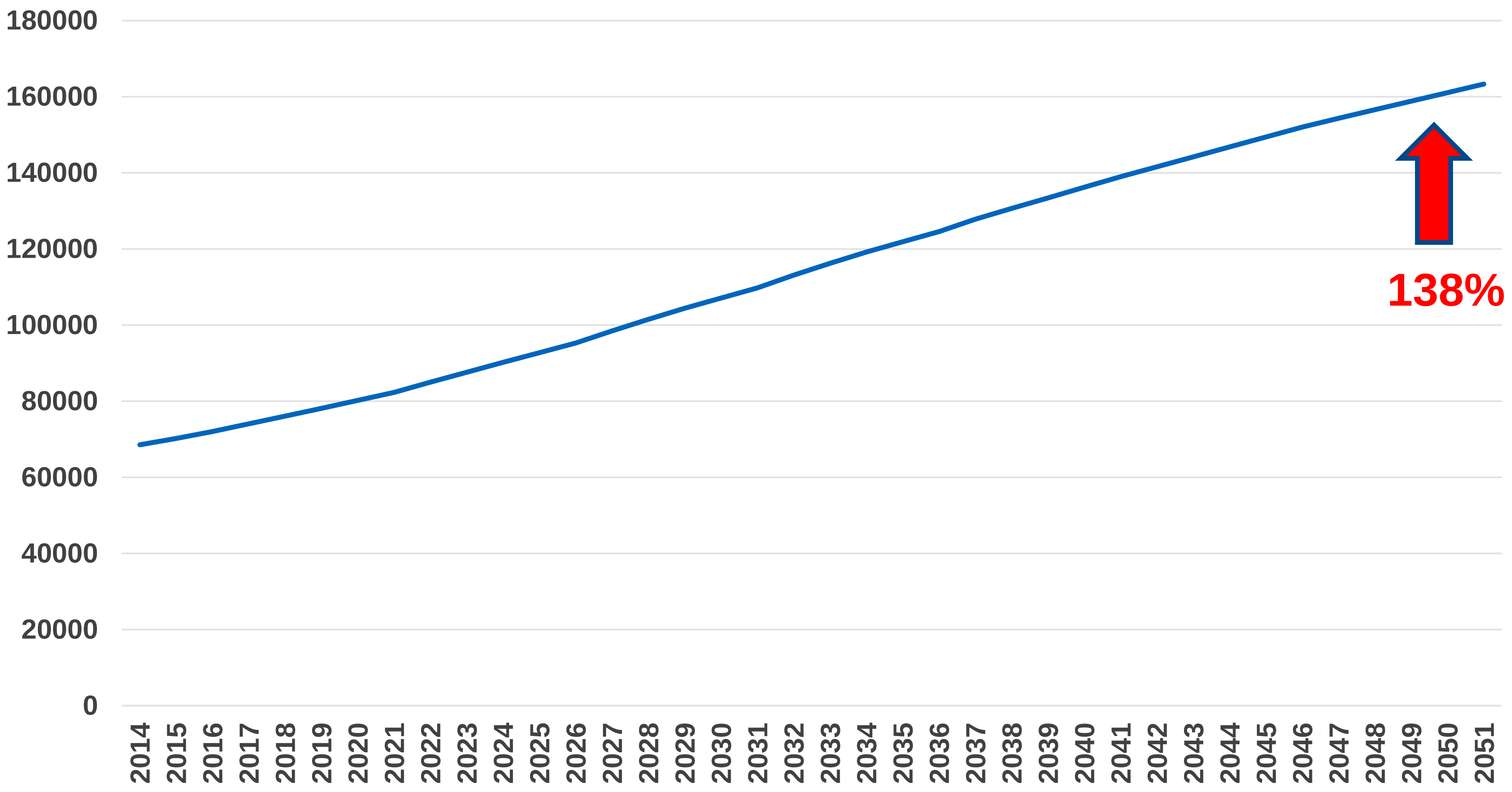


Data source:
Office for National Statistics

Care and support through terminal illness

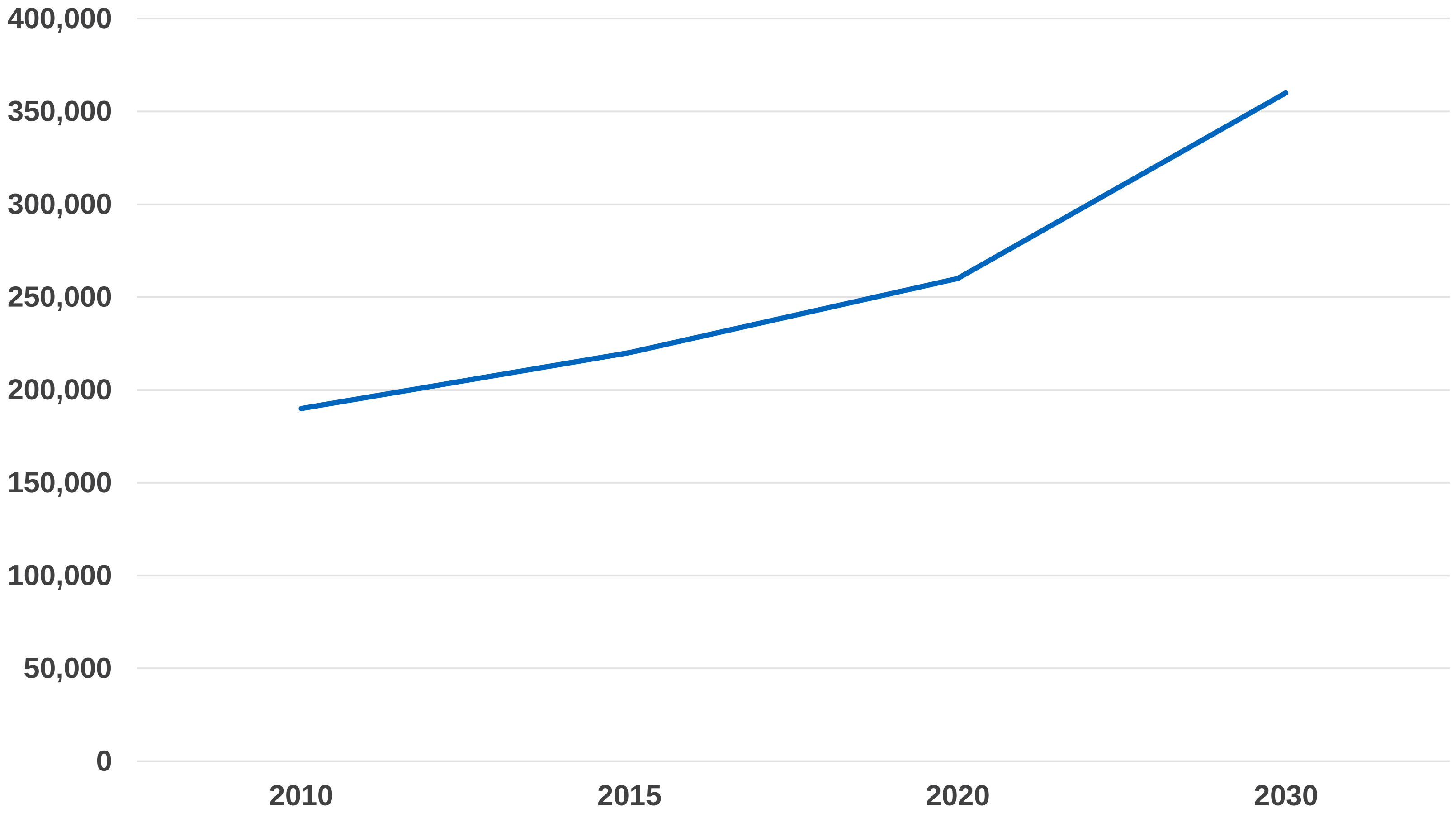
Marie Curie

Prevalence of Dementia: Scotland 2014-2051



Source:Prince, M et al (2014) Dementia UK: Update Second Edition report produced by King’s College London and the London School of Economics for the Alzheimer’s Society. ONS; National population Projections, 2012-based projections.

Prevalence of cancer projections: Scotland 2010-30



Source: https://www.macmillan.org.uk/_images/cancer-statistics-factsheet_tcm9-260514.pdf

Frailty could also rise significantly

Frailty Prevalence rises with increasing age:

