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Executive Summary

1. Purpose of the report
The purpose of this report is to provide a comprehensive summary of activities and outcomes of the Renfrewshire Macmillan Palliative Care Project Jan 2014 - March 2017. Work undertaken in 2014 and 2015 can also be found in Year 1 and Year 2 reports in more detail.

2. Overview
The Renfrewshire Macmillan palliative care project started in January 2014 and closes on 31st March 2017 when funding concludes. The team were asked to “redesign delivery of palliative care services through integration of supportive and palliative care approaches into mainstream primary & community care service provision”.

Many people in Scotland who could benefit from palliative and end of life care (PEOLC) do not currently receive it. The Strategic Framework for Action on PEOLC aims to ensure that by 2021 everyone who needs palliative care will have access to it. We sought to improve consistency and reduce variability in community palliative care in all settings and all conditions, testing ways to develop our vision of a consistent response, so that no-one is missed, that gives people with palliative care needs, and their families, the opportunity to identify and discuss their concerns as well as plan ahead, should they wish to do so.

3. Aims and Objectives
Aiming to promote equal opportunities for holistic person centered assessment, access to services and support via the introduction of a model of care that identifies and streams people with palliative care needs offering a proactive, coordinated, integrated model for palliative or any complex care that is fit for the future.

After engaging with local staff and public (climate surveys, palliative care timeline and an open space event) we used the intelligence gained to design and test potential redesign options and formulate a vision.

Feedback from staff engagement:
“Quality of assessment should not be personality dependant”
“There is difficulty meeting the needs of complex patients with multimorbidity-it needs coordination”

The focus has been on developing a ‘standard response’ for those on a GP practice palliative care register who have new or changing palliative care needs. This involves discussion at a new integrated weekly meeting of health and social care professionals (named service representatives attend from community nursing, rehabilitation and enablement service, care at home, social work, specialist palliative care and crucially administration staff) to facilitate coordination and resource allocation to help pro actively meet these needs as well as those of the carer.

4. Outputs - WISeR palliative care
Working with a small number of local GP practices since March 16, the approach has been refined, the work from March to August 2016 is reported elsewhere (please see embedded report). In September 2016 we established the new integrated weekly meeting (Weekly Integrated Standard Response - WISeR palliative care). As part of the new approach GP practices are asked to categorize patients with any condition who are on the palliative care register as being Red, Amber or Green:
Red - Those who have had sustained irreversible decline or sudden severe irreversible decline – may be expected to live for a few weeks.
Amber - Those whose condition is deteriorating (due to irreversible causes) and whose need for palliative care is clearly changing - may be expected to live for a few months.
Green – Those, whose condition and their need for palliative care is not currently changing, may also be expected to live for six months or more.

The practice then shares their AMBER list with the WISeR palliative care meeting. The patients are discussed and allocated to the appropriate service so that they can be pro actively assessed and a person centred holistic assessment can take place. The carer will also be identified and a direct referral to the new adult support worker team at the Renfrewshire Carers Centre will be discussed and made with the carer’s agreement.

As our vision has expanded we have started work on what a ‘standard response’ could be for those people identified as ‘stable’ (green) but on the register with a focus on social support, building resilience and early access to community based and third sector services. For people identified as being in the last stages of life (red) service responses are already well established within GP, community nursing and specialist services. In all strands there is an emphasis on holistic, person centred assessment, using the Concerns Checklist, and a new patient and carer resource called About Me and My Care.
There are 3 main outputs from the project all of which underpin the Standard Response work, a brief summary of each is below.

- **About Me and My Care**

  *Feedback from public engagement:*

  “I worried I would miss something and there would be negative consequences and it would be my fault. I felt like I was directing care but without the right information to do it well”

A resource for patients and their families designed to provide information and resources to help with co-ordination of care and support Advance Care Planning should they wish it.

- **Electronic Concerns Checklist Resource**

  *Feedback from public engagement:*

  “Finding information and services is one of the most difficult parts of caring”

An online signposting and information tool designed to support Holistic Needs Assessment by assisting Health and Social Care professionals help people manage concerns they identify using the Concerns Checklist.

