Self-Assessment Tool:
Ambitions for Palliative & End of Life Care

Introduction

The NHS England & NHS Improvement Palliative and End of Life Care Team is committed to the six Ambitions for Palliative and End of Life Care and the delivery of personalised, quality care, that is accessible to all and improves the patient experience. To this end, the national team have worked alongside stakeholders to further develop the Ambitions for Palliative and End of Life Care self-assessment tool.

This tool provides a self-assessment framework to support localities to determine their current level of delivery of services against the Ambitions for Palliative and End of Life Care- A National Framework for local action (2015-2020) and to understand where there are opportunities for improvement. Cross-organisational collaboration is vital and localities are strongly encouraged to ensure health and social care are equal partners in this assessment process. This should also include, Health & Wellbeing Boards, CCGs and Local Authorities.

It is envisaged that completion of this self-assessment process will help to raise awareness of the Ambitions for Palliative & End of Life Care whilst also supporting a more coordinated response for localities to assess their current areas of strength, and to identify areas for growth that need prioritising within future strategy.

In order for this self-assessment process to become a meaningful and useful exercise, localities are encouraged to be as honest as possible and to use this opportunity to collate their evidence and supporting information into one place for ease of future reference. The ambitions framework calls for local professionals and local leaders to act and coordinate a process for working towards these ambitions, a process that is open, transparent and effective.

Acknowledgements

NHS England & Improvement National End of Life team would like to thank the Cheshire & Merseyside Palliative & End of Life Care Clinical Network for their kind permission to use the tool which originated in the North West, their support in updating the tool and contribution to developing the technical and good practice guidance.

Guide to using the Self Assessment Tool

1. **The self-assessment tool is structured around the Six Ambitions for Palliative & End of Life Care**:

- **Each person is seen as an individual**
- **Each person gets fair access to care**
- **Maximising comfort and wellbeing**
- **Care is coordinated**
- **All staff are prepared to care**
- **Each community is prepared to help**

Each ambition is represented as a different coloured tab at the bottom of the page.

2. **Localities should assess themselves against all of the 6 ambitions and should consider how these translate to all care settings** i.e. hospital, care homes, hospices, home, prisons

3. **For each ambition you should indicate against each measurement (far left column) the Level that best describes the current status across the locality. When doing this you should refer to the Level descriptors below:**

Level	Locality Level Descriptor
Level 0	Not at all ready to achieve/ anticipate barriers to achievement
Level 1	Desire to achieve this ambition but there are currently no plans in place
Level 2	Plans are in place towards achieving this ambition
Level 3	Limited achievement across one or two organisations only
Level 4	Partially achieving e.g. across most, but not all care settings
Level 5	Fully achieving e.g. across all care settings, with supporting evidence available

4.When you click on the associated box against each measurement, a drop down list of Levels will appear. **Please select the relevant Level - no other entries will be allowed**.

5. You will notice that as you select your Level, the associated Level colour (as in the box above) appears

6. As you indicate each level a summary will be collated within the **'status summary' tab at the bottom of the page**. This will illustrate the proportion of measures that you have indicated at each level for each ambition. NB: The sum of each ambition across levels 0-5 should therefore equate to 100% if you have completed the tool fully and correctly.

7. The status summary also has an area for you to complete **locality details, name of person(s) completing the tool, and the date of completion.**

8. Once you have indicated the current locality status against each measurement, there is a column that asks you **how you would evidence this**. Localities should use this space to list or to embed evidence available where they have indicated a level 3 or above status . For example, this may include a project plan, audit report, referral criteria or Service Specification

9. The final column within the tool is for localities to detail any **gaps or areas for development** that they identify against each measure. Anything identified within this area should subsequently support and inform the development of local strategies for Palliative & End of Life Care in order to realise the ambitions set out within the National Framework.

10. It is recommended that localities **repeat this self-assessment process at least annually**.

11. Self-assessment can take place in a number of dedicated sessions or in entirety on one occasion.

Name of Organisation(s): Staffordshire and Stoke on Trent CCGs

Name of Person or Group completing the self-assessment: Craig Porter

Version Control: Version: 2.1

Date of Completion: Mar-22

Sign off by locality Clinical Lead for Palliative/ End of Life Care: Paddy Hannigan

	Level 0	Level 1	Level 2	Level 3	Level 4	Level 5
Ambition 1: Each Person Seen as an Individual	15.8%	47.4%	15.8%	10.5%	0.0%	0.0%
Ambition 2: Each person gets fair access to care	0.0%	83.3%	0.0%	0.0%	0.0%	0.0%
Ambition 3: Maximising comfort and wellbeing	18.8%	43.8%	0.0%	12.5%	25.0%	0.0%
Ambition 4: Care is coordinated	65.2%	26.1%	8.7%	0.0%	0.0%	0.0%
Ambition 5: All staff are prepared to care	14.3%	42.9%	28.6%	0.0%	14.3%	0.0%
Ambition 6: Each community is prepared to help	50.0%	50.0%	0.0%	0.0%	0.0%	0.0%