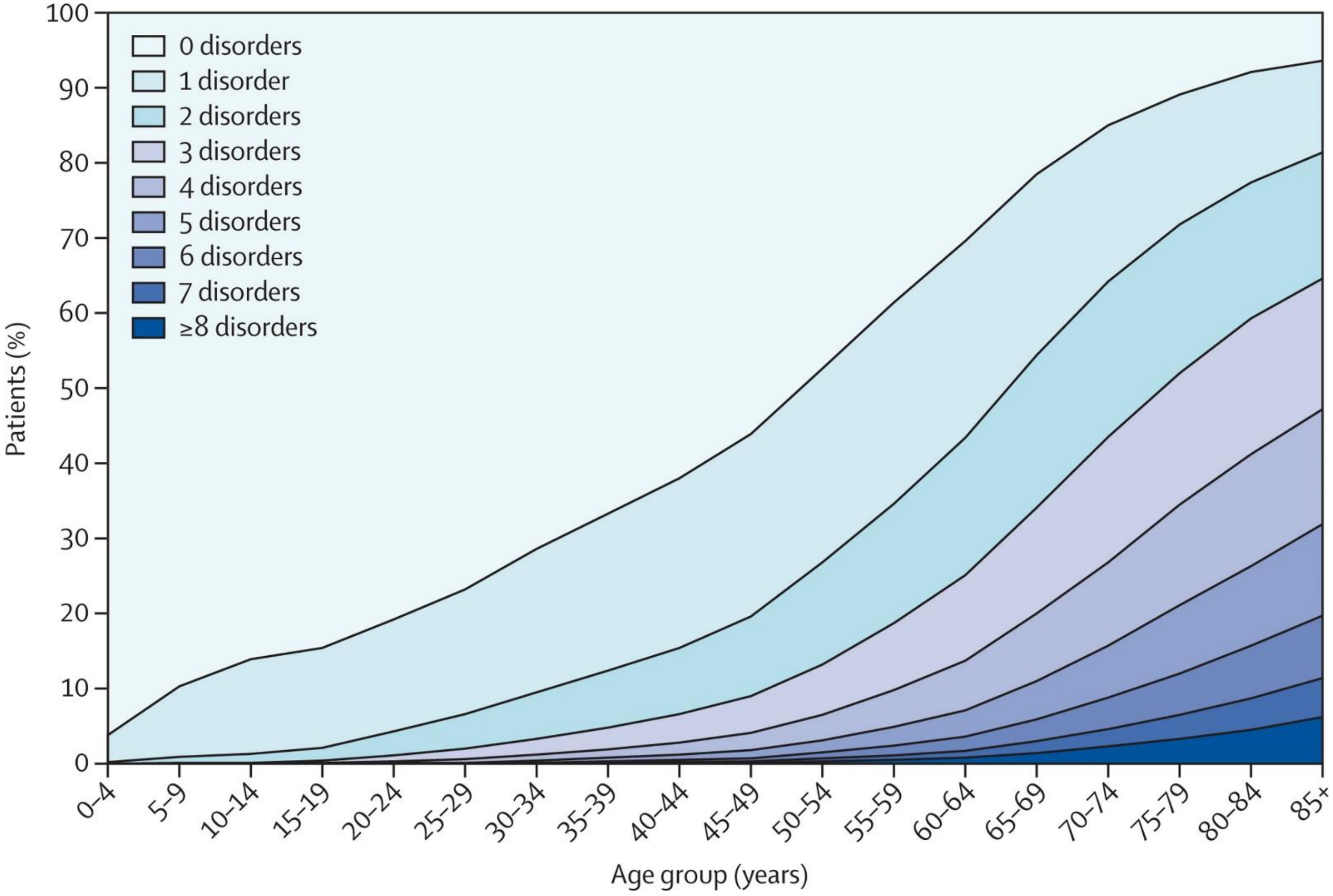
- **6.5% in those >60 years**
- **30% in those >80 years**
- **65% in those >90 years**

(Longitudinal study Age & Ageing 2014)

