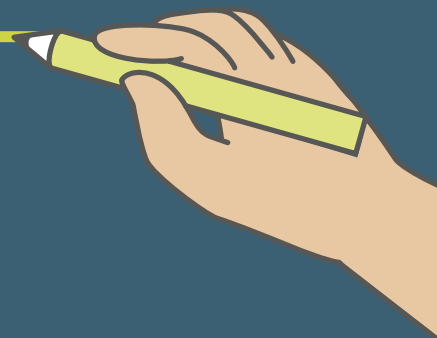


GREATER MANCHESTER COMMITMENTS

TO PALLIATIVE CARE INDIVIDUALS APPROACHING OR WITHIN THE LAST YEAR OF LIFE -

What an individual with Palliative and
End of Life Care needs should expect
across Greater Manchester





The commitments are a pledge from Greater Manchester Health and Social Care Partnership including the voluntary sector and other non-statutory organisations to individuals approaching and within the last year of life. The commitments ensure that the care that they receive at this time is individualised, skilfully and sensitively delivered and of a consistently high standard. The commitments support individual choice in line with the Care Act.

The first 12 commitments centre around the individual's journey in the last year of life and take account of the holistic needs of those close to them during this time and beyond. Some individuals may be identified with advancing/ progressive diseases or deteriorating with incurable illnesses but may not be in the last year of life. It is important to note that these individuals could benefit from access to supportive care.

There are a further 4 supporting, system-wide commitments that will regionally underpin the delivery of local services.

These commitments acknowledge the importance of empowering individuals in making decisions about the treatment that they receive. They support shared decision making between individuals and those providing their care and treatment. For those who lack capacity, the commitments should be considered and delivered in accordance with the best interest decision making process, taking into account the views of those close to the patient, in line with the Mental Capacity Act.

As individuals, we all want different levels of information and involvement in the planning of our care. We also have different views on the sharing of information. Therefore, consent to undertake difficult conversations, to plan care and to share their information is paramount and should be sought from the individual.

Greater Manchester Health and Social Care Partnership recognises that there is current variation in the delivery of these commitments across the region. Some areas deliver care that is outstanding and some are delivering care that requires improvement. Commissioning, provider and community engagement will be required to sustainably deliver these commitments so that meaningful and high-quality equitable outcomes for those who live across Greater Manchester are achieved.

1 IDENTIFY

As I am approaching or within the last year of life, care professionals should recognise this where possible and, if I choose, discuss it with me and those important to me.

Individuals likely to be approaching the last year of life should be proactively identified and offered the opportunity to discuss this with an appropriate care professional. Those important to the individual should be included in this discussion, if the individual wants this.

2 ASSESS

My needs and unique individual circumstances should be assessed by an appropriate care professional.

This holistic assessment may include: physical, emotional, psychological, social, cultural, spiritual, religious, sexual and relational financial, practical, needs/ concerns.

An holistic assessment of the individual's needs should be undertaken by an appropriate care professional applying a standardised approach.

3 PLAN CARE

My existing and on-going care should be planned with me and those important to me in a sensitive way. I will also be asked about my wishes for future care including organ and tissue donation and if I choose an Advance Care Plan will be written.

A person-centred plan of care should be formulated and agreed with the individual and those important to them, by appropriate care professionals. An opportunity for future care planning should also be provided.

4 COMMUNICATE AND COORDINATE

All appropriate professionals and services involved in my care, planned or in a crisis, should be able to access the information about me and my conditions electronically, should I choose to give my consent.

All appropriate relevant professionals, including those involved in crisis care, should be able to read, update and share electronic records of care plans and Advance Care Plans if consent has been given.

5 DELIVER CARE

I should receive appropriate physical, emotional, psychological, social, cultural, spiritual, religious, financial, practical, and relational support, when I need it. This should be in the setting of my choice with all the appropriate care professionals informed of my needs and wishes.

Holistic care should be provided in the most appropriate setting (respecting the individual's choice where possible), at the right time, ensuring all appropriate medication and equipment are available, with co-ordinated care providers involved.

6 SUPPORT CARERS

The people that give me the most help and support should be identified and offered an assessment to support their needs in supporting me, if they so wish.

