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

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Ambition 1: Each person is seen as an individual

I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon.
I am asked what matters most to me.
Those who care for me know that and work with me to do what's possible.

No:	Ambitions & Building Blocks	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)
	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:			
1.1.1	Children and Young People	Level 2	There is a NW agreed approach https://cypacp.uk/	Delivery plan 25/26 - to include review of NW ACP, applicability for C&M and alignment with EPACCS
1.1.2	Adults	Level 3	There is a C&M wide template, although localities can create their own approach. I CARE & Share https://www.england.nhs.uk/north-west/north-west-coast-strategic-clinical-networks/our-networks/palliative-and-end-of-life-care/for-professionals/personalised-supportive-care-planning/	ACP stocktake to confirm any gaps Needs to include Secondary care / urgent care
	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:			
1.1.3	Children and Young People	Level 2	There is a NW agreed approach https://cypacp.uk/	Delivery plan 25/26 - to include review of NW ACP, applicability for C&M and alignment with EPACCS
1.1.4	Adults	Level 4	Each org has their own template	ACP stocktake to confirm any gaps

1.1.5	The locality records and communicates decisions around Cardio-Pulmonary Resuscitation that is consistent across all care settings	Level 4	uDNACPR Anticpatory Clinical Management Plan included in Palliative Care Clinical Practice Summary - https://www.england.nhs.uk/north-west/north-west-coast-strategic-clinical-networks/our-networks/palliative-and-end-of-life-care/for-professionals/clinical-practice-summary/ Knowledge of and uptake of is unclear EPACCS - accessibe by Primary and secondary care, but not "all care settings" EOL Dashboard	ACPs are widely shared, but not always electronic. Delivery plan to include interoperability across "all care settings".
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	Level 5	Mayfly Hub & Spoke - multiple approaches to communications skills training inc advanced skills	
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	Level 4	Via Hub & Spoke - not shared by all	To formalise reporting framework across C&M
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	Level 3	Mixed approaches across C&M	Would require stocktake (localities to complete SA / GTO by June 25)

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	Level 4	EARLY https://www.england.nhs.uk/north-west/north-west-coast-strategic-clinical-networks/our-networks/palliative-and-end-of-life-care/for-professionals/early-toolkit-for-primary-care/ Backed up with EPACCs, reported via Dashboard SHADOW (Care Home tool) https://www.england.nhs.uk/north-west/north-west-coast-strategic-clinical-networks/our-networks/palliative-and-end-of-life-care/for-professionals/early-identification-in-care-homes/	Stocktake / review of localities use of EARLY Explore potential of Enhanced Case Finding tool using patient / market segmentation
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	Level 2	NHS NW site https://www.england.nhs.uk/north-west/north-west-coast-strategic-clinical-networks/our-networks/palliative-and-end-of-life-care/ CYP info via Claire House https://www.clairehouse.org.uk/ This sin't all ages, a single central point, or easily accessible (not on C&M website)	Delivery plan 25/26 - to review existing webpages and consider development of C&M specific pages
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	Level 3	No single C&M approach Mixed approaches across C&M	tbc - Delivery plan 25/26 to include assessment of rapid community responses across C&M and potential development of C&M framework

1.4.2	The locality has in place systems to respond to the social care needs based assessment	Level 3	No single C&M approach Mixed approaches across C&M	tbc - Delivery plan 25/26 to include assessment of rapid community responses across C&M and potential development of C&M framework
1.4.3	The locality has an approach for carers needs assessments with clear referral processes to supportive services	Level 3	No single C&M approach Mixed approaches across C&M	tbc - Delivery plan 25/26 to include assessment of rapid community responses across C&M and potential development of C&M framework
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	Level 3	No single C&M approach Mixed approaches across C&M	
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	Level 3	No single C&M approach Mixed approaches across C&M	
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:			
1.6.2	An approach that supports systems of data sharing for all service providers (For example EPaCCs)	Level 4	EPACSS	"all service provider". EPaCCS is widely shared, but not always electronic. Delivery plan to include interoperability across "all care settings".
1.6.3	Multi-lateral contracting arrangements OR contracting arrangements that support integrated care	Level 3	Mixed picture across C&M Cheshire East: Palliative Care in Partnership - use Continuing Health Care funding North Mersey - IMPACT community response	25/26 delivery plan to include ICB work on Hospice Contracting / Sustainability
1.6.4	Pooled CCG budgets across footprints for high cost, low activity services	Level 3	Mixed picture across C&M For CYP PEOLC there are joint commissioning arrangements in place for Claire House	
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	Level 0	Mixed picture across C&M. So, not 'equitable' Central info available via NWCCN https://www.england.nhs.uk/north-west/north-west-coast-strategic-clinical-networks/our-networks/palliative-and-end-of-life-care/for-professionals/bereavement-services-directory-lancashire-and-cumbria/	

Ambition 2: Each person gets fair access to care

I live in a society where I get good end of life care regardless of who I am, where I live or the circumstances of my life.