Frailty in over 80s	
2016	91,031
2040	177,040

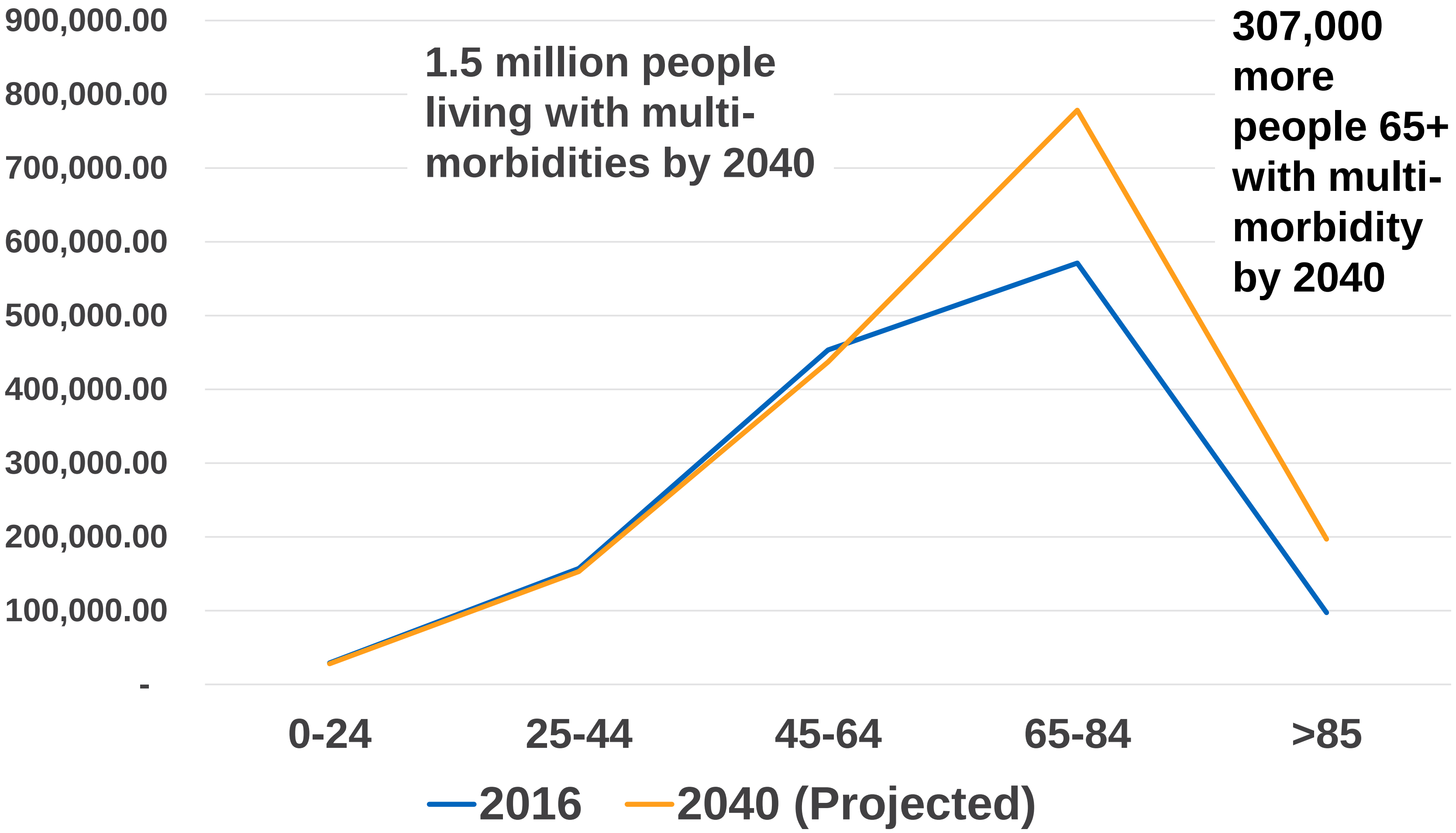
Multimorbidity

Age
0-24 – 1.9%
25-44 – 11.3%
45-64 – 30.4%
65-84 – 64.9%
85+ – 81.5%



Source: Barnett et al

Prevalence of Multimorbidity 2016 vs 2040 (projected)