- **Palliative Care Training Calendar**

  *Feedback from staff engagement:*

  “We need staff training to have the skills to care for complex patients”

Developed to make it easier for health and social care staff within Renfrewshire to find out what palliative care training is available across NHS GG&C, the calendar is collated and distributed via email every 3 months and currently sits on the NHS GG&C palliative care website. [http://www.palliativecareggc.org.uk/?page_id=1013](http://www.palliativecareggc.org.uk/?page_id=1013)

5. **Evaluation**

We have captured an insight into how this model works. We are learning from the experience of the professionals involved and from observing the outcomes for patients as the WISeR meeting develops. A number of improvements have still to be made. However, it appears this model has the potential to impact on a number of government and local strategies, offering a proactive, coordinated, integrated model of palliative, or complex, care fit for the future.

<table>
<thead>
<tr>
<th>Immediate Outcomes</th>
<th>Midterm outcomes</th>
<th>Long term strategic outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>More coordination, joint working and problem solving in MDT</td>
<td>Preventing the preventable crisis</td>
<td>Reduction in unscheduled care</td>
</tr>
<tr>
<td>Consistent opportunities to access care, support and services</td>
<td>More opportunities for equitable care</td>
<td>Preventing inequality</td>
</tr>
<tr>
<td>More carers identified and linked into carers centre</td>
<td>Improved recognition of carers needs</td>
<td>Support the health and wellbeing of carers</td>
</tr>
<tr>
<td>Align multi disciplinary services around GP clusters</td>
<td>Supporting the development of GP clusters</td>
<td>Delivery of well coordinated care that is timely and appropriate to people’s needs</td>
</tr>
</tbody>
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“The big positive is that it is an MDT approach in a service where they (other services) don’t talk to each other routinely. Getting to know each other and what others do is a huge bonus for staff and patients” - WISeR member

“We have already proved that this has prevented crisis, it is helpful that we are getting all this information” - WISeR member

“Time saving for the doctor as you can feel confident you are passing their (the patient and their family) needs on and these will be dealt with” - Participating GP

“Knowing you can pass holistic needs over to others and they will be taken care of makes a big difference to us” - Participating GP
6. Recommendations

As the project draws to a close we have received very positive feedback from Health Improvement Scotland (HIS) who have expressed an interest in sharing this model with the rest of Scotland as “it’s the kind of work that the Scottish Government’s Strategic Framework of Action for Palliative and End of Life Care wants others to replicate” (Improvement advisor HIS).

The following recommendations have been made to our local senior management team to make sure local momentum is not lost on this valuable work:

- Support a phased roll out to the remaining 28 GP practices.
- Continue with a GP cluster based approach.
- Early engagement with the new Practice Quality leads and Cluster Quality leads.
- Secure buy-in from the heads of service and team leads to release staff for the weekly meeting.
- Continue to build on strong relationships with specialist palliative care services.
- Recognising the time and resources required to support and train staff around the introduction of new tools and ways of working, building in the support required around managing that change, whilst recognising this requires a change in attitudes and cultures as well as behaviours and practice.
- Vital to the success of this is appropriate administrative support within GP practices and crucially the HSCP to support the WISeR meeting(s). This is a Band 3 admin role which going forward would benefit from being split into two part time posts to allow for cover. Throughout the project the current Band 3 admin had completed the work required to set up the current process and identified the time required in maintaining the role. Time requirements are low at the moment however this will grow as the remaining 28 GP practices within Renfrewshire come on board and the required number of WISeR palliative care meetings are started.

These recommendations can be implemented within existing local structures and with existing local clinical staff. The WISeR model promotes new ways of working for existing staff providing a common language and forum to identify changing needs and work in an integrated, proactive, person centred way. In return for the relatively small investment of the required administrative support the potential impact on outcomes for patients and on integrated working could be transformational. Should our recommendations be endorsed we have an offer of support from HIS, including advice and support around demonstrating impact, turning information into intelligence for evaluation and health economist support to calculate potential cost savings.
Renfrewshire Macmillan Palliative Care Project Year 3 Final Report
March 2017

1. Introduction

1. Purpose of the report
The purpose of this report is to provide a comprehensive summary of activities and outcomes of the Renfrewshire Macmillan Palliative Care Project Jan 2014 - March 2017. Work undertaken in 2014 and 2015 can also be found in Year 1 and Year 2 reports in more detail.

2. Overview
The Renfrewshire Macmillan palliative care project started in January 2014 and closes on 31st March 2017 when funding concludes. The team were asked to “redesign delivery of palliative care services through integration of supportive and palliative care approaches into mainstream primary & community care service provision”.

