Bristol, North Somerset and South Gloucestershire
Integrated Care Board

**Reference: FOI.ICB-2324/093**

**Subject: Palliative and End of Life Care (PEoLC)**

*I can confirm that the ICB does hold the information requested; please see responses below:*

| QUESTION | RESPONSE |
|---|---|
| In light of the Health and Care Act 2022 and the statutory responsibility for Integrated Care Boards (ICB) to arrange for the provision of palliative care for your population, we request the following information regarding Palliative and End of Life Care (PEoLC) in general, and charitable Hospice services in particular, within your system. | |
| 1. Where does Palliative, End of Life Care and / or 'Dying Well' specifically feature in your overall planning documents?<br>Please choose one or more of the following and include the document link or attachment and the reference to section or pages where it is significantly mentioned:<br><br>a. Integrated Care Strategy (or Joint Health and Wellbeing Strategy)<br>b. Five-year Joint Forward Plan<br>c. in draft or under discussion – please specify where<br>d. not specifically mentioned<br>e. other – please specify what | Dying well features in the Five-Year Joint Forward Plan (pages 57 and 97)<br><br>Joint Forward Plan - BNSSG Healthier Together |
| 2. Where are the PEoLC specific strategies or plans within your system? | a) System level plan<br><br>Improvement plans are in draft and were developed in conjunction with the End of Life Programme Board which |

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|---|---|
| Please choose one or more of the following and include the document link or attachment:<br><br>a. System level PEoLC strategy or plan<br>b. all Places within the system have a Place level PEoLC strategy or plan<br>c. some Places within the system have a Place level PEoLC strategy or plan<br>d. in draft or under discussion – please specify where<br>e. no PEoLC specific strategies or plans<br>f. other – please specify what | previously was governed by the Integrated care Steering Group. As part of the restructure of the ICB these are likely to sit within one of the forming Health and care Improvement Groups.<br><br>Question 2 - EoLC future work and ma |
| 3. Where are strategic decisions made in your system regarding PEoLC planning and funding?<br><br>Please choose one or more of the following and include links or an attachment showing the relevant governance structures:<br><br>a. PEoLC is a named ICB sub-committee or sub-group<br>b. PEoLC decisions are made at one or more ICB sub-committee or sub-group with a wider remit (please name the sub-committee or sub-group and its remit)<br>c. PEoLC is a named ICP or Joint Health and Welling Board sub-group<br>d. PEoLC decisions are taken at our Regional NHS England PEoLC Strategic Clinical Network (SCN) | a) The End of Life Care Programme Board.<br><br>The draft ICB decision making framework which outlines high level decision making is linked below:<br><br>BNSSG ICS Operating and Decision-Making Framework (icb.nhs.uk) |

| | |
|---|---|
| e. PEoLC decisions are delegated to Place-based ICB structures (please show where in their governance structures)<br>f. PEoLC decisions are delegated to provider alliances (please state which ones)<br>g. There are PEoLC discussion groups / alliances but they are not formally linked to the ICS decision making structure<br>h. other – please specify where | |
| 4. How are charitable Hospice providers involved in PEoLC planning and decision-making in your system?<br><br>Please choose one or more of the following:<br><br>a. member of ICB Board<br>b. member of ICP Board<br>c. member of Voluntary, Community and Social Enterprise (VCSE) alliance represented on ICB / ICP Boards<br>d. member of relevant sub-committee or sub-group<br>e. member of relevant Place-based structure or alliance (please state which ones)<br>f. member of PEoLC discussion group / alliance<br>g. engaged via community outreach<br>h. consulted on proposals as and when<br>i. not involved<br>j. other – please specify how | **d. Members of ICB subgroups** |

| | |
|---|---|
| 5. The NHS England PEoLC statutory guidance is based upon the Ambitions for PEoLC Framework. What level have your ICB or Places self-assessed against these 6 ambitions?<br><br>Please include the self-assessment link or attachment:<br><br>a. between levels 0 and 2<br>b. mostly level 3<br>c. between levels 4 and 5<br>d. we are planning to start self-assessment (please state when)<br>e. we haven't done any self-assessment<br>f. other – please specify | **a) mostly level 3**<br><br>  <br>Question 5 - Regional Ambitions |
| 6. Where are charitable Hospice provider contracts held within your system?<br><br>Please only consider contracts with charitable Hospices not NHS Trust provided hospices, but please include both adult and children's hospices:<br><br>a. all hospice contracts are held by the ICB<br>b. some hospice contracts are held by the ICB and some by Place-based ICB structures or provider alliances<br>c. all hospice contracts are held by Place-based ICB structures<br>d. all hospice contracts are held by provider alliances<br>e. other – please specify what | a. all hospice contracts are held by the ICB |

| | |
|---|---|
| 7. What types of contract do you use with charitable Hospice providers?<br><br>Please choose one or more of the following:<br><br>a. NHS standard contract (full length)<br>i. Is it annual or multi-year<br>ii. Is it block or bed / activity-based funding<br>iii. Does it include risk sharing around activity thresholds<br>b. NHS standard contract (short form)<br>i. Is it annual or multi-year<br>ii. Is it block or bed / activity-based funding<br>iii. Does it include risk sharing around activity thresholds<br>c. grant or service level agreement – block funding<br>d. grant or service level agreement – bed / activity-based funding<br>e. fast-track continuing healthcare funding<br>f. continuing care funding (children)<br>g. other – please specify what | NHS standard contract (short form)<br>i. multi – year<br>ii. block and activity-based funding depending on the contract held<br>iii. No<br>Fast track continuing healthcare funding and continuing care funding is included as an element within the relevant hospice contracts. |
| 8. What was the total value of all these charitable Hospice contracts for 2022-23?<br><br>a. for adult services<br>b. for children and young people's services | a. adult services: £3,683,000<br>b. children and young people services: £345,000 |
| 9. What uplift percentage did you apply to these contracts in April 2022? Did all charitable Hospices receive it? | 1.7% uplift was applied to all hospice contracts. |