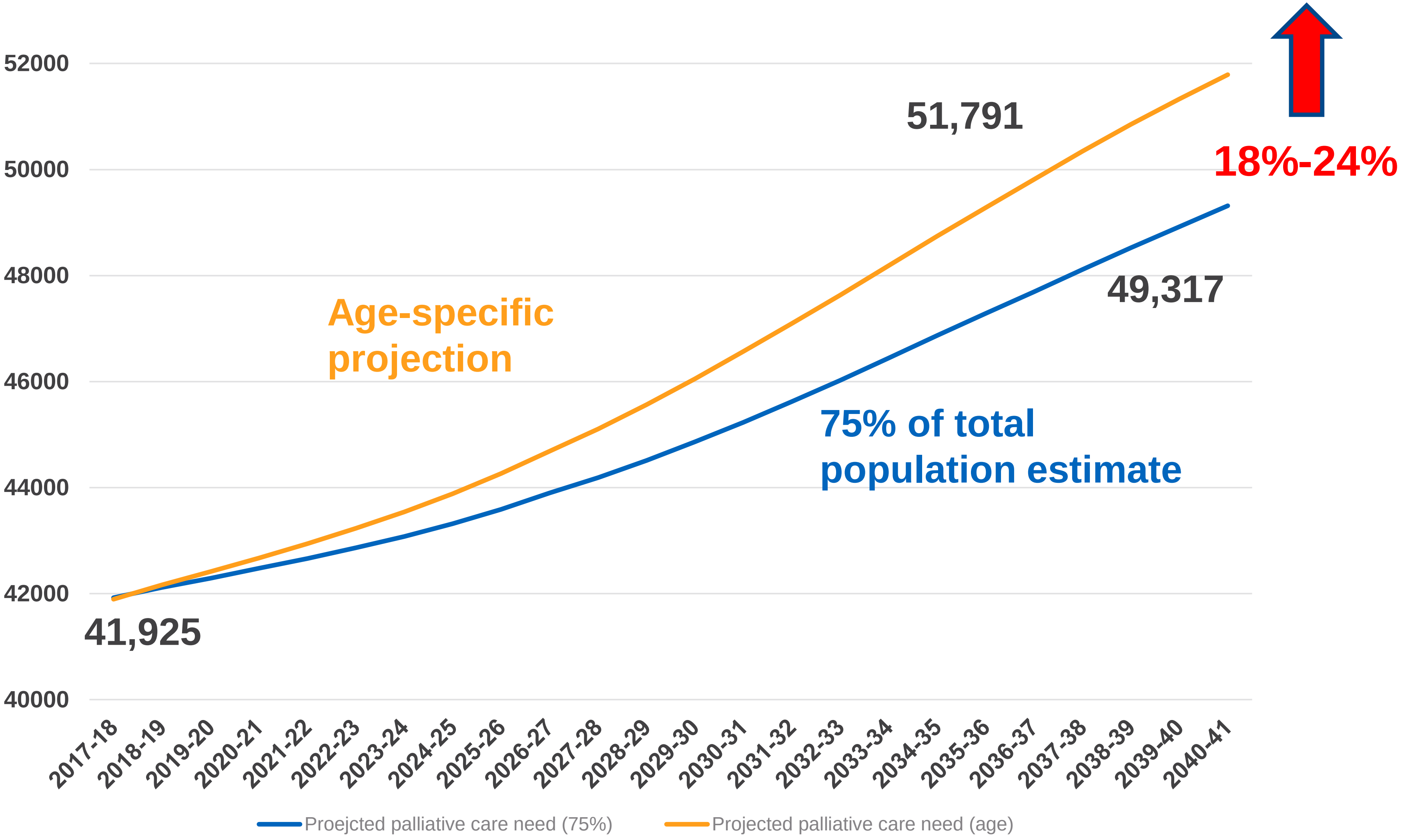


1.5 million people living with multi-morbidities by 2040

307,000 more people 65+ with multi-morbidity by 2040

Source: details here (or delete)

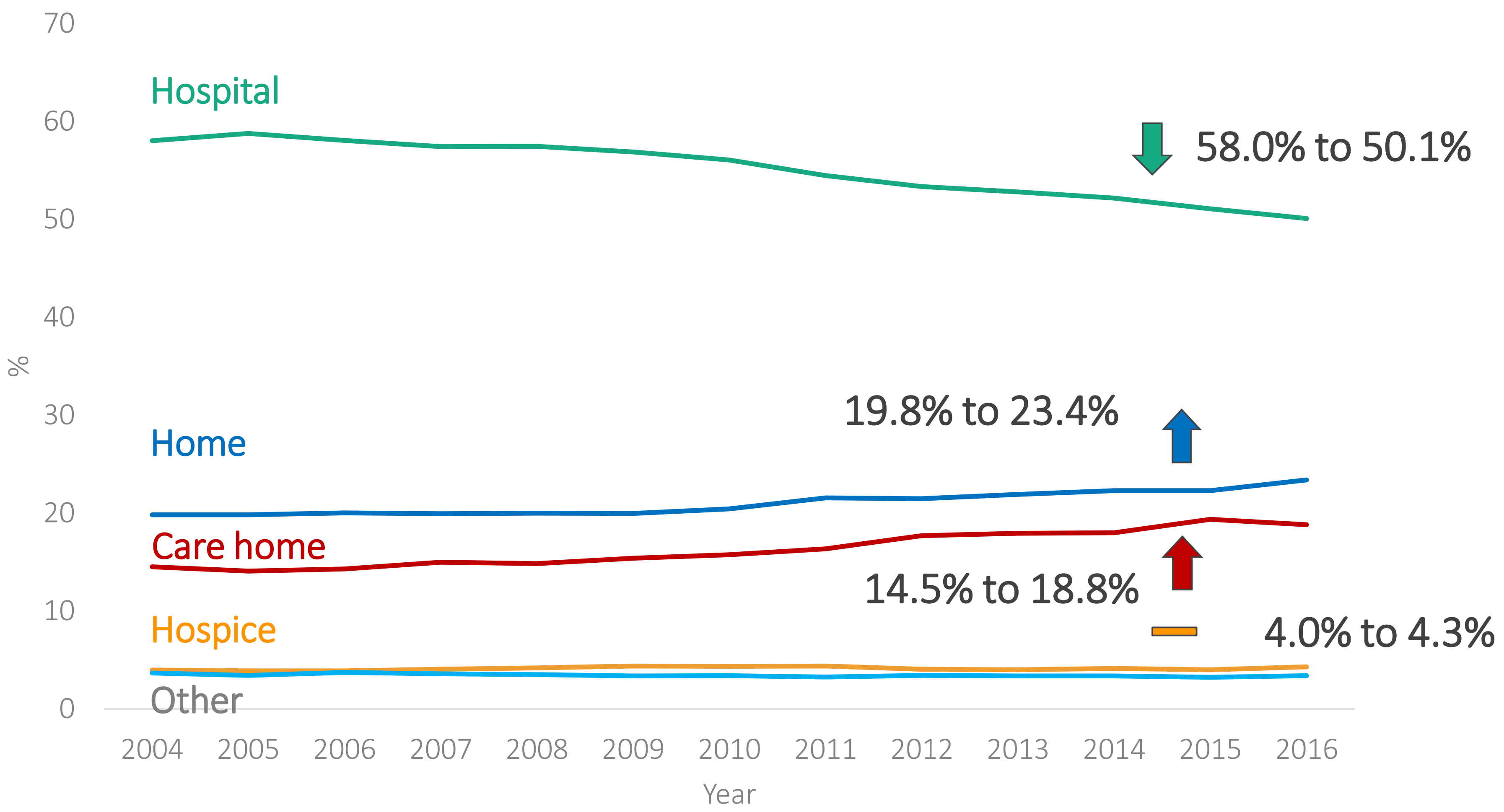
Estimated Palliative Care Need in Scotland 2017-2040