Informal identified carers will be recognised as being integral to care planning, delivery and review. They should be offered a carers assessment and their needs be agreed and supported, if they wish.

7 PROACTIVE CARE

My care should be reviewed at the request of me or my carers and as my needs, preferences, or situation changes and the necessary adjustments made to plans.

Individuals and their carers should be reviewed as part of a standardised assessment, on request or as their needs, preferences or situation changes, to ensure the care being provided is needs led, with adjustments made as required. This will be reflected in the individualised care plan.

8 REVIEW – CRISIS CARE

I should have an identified service/team who will be my main point of contact and I shall be informed of who to call in a time of crisis. My plan of care should be available to me and those who require it, at all times; including at a time of crisis.

Individuals should know at all times who and how to contact services, especially in a time of crisis. Care plans should be available and accessible, and individuals should receive responsive care linked to their urgent care needs.

9 IDENTIFY DYING

If I am likely to die in the coming days, care professionals should recognise this and, if I want, discuss it with me and those important to me with my consent where possible.

Where the possibility is identified that an individual is likely to die in the coming days, they should be assessed for possible reversible causes, before being recognised as dying. If appropriate, and in accordance with the individual's wishes, the assessment should be discussed with the individual and those important to them.

10 PLAN OF CARE FOR THE LAST DAYS OF LIFE

When I am dying, I should be cared for with dignity and compassion in the place of my choice, where possible. My physical, emotional, psychological, social cultural, spiritual, religious, relational, financial, practical, and needs/ concerns should be addressed in accordance with my wishes and as my needs change.

Individuals in the last days of life should be cared for in accordance with their wishes and supported by a holistic plan of care, tailored to that individual and those important to them.

11 CARE AFTER DEATH

When I die and in the hours after, I and those important to me, should be cared for and supported according to our wishes.

Individuals who have died, and those important to them, should be continued to be cared for in a sensitive, dignified and culturally appropriate way in accordance to their wishes.

12 BEREAVEMENT SUPPORT

Those identified as important to me should know how and where to access appropriate bereavement support following my death, if it is required.

Access to appropriate bereavement support at the point of need should be available and offered or directed to as necessary.

ADDITIONAL COMMITMENTS

UNDERPINNING THE PROVISION OF
THE 12 GREATER MANCHESTER
INDIVIDUAL COMMITMENTS
TO SUPPORT INDIVIDUALS
APPROACHING OR WITHIN THE
LAST YEAR OF LIFE



1 **SPECIALIST PALLIATIVE CARE SERVICES**

I should have access to Specialist level Palliative and End of Life Care in my place of care if I need their support, advice and care.

Specialist Level Palliative Care services should be available for face to face contact seven days a week across all settings, and advice should be available 24 hours a day. Inpatient specialist palliative care provision should be available to those requiring it, with admissions seven days a week.

2 **HEALTH, SOCIAL, VOLUNTARY AND OTHER CARE SERVICES**

Care services are in place and available to ensure that I will receive the right care, at the right time, in the right place delivered by a skilled and competent workforce.

Services should be available, accessible, equitable and responsive so that individuals can access appropriate services including:

- Adequate provision of coordinated services, which are able to communicate effectively
- A workforce who are knowledgeable, appropriately trained, competent and have the right qualities to support individuals

3 THE COMMUNITY

I would like to live within a community that feels safe and comfortable talking about death and dying. It should be a community that supports me, if I choose, and those close to me, as I approach the end of my life and die in that community.

The community should have support structures in place to actively encourage discussions about death and dying and encourage communities to support those dying in their community.

4 EVALUATION

I would like to be given the opportunity to discuss and, if I wish, to participate in research and studies to benefit my own and others care.

All providers of care and support should promote the values of innovation, research, audit, evaluation and patient and family reported outcomes of care within their organisations. This will underpin evidence based, high quality and effective provision and delivery of care.

GET IN TOUCH

All specific enquiries on the GM Commitments to palliative care individuals approaching or within the last year of life please contact:
England.GMEC-EOLC@nhs.net

GENERAL ENQUIRIES

0161 625 7791 (during office hours)

gm.hscinfo@nhs.net

www.gmhsc.org.uk

www.gmecscn.nhs.uk

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