| | |
|---|---|
| Did you pass on the additional 1.7% uplift (as per this NHSE letter) in July 2022? Did all charitable Hospices receive it?<br><br>What uplift percentage are you applying to these contracts in April 2023? | 1.8% national defined uplift has been applied to all hospice contracts from April 2023 |
| 10. Do you have a shared care record or shared care plans across your ICS or Places? If so, do charitable Hospices have access to it?<br><br>Please choose one for shared care records and one for shared care plans<br><br>a. shared care record – hospices are included<br>b. shared care record – hospices are not included (please state which providers are and whether there are plans for expansion)<br>c. there are no shared care records<br>d. shared care plans (urgent or end of life) – hospices are included<br>e. shared care plans (urgent or end of life) – hospices are not included (please state which providers are and whether there are plans for expansion)<br>f. there are no shared care plans<br>g. other – please specify what | **A) SHARED CARE RECORD**<br>**D) SHARED CARE PLANS** |

***The information provided in this response is accurate as of 11th July 2023 and has been approved for release by Sarah Truelove, Deputy Chief Executive and Chief Finance Officer for NHS Bristol, North Somerset and South Gloucestershire ICB.***

Healthier Together

**Improving health and care** in Bristol,
North Somerset and South Gloucestershire

# Palliative Care Guidance and Ambitions Framework

Work of the EoLC Programme, our progress as a system, and the work we have left to do.

xxxxx xxxxx, Transformation Programme Manager.
xxxxx xxxxx, Senior Project Officer.
13th March, End of Life Care Programme Board.

# In this item

- Context:
  - ICB statutory guidance
  - National Council for Palliative Care 6 Ambitions
- Mapping our progress:
  - Statutory guidance - headlines
  - Refreshed Ambitions foundations analysis
  - Focus on 24/7 provision
- Our work moving forward
  - Bringing this all together and next steps

# Health and Care Act 2022 - ICB Statutory Guidance

This set out the legal responsibility to commission health services that meet their population needs.

- Integrated Care Systems (ICSs) have a key role to play in ensuring that people with palliative and end of life care (PEoLC) needs can access and receive high quality, personalised care and support.
- There is a duty for ICBs to commission palliative care services within ICSs
- Definition of Palliative Care in the guidance:

*"Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening or life-limiting illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual."*

Existing frameworks exist for BNSSG ICS to evaluate the commissioning and delivery of PEoLC services:

- The Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026 provides such a framework and is already in use in BNSSG to drive our work
- NHSE is developing core metrics to support colleagues in monitoring the impact of this delivery
- The NHS England Delivery Plan (p10) sets out, at a high level, the NHS England approach to improving PEoLC and what should be implemented locally

# ICB Statutory guidance – Key considerations to meet ICB legal duties

The core responsibility for commissioners is to commission high quality safe services that are tailored to the needs of the individual:

- People with PEoLC needs should be supported by a whole system approach, by the right professional at the right time, including out of hours (OOH) access to palliative and end of life care
- There should be access to a wide variety of non-specialist palliative care delivered by primary, community, acute and urgent care services, as well as specialist-level palliative care services to enable the system to provide personalised care to the person.
- The consideration of commissioned palliative and end of life care services applies to people of all ages. There are important differences between adults and children's palliative and end of life needs, including at the transition between childhood and adulthood, which must be taken into account in the commissioning and design of services.
- ICBs should have a clear vision of how the package of services they commission locally deliver against the Ambitions Framework and should actively seek out commissioning resources to achieve this.
- There must be sufficient workforce in place across all settings, with the knowledge to deliver the care required.

# ICB Statutory guidance - specific actions

Every ICB should commission services that align to the commitments in the National Council for Palliative Care Ambitions for Palliative Care, which sets out what is required across the whole system.

- Action an a Ambitions for Palliative and End of Life Care self-assessment to identify progress and gaps
- Develop and implement a PEoLC service specification that aligns closely with the national PEoLC service specifications
- Specify what needs to be in place to deliver high quality PEoLC for their populations and ensure sufficient provision available, particularly in relation to:
    - access to specialists palliative care services
    - equipment
    - spiritual care
    - access to information
- Ensure access to general medical and nursing services, out of hours services and
- Complete an Equalities and health inequalities assessment and action plan