No:	Ambitions & Building Blocks	ICP/ICS	How would you evidence achievement or progress at this level?	Where are the current gaps for your locality (NB: consider all care settings)	CCG Commentary	Digital Commentary	Potential Actions
	Measurement						
1.1	**Honest conversations**						
	The locality has a recognised approach for personalised care and support planning **for palliative care** that is recognised and accepted across care settings for:	ICP - Delivery of personalised care					
1.1.1	Children and Young People	ICP - Delivery of personalised care	All CYP have a PCSP but it may not be labelled as such.	The gap is lack of a multi disciplinary PSCP. CYP are likely to have PSCP for each service that they access. Need a multi disciplinary/ multi agency assessment tool and PSCP template Need to consider needs of YP transitioning to adult care services	Needs to be evidenced in CCN spec and hospice contracts. There will be some common themes /principles. If there is a commitment to have PCSP this will need to be a West Midlands approach similar to the ACP.	We have access to a common integrated care planning tool which is able to sit above all existing systems and offer multi-disciplinary, multi-organisational care planning tools. A single updatable care plan can surround the patient with numerous professionals (and other carers eventually) being able to update appropriate parts of the plan. The requirements may be covered as part of an EPACCS solution but where this isn't the case further plans can be developed for specific purposes. The technology can easily be adapted to support common assessment tools depending on requirements. In respect of transition from children's to adult services, the tools can be developed as separate care plans if different, a common care plan if the same or a transition which automatically copies elements from a children's care plan into an adult care plan to avoid re-entry.	Development of Integrated assessment tool / EPACCs solution -- Needs inclusion in CCN spec and Hospice contracts
1.1.2	Adults	ICP - Delivery of personalised care	Agreed pathways, agreed policies, and clinical benchmarking.	Haven't got recognised approach, inconsistent use of a range of approaches, e.g - GSF, advanced care planning and roll out of ReSPECT is at different stages. Hospice ACP documents are used across the system - there are some gaps in consistency and opportunities to embed further		Digital can be used to offer the common platform from consistency of approach but will obviously need to be wrapped by transformation support to move everybody into the same way of working.	
	The locality has a recognised approach to personalised care and support planning for care at the end of life (the last days and hours of life) that is recognised and accepted across care settings for:	ICP - Delivery of personalised care					
1.1.3	Children and Young People	ICP - Delivery of personalised care	Audit against NG61 Undertaken across SSCPCN. CYP will have an ACP and Symptom mngt plan alongside their usual PCSP. The PCSP includes care of family members	North locality recognised approach to care and support planning, led by palliative care consultants as part of the DLT grant, supported by MPFT, CCN Nursing Team. For SW and East, ACP and care plans are documented and agreed at source within the acute hospital.	Needs to be evidenced in CCN spec and hospice contracts.	Could be supported by EPACCS model	Need to ensure approach is System wide
1.1.4	Adults	ICP - Delivery of personalised care	*As above*	Agreement to use ReSPECT, and now got Staffs wide policy (in the process of CCG approval) Agreement in principal to use Hospice ACP documentation across the system (North and South) as the document of choice. Gap in terms of people's personal wishes. The roll out of ReSPECT is at the early stages, and its use is inconsistent across acute, Primary Care, Community, Hospices and Nursing Homes but is beginning to be a recognised document. Lack of clarity re. roles and responsibilities and variation in competencies. Patients known to hospices tend to have a higher likelihood of ACP and Respect being in place.		Digital aim is to support the development of the ReSPECT document into an electronic format which sits as part of the patient record and readily accessible. This will form a part of the EPACCS solution but also be available as a stand-along part of the system. Will be readily marked on a patient record so people such as ambulance can clearly see this upon an initial view of a patient record.	
1.1.5	The locality records and communicates decisions around Cardio-Pulmonary Resuscitation that is consistent across all care settings	ICP - Respect documentation	DNR/ Active interventions are recorded in CYP ACP. This includes RESPECT document	Children - Consider needs of YP in transition. Issues of consent and mental capacity may arise Adults - Agreement to use ReSPECT, and now got Staffs wide policy (in the process of CCG approval). The roll out of ReSPECT is at the early stages, and its use is inconsistent across acute, Primary Care, Community, Hospices and Nursing Homes but is beginning to be a recognised document. Lack of clarity re. roles and responsibilities and variation in competencies. Across the county, DNARCPR documentation still in use in conjunction with ReSPECT or stand alone. Aware that UHDB has their own policy for ReSPECT (need to check alignment with Staffs policy) need to check the situation for other out of area acute trusts e.g; Wolverhampton. hospices agree with these comments		There is common support for this digitally through a variety of means. Codes from GP records where recorded can be incorporated into ReSPECT and EPACCS or policy can be made to specifically report this as part of EOL care. We have many options to support this digitally through the ICR and associated tools and largely need to be driven by operational requirements.	
1.1.6	The locality has a training strategy for developing communication skills which covers all health and social care staff and includes skills in meaningful PCSP conversations	ICS / ICP	Communications skills training is available for staff working in CPC . This training is different to the adult modules	Children - No Staffordshire wide training and strategy plan in place for staff working with CYP & Families. Adults - No Staffordshire wide training and strategy plan in place for staff working with CYP & Families. Training is in place and available from hospices but not commissioned so delivered in a more adhoc way - no system wide strategy	Links with PCCC spec	Whilst I don't have anything specific it would be worth referencing digital support for training delivery not just in terms of traditional eLearning but also use of Teams/Zoom to make this type of training which will often require a more personalised delivery to be more accessible to all.	
1.1.7	The locality can evidence the number of staff accessing communication skills at core, intermediate and advanced level by staff group and or grade	ICS / ICP	Is this relevant to just NHS services? Where will independent services / hospices fit into this ?	Children - No system available across the localities to capture this for CPC Services. Adults - North locality, some data collated by MacMillan PNF of numbers of Primary Care and Nursing home staff who have completed training. Local training data available but not as part of a system data collection or with consent to share from individuals attending	KPI for PCCC spec	Digital can help where there are consolidated platforms for booking and/or delivery of training but outside of this it will be down to compilation of statistics from multiple parties.	
1.2	**Systems for person centred care**						
1.2.1	The locality is utilising validated tools (e.g. IPOS) to measure patient outcomes against an individual's personally defined goals and these are consistent across all settings	ICS / ICP		Children- The national IPOS for children in still in early stages of development. There is currently no national tool for measuring outcomes in CPC Adults - There is currently no national tool for measuring outcomes in CPC IPOS is in place at SGH & DMH, it is a standard national tool for measuring outcomes but hasn't been selected as an option for the system and has significant training & technical challenges for a full roll out	PCCC spec	Looking at IPOS there is potential for this to be part of an EPACCS solution or moreover part of a remote care solution. Would need more info on the aspirations in this area but definitely think it is something we can help to build solutions that support.	Integrate in to PCC spec , EPACCS supported
1.2.2	The locality has in place an agreed approach to early identify of those at end of life which includes all care settings	ICP	None of these standards frameworks are used/ relevant in CPC. TFSL quality standards and pathway as recognised as the national framework/ pathway and quality standards	There is not a formally agreed approach, however there is inconsistent use of the gold standard framework in Primary Care. Hospices agree with these comments			
1.3	**Clear expectations**						
1.3.1	The locality has a central information point where people can easily access clear information about 'all ages' local palliative and end of life care services, including details about the level of service that they should expect and what they are entitled to	ICP	Not available across CPC Services	Nothing in place, opportunities may exist e.g; Stoke, LA directory, MYDOS - hospices have local directories in place as part of the Advice and Referral Centre plus there is the Staffordshire Connects database - discussions have been ongoing about a centralised data set - no conclusion was reached	18.01.21 - MYDOS is palliative care in this avenue to explore	Staffs CC have a website they maintain which is a directory to all services across the county	MiDOS patient action
1.4	**Access to social care**						

