A collaborative approach to improving identification and care planning for people approaching the end of their life

As supported by the BwD Clinical and Care Professional Leadership Forum and Pennine Lancashire PEOLC Steering Group in August 2025

Final draft 29.08.25

Objective

Provide a seamless and comprehensive end-of-life care service, integrating the strengths of primary care and the Hospice-Led UEC Avoidance Project. Aiming to ensure patients receive care in their preferred settings and, in-turn, reduce unnecessary hospital admissions .

Overview

Model leverages the EARLY identification tool used by GPs to identify patients nearing end of life and links these patients to hospice support

Additional capacity being recruited to support primary care – Advance Care Planning Practitioners (ACPPs)

By combining the efforts of GPs/ACPPs and hospices, we aim to provide coordinated care, prepare advance care plans (ACPs), and manage patients effectively and holistically to care for people in their preferred place

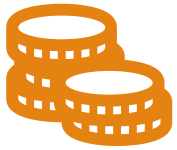
Benefits

Enhanced patient care: Coordinated, personalised care in their preferred settings.

Additional value: improved patient and carer outcomes and enhanced reputation for compassionate care

Reduced hospital admissions and attendances: Effective management and timely interventions reduce the need for hospital attendances/admissions

Improved Efficiency: By integrating the strengths of primary care and hospice services, the model ensures efficient use of resources and avoids duplication



Financial Savings: Significant cost savings from reduced hospital admissions and shorter lengths of stay can be reinvested to sustain the program.

Pennine ACP Pathway / Process

GPs directly supported by ACP Practitioners (ACPPs) co-ordinate across project partners, improve awareness and support use of EARLY tool

- *BwD is using 2xACPP*
- *East Lancs is 3x ACPP*
- *Plus flexible approach with GPs/ELHT*

- GPs clinically validate EARLY list via existing/issued LES
- ACPPs provide co-ordination/support, target work to areas of greatest need and link partners
- GPs and ACPPs refer patients to hospices where patient would benefit from hospice support
- Hospices to undertake identification for those in their care

To achieve 1% of practice list on GSF register….*

- *BwD is targeting need/equity*
- *East Lancs is pushing beyond national targets and levelling up areas of variation*

- ACPPs will support GPs to produce ACPs
- Where patient is referred to hospice, hospice works with patients to prepare ACP.
- All to add to EMIS, hospices to share back to GP/ACPP
- Lead practitioner to notify ICAT of ACP completion (via ICATReferrals@elht.nhs.uk), ICAT to add to EMIS alert banner for community teams
- ACPP co-ordinates records/progress - promotes use/adoption of prepared ACPs with wider partners

To achieve 60% national target…

- *BwD is targeting need/equity*
- *East Lancs is pushing beyond national targets*

- Monthly MDTs - GPs, community, hospices, hospitals and social care committed to increasing GSF patient care meetings with aim of increasing % people dying in their preferred place of care – good practice outlined further on in this slide deck