# ICB Statutory guidance - Our progress against these actions and gaps – a summary

| Action | Progress | Gaps | Next steps |
|---|---|---|---|
| Complete a self assessment against the national ambitions | Completed in 2020 and refreshed in 2022/3. Significant progress towards some ambitions especially 1,3, and 4 | Assessment highlighted areas to focus on to support progress including 2, 5 and 6. | Establish resources needed to deliver this work and where best it should sit. |
| Develop and implement a PEoLC service specification that closely aligns with the national PEoLC service specs | Specialist palliative and end of life care services adult service specification was published on 18th January 2023. Comparison to current service specifications is underway. | To be identified as part of the initial review against national specifications. | Share results of comparison by 31st March and establish where this work is best taken forward. |
| **Specify what needs to be in place to deliver high quality PEoLC for their populations and ensure sufficient provision available, particularly in relation to:** | | | |
| 1. Access to specialists palliative care services<br>2. Equipment<br>3. Spiritual care<br>4. Access to information | 1. Mapping/baselining considered access to specialist palliative care.<br>2. Previous discussions highlighted issues with access to syringe drivers, though workforce related (?)<br>3. Mapping by programme team looked at bereavement support (including preparing for death).<br>4. Resources are available on a number of provider and VCSE sector sites. | 1. Mapping found while staff and carers/patients have access to 24/7 remote specialist palliative care guidance/advice, 24/7 face to face care is not available across all of BNSSG.<br>2. Access to equipment for staff and patients/carers not confirmed at a system level.<br>3. Gaps not currently known.<br>4. We know information and resources are not as easy to access as they could be – options paper completed on consolidation of digital resources into one location. | 1. Confirm mapping findings and agree action plan to address.<br>2. Establish with operational teams if known issues or delays with access to equipment for staff or patients<br>3. Focussed mapping in March to identify spiritual support available and any issues with access/ability to refer.<br>4. Agree preferred option and establish delivery plan. |
| Ensure access to general medical & nursing services, OOH. | Mapping found 24/7 access to generalist services are in place including OOH. | No gaps identified by mapping. | Share detailed results of mapping for confirmation. |
| Complete an Equalities & health inequalities assessment & action plan | HEAT assessment carried out & shared with board in March 22. HI in social inequality, physical inequality, ethnic communities & groups with protected characteristics. Action plan created. | Action plan created has fed into workplan e.g. improving access to information, training review, inclusion of compassionate communities in workplan. | Revisit action plan and identify other priority actions. |

# NHS England National Delivery Plan

Included in our plans/work underway

Not previously explicitly specified in plans

| NHS England National Delivery Plan | | |
|---|---|---|
| **Priority** | **Action** | **Delivery Asks of ICS/ICB** |
| **Improving Sustainability** | **People are identified as likely to be in the last 12 months of life and are offered PCSP** | • Palliative care registers across primary and secondary care in place, for timely PCSP<br>• Identification tools implemented to increase identification of people in last year of life<br>• Full implementation of EPaCCs |
| | **Staff, patients and carers can access the care and advice they need, whatever time of day** | • All patients with PEoLC needs, including those not yet listed on palliative care registers, can access the appropriate advice and signposting supported by a SPOC<br>• Collaborative working to achieve seamless transition between care settings |
| | **Equitable access to PEoLC for all, focussing on locally identified under-served populations.** | • Evidence how plans and actions address priority underserved populations<br>• Equalities and Health inequalities impact assessment and action plan focused on PEoLC and EARLY/risk stratification extractions |
| **Improving Quality** | **High quality PEoLC for all, irrespective of condition or diagnosis** | • Collaborate with system-level networks, e.g. CYP, dementia, frailty, cancer to ensure high quality personalised PEoLC for all, across all settings |
| | **A confident workforce with the knowledge, skills and capability to deliver high quality PEoLC** | • Roll out training for staff in terms of personalised PEoLC, including PCSP, e.g. QoF Qi training, E-eLCA and Personalised Care Institute [3] |
| | **High quality PEoLC across all system** | • Adopt QI Methodology for PEoLC, at system level engage with local quality and improvement leads, in both acute and community settings, to ensure an outstanding CQC rating is achieved consistently across the ICS |
| **Improving Sustainability** | **PEoLC is sustainably commissioned** | • ICB Plans have PEoLC as a strategic priority<br>  ○ PEoLC service specification, contracting arrangements against investment framework and data collection methodologies<br>• Sustainability of CYP PEoLC through CYP match funding and CYP hospice grant |
| | **The PEoLC workforce is fit for purpose, now and in the future** | • Future workforce evidenced in all ICB generic workforce plans<br>• Implementable specialist palliative care workforce plan, progress in implementing that plan and utilising the regional mapping tool |
| | **Personalised and community approaches are fundamental to improving PEoLC experience** | • Personalised and community centred approaches across ICS, place and PCNs |
| **Ambitions Outcomes**<br>*Everyone person is seen as an individual*<br>*Each person gets fair access to care*<br>*Maximising comfort and wellbeing*<br>*Care is coordinated*<br>*All staff are prepared to care*<br>*Each community is prepared to help* | | |

# Ambitions for Palliative Care: A national framework for local action

The ambitions themselves – a reminder

# Ambitions for Palliative Care: A national framework for local action – Foundations and Building Blocks

# Ambitions for Palliative Care: A national framework for local action – Self Assessment

The first review of the self assessment against the ambitions has been completed.