1.4.1	The locality has an established process in place to enable rapid access to assessment for needs based social care	ICS / ICP	Children's social care legislative framework is different - identifying need etc.	Children - There is currently no system in place for rapid assessment for end of life care. To confirm with LA. To be addressed as part of the ICP project Adults - Don't know, Annette, Simon and Jane to find out **Update from AA:** The LA process in Staffordshire is anyone can refer someone for rapid social care by calling one of the numbers following number – Adult Call 0300 111 8018 (normal hours), Children (normal hours) First Response Team on 0800 131 3126, and OOH 0345 604 2886" **Update from JB** - All information would ordinarily go through to SRT (Safeguarding Referral Team). This would result in a contact, followed by a referral being placed. Discussions will then take place with the relevant Team Manager (Children's Disability Team). At this point a decision will be made as to whether a child and family assessment is completed. This will be progressed within 24 hours. work has been underway to improve fast track CHC assessments - Natalie Cotton and Craig Porter	***18.01.21 - Action - SR - look into process for South, AA look for East and JB North process.*** (look at children's another time - rapid access) 21.01.21 - Update received from JB and AA		
1.4.2	The locality has in place systems to respond to the social care needs based assessment	ICS / ICP		Children- To be addressed as part of the Integrated care pathway project. To confirm with LA Adults - Don't know, Annette, Simon and Jane to find out. **Update from JB -** In conjunction with the child and family assessment a Needs Identification Tool is completed by the Social Worker, and this will look at the needs of the child and determine the support that will be needed relationships between this part of system and hospice teams is strong and works well	***18.01.21 - Action - SR - look into process for South, AA look for East and JB North process.*** (look at children's another time - rapid access)		
1.4.3	The locality has an approach for carers needs assessments with clear referral processes to supportive services	ICS / ICP		Children - For most children and young people parents are not recognised as carers. During Transition this needs to be reviewed as parents do become carers when the YP turns 18. To confirm with LA. Adults - Don't know, Annette, Simon and Jane to find out. **Update from JB** - As part of the child and family process, a carer's assessment is offered to parents/ carer's at the point the child and family assessment is being completed. SGH/DMH hospices use CSNAT an evidence based carers needs assessment for palliative and end of life care	***Action - SR - look into process for South, AA look for East and JB North process. (look at children's another time - rapid access)***		Needs to be covered of in PCCC
1.5	**Helping people take control**						
1.5.1	The locality is supporting people to take control and to tailor their end of life care through the use of personal health budgets /integrated budgets	ICS		Children - Different approaches and framework for CYP. Across the patch, there is some access to PHB but it is not consistent. Action - link with PHB lead to understand process for accessing PHB and also eligibility Pre COVID the EOLC Board were going to look at the PHB pilot St Giles has been part of in Birmingham - this didn't happen	18.01.21 - No lead for PHBs, unsure who is eligible. Limited access to PHB, only when have CHC ***Action - There is a gap here - link with PHB lead to understand process for accessing PHB and also eligibility***		Still need to linking with PHB
1.5.2	The locality offers support to enable patients and the people who care for them to self-manage those aspects of their condition which help improve the quality of their life	ICP	Not used in CPC	Children - This needs to be considered for Transition and care of YP This is articulated within the CCN and the hospice DLT grant Adults - within community nursing specifications (check for North) this is embedded in the way hospices operate	***18.01.21 - Action - JB to check North - Sharon Cooper***		
1.6	**Integrated Care**						
1.6.1	The locality has a strategy to reduce traditional barriers between care providers and provide seamless transfers of care including:	ICP		Children - No systems available for data sharing in CPC Adults - No systems available for data sharing in CPC			
1.6.2	An approach that supports systems of data sharing for all service providers (For example EPaCCs)	ICS		Children - Currently being considered as part of the CPC integrated care pathway. Adults - Mapping has been done (need to locate this) Generally, there is not a data system that supports data sharing across service providers. Graphnet was going to do this - no identified strategy for integrated data share - work was in place pre-COVID EOLC Sprint	***18.01.21 - Action - JB attended EOL Board, JB to find out - ? included in minutes / sept task and finish group, JB to look for this to see if its included in minutes.***	EPACS solution available for configuration and deployment. Multi-organisation and multi-disciplinary.	
1.6.3	Multi-lateral contracting arrangements OR contracting arrangements that support integrated care	ICP		Children - ? Sharon to supply info. Currently contracting arrangements do not support integrated care, however in the North locality, sub-contracting arrangement between DLT and UHNM to provide integrated ACP and on call support. Adults - Sub-contracting arrangement between Douglas Macmillan and UHNM to provide on call support. Currently contracting arrangements do not support integrated care. Discussion hasn't taken place specifically with hospices - there isn't a sub-contract in place between DMH and UHNM.	18.01.21 - UHNM palliative work with Douglas Macmillan		
1.6.4	Pooled CCG budgets across footprints for high cost, low activity services	ICS		CCGs working in principle to commission on a Staffordshire and Stoke wide footprint, covering all six CCGs where applicable, consideration given to wider boundaries where applicable. E.g; Last days of life support for CYP. Discussion hasn't taken place	Relevant to last days of life CYP		
1.7	**Good end of life care includes bereavement**			_			
1.7.1	Bereaved people within the locality all have equitable access to bereavement and pre-bereavement care, including children and young people and those affected by sudden or traumatic death	ICS / ICP		Children - Access to bereavement services for CYP &families is dependent upon the serviced accessed. The needs of CYP and families are currently being considered and included in the Staffordshire wide/ all age bereavement network plan. Adults - There is some availability of bereavement services, however access is unlikely to be equitable as access will depend on current support provision. Eng; Hospices have access to bereavement support for their patients standard services are not available across the system. St Giles offers support for the whole of it's locality whether patients or not (adults and children), there is a new Bereavement Network that has been established by providers and chaired by Support Staffordshire and other provision such as Dove Service, Staffordshire Bereavement and Loss service in in place. Signposting is in place as required. No commissioning strategy and inequitable funding Scored 2 because whilst some areas might be a 3 - the lack of consistency & strategy brings the score down Support Staffordshire have recently started a piece of work with a view to ensuring equitable access. Further opportunities - e.g; MYDOS.	18.01.21 - Staffs & stoke bereavement services - JB pulling together people but still early days. (LA should provide but services cut)		MIDOS demonstration following EOL care update by PG