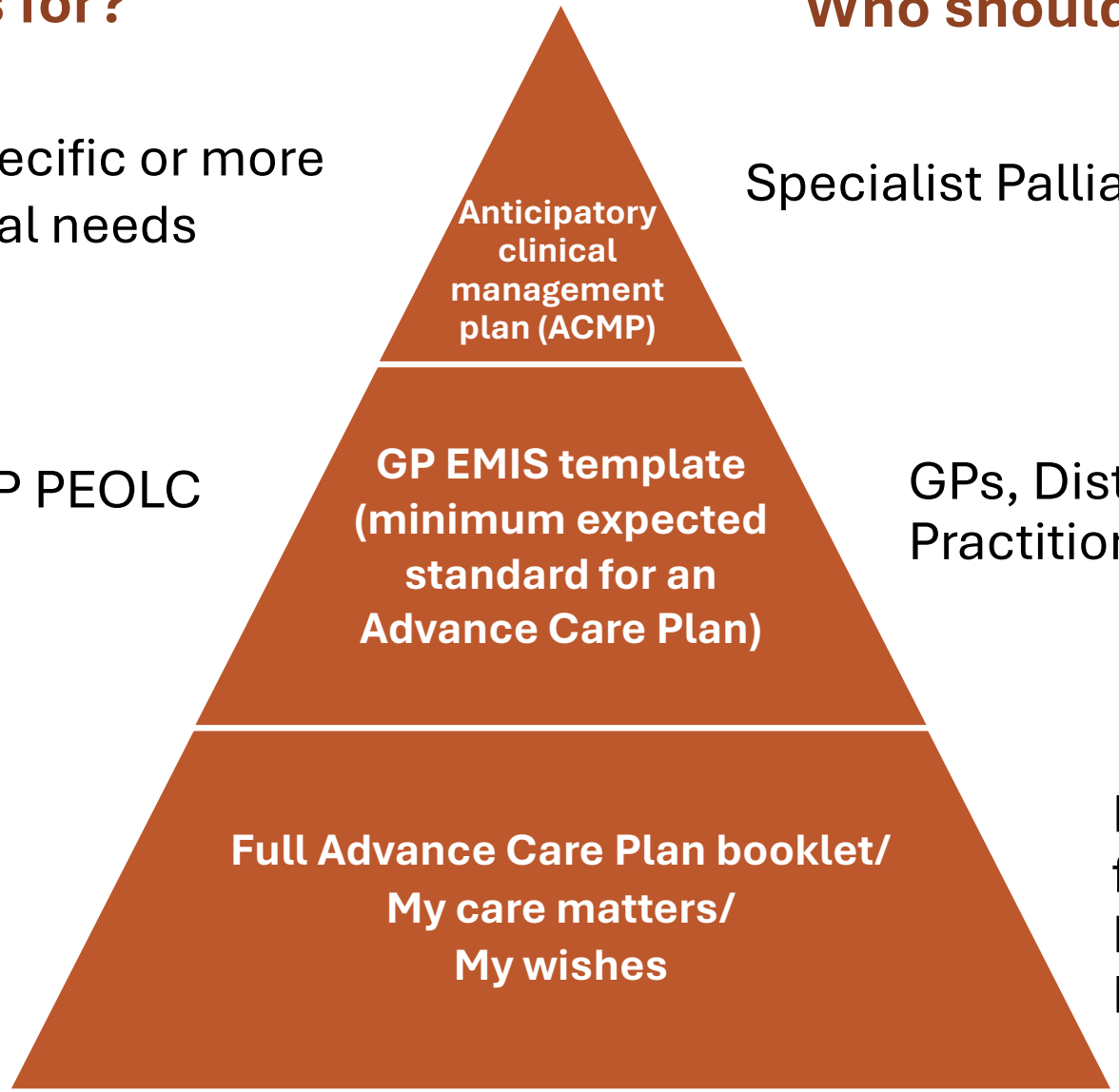
Incremental improvement to GSF meeting attendance:

- *ELH & Pendleside aim increased attendance (targeted)*
- *Rossendale maintaining 100%*

ACP/ACMP Framework – right process right time

Who is this for?

Who should complete this?



People with specific or more complex clinical needs

Specialist Palliative Care with GPs

Everyone on a GP PEOLC register

GPs, District Nurses, ACP Practitioners, Hospice teams

Universal

Patient's and their families/carers, ACP Practitioners, Hospices, Age UK, etc

Areas for development

- It has been recognised that further work is needed to proactively support people with a number of LTCs because it is very difficult to identify when people may be approaching the last 12 months of their life, these include:
    - Dementia
    - Heart failure
    - COPD (to some extent)
- There is work to do around EMIS utilisation and ensuring the right codes are used when completing ACPs
- There is a need to ensure that completed ACPs (EMIS templates) and ACMPs are shared as timely as possible with GP practices, this could be via an alert on EMIS (ideal but not yet in place) but most likely via an email direct to practice, the nominated GP or the practice nominated PEOLC lead

Recommended standard approach for EoL MDT meetings in primary care

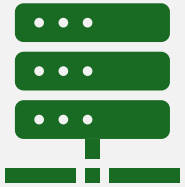
Considerations

- Scheduling
- Format
- Attendance
- Agenda of meeting
- Outcomes/follow up

Scheduling

Nominating administrative support will be critical

We recommend meetings are held monthly



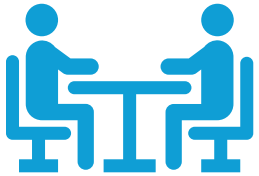
Helps to have a regular slot (possibly combine with clinical meeting)

Schedule meetings 12 months in advance to allow for agenda planning and diary management

Format

Teams/hybrid should be standard as will help to maximise attendance

But face to face would be the ideal to help with relationship development



Think about documentation of the discussion for individual patients and also minute meeting (anonymised).

