End Of Life Care Strategy

Document Control:

Document Author:	**Director of Nursing**		
Document Owner:	**Board Of Directors**		
Electronic File Name:	**End of Life Care Strategy dated June 2016**		
Document Type:	**Corporate Strategy**		
Stakeholder Consultation:	**Reader Panel (as described within this document) and Trust Board**		
Approval Level:	**Board Of Directors**		
Approval Body:	**Chair of the Board Of Directors**		
Version Number:	**1.0**	**Reference Number:**	**STR/TWD1905/01.0**
Version Issue Date:	**June 2016**	**Effective Date:**	**June 2016**
Review Frequency:	**Yearly**		
Method of Dissemination:	**Intranet**		
Search Keywords:	**End of Life care, specialist palliative care**		
For Use By:	**All Staff**		

Version History:

Version	Date	Author	Reason
V1.0	January 16 January 16 February 2016 June 2016	Director of Nursing and Workforce	To originate document
			To include Transforming End of Life Care in acute hospitals
			Final amendments from SPC team/ CAEOL group
			Approved at Board of Directors meeting
V2.0			

CONTENTS

1.0 INTRODUCTION

1.1 Background

Improving end of life care is a priority at both a national and local level. Helping people to die with dignity, compassion and comfort is an important goal of any Health Service but achieving it can be difficult to do.

Research conducted to date has given us a clearer idea of the problems facing the service. These problems include persistent inequalities and variations in care, with poorly coordinated services and limited access to specialist palliative care for those with conditions other than cancer. Research exploring patient choice has challenged current notions, suggesting place of death is not always a priority for patients and families and noting the changing and ambivalent nature of expressed choice. More people are now dying from longer term, life-limiting disease with uncertain trajectories which can make planning ahead difficult. (NIHR 2015)

It is known that more people die in hospital than anywhere else. Two thirds of people say they would prefer to die at home (Gomes 2011) but currently less than a quarter of people achieve this (Public Health England 2015).(NIHR). Disappointingly the quality of care for dying people in hospital has been consistently rated lower than in hospices, at home or in care homes in successive national surveys of bereaved people (ONS 2014 and earlier).(NIHR).

A key part of delivering good care for dying patients and their carers is to be able to support them to make informed decisions about their care. Research continues to show how difficult it was for many clinical staff to initiate timely conversations with patients and their families and importantly that these were not always welcomed.

1.2 Trust Values

This Strategy conforms to the Trust's values of putting patients first, aiming to get it right, recognising that everybody counts and doing everything openly and honestly. The Strategy incorporates these values throughout and an Equality Impact Assessment is completed to ensure this has occurred.

1.3 Distribution Control

Printed copies of this document should be considered out of date. The most up to date version is available from the Trust Intranet.

1.4 End of Life Ambitions

In 2015 the National Palliative and End of Life Care Partnership published a set of ambitions a Framework for local action. The ambitions are:-

> **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.

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.

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

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.

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.

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.

These ambitions have been used to inform the Trust strategy.

1.5 Transforming End of Life Care in Acute Hospitals

NHS England Route to Success guidance Transforming End of Life Care in Acute Hospitals (December 2015). This national "how to" guide uses NHS improvement methodology familiar to this organisation and identifies five key enablers to support delivery of improvement.

The five enablers are:-

- Advance Care Planning (ACP)
- Electronic Palliative Care Coordination Systems (EPaCCS)
- AMBER Care Bundle*
- Rapid Discharge Home
- Ambitions for Care from "One Chance To Get It Right"

***AMBER**

- **A**ssessment
- **M**anagement
- **B**est Practice
- **E**ngagement of individuals and carers
- For people whose **R**ecovery is uncertain

This guidance will be used as the framework for delivery

1.6 Links to other Stakeholders

The CCG commissioning framework describes how all parts of the system will be developed to ensure that
"to work in partnership with continuing health care, integrated care, the statutory and voluntary sector and community services to re-engineer the community care model to enable more support for patients and informal carers in their home care settings".
The Trust is an active participant in the CCG led End of Life Programme Board.