No:	Ambitions & Building Blocks	ICP/ICS	Current Status	How would you evidence achievement or progress at this level?	Where are the current gaps for your locality (NB: consider all care settings)	CCG Commentary	Digital Commentary	Potential Actions
	Measurement							
2.1	**Using existing data**							
2.1.1	The locality fully understands the current reach of palliative and end of life care services, and local population-based needs assessments across different diseases, social and ethnic groups and are using this information to plan future services	ICS/ICP	Level 1		Children - This piece of work needs to be done for CYP Adults - A detailed piece of work was completed around 3 years ago. This work needs re-visiting. Hospices agree with the comments - no system wide plan, a reliance on individual providers internal strategy	18.01.21 - SR recent piece of work ***Action - Jane Moore team - gap East staffs will be difficult as not part of tender.***	Don't want to promise too much here but the solutions we are building offer the opportunity to report across the system and therefore should be able to help though we would need to unpick the requirement in more detail to build a plan.	
2.2	**Community partnerships**							
2.2.1	The locality has representatives of the population e.g. different faith & cultural groups, as well as those supporting the young and old, feeding into locality specific (STP/ICS level) palliative and end of life care strategy	ICS / System Groups	Level 1		Children - Engagement is service specific, no input into strategy. This was in place with the Macmillan work a few years ago and the data was used to drive the commissioning strategy - some of that data would be relevant today			
2.3	**Gathering new data**							
2.3.1	The locality routinely collect and report on Palliative and End of Life Care activity to inform ongoing **quality improvement** work including that of equal access and meeting the needs of diverse groups	ICS /ICP	Level 1	UHNM Specialist Palliative Care Team take part in the National Audit of Care at the End of Life (NACEL) The audit measures progress against the five priorities for care and NICE Quality Standards 144 and 13, and NICE guideline NG31 as well as NHSE/I improvement plans. Recommendations and action plans are produced following the audit.	Children - Data gathered is serviced specific. No central data gathering system in place for CPC Adults - Not aware of any activity monitoring. Hospices monitor their data closely and take part in a variety of quality improvement work streams as relevant locally and nationally	18.01.21 - Any measurements in spec, palliative caseload. Didn't get anywhere with dashboard	The ICR incorporates a BI module which is able to analyse information across care providers within the area. Even in the absence of EPACCS we could work together to look to identify EOL activity recorded in source systems and offer a report to aid this. We have a pre-requisite that we need to complete our IG work on secondary use of the data but could certainly report on primary care data now. The issue we potentially have is in accurate demographic data for equality monitoring as the data at this level from practices is not always the best.	
2.4	**Unwavering commitment**							
2.4.1	The locality has accountability mechanisms, such as Equality Impact Assessments, in place to demonstrate equity of access and responsiveness for palliative and end of life care services	ICS /ICP - ICS set the EIA/QIA and ICP to complete			CCG specific. CCGs all service redesign requires completion of Equality Impact Assessments. Assume these are in place			
2.5	**Population based needs assessment and commissioning**							
2.5.1	The locality can demonstrate how end of life care services have been influenced by local population based needs assessments	ICP - Each ICP needs to assess local population needs	Level 1		Children - Not sure if localities have any data on the need/ demand for CPC services. National demographic data exists which has been used to identify Staffordshire wide need. Would be difficult to demonstrate how EOL services have been influenced. Adults - Can not demonstrate. There are some data sets available via the CSU and local examples - massive gaps here - population health strategy hopefully will see some progress	18.01.21 - Stoke is working on this, and key theme is EOL		
2.6	**Person centred outcome measurements**							
2.6.1	The locality has a process for independently analysing person centred outcome measures (e.g. IPOS) in order to hold providers to account and ensure fair access to care	ICS - Monitoring achievement of outcomes / For example the introduction of IPOS. ICP to action	Level 1	Not applicable for CYP UHNM Specialist Palliative Care Team take part in the National Audit of Care at the End of Life (NACEL) The audit measures progress against the five priorities for care and NICE Quality Standards 144 and 13, and NICE guideline NG31 as well as NHSE/I improvement plans. Recommendations and action plans are produced following the audit.	No process in place for measuring person centred outcomes for children and adults. Check UHNM EOL service. DMH & SGH use IPOS but no systematic use across the system	18.01.21 - IPOS help us to do that, ***Action - JB to check UHNM EOL service***	I am no expert on this but looking at IPOS there is potential for this to be part of an EPACCS solution or moreover part of a remote care solution. Would need more info on the aspirations in this area but definitely think it is something we can help to build solutions that support.	