Many people in Scotland who could benefit from palliative and end of life care (PEOLC) do not currently receive it. The Strategic Framework for Action on PEOLC aims to ensure that by 2021 everyone who needs palliative care will have access to it. We sought to improve consistency and reduce variability in community palliative care in all settings and all conditions, testing ways to develop our vision of a consistent response, so that no-one is missed, that gives people with palliative care needs and their families, the opportunity to identify and discuss their concerns as well as plan ahead, should they wish to do so.

3. Team Structure and setting
The Renfrewshire Macmillan Palliative Care Project team, is a multidisciplinary team consisting of the following people:

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Susanne Gray</td>
<td>Macmillan Nurse</td>
<td>1 WTE</td>
</tr>
<tr>
<td>Katie Clark</td>
<td>GP Palliative Care Facilitator</td>
<td>4 sessions per week (2 sessions per week from September 2016)</td>
</tr>
<tr>
<td>Cathy Quinn</td>
<td>Macmillan Palliative Care Facilitator</td>
<td>1 WTE</td>
</tr>
<tr>
<td>Jackie Mearns</td>
<td>Macmillan Clinical Effectiveness Facilitator</td>
<td>0.6 WTE</td>
</tr>
<tr>
<td>Alison McGill</td>
<td>Macmillan Administrator</td>
<td>1 WTE</td>
</tr>
</tbody>
</table>

The team did not carry clinical caseloads throughout the project which allowed them to engage, support and liaise with a wide range and variety of staff in all care setting in Renfrewshire. The team themselves were advised and supported by a steering group and operational group.

2. Aims and Objectives

1. Aims and Objectives
After engaging with local staff and public (climate surveys, palliative care timeline and an Open Space Event) we used the intelligence gained to design and test potential redesign option and formulate a vision. This report uses a summary of that feedback, more complete information can be found in the embedded documents.

Feedback from staff engagement:

“Quality of assessment should not be personality dependant”
“There is difficulty meeting the needs of complex patients with multimorbidity—it needs coordination”

Our overarching aims are:
1. Continuous improvement of palliative care in all community settings
2. Making palliative care every bodies business
3. Enhance continuity and reduce variation
These fall into 2 key strands, with agreed objectives and progress detailed in the table below:

<table>
<thead>
<tr>
<th>Improving patient experience</th>
<th>Progress</th>
<th>Education</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop and test an electronic resource to facilitate navigation of the NHS</td>
<td>Complete</td>
<td>Develop and test a Renfrewshire Palliative Care Training Calendar</td>
<td>Complete</td>
</tr>
<tr>
<td>Explore the role of the Concerns Checklist (a holistic needs assessment tool) in reducing variability by providing a consistent person centred approach to assessing patients with palliative care needs</td>
<td>Complete</td>
<td>Deliver a range of training on palliative care tools and frameworks to support palliative care practice.</td>
<td>Complete</td>
</tr>
<tr>
<td>Develop and test a pack to support patients and their families with the informal coordination of care,</td>
<td>Complete</td>
<td>Initiate regular lunchtime training sessions on a wide range of palliative care topics- Tea &amp; Topic (hosted by ACCORD Hospice)</td>
<td>Complete</td>
</tr>
</tbody>
</table>

2. Redesign
As well as finalising and testing the resources mentioned above (development and progress is described in previous reports), the focus in 2016/17 has been on developing a redesign based on a 'standard response' for those on a GP practice palliative care register who have new or changing palliative care needs. Aiming to promote equal opportunities for holistic person centred assessment, access to services and support via the introduction of a model of care that identifies and streams people with palliative care needs offering a proactive, coordinated, integrated model for palliative or any complex care that is fit for the future.

3. Outcomes Against Aims and Objectives
The project team have successfully delivered on each of the agreed project aims. This section of the report will focus on a brief description of the outputs and outcomes and further detailed information can be found in the embedded evaluation reports.

You said:

We need staff training to have the skills to care for complex patients

One of the top priorities at open space

We did:

- Palliative Care Training Calendar

Developed to make it easier for health and social care staff within Renfrewshire to find out what palliative care training is available across NHS GG&C, the calendar is collated and distributed via email every 3 months and currently sits on the NHS GG&C palliative care website.

Realised that a lot of training available but people not aware

Approached education providers and pulled together what they offer into one calendar which is located online with reminders and prompts sent out quarterly-

Renfrewshire Palliative Care Training Calendar

Project team plugged local gaps: DNACPR, Nurse Verification of Expected Death (VoED), Sage and Thyme Communication Training, Syringe Driver Competencies and palliative care induction for care at home staff

Tea and Topic
You said:
I worried I would miss something and there would be negative consequences and it would be my fault. I felt like I was directing care but without the right information to do it well.