This Trust Strategy describes the approaches to those people who die in hospital but is written to reflect the aims of the commissioners and all stakeholders to increase the number of people enabled to die in their preferred location.

1.7 Principle Legislation or Guidance Referenced

There is a plethora of guidance and publications relating to care at end of life. This strategy has been developed making reference to the following key national publications:-

Care Quality Commission Key lines of enquiry, End of Life Care.
More Care Less Pathway 2013
National Institute for Clinical Excellence (NICE) QS13,CG140, and NG31.
5 Priorities Leadership Alliance for Care of Dying People (LACDP) 2014
Ambitions for Palliative and End of Life Care:
A national framework for local action 2015-2020 National Palliative and End of Life Care Partnership (August 2015)
Better Endings National Institute for Healthcare Research (NIHR) 2015
Dying without Dignity, Parliamentary and Health Service Ombudsman 2015
Transforming End of Life Care in Acute Hospitals (NHS England December 2015)

The Great Yarmouth and Waveney Clinical Commissioning Group End of Life Care Commissioning Framework 2013-15 has also been referred to in developing this strategy.
The framework for this strategy is based on the 5 priorities developed by the Leadership Alliance for Care of Dying People (LACDP)

2.0 STRATEGIC OBJECTIVES

Through implementing this Strategy, the Trust will:
Deliver the five priorities as determined by the Leadership Alliance for Care of Dying People and use the NICE guidance (NG31) to support direct care.

Priority One

This possibility [that a person may die within the next few days or hours] is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.

Trust actions

- The trust will implement the AMBER care bundle (or similar) to support managing patients where recovery is uncertain

- The trust will provide education to all relevant staff groups to improve identification and recognition of patients at end of life including understanding of mental capacity.
- The trust will develop communication skills and confidence to support clinicians to have meaningful discussions with patients.
- The Trust will develop relevant documentation and care plans to guide staff to provide safe effective care and decision making
- The Trust will deliver an MDT weekly where clinicians can discuss and seek guidance from the specialist palliative care team relating to patients within hours or days of dying. This will include patients with changing needs to provide best supportive care earlier in the discharge process.
- The Trust will provide specialist palliative care input to those patients requiring more specialist intervention and continue to work across the health and social care system to ensure access to specialist care provision.
- The Trust will ensure resources are available to staff on the Trust intranet.

Priority Two

Sensitive communication takes place between staff and the dying person, and those identified as important to them.

- The Trust will provide education to support staff to have sensitive communication and involvement of those people important to the patient, and ensure these conversations are recorded in a timely and sensitive manner.

Priority Three

The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.

- The Trust will provide education to support staff to involve patients in decision making where desired by the patient, and ensure these conversations are recorded in a timely and sensitive manner.
- The Trust will implement the recently revised DNACPR policy.
- The Trust will audit compliance with the DNACPR policy.
- The Trust will consider and implement any changes determined at a national level.

Priority Four

The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.

- The trust will on a regular basis seek the views of patients and families on the quality of care delivered, in order to learn and improve. This links with the Carer and Patient Experience Strategy.
- The Trust will continue to promote the use of the Louise Hamilton centre to support families and carers.

Priority Five

An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

- The trust will review the current care planning documents in light of the recently published NICE Guidance (NG31)
- The Trust will roll out the use of the agreed plan of care documents (nursing care plan and clinically agreed plan (CAP) to all relevant areas of the Trust.

- The Trust will audit the use of the documentation on a regular basis to further learn and refine.

3.0 STRATEGY ROLES AND RESPONSIBILITIES

3.1 Chief Executive

Although the Chief Executive has ultimate responsibility for the implementation of this Strategy in ensuring its requirements are met, responsibility has been delegated to the Director of Nursing and Workforce.

3.2 Executive Director (Director of Nursing)

The Executive Director is responsible for providing Board Level Leadership for End of Life Care. They will ensure that there are Trust wide policies, processes and structures to support the delivery of assurance regarding the quality of care. The Director also chairs the Care at End of Life Group.