No:	Ambitions & Building Blocks	H	Current Status	How would you evidence achievement or progress at this level?	Where are the current gaps for your locality (NB: consider all care settings)	CCG Commentary	Digital Commentary	Actions
	Measurement							
3.1								
3.1.1	The locality has in place a formal system in place to **recognise and acknowledge** physical, psychological, emotional, social, or spiritual distress at the end of life	ICP	Level 1	Children - TBD Adults - Need to check with providers. At a provider level there are systems in place but nothing at system level - scoring reflects a formal system - standardised response		distress tool	I don't know the EPACCS tool in detail so it may be that such a tool is incorporated. If not and such a tool exists then we can work with graphnet to see if this can be incorporated towards the higher escalated levels in EPACCS.	
3.2	Addressing all forms of distress							
	The locality have accessible & responsive services to address the following:							
3.2.1	Physical Distress	ICP	Level 1	Children- TBD at meeting this PM Adults - Need to check with providers. In place with some providers - would score higher if organisation level would be a 3 or 4 for hospices but not system wide		suggestion that this is discussed at the EOL cell meeting where all the clinicians are available.		To be raised at EOL Cell or ops's group
3.2.2	Emotional Distress	ICP	Level 1	Children- TBD at meeting this PM Adults - Need to check with providers. In place with some providers - would score higher if organisation level would be a 3 or 4 for hospices but not system wide				
3.2.3	Social Distress	ICP	Level 1	Children- TBD at meeting this PM Adults - Need to check with providers. In place with some providers - would score higher if organisation level would be a 3 or 4 for hospices but not system wide				
3.2.4	Spiritual Distress	ICP	Level 1	Children- TBD at meeting this PM Adults - Need to check with providers. In place with some providers - would score higher if organisation level would be a 3 or 4 for hospices but not system wide				
3.3	Skilled assessment and symptom management							
3.3.1	There is a consistent approach across all care settings in the locality to anticipatory prescribing	ICS	Level 3		Children - WMPPCN Toolkit followed. No local policy for CYP Adults - Staffordshire wide policy under development. CYP approach is to be considered along with Adult anticipatory document there is scope for it to cover children as it follows NICE guidance for CYP , will be confirmed at review.	18.01.21- DW working on prescribing. Submitted policy for review & approval.		Anticipatory prescribing policy to be present to Clinical chairs and then MB
3.3.2	The locality have 24 hour access to specialist symptom control advice and support for those nearing end of life	ICS	Level 4	Children - Available when hospice open 24/7 for CYP known to TDL hospice. 24/7 on call available for CYP under the care of UHNM Consultants. Adults - David to link in with Sam Buckingham. Awaiting Paul Garner response 24/7 access to specialist symptom control and advice in place via hospices including consultant level escalation	Children - Gaps in South and East Staffs	Community pharmacy's providing EOL medication in system, although not full 100 % coverage	Potential for use of virtual consultation solutions to support the process and potential for use of remote monitoring tools to capture symptomatic information and alert advisors for a pro-active service level.	
3.3.3	The locality have recognised providers for dispensing end of life medications 24/7	ICS	Level 0	Adults - David to link in with Sam Buckingham. We have the community pharmacies providing EOL medication access between 8am – 10pm across the system. Outside of these hours only alternatives would be the urgent care system. No consistent system in place - down to individual organisations	Children - Not in place for CPC- but probably not needed due to high level of anticipatory prescribing and low numbers of end-of-life care			
3.3.4	The workforce have central access to all locally supported symptom management guidelines	ICS	Level 4	Children - Use of WMPPCN Toolkit as guideline Adults - System already in place that potentially will be able to be used in future, but currently no central access. WM Palliative Care Guidelines used				Tool kit to be added to MIDOS
3.3.5	The locality have a strategy for providing education and training in simple procedures and care processes to unpaid carers where appropriate	ICS	Level 0	Children- The link provided is not relevant to CPC Adults - No	Children - No Staffordshire wide training strategy for providing Education and training for the CYP workforce.	Feedback from Acorns - Might be an area Acorns could work on with	Potential for eLearning, electronic training delivery, common training platform/resource etc and in general a website with information to support carers in this area.	
3.4	Priorities for care of the dying person							
3.4.1	The locality has robust audit plans in place to monitor the achievement of the 5 priorities for care of the dying person	ICS / ICP	Level 0	Children - Not sure that this has been applied to CPC. TFSL quality standards should be used as audit tool Adults - No			if the priorities are recorded in a solution then fairly sure we can get the audit and compliance reporting out. Would need to pick up more conversations on this.	
3.5	Specialist Palliative Care							
3.5.1	The locality has a 7 day service for Specialist Palliative Care assessments	ICP	Level 4	Children - North - Yes. South, East and West - only at the EOL phase. Adults - Scope the palliative care assessment across providers e.g MPFT, and hospices. 7 day access to IPU & CNS teams for specialist palliative care	Children - Not the right model for CPC. Being considered as part of the ICP project	18.01.21 - doesn't happen consistently		
3.5.2	Specialist Palliative Care advice is available 24/7 across the locality	ICP	Level 4	Children - In North - Yes, South, East and West only at EOL phase. Adults - North - Douglas Macmillan 24/7 hr helpline. South - Simon to find out (KHH) KHH provide a responsive service but wider access if via the other two hospices.. Annette to find out in East (St Giles) St Giles have an accessible 24-hour telephone advice for Specialist Palliative Care which can also be accessed without a referral covers South East & East and Cannock/Rugeley part of South West and up to consultant level	Children - Not the right model for CPC. Being considered as part of the ICP project	***Action; South - Simon to find out (KHH). Annette to find out in East (St Giles)***		
3.5.3	The locality have a framework in place to develop the capability of the generalist workforce supported by the Specialist Palliative Care Team(s)	ICS	Level 1	Children - No framework Adults - No frame work, MPFT have ambition of developing workforce. Hospice have supported generalist workforce development but not framework	Children - Needs to be considered as part of the CYP workforce development strategy for Staffordshire or WM **Update from SR:** Hospices, and CYP services have on call for palliative/EOL cared paid for on an on-call basis for consultants at UHNM. South west rely BCH palliative care consultant for support but not funded for 24 hour so require on call consultant. For CYP under care of New cross and not known to UHNM or BCH less support is available and teams access on call consultant if the CYP consultant is not available.	Feedback from Acorns - Anticipatory planning is key here		
3.6	Rehabilitative palliative care					Rehabilitative palliative care		
3.6.1	The locality have access to rehabilitative services for people approaching the end of life	ICP	Level 1	Children - For CYP this will be the 'living with' phase of care. Scope availability for rehabilitation services. Access to AHP's is vital for many CYP Adults - Scope availability for rehabilitation services. Hospices have provided this for it's cohort of patients but a lot of opportunities in this area for improvement		Feedback from Acorns - Step down provision has been used in our hospices to support this , this is a paid for basis		