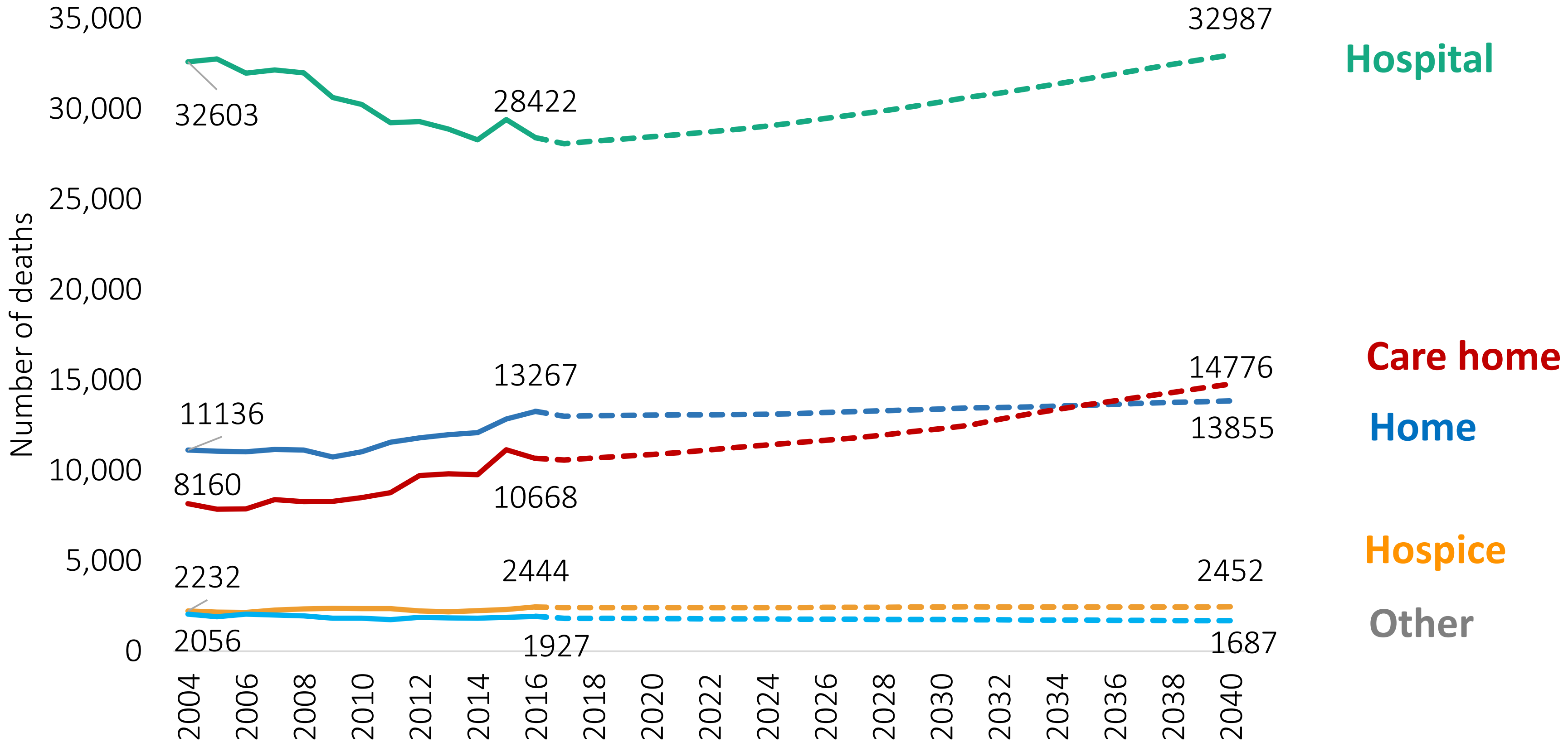
Care and support through terminal illness