The assessment identifies level of achievement against each of the building blocks and then provides a summary of progress as follows:

| | Level 0 | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 | % at level 3 & above |
|---|---|---|---|---|---|---|---|
| Ambition 1: Each Person Seen as an Individual | 10.5% | 5.3% | 15.8% | 36.8% | 21.1% | 0.0% | 57.9% |
| Ambition 2: Each person gets fair access to care | 0.0% | 0.0% | 66.7% | 33.3% | 0.0% | 0.0% | 33.3% |
| Ambition 3: Maximising comfort and wellbeing | 0.0% | 12.5% | 12.5% | 25.0% | 37.5% | 12.5% | 75% |
| Ambition 4: Care is coordinated | 0.0% | 0.0% | 26.1% | 39.1% | 21.7% | 4.3% | 65.1% |
| Ambition 5: All staff are prepared to care | 0.0% | 0.0% | 57.1% | 42.9% | 0.0% | 0.0% | 42.9% |
| Ambition 6: Each community is prepared to help | 25.0% | 50.0% | 0.0% | 25.0% | 0.0% | 0.0% | 25.% |

| 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 |

# Ambitions for Palliative Care: Progress

## We have made significant progress in the following areas:

- Honest conversations
- 24/7 support and guidance
- Using PHM and system wide data
- Skilled assessment and symptom management
- Addressing all forms of distress
- Shared care records
- Specialist palliative care

## We have plans underway or included in plans:

- Improving our understanding of the reach of our services
- Improving identification
- Improving our use of data to drive decisions/improvement
- Using person centred outcome measures
- Improving access to information and training

## We have progress to make on plans for:

- Compassionate and resilient communities
- Monitoring as a system how we are doing
- Ensuring our contracting meets the needs of our population

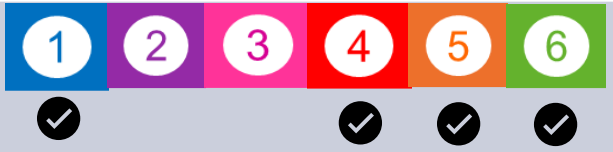
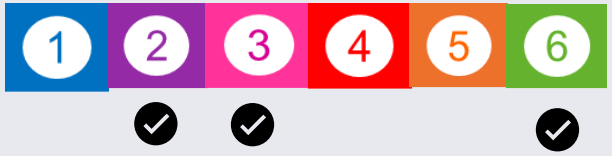
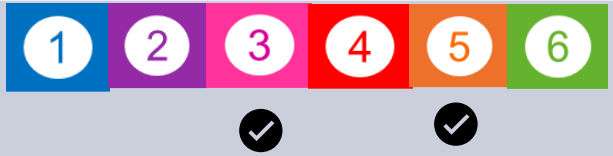
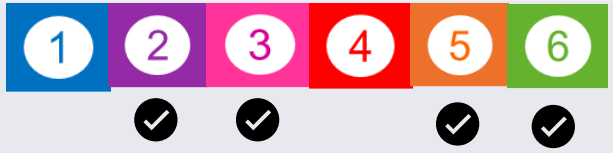
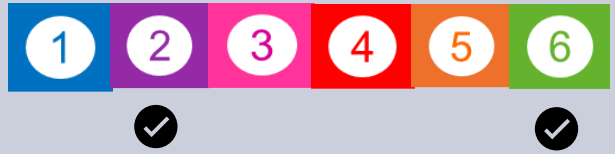
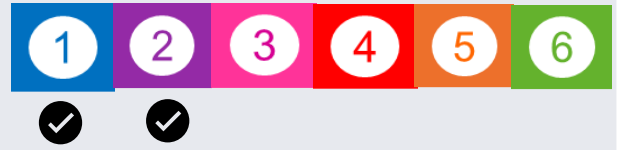
# Ambitions for Palliative Care:  Next steps

- Actions are being set against each of the building blocks to identify next steps to support progress
- Assessment findings to be confirmed with providers
- Ensure each building block is included in current improvement plans
- Identify any additional areas of focus
- Identify where best and how best to deliver this work.
- Form these develop and confirm action plan

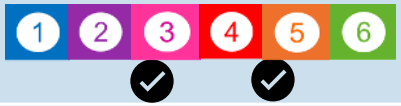
# A reminder of our existing workplan, showing the ambitions, and parts of delivery plan this will help us meet:

| High-level tasks | Ambitions | Statutory guidance core resp. | Progress/status/next steps |
|---|---|---|---|
| Identify support and training needs and map training opportunities for profs., carers & patients, Identify gaps and how to deliver. | 1 5 6 NHS | There must be sufficient workforce in place across all settings, with the knowledge to deliver the care required. | Mapping completed, workstream established, proposal in development. Linked with comms work to consolidate resources. Options paper to be circulated for consideration. |
| Consolidation of online resources and information for professionals, patients and carers. | 5 6 | Access to high quality information | Options paper complete with recommendations, to be shared with board members for consideration. If preferred option is approved, funding will need to be sourced. |
| Identify health inequalities and reach of services, implement action plan to address | 1 2 NHS | Complete an Equalities and health inequalities assessment and action plan. | EIA and HEAT analysis previously completed and fed into workplans. Action plan to be refreshed and priority actions agreed. |
| Shared care records and a person-centred approach to care planning | 1 3 4 NHS 6 | Shared care records are key to realising the ambitions, and guidance states ICBs should action an a Ambitions for Palliative and End of Life Care self-assessment to identify progress and gaps | ReSPECT Plus implementation will deliver much of what is required to realise ambitions and meet statutory obligations. |
| Improve use of data incl. PCOMs/PREMs and population level data to inform services and improvements, and measure progress | 1 2 NHS | Use of data and outcome measures is key to ambition 1, and guidance states ICBs should action an a Ambitions for Palliative and End of Life Care self-assessment to identify progress and gaps | Deaths data now in system-wide data set, working to include hospice data. Outcome measures proposal due for completion in April, EoL Dashboard development has commenced. Work to be shared with board members in April. |
| Improve identification | 1 NHS | Improving identification is key to ambitions 1 guidance states ICBs should action an a Ambitions for Palliative and End of Life Care self-assessment to identify progress and gaps | Joining with system wide approach to segmentation, CMS (Cambridge Multimorbidity Score) has been proposed to support identification. Pilot ion development at NBT – requires funding. |
| Identify gaps/improvements required in services and develop action plan through mapping and 6 ambitions self assessment. | 3 6 | There should be access to a wide variety of non-specialist palliative care delivered by primary, community, acute and urgent care services, as well as specialist-level palliative care services to enable the system to provide personalised care to the person. | Mapping and assessment complete. Detailed 24/7 provision results to be shared at board on 13th March, propose next focus is national service specification. |