No:	Ambitions & Building Blocks	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)
	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	Level 2	PBNA was in 24/25 delivery plan	PBNA to conclude Aug 25
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	Level 3	Define "feeding into" Public Advisor role on Programme Board (only 1 person)	Paper agreed in Dec sets out approach to takeinto account various views (ICB coms, Healthwatch etc)
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	Level 3	Dashboard data is available fo rall localities - although useage is limited.	Re-design of dashboard will make locality reporting easier. Setting of local improvement plans
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	Level 2	PBNA was in 24/25 delivery plan	PBNA to conclude Aug 25
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	Level 2	PBNA was in 24/25 delivery plan	PBNA to conclude Aug 25 EOL Strategy to follow by March 26
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	Level 3	Mixed approaches across C&M	

Ambition 3: Maximising comfort and wellbeing

My care is regularly reviewed and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible.

No:	Ambitions & Building Blocks	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)
	Measurement			
3.1	**Recognising distress whatever the cause**			
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	Level 3	Mixed approaches across C&M Assume not formal.	No plans to adopt a C&M wide approach
3.2	**Addressing all forms of distress**			
	The locality have accessible & responsive services to address the following:			
3.2.1	Physical Distress	Level 3	Mixed approaches across C&M	No plans to adopt a C&M wide approach
3.2.2	Emotional Distress	Level 3	Mixed approaches across C&M	No plans to adopt a C&M wide approach
3.2.3	Social Distress	Level 3	Mixed approaches across C&M	No plans to adopt a C&M wide approach
3.2.4	Spiritual Distress	Level 3	Mixed approaches across C&M	No plans to adopt a C&M wide approach
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	Level 4	AP is included in the Palliative Care Clinical Practice Summary - https://www.england.nhs.uk/north-west/north-west-coast-strategic-clinical-networks/our-networks/palliative-and-end-of-life-care/for-professionals/clinical-practice-summary/ Some localities may need to use more than one process (eg Patients to transfer into GM)	Knowledge of and uptake of CPS is unclear. Programme will promote CPS once review is conclded in March 25.
3.3.2	The locality have 24 hour access to specialist symptom control advice and support for those nearing end of life	Level 4	Achievement is mixed across C&M. Most of Merseyside has 24/7 cover, Cheshire does not.	24/7 workstream
3.3.3	The locality have recognised providers for dispensing end of life medications 24/7	Level 4	No central C&M wide approach. Locality arrangements Locality data packs report 100hr pharmacies and stock drugs - based on 2020 scoping	

3.3.4	The workforce have central access to all locally supported symptom management guidelines	Level 4	https://www.england.nhs.uk/north-west/north-west-coast-strategic-clinical-networks/our-networks/palliative-and-end-of-life-care/for-professionals/clinical-practice-summary/	Unclear how well used the NW site is. Needs to be part of web development
3.3.5	The locality have a strategy for providing education and training in simple procedures and care processes to unpaid carers where appropriate	Level 3	Via Hub & Spoke arrangements and via Hospice education There is no C&M strategy behind this Knowledge of and uptake of is unclear	
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	Level 0	Not a C&M stated priority. This may feature in locality service specs NACEL should show hospital performance, but community unsighted	Not prioritised by PB for 25/26 delivery p
3.5	**Specialist Palliative Care**			
3.5.1	The locality has a 7 day service for Specialist Palliative Care assessments	Level 2	This is a stated C&M ambition. Performance is mixed. Could be Level 2?	This is a C&M Standard - but no active plans in place Each locality to include reference to 7 days in LIP
3.5.2	Specialist Palliative Care advice is available 24/7 across the locality	Level 3	Most in Merseyside have 9-5 7/7, but NOT Cheshire 24/7 workstream	This is a C&M Standard - but no active plans in place Each locality to include reference to 24/7 in LIP
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)	Level 4	Hub and Spoke Educational frameworks	
3.6	**Rehabilitative palliative care**			
3.6.1	The locality have access to rehabilitative services for people approaching the end of life	Level 3	Not a C&M stated priority. Will have different approaches	Would require mapping across localities
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.	Level 3	Not a C&M stated priority. Will have different approaches	Would require mapping across localities

Ambition 4: Care is coordinated

I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of the day or night.