3.6.2	The locality has systems in place to ensure access to equipment to support people with movement, comfort care and activities of daily living.	ICS / ICP	Level 3	Children - Timely access to equipment for CYP without undue delay, for support with movement, comfort care and activities of daily living is an issue that requires further exploration. Simon to pick up process for children's. Adults - Jane to pick up what process is for adults. access to equipment via MEDEQUIP, MPFT and some hospice held and loaned equipment **Update from JB** - As part of the child and family assessment, following consent from parents, contact would be made with all the health professionals involved in the child's/ young person's care. This would also be similar to adult's who require equipment to support their needs. This would be regularly reviewed as part of the Care Plan that would be in place. **Access to Equipment-** As part of the child and family assessment, should it be evident that a child/young person needs to access specialist equipment, than a referral would be made to the Occupational Therapist, in order that a further assessment be made to assess what equipment would be needed. In terms of adults, and other health professionals, a referral process would be needed following an assessment that would be completed by the Well-Being Team (Adults Services).	**Update from SR :** Medequip is the avenue for ordering equipment, some equipment ordering is limited to staff qualified to do so, for example, positioning equipment/beds should only be ordered by OT/Physio as its their speciality and incorrectly used equipment can do more harm than good.	18.01.21 - gives us a starter, should see benchmarking improving nationally recognised tool - gap analysis against measures (Medequip , social care) ***Action - SR to pick up who initiates support ? Comm nurses or GPs.*** ***Jane to pick up with Paul Garner re scope/ what process is for adults***		PCCC

No:	Ambitions & Building Blocks	ICP/ICS	Current Status	How would you evidence achievement or progress at this level?	Where are the current gaps for your locality (NB: consider all care settings)	CCG Commentary	Digital Commentary
	Measurement						
4.1	**Shared records**						
4.1.1	The locality has a dedicated data sharing (such as EPaCCS) project/steering group with representation from all care settings	ICS	Level 0	CCGs are currently working towards Care Connect, which is a data sharing tool	Nothing in place for CYP ACP's Gaps for locality are involving all service providers within the project group.	SR / DW to pick up in EOL cell	If we create a project mandate for use of EPCAS this would be an early deliverable. We also have an established IG group which sits across the ICS, all main partners are represented and would be happy to include either partners for specific agenda items and projects.
4.1.2	EPaCCS information is being shared with the following services:	ICS		ACP's are shared and distributed for CYP by professionals involved. All organisations across Staffs providing CPC have a policy in place to ensure safe and effective use of ACP's. No current system in place, unable to evidence achievements	No system in place across localities to enable this to happen		Should be implement EPACCS on the ICR then the following organisations will have access to the that system. If not then they will have access to the data contained within the ICR such as GP data, acute data, social care etc.
	Ambulance Service	ICS	Level 0				Live now - data access, no plans to share.
	Out of Hours Service	ICS	Level 0				Live within the next few weeks - data access initially with plans underway to look at sharing data.
	NHS 111	ICS	Level 0				Live within the next few weeks - data access initially with plans underway to look at sharing data.
	Specialist Palliative Care Teams	ICS	Level 0				TBC - largely depends where they are. If they are in MPFT. UHNM, UHDB then they already have access.
	Primary Care	ICS	Level 0				Live - data access and data sharing
	Community Teams e.g. District Nurses, Matrons	ICS	Level 0				Live - data access, live by end April for data sharing
	Hospitals	ICS	Level 0				UHNM live for access and sharing, UHDB due to go live in the next couple of months
	Care Homes	ICS	Level 0				No current plans. We are building a local digital care homes group to look at the digital requirements of care homes and would be keen to include access as part of the blueprint in this area.
	Hospice	ICS	Level 0			Acorns is not on system 1	No current access - likely to be driven as part of EOL/EPACCS project.
	Social Care	ICS	Level 0				Live for data access and high level data sharing.
4.1.3	The locality can evidence the proportion of people dying with an EPaCCS record	ICS	Level 0	This data is captured as part of CDOP process for children.	Unable to evidence this for adults.		This would be easily evidenced once EPACCS in in place.
4.1.4	Palliative Care Multi-Disciplinary Meetings (MDT) are informed as appropriate through data sharing systems (such as EPaCCs)	ICP	Level 1	Some data sharing is in place between specific providers - but provider level and adhoc N/A for CYP	Unable to evidence this for adults.	Feedback from Acorns - EPaCCs? MDT should be undertaken virtually with the learning gained in 2020	EPACCS solution would support this. Virtual MDTs could be supported through a range of technologies.
4.1.5	As part of their EPaCCS system the locality are able to share electronically the personalised care and support plans of people nearing the end of life	ICS	Level 0		Not possible currently due to different IT systems/ lack of integration of systems		Use of EPACCS solution (supplemented by common care plans if necessary) would fulfil this.
4.1.6	The locality has mechanisms in place for the person approaching end of life to review and update their wishes and preferences within their electronic record	ICS	Level 0	For CYP the ACP will be regularly reviewed and discussed with CYP / parents and carers. Conversations will be led by health professionals caring for and supporting the family	Unable to evidence, no electronic records.		This will be potentially available through a variety of means but would not look to enable this functionality at go-live of EPACCS. It would very much be a part of the roadmap through the integrations with NHSApp.
4.2	**Clear roles and responsibilities**						