# So what have we achieved?

| Tasks/Milestones | Progress towards ambitions |
|---|---|
| Implementation of ReSPECT PLUS across primary, community and hospice care, and partial implementation in acutes.<br>ReSPECT Plus evaluation has started. |  |
| Mapping of services, self assessment against ambitions and statutory guidance, with gaps identified.<br>Review of 24/7 provision.<br>Updated action plan in development.<br>Anticipatory drugs guidance and charts reviewed and updated. |  |
| Review of end of life care core skills framework and training needs mapped.<br>Proposal in development for delivery – linked with comms work. |  |
| Review of professional and public resources mapped and proposal for consolidation of online resources complete. |  |
| EIA and HEAT Analysis completed and used to inform action and workplans. |  |
| Baselining end of life data and activity complete.<br>Deaths data in system wide data set with hospice data to shortly be incorporated.<br>Outcome measures proposal due April<br>Identification proposal agreed with pilot at NBT to start shortly<br>Activity and financial analysis |  |

# Updated high level workplan and next steps

| | Q1 | Q2 | Q3 and beyond | Ambitions/Delivery plan |
|---|---|---|---|---|
| W&T | • Training and support delivery proposal | Link with People Directorate and System workforce plans, ensuring PEoLC workforce is evidenced in system plans, incl. specialist palliative care. NHS | Implementable specialist palliative care workforce plan, progress in implementing that plan and utilising the regional mapping tool NHS |   |
| C,E&I | • Agree preferred option for consolidation of online resources including access to training/support. | Refresh action plan arising from HEAT analysis, incl. focus on identification/risk strat. NHS | Engagement with underserved communities NHS |   |
| Digital | • ReSPECT Plus milestones/tasks NHS | • ReSPECT Plus milestones/tasks | • ReSPECT Plus milestones/tasks |   |
| BI, R &E | • Outcome measures proposal – **IN PROGRESS**<br>• Secure funding for identification pilot at NBT<br>• First 'draft' dashboard | • Establish outcome measures implementation<br>• First 'draft' dashboard<br>• NBT ID pilot | Implementation of ID tool NHS<br><br>Establish plan to improve use of palliative care register NHS |   |
| Service etc | Map example patient journeys and identify areas for improvement to transition between services. NHS | • Review existing services specifications against national service spec.<br>• Work with locality partnerships on regional/local differences and priorities NHS | • Compassionate communities<br>• Carers services review<br>• Consider plan to achieve CQC outstanding across system NHS |   |

# Drawing all this together – towards a 5 year strategy for EoLC in BNSSG

What is the ICS Joint Forward Plan?

- Sets out how the ICB intends to deliver on the national vision to ensure delivery of high quality healthcare for all
- Sets out how the priorities identified in the strategy will be delivered over the next five years
- Uses objectives reflecting system intelligence and aligned metrics
- Following a draft submission based on priorities and aims already agreed by the end of life care programme, there will be additional opportunities to feed into a 5 year plan for end of life care services. The current draft is the first iteration of a rolling process.

## NATIONAL DRIVERS

6 ambitions


NHSE Delivery Plan and Guidance for ICS' ICBs

## LOCAL DRIVERS

Our areas of collective focus agreed last Spring

Supporting the whole person and those close to them

Understanding, sharing and following people's wishes

Access to high quality, timely care at home.

High level ICS strategy

# High level Draft EoLC strategy for BNSSG

## Drivers

**OUR 3 AREAS OF FOCUS**

- Support the whole person and those close to them
- Understanding, sharing and following people's wishes
- Access to high quality, timely care at home.

**Ambitions**

1 2 3 4 5 6

## 5 key areas of work that will together help us meet the ambitions

### Deliver Respect Plus

- Shared care records
- Patient centred care
- Personalised care
- Supporting staff to have honest conversations
- Meeting preferences for care
- Supporting people to die in their preferred place

### Deliver an online resource centre

- Improved access to high quality, up to date info
- Consolidation of digital resources into one location
- Training accessible in the same place for professionals and cares/patients alike
- Helping people access information and support at any time of day

### Dashboard and data

- Tools for systematic use of Intelligence informed services
- PHM informed interventions
- A dashboard of qual.and quant. Data to measure and monitor progress
- Insights that inform priorities and services to address HI.

### Services and pathways review

- Addressing transition between services
- Addressing geographical and temporal inequities' in access
- Aligning local service specs with national specifications

### Workforce support and development

- A supported workforce with the skills they need
- Access to training and support
- Align with system workforce plans

We need to consider inequalities throughout this work

## System objectives this will support

*Improve outcomes in population health and healthcare*

*Tackle inequalities in outcomes, experience and access*


## Supporting delivery

National service specification review – mapping – HEAT action plan – 6 ambitions assessment – people with lived experience

# 24/7 service provision

We agreed at the January Board meeting to start with 24/7 provision. This is a key area identified in both statutory guidance and in National Ambitions and building blocks.