Marie Curie

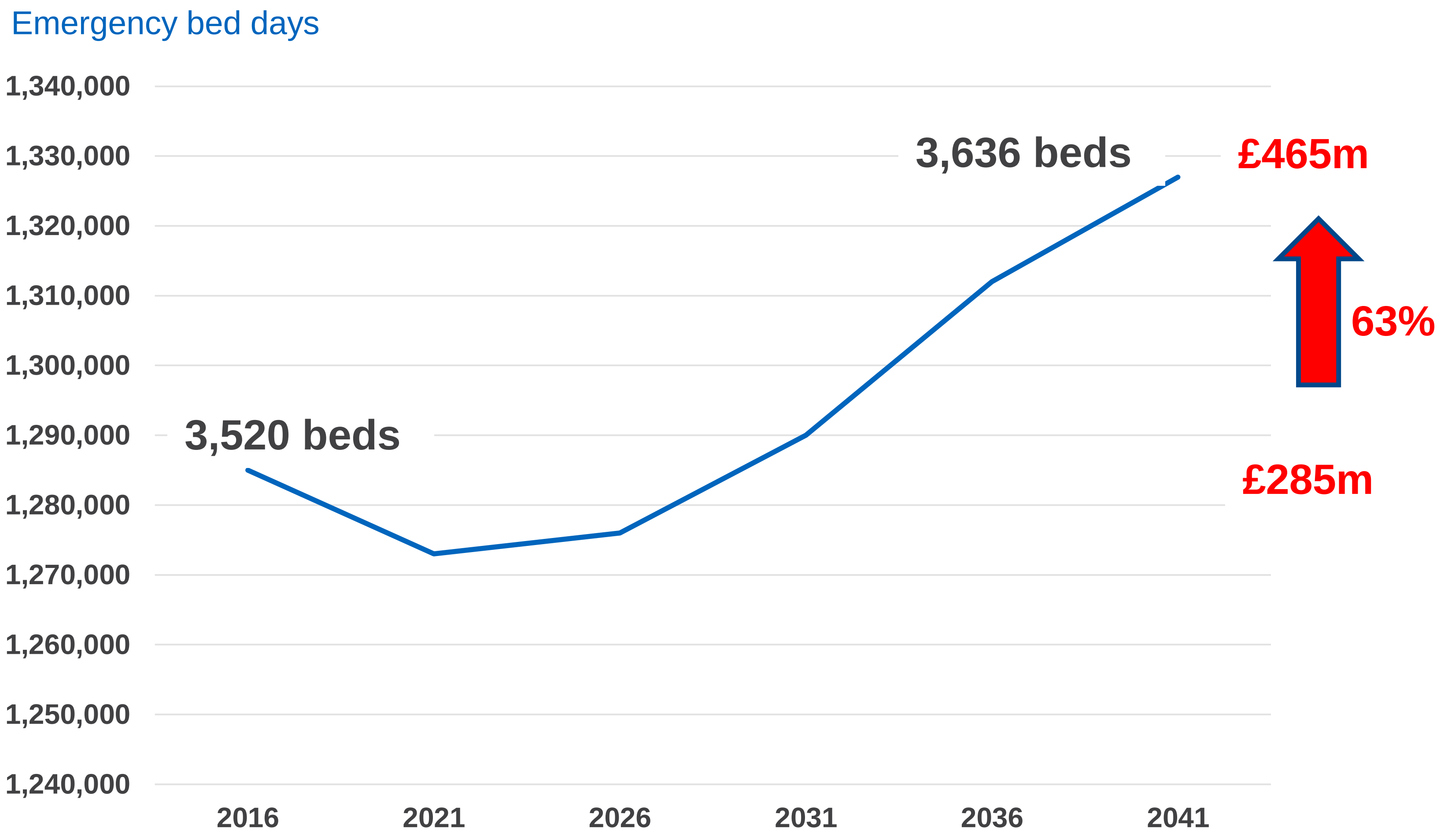
13-year trends in place of death in Scotland (2004-2016)