54% of staff rely on information from the patient/family

Only 10% felt the patient/family prepared to provide

We did:

• **About Me and My Care**

A resource for patients and their families designed to provide information and resources to help with co-ordination of care and support Advance Care Planning should they wish it.

| Produced LEAFLETS – Useful contacts, Information for carers, Finances-costs and benefits, Going into and coming home from hospital, Who provides care |
| Produced RESOURCES- My Questions, My Appointments, My care-who is involved and how to contact them, My what matters to me |
| Includes advance planning document- Thinking ahead and making plans |

You said:
Finding information and services is one of the most difficult parts of caring

We need a service directory

It’s hard to navigate health and social care.

We did:

• **Electronic Concerns Checklist Resource**

An online signposting and information tool designed to support Holistic Needs Assessment by assisting Health and social care professionals help people manage concerns they identify using the Concerns Checklist.

| Created a resource based around an established and validated Concerns Checklist – a holistic needs assessment. |
| This developed into an electronic resource which is hosted online and has self management information as well as support for professionals- electronic Concerns Checklist (eCCR) |
| Links with ongoing local and national (NHS 24) service directory work |
| [www.palliativecareggc.org.uk/eccr](http://www.palliativecareggc.org.uk/eccr) |
You said:

Quality of assessments should not be personality dependent

There is difficulty meeting the needs of complex patients with multimorbidity – it needs coordination

Major theme emerged around lack of consistency and need for equity.

We did:

Redesign - Standard Response for patients with NEW or Changing palliative care needs - WISEr palliative care

The focus has been on developing a ‘standard response’ for those on a GP practice palliative care register who have new or changing palliative care needs. Working with a small number of local GP practices since March 16, refining the approach, the work from March to August 2016 is reported elsewhere (please see embedded report).

In September 2016 (we established the new integrated weekly meeting (Weekly Integrated Standard Response – WISEr palliative care). GP practices are asked to categorize patients with any condition who are on the palliative care register as being Red, Amber or Green:

Red - Those who have had sustained irreversible decline or sudden severe irreversible decline – may be expected to live for weeks.

Amber - Those whose condition is deteriorating (due to irreversible causes) and whose need for palliative care is clearly changing - may be expected to live for months.

Green – Those, whose condition and their need for palliative care is not currently changing, may also be expected to live for six months or more.

The practice then shares their AMBER list with the WISEr palliative care meeting, a new integrated weekly forum of health and social care professionals (named service representatives attend from community nursing, RES, care at home, social work, specialist palliative care and crucially administration staff) to facilitate coordination and resource allocation to help pro actively meet these needs as well as those of the carer. Patients are discussed and allocated to the appropriate service so that they can be pro actively assessed and a person centred holistic assessment can take place. The carer will also be identified and a direct referral to the new adult support worker team at the Renfrewshire Carers Centre will be discussed and made with the carer’s agreement.

As our vision has expanded we have started work on what a ‘standard response’ could be for those people identified as ‘stable’ (green) but on the register with a focus on social support, building resilience and early access to community based and third sectors services. For people identified as being in the last stages of life (red) service responses are already well established within GP, community nursing and specialist services.

The Vision

A consistent approach, so that no one is missed, that gives people with palliative care needs and their families the opportunity to identify their concerns and to plan ahead, should they wish to do so.
Service Redesign
In all strands there is an emphasis on holistic, person centred assessment, using the Concerns Checklist, eCCR and About Me and My Care. This model pulls together all aspects of the project work redesigning delivery of palliative care services through integration of supportive and palliative care approaches into existing mainstream primary & community care service provision. This redesign is implemented within existing local structures and with existing local clinical staff. The WiSeR model promotes new ways of working for existing staff providing a common language and forum to identify changing needs and work in an integrated, proactive, person centred way. In return for the relatively small investment of the required administrative support the potential impact on outcomes for patients and on integrated working could be transformational.

“it's the kind of work that the Scottish Government's Strategic Framework of Action for Palliative and End of Life Care wants others to replicate” (Improvement advisor HIS).

4. Service Evaluation

Evaluation has been a major aspect of the project for the last 15 months. Below is a summary of key findings of the evaluation of all project outputs. More comprehensive information can be found in the embedded reports.