**03 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.*

- 24 hour access to specialist symptom control advice and support for those nearing the end of life.
- 7 day service for specialist palliative care assessments
- Specialist Palliative Care advice is available 24/7

**Statutory guidance**

- Ensure access to general medical and nursing services, out of hours services access to medicines.
- Develop and implement a PEoLC service specification that closely aligns with the national PEoLC service specs

## Overview of findings from mapping exercises:

| Requirement | Have we achieved in full? | What or where are the gaps? |
|---|---|---|
| 24/7 access to generalist services | ✓ | None identified |
| 24/7 remote access for staff to specialist advice | ✓ | None identified |
| 24/7 remote access for carers/patients to specialist advice | ✓ | None identified |
| 7 day face to face specialist services | | • Inequitable access based on geography<br>• Only patients living in areas covered by St Peter's have access to 7 day face to face specialist care |

# Patients have access to 24/7 adult generalist services

3

| Status by area: | Bristol | |
|---|---|---|
| | North Som. | |
| | South Glos. | |

*"Staff, patients and carers can access the care and advice they need, whatever time of day"* NHS

| Severnside IUC (BrisDoc) | Sirona | Where are the gaps? |
|---|---|---|
| • 24/7 NHS Urgent Care Service<br>• Out of hours telephone/video Clinical Assessment Service when GPs are closed<br>• Out of hours F2F appointments at treatment centres<br>• Out of hours home visits<br>• Covers Bristol, North Somerset and South Gloucestershire<br>• Partnered with BrisDoc | • EoL and Palliative Care Service<br>• Working with district nurse team, GPs and therapists<br>• Support for families and carers<br>• Single Point of Access (SPA)<br>• Mon-Fri 07:00-22:00<br>• Additional out of hours service | • No gaps identified by mapping. |

# Staff have 24/7 remote access to adult specialist palliative care advice

3

| Status by area: | Bristol | |
|---|---|---|
| | North Som. | |
| | South Glos. | |

*"Staff, patients and carers can access the care and advice they need, whatever time of day"* NHS

| St Peter's Hospice advice line | Weston Hospicecare advice line | BrisDoc Weekday Professional Line | Where are the gaps? |
|---|---|---|---|
| • 24/7 service<br>• Advice and support including pain and symptom control advice<br>• For all HCP colleagues in the community<br>• Patient does not need to be known to the hospice<br>• Covers Bristol, South Gloucestershire and parts of North Somerset | • 24/7 service<br>• Staffed by registered nursing team from the hospice<br>• Complex cases can be passed to the on call hospice doctor<br>• Covers Weston and Worle | • Mon-Fri 08:00-18:30 phone support<br>• For HCPs considering an adult medical admission<br>• Advice on urgent medical problems in the community<br>• Exploration of alternative pathways to avoid admission<br>• Covers Bristol, North Somerset (and South Gloucestershire?) | • No gaps identified by mapping. |

# Carers have 24/7 remote access to adult specialist palliative care advice

3

| Status by area: | Bristol | |
|---|---|---|
| | North Som. | |
| | South Glos. | |

*"Staff, patients and carers can access the care and advice they need, whatever time of day"* NHS

| St Peter's Hospice advice line | Weston Hospicecare advice line | Where are the gaps? |
|---|---|---|
| • 24/7 service<br>• Advice and support including pain and symptom control advice<br>• For all EoL carers in the community<br>• Patient does not need to be known to the hospice<br>• Covers Bristol, South Gloucestershire and parts of North Somerset | • 24/7 service<br>• Staffed by registered nursing team from the hospice<br>• Complex cases can be passed to the on call hospice doctor<br>• Covers Weston and Worle | • No gaps identified by mapping. |

# 7 day face to face specialist adult palliative care services (1/2)

| Status by area: | Bristol | |
|---|---|---|
| | North Som. | |
| | South Glos. | |

*"Staff, patients and carers can access the care and advice they need, whatever time of day"* NHS

| St Peter's Hospice | Weston Hospicecare | NBT Palliative Care Team | UHB Palliative Care Team | WGH Palliative Care Service |
|---|---|---|---|---|
| • 27/4 admissions to inpatient unit<br>• Mon-Fri Day Hospice service<br>• Mon-Fri 09:00-17:00 CNS full team, reduced cover for Sat/Sun/bank hol<br>• 24/7 Hospice at Home depending on staffing<br>• Covers Bristol, South Gloucestershire and parts of North Somerset | • Mon-Fri working hours admission to inpatient unit, or out of hours by exception<br>• Tue/Wed Day Hospice service for 12 patients<br>• Mon-Fri 08:30-17:00 CNS team<br>• Covers Weston and Worle | • Mon-Fri 08:30-17:00 (TBC – is it Mon-Sat?) in-hospital specialist palliative care service | • Mon-Fri 08:30-17:00 (TBC) in-hospital specialist palliative care service | • Mon-Fri 09:00-17:00 in-hospital specialist palliative care service |

# 7 day face to face specialist adult palliative care services (2/2)



| Status by area: | Bristol | |
|---|---|---|
| | North Som. | |
| | South Glos. | |