No:	Ambitions & Building Blocks	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)
	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	Level 5	EPACCS steering group - primary, acute, hospice, and LA involvement. Not care home, NWAS or 111. Programme meets seperately with NWAS	
4.1.2	EPaCCS information is being shared with the following services:			
	Ambulance Service	Level 2	Not electronically	Monthly meetings with NWAS to progress - needs a NW solution
	Out of Hours Service	Level 3	via EMIS	3 elements req'd: 1) Need to agree to use common template 2) Need to improve ability to share electronically 3)Need to improve availability of Training & Ed
	NHS 111	Level 3	Not electronically	As above
	Specialist Palliative Care Teams	Level 3	via Share2Care / CCR	As above
	Primary Care	Level 3	via EMIS	As above
	Community Teams e.g. District Nurses, Matrons	Level 3	via EMIS	As above
	Hospitals	Level 3	via Share2Care / CCR	As above
	Care Homes	Level 3	Not electronically	As above
	Hospice	Level 3	Not electronically	As above
	Social Care	Level 3	Not electronically	As above
4.1.3	The locality can evidence the proportion of people dying with an EPaCCS record	Level 5	EOL Dashboard	
4.1.4	Palliative Care Multi-Disciplinary Meetings (MDT) are informed as appropriate through data sharing systems (such as EPaCCs)	Level 3	Technically, EOL Dashboard can be used. Variation across pratices	As above - focus on training
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	Level 3	Primary care based system. Most hospitals can access EPACCS / ACP records electronically. But not across other settings.	As above - focus on interoperability

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	Level 3	Not sure there is a recognised / formal review process (eg every month, once a 1/4) However, if a patient wants to update their ACP they should be able to,	More work to be done to inc awareness that patients can change / update.
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	Level 3	This is true for hospital providers. Questionable whether this constitutes all "key providers". Mixed acrosslocalities and community teams	Continue to work with recognised locality clinical leadership
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	Level 5	ICS Forward Plan https://www.cheshireandmerseyside.nhs.uk/media/m3wjdm3t/11115_cm-joint-forward-plan-re-freshdeliveryplan_v5-050824_ccd_ac2.pdf	
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)	Level 3	Public Advisor role on Programme Board (only 1 person) Paper agreed in Dec sets out approach to takeinto account various views (ICB coms, Healthwatch etc)	Work in 25/26 delivery plan - HW, C&M Coms etc…
4.4	**Everyone matters**			
	Local end of life strategy is inclusive of approaches to the following groups:			
4.4.1	Children and young adults	Level 2	To develop after PBNA	EOL Strategy in 25/26 delivery plan
4.4.2	Those of older age and those with frailty	Level 2	To develop after PBNA	EOL Strategy in 25/26 delivery plan
4.4.3	Those with Dementia	Level 2	To develop after PBNA	EOL Strategy in 25/26 delivery plan
4.4.4	Those with Learning Disabilities	Level 2	To develop after PBNA	EOL Strategy in 25/26 delivery plan
4.5	**Continuity in partnership**			
4.5.1	The locality has active partnerships driving forward development of community-based approaches accessed via social prescribing.	Level 1	Not a C&M stated priority. Will have different approaches	This is not seen as a C&M programme priority and will remain a locality issue

Ambition 5: All staff are prepared to care

Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care.

No:	Ambitions & Building Blocks	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)
	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	Level 4	Hub & Spoke arrangements	Prospectus - needs to be published
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	Level 3	No single C&M approach Mixed approaches across C&M CE. Schwartz round. Sefton. Queenscourt ECHO	PB discussed Feb 25 - not seen as a C&M priority, will remain a locality or provier focus.
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	Level 5	Hub & Spoke	
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	Level 5	Hub & Spoke Mayfly	
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	Level 2	Mixed approaches across C&M - previously local websites replaced by single NHS C&M site.	To be included in web review Consider assets across other websites (eg GM / L&SC) E ELCA training modules
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	Level 5	C&M and most localities. Exec lead, SRO	
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	Level 2	Needs to be included in EoL Strategy	EoL Strategy

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	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)
	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	Level 3	Mixed approaches across C&M Halton & Warrington has Compassionate Communities	Paper agreed in Dec sets out approach to takeinto account various views (ICB coms, Healthwatch etc)
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	Level 2	Dec PB paper sets out C&M approach.	Needs to be incorporated into strategy
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	Level 3	Mixed approaches across C&M - most loc	This is not seen as a C&M programme priority and will remain a locality issue
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	Level 3	Variable. Some good practice, eg Butterflies in Mid Cheshire (check SWAN) Liverpool Companion. LUFT SWAN	This is not seen as a C&M programme priority and will remain a locality issue