Renfrewshire Palliative Care Training Calendar
At the end of 2016 we conducted a webropol survey with all staff who received the training calendar every 3 months. 74 people responded (n=74). 54/74 knew about the calendar with staff ranking all aspects of this resource as very useful including content/ colour coding and contacts. The source of awareness of this resource (31/54) came from email via Project Secretarial Administrator, closely followed by word of mouth. (14/54).The majority of staff (49/54) said that it influenced their ability to find the palliative care training available going on to say:

‘made it easier to locate’
‘reduces time looking on different sites’
‘Being aware of what is available for myself and my staff, which we would otherwise miss out on’

11/20 who did not know about the calendar work in Care Homes. We know from discussion that Care Home managers are not routinely sharing or displaying the calendar, instead they use it to allocate training based on their knowledge of staff training needs. This could be improved by finding better ways to promote and share the calendar in Care Homes. It is worth noting that when asked, respondents rated their overall awareness of palliative care training available as low prior to receiving the calendar, and 59% of respondents have accessed training as a direct result of using the calendar.

‘I was unaware of some of the training available, so it helped me to access things’

Tea & Topic
Tea & Topic is an hour long, over lunchtime, monthly palliative care master class facilitated by experts in their field. We started these in October 2014, and Tea & Topic has now been offered to staff 23 times. Below is a summary of attendance.

<table>
<thead>
<tr>
<th>Number of Tea &amp; Topic sessions</th>
<th>Number of attendees</th>
<th>Evaluation ≥8/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>288</td>
<td>177/ 201 completed evaluations (69.7%)</td>
</tr>
</tbody>
</table>

Attendance at Tea & Topic has been sporadic, therefore as part of our evaluation we sent a webropol survey to staff who receive the training calendar, 36 people responded. The highest number coming from GP’s (n=15) and Community Nurses (n=8). 34/36 respondents knew about the Tea and Topic Sessions. Respondents highlighted that work commitments (n=28) and time (n=15) were the top factors stopping them attending some or all of the sessions. With one respondent going on to say ‘Impossible in working day, don’t even get proper lunch break One partner down out of 3 for 6 months but even before this!’. Another suggesting ’Would be better to attend if out of hours’. It would appear that staff know about Tea & Topic and have described difficulties they encounter in attending. However, when staff are able to attend the opportunity is there to learn from experts and to improve practice, see some feedback from staff below:
<table>
<thead>
<tr>
<th>Session</th>
<th>Facilitator</th>
<th>Comments from attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 must dos for older adults</td>
<td>Kingsleywood &amp; Co Solicitors</td>
<td>“Brilliant session, massively applied now in practice for both older and younger people”</td>
</tr>
<tr>
<td>Cancer Cachexia</td>
<td>Professor Rosemary Richardson</td>
<td>“Unfamiliar ground here and now able to have more informed conversations with patients and make suitable referrals”</td>
</tr>
<tr>
<td>Oral health and wellbeing in cancer and palliative care</td>
<td>Pertina Sweeny, and Nicholas Beacher Specialist Dentists</td>
<td>“i now have good clinical reasoning for making requests (for artificial saliva replacements)”</td>
</tr>
</tbody>
</table>

**About Me and My Care**

A major success of the project is About me and My Care. Without exception every professional, carer and member of the public with whom we have shared the pack is incredibly enthusiastic about its use for patients and carers. We have conducted 3 small scale evaluations:

1. With Transforming Care After Treatment (TCAT) patient experience panel (n=5)
2. With former carers (n=2)
3. DN service and the TCAT project team (n=14)

About Me and My Care evaluated very highly from both lay person and staff perspective. Some concerns were raised which were mainly about the pack design and these have been picked up in the latest version:

- Durability of pack - resolved by the addition of a plastic coating on updated version of the cover
- Security of the pack in terms of how the leaflets fit - resolved by making the pockets deeper with a reduced capacity
- Wording of some leaflets amended based on feedback

Overall the feedback was very positive:

- “everything in one pack, not everyone can talk about issues, so writing them down makes it easier”
- “often difficult for patients/cares to take in information- back up what is said. Patients often forget questions”
- “patient centred- ie what matters to the patient”
- “i would have really liked to use this as it was hard for me to say what mattered to me”

**eCCR**

In order to test the eCCR we sought volunteers from the DN service and the Transforming care after Treatment (TCAT project) to use scenarios to identify patients concerns then use the eCCR to find information, sign post and care plan, 15 participants took part. The eCCR was very well received for a first draft. 100% of participants liked the overall design, layout and language used in the resource and they also stated that the eCCR helped them to find information regarding concerns. Despite small numbers involved in testing, evaluation is extremely positive;

- ‘Takes you directly to the information required instead of scrolling through lots of information to find what you need.’
- ‘Does the work for you! Saves you having to externally find information. Takes you to what you need.’
- ‘This is a key bonus to the document’ (external links)
- ‘Very colourful, inviting and easy to understand’

Like all directories, unless maintained the eCCR will become out of date. Therefore in order to ensure sustainability we have been linking in to the national work with NHS 24 in developing a national service directory which is likely to employ a similar approach to the eCCR with a self assessment option based around the Concerns Checklist.