*"Staff, patients and carers can access the care and advice they need, whatever time of day"* NHS

| Fast Track (Continuing Healthcare) | Fast track funded beds | Marie Curie Variable Nursing Service | Where are the gaps? |
|---|---|---|---|
| • Arranges care packages for rapidly deteriorating patients at end of life<br>• Delivery of home support<br>• Nursing home care arrangements<br>• Service gaps due to resourcing? | • Spot purchase beds at St Peter's and Weston Hospice care inpatient units<br>• Max 2 beds at St Peter's (TBC)<br>• Max 5 beds at Weston (TBC) | • Overnight care<br>• 22:00-07:00<br>• Supported by partner out of hours services for advice when needed<br>• Covers Bristol, North Somerset and South Gloucestershire<br>• Gaps/resourcing issues TBC | • Inequitable access based on geography<br>• Only patients living in areas covered by St Peter's have access to 7 day face to face specialist care |

# Next steps

- Map example patient journeys and identify areas for improvement to transition between services
  - *Rapid scoping and mapping work over next 2 weeks*
  - *Opportunity to join a face to face session at St Peter Hospice on Monday 27th March*
  - *Look out for an email with other ways to feed in*

- Draft strategy drawing on work plan, ambitions and ICS guidelines to be circulated for comment *by 20 March*

- Establish what resources might be needed to deliver work

- Establish with the ICB the priorities for delivery that take account of resourcing challenges

- Circulate options paper for consolidation of online resources *by 20 March*

- **Next Board scheduled for May – proposing an additional board in April for those able to attend to finalise plans before the ICB implements the new structure.**

- Confirm where work will sit in the new structure

| | |
|---|---|
| **Name of Organisation(s):** | |
| **Name of Person or Group completing the self-assessment:** | |
| **Version Control:** | |
| **Date of Completion:** | |
| **Sign off by locality Clinical Lead for Palliative/ End of Life Care:** | |

| | Level 0 | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|---|---|
| Ambition 1: Each Person Seen as an Individual | 10.5% | 5.3% | 15.8% | 52.6% | 5.3% | 0.0% |
| Ambition 2: Each person gets fair access to care | 0.0% | 0.0% | 66.7% | 33.3% | 0.0% | 0.0% |
| Ambition 3: Maximising comfort and wellbeing | 0.0% | 12.5% | 12.5% | 25.0% | 37.5% | 12.5% |
| Ambition 4: Care is coordinated | 0.0% | 0.0% | 26.1% | 39.1% | 21.7% | 4.3% |
| Ambition 5: All staff are prepared to care | 0.0% | 0.0% | 57.1% | 42.9% | 0.0% | 0.0% |
| Ambition 6: Each community is prepared to help | 25.0% | 50.0% | 0.0% | 25.0% | 0.0% | 0.0% |

## 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 | | | |
| 1.1.2 | Adults | Level 3 | ReSPECT Plus is a digital read/write shared care plan for people who would benefit from advanced care planning. It has been implemented and is live across primary, community and hospice care, with acutes able to access through connecting care.<br>Builds on ReSPECT form which was rolled out across BNSSG in 2020. | Social care does not yet have access to ReSPECT PLUS, though use ReSPECT. - planned for consideration in later phases. |
| | 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 | | | |
| 1.1.4 | Adults | Level 3 | ReSPECT PLUS | Social care see above |
| 1.1.5 | The locality records and communicates decisions around Cardio-Pulmonary Resuscitation that is consistent across all care settings | Level 3 | ReSPECT PLUS | Social care see above |
| 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 3 | Training for use of ReSPECT PLUS includes support for professional in having honest conversations. Form is deigned to support these conversations.<br>Mapping of al trianing for EoLC skills (including for informal carers) is underway. | Social care see above |
| 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 0 | TBC - not known. | Establish how this might be implemented - look for examples from other systems. |
| **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 2 | Review of PCOMs/PROMs carried, work also informed by regional' what matters survey'. Evidence team recommended ICECAP and IntegRATE. Evidence/BI group to progress this work. | No plan in place yet for roll out once approach to outcome measures has been agreed. |
| 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 2 | To join up with system work on PHM and segmentation, proposig to use Cambridge Morbidity Score to support identification. Although ont a validated tool for identifying people at risk of death, this has been found to be a good indicator. Pilot in development at acute trust to aply retrospectively to test this assumption. | |
| **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 | Review of online professional/public resources, options paper complet for development of online resources. Information on what to expect is available on provider sites, but not yet on central information point. | Work ongoing to improve and centralise digital information, but no plan oin place for reviewing availability of non digital information. |
| **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 | | |
| 1.4.2 | The locality has in place systems to respond to the social care needs based assessment | Level 3 | Access to social care is challenging across the system., however, the Fast Track team have access to brokerage for patients referred to the service. | Not understood if there are place based issues for rapid access to social care for people at the end of life. |
| 1.4.3 | The locality has an approach for carers needs assessments with clear referral processes to supportive services | Level 3 | Carers strategy under development for BNSSG which will include carers assessments. | Links between carers work and end of life care programme not sufficent to have clarity on this. |
| **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 | PHB reviewed in 2020. | Confirm with CHC team to identify gaps |

| | | | | |
|---|---|---|---|---|
| 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 | Support available from Srona PEoLC team and 24/7 remote guidance available across BNSSG. | Gaps in training for carers and patients will e idetified as part of the mapping being carried out by workforce and training workstream. Accessibility of suport not understood at this time |
| **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 3 | ReSPECT Plus - see above | ReSPECT Plus - see above |
| 1.6.3 | Multi-lateral contracting arrangements OR contracting arrangements that support integrated care | Level 1 | PEoLC contracts to be reviewed against n | PEoLC contracts to be reviewed against national service specification. |
| 1.6.4 | Pooled CCG budgets across footprints for high cost, low activity services | Level 0 | | |
| **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 4 | Bereavement mapping identified bredth of services available | No sigificant gaps identified by mapping. |