Patient consent will be needed to share information

Attendance

(core group then wider ad hoc as per patient need)

GP's – including named clinical lead for palliative care.

Admin staff

Practice nurses

District Nurses

Advance Care Planning Practitioner

Hospice

Specialist palliative care

Consider if helpful for specific meetings/ad hoc:

- INT representation, Pharmacists, Care home staff (link to care home ward rounds), etc.

Standard Agenda

Review of register - new patients, changes in status, deaths to reflect on

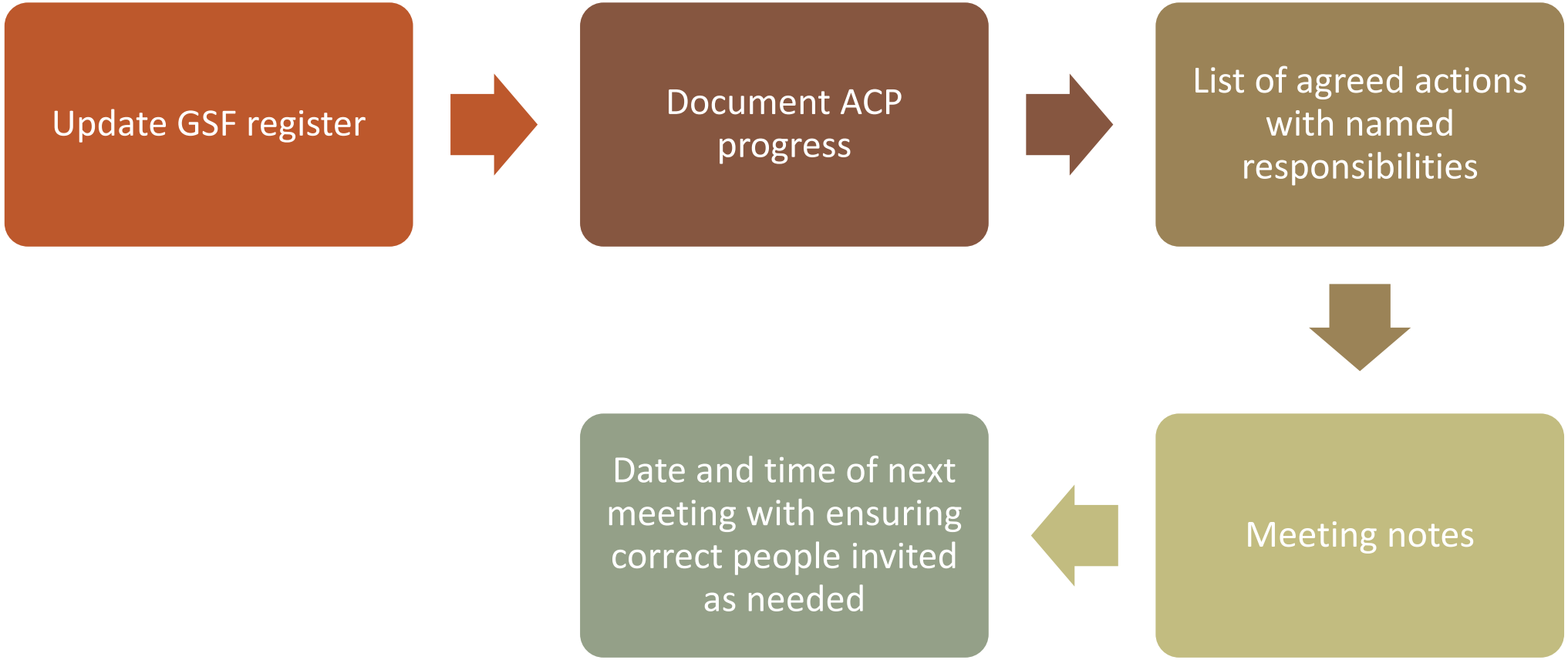
Prioritised patient list - e.g. those deteriorating or at risk of crisis – urgent “on the day” cases if required