**WISeR palliative care**

The WISeR palliative care meeting

The weekly meetings started on the 28th September 2016. Attendance had been excellent from all services. We observed the development of the meeting over the first 15 weeks using an event log to record our observations. When analysed the event log revealed weekly themes that suggest the team were following an expected pattern as they found their role and became comfortable working with one another:
Following the meeting each week, staff completed an opinion matters survey asking them their thoughts on the structure, function and purpose of the meeting. In total 45 completed opinion matters were analysed. The majority strongly agreed that the meeting was supportive in team communication, feeling valued, and their own role in palliative care and improving outcomes for patients and carers.

The majority also said that the meeting was “just right” in terms of length, frequency and content and that it was too early in the process to suggest improvements. When asked what hat they liked most 42 comments were made: communication (n=16), information sharing (n=15), networking (n=11) and joint working (n=8). In terms of what they liked least 12 comments were made: nothing (n=5), too soon to tell (n=2), time pressures (n=2) and environment (n=2).

We have asked staff to allocate 1 hour for the meeting. The intention is that the meeting is very focussed on coordination of care and resource allocation, however as processes became slicker and the initial back log of patients were allocated it now takes around 20-25 minutes. This time would obviously increase as more GP practices AMBER lists are added.

Some of the comments staff made about the meeting are below more detail can be found in the embedded report:

“less fragmented-thinking of ways to work together”

“action on issues/concerns which benefits the patient/carer”

Redesign overall

We used focus groups and observation to evaluate the work to date, with all doctors in the GP practice (n=6), and all professionals who attend the WISEr palliative care meeting (n=5) taking part (please see embedded reports for comprehensive summary of the feedback from both focus groups). Using these methodologies we have captured an insight into how this model is working and potential outcomes. We are learning from the experience of the professionals involved and from observing the outcomes for patients as the WISEr palliative care meeting develops.

Overall the response from all professionals involved is overwhelmingly positive recognising that this way of working delivers outcomes:

- **Improved /increased access to assessment and services for patients and carers**
  
  “knowing you can pass holistic needs over to others and they will be taken care of makes a big difference to us” Participating GP

- **Time savings benefits for GPs initially**
  
  “Time saving for the doctor as you can feel confident you are passing their (the patient and their family) needs on and these will be dealt with” Participating GP

- **Crisis prevention**
  
  “we have already proved that this has prevented crisis, it is helpful that we are getting all this information” WISEr member

- **Improved communication**
  
  “the big positive is that it is an MDT approach in a service where they (other services) don’t talk to each other routinely. Getting to know each other and what others do is a huge bonus for staff and patients” WISEr member
• Improved integrated working and problem solving
  
  "I am no longer in a bubble with lots to deal with for this patient, you are all there and its the wider team" WISeR member

We did not formally evaluate from a patient or carer perspective, however observation of the WISeR palliative care meeting did show that the improvements in information sharing, joint working and problem solving resulted in quicker, earlier interventions for patients (examples being: other professions getting involved in care, equipment being ordered and staff trying different approaches based on suggestions from other disciplines in the group) and that carers were directly linked to the carers centre when previously professionals would not have been so proactive. Use of the Concerns Checklist is also positive especially in the identification of unknown needs:

  “we have identified issues that patients and families have that they may not have mentioned to us as nurses. They now mention finance etc therefore it can be dealt with” WISeR member

  “prompting them (patients) and giving them the opportunity to say things you might not have heard previously” WISeR member

From this it is not unreasonable to conclude that this way of working can improve outcomes for patients and carers however this will require further investigation.