## 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 | Work carried out by BI and ecidence group looked at protected charateristics and plac of death, HEAT analysis identified Health Inequalties which have fed into action and work plans | Demgraphics not understood at a system level |
| **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 2 | ICB has carried out engagement with population on priorites for the system, with End of Life forming a key part of the lifecourse framework. | |
| **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 2 | Deaths data is now part of the system wide data set.<br>Plans underway to devleop a dashboard for PEoLC activity. | |
| **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 3 | EIA and HEAT assessment | Need updating. |
| **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 3 | PHM/SWD/ Cohort 5 CMS | |
| **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 2 | Review of PCOMs/PROMs carried, work also informed by regional' what matters survey'. Evidence team recommended ICECAP and IntegRATE. Evidence/BI group to progress this work. | No plan in place yet for roll out once approach to outcome measures has been agreed. |

## 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 | Assessments carried out by providers | Ned to establish what assements are used by each provider to eividence this. |
| **3.2** | **Addressing all forms of distress** | | | |
| | The locality have accessible & responsive services to address the following: | | | |
| 3.2.1 | Physical Distress | Level 4 | specialist pall care/2 hour or rapid response. 24 hour advice and guidance | |
| 3.2.2 | Emotional Distress | Level 4 | IAPT services/VCSE, services mapping which included beareavement servcies, online resoucres | |
| 3.2.3 | Social Distress | Level 3 | Services mapping identified sources of practical spport, rapid access to social care in place across some organisations, online resources | Known issue with people at End of Life being referred to discharge pathways not designed for people in fina weeks of life. |
| 3.2.4 | Spiritual Distress | Level 3 | Online resources and signposting, services mapping | Gaps in privison not known. |
| **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 | karla and anticipatory drug guidance | |
| 3.3.2 | The locality have 24 hour access to specialist symptom control advice and support for those nearing end of life | Level 5 | Q amy - is this the case across the patch? | |
| 3.3.3 | The locality have recognised providers for dispensing end of life medications 24/7 | Level 4 | Q amy - is this the case across the patch? JIC meds, LES pharmacies (Karla) | |
| 3.3.4 | The workforce have central access to all locally supported symptom management guidelines | Level 4 | Remedy and gp team net. | |
| 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 2 | workforce and training workstream | |
| **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 1 | Priorities are communicating sensitively with them and their family; involving them in decisions; supporting them and their family; and creating an individual plan of care that includes adequate nutrition and hydration. These align with programme of work. | Not understood at a system level which of these are included in patietn eedback surveys, no systemp plan for monitoring. |
| **3.5** | **Specialist Palliative Care** | | | |
| 3.5.1 | The locality has a 7 day service for Specialist Palliative Care assessments | Level 4 | Mapping found available 7 days per week. | |
| 3.5.2 | Specialist Palliative Care advice is available 24/7 across the locality | Level 5 | Mapping founds avilable 24/7 | |
| 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 2 | workforce and training workstream leading on mapping and identifcation of gaps. | |
| **3.6** | **Rehabilitative palliative care** | | | |
| 3.6.1 | The locality have access to rehabilitative services for people approaching the end of life | Level 1 | | Access not understood at this time |
| 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 | Issues previously hghlighted with access | Access and availability not understood as a system |

## 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 | ReSPECT Plus Clinical oversight group and EoLC programme board | |
| 4.1.2 | EPaCCS information is being shared with the following services: | | Below is for ReSPECT Plus NOT epaccs | |
| | Ambulance Service | Level 2 | Flag on summary care record | |
| | Out of Hours Service | Level 2 | Flag on summary care record | |
| | NHS 111 | Level 2 | Flag on summary care record | |
| | Specialist Palliative Care Teams | Level 4 | Available on patitent reods at hospices, avaiable on connecting care for hospital teams, available in patient records in community team ssytems | |
| | Primary Care | Level 4 | yes | |
| | Community Teams e.g. District Nurses, Matrons | Level 4 | yes | |
| | Hospitals | Level 3 | yes | |
| | Care Homes | Level 2 | not yet | |
| | Hospice | Level 4 | yes | |
| | Social Care | Level 2 | not yet | |
| 4.1.3 | The locality can evidence the proportion of people dying with an EPaCCS record | Level 4 | yes | |
| 4.1.4 | Palliative Care Multi-Disciplinary Meetings (MDT) are informed as appropriate through data sharing systems (such as EPaCCs) | Level 3 | | |
| 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 | | |
| 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 | | |
| **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 2 | | |
| **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 3 | | |

| | | | | |
|---|---|---|---|---|
| 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 | | |
| **4.4** | **Everyone matters** | | | |
| | Local end of life strategy is inclusive of approaches to the following groups: | | | |
| 4.4.1 | Children and young adults | | | |
| 4.4.2 | Those of older age and those with frailty | Level 3 | | |
| 4.4.3 | Those with Dementia | Level 3 | | |
| 4.4.4 | Those with Learning Disabilities | | | |
| **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 3 | | |

## 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 2 | All to be reviewed by Workforce and training group | |
| **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 | All to be reviewed by Workforce and training group | |
| **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 3 | All to be reviewed by Workforce and training group | |
| **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 3 | All to be reviewed by Workforce and training group | |
| 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 | All to be reviewed by Workforce and training group | |
| **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 2 | | |
| **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 | | |

## 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 1 | | |
| **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 1 | | |
| **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 | | |
| **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 0 | | |