Advance care plans update

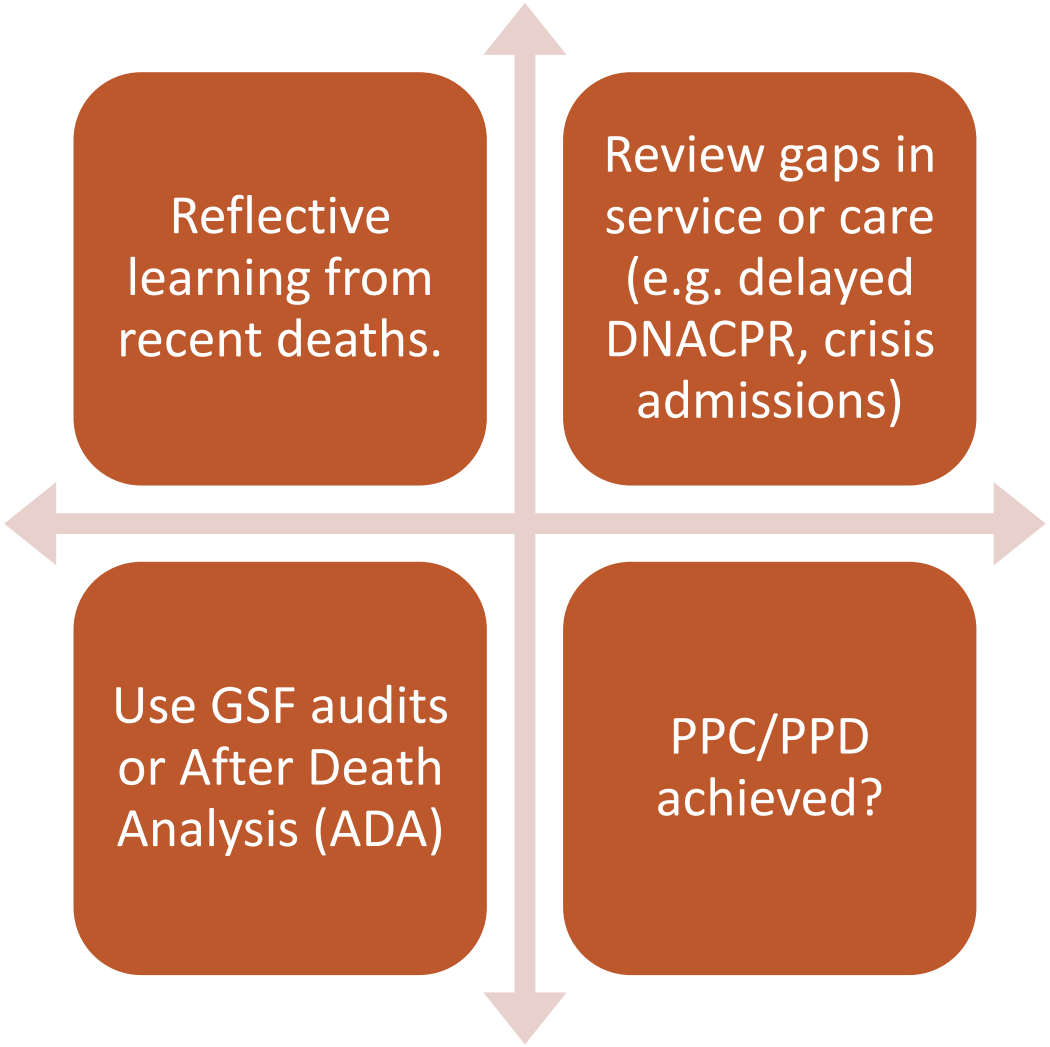
Specific patient discussions – have correct people in meeting for those discussions.

Risk rating? GSF coding green/amber/red

Outcomes/Follow up



Embedding a Quality Improvement Culture



Initial recommendation is that practices should complete learning reviews, ideally in collaboration with partner organisations, on an annual or bi-annual basis