  “I think a lot of things have been dealt with quicker rather than waiting month to month for GSFS meeting. Things which are not particularly urgent maybe lying waiting for these meetings, and can be dealt with quicker through WISeR. Weekly meeting picks things up quicker” WISeR member

We have purposefully kept the categorising of patients changing needs simple (see section above describing Red, Amber and Green), in essence we are asking the GPs who are you worried about and why. Interestingly when we got the first amber list from the practice it contained the details of 18 patients. When this list was shared with the WISeR palliative care members it quickly became apparent that 11/18 were currently not receiving any form of health or social care service in the community. This was very enlightening information for all and seems to confirm that WISeR palliative care presents an opportunity to provide proactive assessment of care needs and concerns ensuring that patients and carers are linked into the right care, from the right service at the right time. The realisation that so many Amber patients were not currently receiving services opened the discussion around professionals contacting patients to arrange to see them for assessment “out of the blue”. This led to the development of an information leaflet for patients called “About me and My Care” which describes WISeR palliative care, the benefits for patients and carers and how professionals share information (see leaflet which is embedded in this report, it has the same name as the pack to help patients and carers understand that it is all part of the same care). When patients are new to the palliative care register, as part on their care the GP discusses WISeR, gives the patient and family the leaflet and confirms that they are happy for a member of health or social care services to arrange a visit to assess their needs.

It is still early days with this redesign and a number of improvements have still to be made:

• The way of collating and sharing the Amber list with the GPs
  
  “not easy, we need an easier format”

• Formal referral processes can impede “passing the baton” between services in response to patient and carers changing needs
  
  “if there was something identified for SW to do i would require someone to make a formal referral” WISeR member

• The role of all members of the MDT
  
  “i think a lot of the needs are health which we would not take forward” WISeR member

  “meetings giving good outcomes for patients, purely from not being attached to practice i feel im nor giving or getting much” WISeR member

Overall there is a sense that this model could and should be rolled out, 100% of participants in both focus groups stating they would support this and could see benefits. Their enthusiasm did come with the realisation that roll out would require appropriate resources to ensure sustainability:

  “ I have seen cases in other surgeries where this would be ideal, but its how is this going to work time wise and staff wise” WISeR member

  “Advance care planning and outcomes, this is where we should be going. But how we scale that up im not sure” WISeR member

  “Weeks 1-4 we had masses of patients, but there were a lot who needed service who hadn’t had it. Now not adding many at all. Might be a back log initially then sustainable after that. Will need to front load it staff wise” Participating GP
Further developments and wider-scale testing are required to confirm results to date and evaluate the impact on patients and carers as well as staff. And finally in the words of one participant when asked if the model could be rolled out and expanded:

“Absolutely, love it, love it works with small group, service users and staff benefits. Would grab it with both hands” WISER member

## 5. Service Impact

It appears that WISER palliative care has the potential to impact on a number of government and local strategies, offering a proactive, coordinated, integrated model of palliative, or complex, care fit for the future.

<table>
<thead>
<tr>
<th>Immediate Outcomes</th>
<th>Midterm outcomes</th>
<th>Long term strategic outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>More coordination, joint working and problem solving in MDT</td>
<td>Preventing the preventable crisis</td>
<td>Reduction in unscheduled care</td>
</tr>
<tr>
<td>Consistent opportunities to access care, support and services</td>
<td>More opportunities for equitable care</td>
<td>Preventing inequality</td>
</tr>
<tr>
<td>More carers identified and linked into carers centre</td>
<td>Improved recognition of carers needs</td>
<td>Support the health and wellbeing of carers</td>
</tr>
<tr>
<td>Align multi disciplinary services around GP clusters</td>
<td>Supporting the development of GP clusters</td>
<td>Delivery of well coordinated care that is timely and appropriate to people’s needs</td>
</tr>
</tbody>
</table>

As the project draws to a close we have received very positive feedback from Health Improvement Scotland (HIS) who have expressed an interest on sharing this model with the rest of Scotland as “it’s the kind of work that the Scottish Government’s Strategic Framework of Action for Palliative and End of Life Care wants others to replicate” (Improvement advisor HIS). Should our recommendations to roll out be endorsed we have an offer of support from HIS, including advice and support around demonstrating impact, turning information into intelligence for evaluation and health economist support to calculate potential cost savings.

## 6. Trophy Cabinet

- Highly commended in the RHSCP staff awards in 2016 in the “Impact on the people we care for category”
- Project poster came 3rd (out of 36) and the Scottish Partnership for Palliative Care (SPPC) conference in September 2016

## 7. Future Directions

### 7.1 Standard Response for patients with new and changing palliative care needs - WISER palliative care

**Red**

For people identified as being in the last stages of life (red) service responses are already well established within GP, community nursing and specialist services.