Assumes proportions of deaths in each setting in 2016 are unchanged

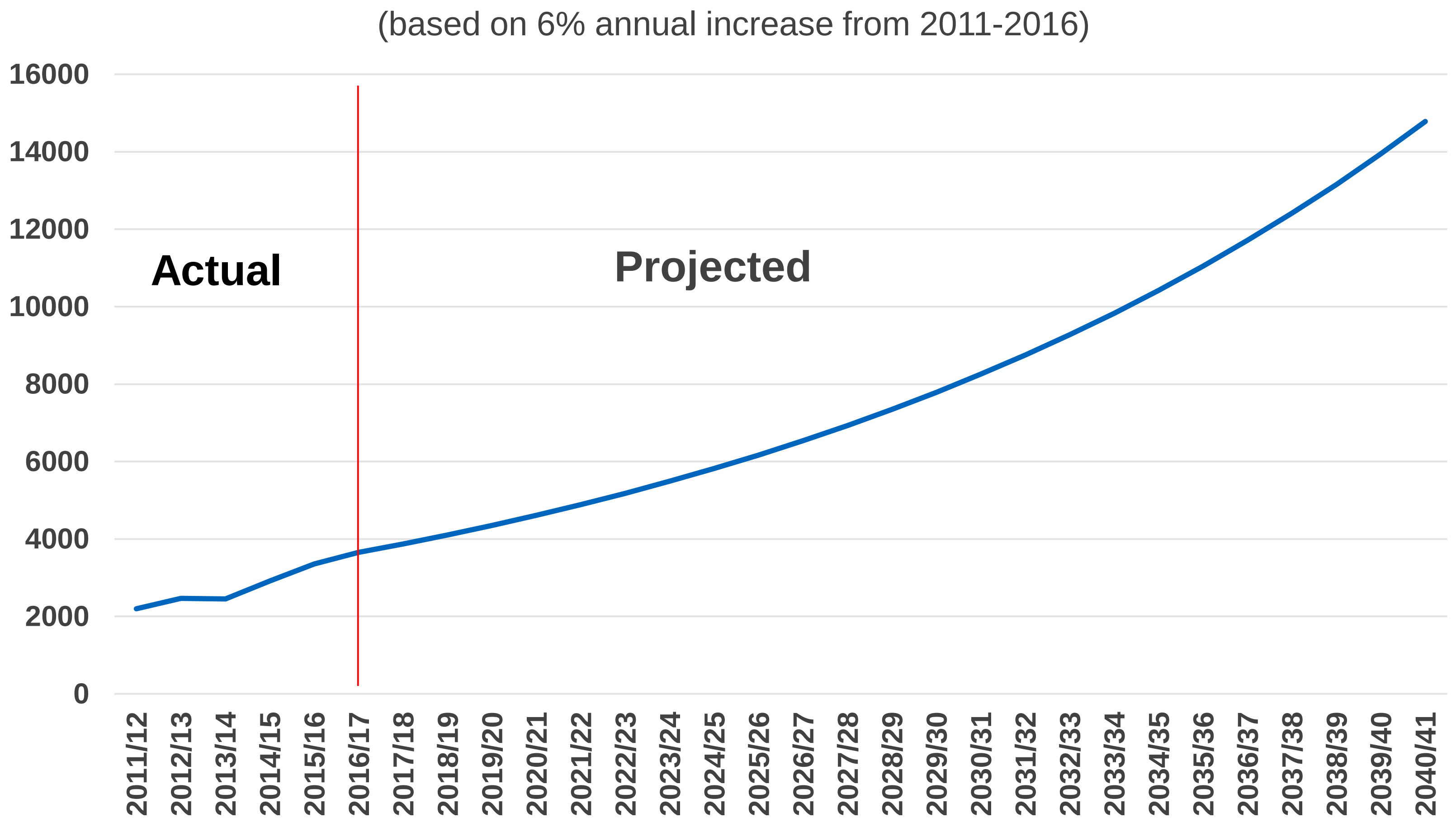


Emergency Admissions at end of life



Source: Marie Curie Emergency Admissions Report 2018

Dementia Emergency bed days – projected 2041



Source: details here (or delete)

What does all this mean

More people living longer, with multi-morbidities, most likely to include dementia, cancer and frailty.

- Increasing pressures on every care setting?
- Increasing pressures on workforce and resources
- What about informal carers?
- Changing models and ways of care?
- Are we doing enough to prevent/reduce challenges
- Specialist vs generalist palliative care

Workforce Challenges Projected forward

GP/DN nursing

Care homes

Care at home services

Palliative care services

ISD – 3700 GPs (WTE) in 2009 and now 3,575 GPs (WTE) in 2017 – 3.4% decrease

By 2042

Notes: further details here (or delete)

Source: details here (or delete)

Palliative Care Consultant Workforce

The projected population of Scotland in 2041 according to the high migration variant was previously labelled as 5.99 million.

Challenges

- Need more research and thinking to be done around the future.

Lunch & Networking

World café

World Café methodology is a simple, effective, and flexible format for hosting large group dialogue.

http://www.theworldcafe.com/key-concepts-resources/world-cafe-method/

Purpose

Get talking about care coordination and the change ideas being tested and implemented. Move, oppose, bystand and follow to create generative dialogue.

Why

"Generative Relationships – occur when interactions among parts of a complex system produce valuable, new, and unpredictable capabilities that are not inherent in any of the parts acting alone"

David Lane and Robert Maxfield - Foresight, Complexity, and Strategy

What matters to you? – Paul Baughan

Final thoughts – Tim Warren

Keep in touch

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