4.2.1	A clinical lead is identified for each key provider with allocated time e.g PAs assigned for developing local services and who ensure systems are in place for communication with other providers and agencies	ICS/ICP	Level 0		No clinical lead for CPC identified by any provider or CCG for CPC No system wide clinical network meeting with dedicated clinical and CCG leads.	Feedback from Acorns - Where do we see the WMPPCN in this and the range of PPC across the region	I feel there is possibly something we can do to support inter-agency communication but perhaps need to understand more before offering any real suggestions.
4.3	**A system wide response**						
4.3.1	The locality has Palliative & End of Life Care as a core component of the STP/ ICS Operational Plan	ICS	Level 1	Project plan completed, regular EOL meeting taking place. COVID has stalled this progress - the EOLC Board needs to be brought back. Vision: Maintaining personalised care for people at the end of life Objective 1: Increase the number of patients identified in Primary Care as being at end of life, and improve the Advance Care Planning for those patients Objective 2: Adopt standard patient documentation for end of life care that is recognised by all practitioners and roll out ReSPECT across our system Objective 3: Redesign our End of Life Pathway within the existing resource envelope to deliver improved and co-ordinated care at the right time and in the right place Objective 4: Commission an Integrated Children's and Young Peoples Palliative and End of Life Care Pathway within our current resource envelope	Inclusion of CPC in CCG plans?		It has always been as aspiration of the STP/ICS digital programme so really keen to consolidate this aspiration into a mandate then it will be reflected on the annual delivery plans for the ICS Digital.
4.3.2	The locality includes people with a personal or professional experience of death, dying and bereavement to collaborate in the design of new services (co-production)	ICS/ICP	Level 1	Do have professional people from other organisations working within the project and attending the EOL cell, demonstrated through minutes in place at a provider level, Macmillan Cancer Support did a lot of engagement in this area during the EOLC and Cancer Tender - this work might still be relevant	Service user engagement/ collaboration and coproduction is currently service specific – where it does exist. Within the adult services, we don't have service users or carers.		
4.4	**Everyone matters**						
	Local end of life strategy is inclusive of approaches to the following groups:	ICS		Collective approach to all groups through EOL plan,		AA to ask Charlotte Evans	
4.4.1	Children and young adults	ICS	Level 1		Currently have separate project-based stakeholder group but a more consistent, statutory sector supported strategy / working		
4.4.2	Those of older age and those with frailty	ICS	Level 2	Aware of some work re frailty strategy	No specific defined strategy		
4.4.3	Those with Dementia	ICS	Level 1	For the North, there is a task and finish group There is a Dementia Service Development Group for the SE and SW localities ,and a Dementia Pathway for different stages of the illness. Organisational specific - no county wide strategy - significant around care planning and provider confidence in some parts of the system	No specific defined strategy	28.01.21 - AA provided update	
4.4.4	Those with Learning Disabilities	ICS	Level 1	not aware of a county wide approach	No specific defined strategy		
4.5	**Continuity in partnership**						
4.5.1	The locality has active partnerships driving forward development of community-based approaches accessed via social prescribing.	ICP	Level 2	Do have social prescribers in place (detail to follow) Probably a level 1 in the North, EOLC Action Alliance in place for the South E&E and South West - some links into social prescribing possibly a 3 in the South so settled on a 2 overall	No discussions have taken place around social prescribing / community-based approach for CPC	JB to provide detail around partnerships	