**Amber**

The following recommendations have been made to sure local momentum is not lost on this valuable work:

- Support a phased roll out to the remaining 28 GP practices
- Continue with a GP cluster based approach
- Early engagement with the new Practice Quality leads and Cluster Quality leads
- Secure buy in from the heads of service and team leads to release staff for the weekly meeting
- Continue to build on strong relationships with specialist palliative care services
• Recognising the time and resources required to support and train staff around the introduction of new tools and ways of working, building in the support required around managing that change, whilst recognising this requires a change in attitudes and cultures as well as behaviours and practice.
• Vital to the success of this is appropriate administrative support within GP practices and crucially the HSCP to support the WISER meeting(s). This is a Band 3 admin role which going forward would benefit from being split into two part time posts to allow for cover. Throughout the project the current Band 3 admin had completed the work required to set up the current process and identified the time required in maintaining the role. Time requirements are low at the moment however this will grow as the remaining 28 GP practices within Renfrewshire come on board and the required number of WISER palliative care meetings are started.

Green
This work has highlighted a gap and as our vision has expanded we have started work on what a ‘standard response’ could be for those people identified as ‘stable’ (green) but on the palliative care register. The focus is on social support, building resilience and early access to community based and third sectors services. Macmillan Cancer Support have agreed to fund a 1 year fixed term Band 4 Macmillan Pathway Coordinator post. The main objective of the Macmillan Pathway Co-ordinator is to finalise this aspect of the current project, facilitating channelling of patients with palliative care needs into and through a recognised pathway, depending on whether their needs were stable, changing or rapidly changing. The main focus of the role of pathway co-ordinator will be to establish a sustainable route into and through the stable (green) pathway. Offering the opportunity to be pro-active with this group of patients, offering holistic needs assessment, About Me and My care and referring them in to existing services (statutory and third sector) already operating within Renfrewshire. The benefits of this approach will be to offer support at a much earlier stage, keeping the patient as active as possible and integrating and mobilising all services in the area in order to improve outcomes for patients and their families.

7.2 About Me and My Care
RHSCP have expresses an interest in using this resource much more widely than with patients with palliative care needs. This final version is expected by the end of March when local management will give guidance on further use and testing.

7.3 Electronic Concerns Checklist Resource
It has been agreed that this resource will sit in the RHSCP website. Local arrangements are being made re sustainability until it can ultimately link in with and be replaced by the national service directory work currently ongoing in NHS 24.

7.4 Palliative Care Training Calendar
It has been agreed that this work will be continued locally until such time that it can link in with the NHS GGC palliative care training calendar, currently under construction which acknowledges that is is based in the work undertaken within this project.

8. Summary
The Renfrewshire Macmillan Palliative Care project has successfully met its aim of redesigning palliative care services through integration of supportive and palliative approaches into mainstream primary and community services. We have also supported and exceeded this aim by taking the opportunity to develop new resources whose value is being recognised beyond palliative care and beyond Renfrewshire. This work had been undertaken during a time of enormous change in health and social care services. The formation of Renfrewshire Health and Social care Partnership presented the opportunity for us to embrace the integrated approach at the heart of our redesign. This innovative new model champions pro-active, integrated working this patients and carers as partners in the care, working towards the right help at the right time:

“Not just what services can provide, but what individuals themselves want and what those around them want”

Health and Social care delivery Plan Scottish Government 2016

This approach has the potential to ensure Renfrewshire Health and Social Care Partnership and NHS GGC fulfil the Scottish Governments aim that palliative and end of life care is available for all who need it by 2021:

Commitment 1
Support Health Care Improvement Scotland in providing HSCPs with expertise on testing and implementing improvements in the identification and care co-ordination of those who can benefit from palliative and end of life care.

Strategic framework for action on palliative and end of life care 2016-2021 Scottish Government 2015
Embedded Reports

1. End of Year 1 Report

2. Year 2 Interim Report

3. End of Year 2 Report

4. Year 3 Interim Report

5. About me and my care pack

6. electronic Concerns Checklist Resource

7. Training Calendar

8. Tea and Topic
   a. Focus Groups - GP and WISeR palliative care

9. WISeR palliative care meetings

10. Climate Surveys
   a. Staff
   b. Public

11. Open Space Event
References

- The Healthcare Quality Strategy for NHS Scotland Scottish Government 2010
- Strategic framework for action on palliative and end of life care 2016-2021 Scottish Government 2015
- Health and Social care delivery Plan Scottish Government 2016