No:	Ambitions & Building Blocks	ICS/ICP	Current Status	How would you evidence achievement or progress at this level?	Where are the current gaps for your locality (NB: consider all care settings)	CCG Commentary	Digital Commentary	Actions
	Measurement							
5.1	**Professional ethos**							
5.1.1	The locality have a strategy for providing education and training to all paid carers and clinicians' at every level of expertise	Question to be raised with LA / Social care colleagues	Level 2	Education and training work stream tied in to strategic plan for EOL not system wide and education providers not engaged in this strategy. Many providers are providing access to training for their staff. Needs joining together to assess the score	No strategy for CYP workforce There is no system wide strategy to support community nursing services in the delivery of safe and effective EOL care	Feedback from Acorns - Acorns could share training resources	Potential for use of digital platforms and methods for delivering training could be included as part of a strategy.	
5.2	**Support and resilience**							
5.2.1	The locality have specific wellbeing interventions in place to support resilience among the workforce who care for those approaching the end of life e.g. clinical supervision, counselling, peer support	ICP	Level 1	It is widely recognised by current providers the impact of the current increase in EOL / deaths. **Response from UHDB;** - Access to psychological support, counselling and therapeutic intervention via EAP provider. - Rapid access to counselling services locally for managing loss/grief – contact withing 24hrs, seen within 3 days. - Bereavement support from partnerships with local hospices (Treetops- Derbyshire / St Giles- Staffordshire) - Reflective practice and listening events provided locally via OH clinical Psychologist, bereavement partners or as drop-in events via Wellbeing team. - Team of MHFA's trust wide, Psychological First Aid training available trust wide. - Locally, Wellbeing Champions, of which circa 200 across the trust provide peer support with access to Psychological first aid training and signposting - Currently rolling out StRaW (Sustaining Resilience at work) and TRiM (Trauma Risk Management) training across the trust (complete by April 2021) - REACTMH training also being developed to provide all leaders and managers across the trust with ability to have a conversation about the impact of work on our mental health no coherence across the system hence why a low score - individual organisations would score more highly - but if scoring based on overarching system strategy - so dependent on scoring strategy	Service/ provider specific support interventions available	Ask operational managers SR to email Hayley and Paul G & cc. DW / SC/JB/AA - AA will send over to Burton		
5.3	**Knowledge based judgement**							
5.3.1	The workforce have access to a diverse range of education and training opportunities' within the locality provided by credible trainers	ICS	Level 2	Would need to be considered as part of the workforce development strategy. Skills for Care: Common Core Principles and Competencies 2014 Framework not applicable for CPC RCN competencies for CPC do exist there is a lot in place at organisational level and access for the wider workforce but not joined up or evaluated as a strategy - partnerships with Keele, Staffs, Wolverhampton Unis, local colleges & Skills for Care accredited provision		Is this a provider question	See above ref digital provision and platforms. Strikes me on a wider level there is an opportunity for a whole micro-site of resources to support those dealing with EOL ranging from access to services, support for care givers, delivery of training, access to protocols etc. Maybe a way to obtain a register of carers at the same point - worth more thought.	
5.4	**Awareness of legislation**							
5.4.1	Training in end of life care includes raising awareness of relevant legislation e.g. Mental Capacity Act, Care Act, Children & Families Act & Lasting Power of Attorney	ICS	Level 4	Provider specific training. Statutory training for most providers therefore should be in place		PCCC spec	See above	
5.4.2	The workforce have access to information pertaining to the diverse approaches to death, dying and bereavement across different communities, to ensure equity of end of life care delivery	ICS	Level 1	There are gaps for some communities re diverse approach eg LD, Autism, LGBTQ, homelessness and disease groups	Would need to be considered as part of the workforce development strategy.			
5.5	**Executive governance**							
5.5.1	There is strong and clearly defined leadership for palliative and end of life care across the locality and at regional level	ICS/ICP	Level 1	There is some strong and clearly defined leadership at provider level and some at locality and regional level	Not currently in place for CPC			
5.6	**Using New Technology**							
5.6.1	Localities have a strategy for using technologies in the advancement of care i.e. remote monitoring equipment, virtual consultation	ICS/ICP	Level 0	Recent examples for both adults and children being used of virtual symptom management clinics and reviews; virtual counselling and emotional support, virtual play and activities some progress during COVID but provider responsive rather than a system strategy and approach	We do not have a strategy.		I would really like to see us explore how we can use remote monitoring for patients on EOL pathway. Support for carers, pro-active services, better supported wishes, avoid hospital admissions etc. I have lots of info on this more about COVID and LTCs but increasingly this is being used to explore many pathways EOL included. Potential access to funding if we can commit to numbers through systems. I also have potential access to software contracts to support in this area.	

Ambition 6: Each community is prepared to help

I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss.
People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways.

No:	Ambitions & Building Blocks	ICP/ICS	Current Status	How would you evidence achievement or progress at this level?	Where are the current gaps for your locality (NB: consider all care settings)	CCG Commentary	Digital Commentary	Actions
	Measurement							
6.1	**Compassionate and resilient communities**							
6.1.1	The locality has a dedicated work programme aimed at building community capacity e.g. Developing the social prescribing offer, promotion of the Dying Well Community Charter, or through the nourishing of compassionate communities	ICP	Level 0	EOLC Action Alliance in SE&E and SW supported via VCSE NHS England Accelerator Programme, community group under SE&E ICP. No system wide approach or resource strategy. No visible commitment other than at provider level. Probably a 1 in the South but 0 overall		JB to check for Stoke and come back with answer Feedback from Acorns - Really keen to see this programme	Refer back to the concept of creating a website (hub) where we can build communities around these themes. I think we could run a session with interested partied in the creation and development of an EOL resource hub which we can unpick from a functionality perspective then build as a way forward. There are many ways of looking at such things from a tech perspective so best starting with the concept and what would be in it.	
6.2	**Public awareness**							
6.2.1	The locality can evidence within strategy how they intend to support the promotion of the public discussion around death, dying and bereavement	ICS/ICP	Level 0	Ensure public and patient engagement in developing our plans. Collect views from the Commissioning Patient Congress, Commissioning Patient Council on specific areas for improving the experience for people at the end of their lives. Listening event on PEOL with public. Organise listening event and update plan based on feedback. Discuss with Commissioning Patient Council and Patient Congress. individual organisations have done work here but no locality plan at a system level - not seen as a priority			Use of Teams or similar to make sessions accessible (if applicable). Use of the resource hub, use of social networking and other comms platforms. Use of alexa or similar.	
6.3	**Practical support**							
6.3.1	The locality has a clear referral process from all key providers to Social Prescribing Link Workers, for all ages	ICP	Level 1	Some progress in the South East/East with SGH leading on social prescibing and partnerships with Support Staffordshire		?	Potential to include social prescribing resources into the EOL resource hub??	
6.4	**Volunteers**							
6.4.1	The locality recruit and train volunteers to specifically support people approaching the end of life, their families and communities	ICP	Level 1	Unable to evidence this, however we are aware of individual organisations responses that do recruit and train volunteers evidence is available at provider level of the impact and recruitment of the volunteers	Understanding needs to be developed.		Can we tap into NHS volunteers. Can this be part of a social prescribing initiaitve to connect people together - some need company/purpose some need help. Could either do this through analytics or tapping into apps etc.	