3.3 Non Executive Director

A Non Executive Director is responsible for the development and on-going effectiveness of End of Life Care and that there is regular reporting to the Board of Directors. Two national reports refer to the role of a Non Executives or equivalent.
More Care, Less Pathway 2013 (A Review of the Liverpool Care Pathway Independent Review Of the Liverpool Care Pathway)
"It is not only clinicians that are accountable and liable: organisations providing care for the dying need to take particular care to ensure that the right systems are in place to ensure they deliver consistently good care. The Review panel recommends that the boards of healthcare providers providing care for the dying give responsibility for this to one of its members – preferably a lay member whose focus will be on the dying patient, their relatives and carers – as a matter of urgency. This is particularly important for acute hospitals, where the Review panel has found most cause for concern."

Ambitions for Palliative and End of Life Care:
A national framework for local action 2015-2020 National Palliative and End of Life Care Partnership (August 2015)
"Executive governance
The accountability for ensuring environments that support all professionals to give their best lies with the executive governance of the organisation. Every organisation should have clear governance at Board level for high quality palliative and end of life care and environments in which all staff can provide the best of their professionalism and humanity."

3.4 Trust Clinical Lead for End of Life Care

The Trust Clinical Lead for End of Life Care has overall responsibility for the development and implementation of this strategy and the trust approach to care at end of life.

3.5 Matron/Senior Nurse with responsibility for End of Life Care

The Matron/Senior Nurse with responsibility for End of Life Care will work collaboratively with the Clinical Lead in delivering this strategy and ensuring the nursing

and midwifery contributions are made. They will also ensure that the specialist palliative care team provide clinical leadership and oversight to the specifics of care at end of life within the Trust and also that there is alignment with care across Great Yarmouth and Waveney.

3.6 Specialist Palliative Care Team

The Team will ensure alignment of this strategy with that of the GYW Specialist Palliative Care Service will support the development and improvement of care across the Trust. They will deliver End of Life Care education and support. They will support the development of audit and outcomes information. They will ensure that failure to follow pathways and protocols are reported in order to support learning and education. The Team will provide expertise and advice on programmes of work.

3.7 Divisional teams

The Divisional Teams will be responsible for the implementation of this strategy and monitoring of care through existing frameworks and audit programmes.

3.8 All staff

All staff employed by the Trust have a responsibility for the quality of the service which they provide, and all clinically qualified staff are individually accountable for ensuring they audit their own practice in accordance with their professional codes of conduct and in line with the standards set out within this document.

4.0 IMPLEMENTATION AND MONITORING OF THE STRATEGY

4.1 Implementation of the Strategy

The Care at End of Life Group led by the Executive lead will ensure the implementation of this strategy through a work programme designed around the Transforming End of Life Care In Acute Hospitals (NHS England Dec 2015) and action plan. This group reports to Carer and Patient Experience Group and to Safety and Quality Governance Committee of the Board of Directors.

This strategy covers a one year period. It will be reviewed by the Care at End of Life Group at the end of that period and refreshed in light of review and development of a new commissioning framework within the GYW CCG, new national work on definitions of care linked to a proposed new tariff, and other guidance likely to be published nationally.

4.2 Monitoring

An audit programme will be developed to ensure regular review of practice and compliance. This will report to the Care at End of Life Group.

A set of quality measures will be developed and reported to the Care at End of Life Group.

An Annual report will be developed and will report to Safety Quality Governance Committee.

Appendix - Equality Impact Assessment

Policy or function being assessed: Care at End of Life Strategy **Department/Service:**
Assessment completed by Liz Libiszewski Director of Nursing and Workforce **Date of assessment: January 2016**

1.	Describe the aim, objective and purpose of this policy or function.		To set the direction of travel in delivering Endo f Life care within the James Paget Hospital	
2i.	Who is intended to benefit from the policy or function?		**Staff** ☐ **Patients X**☐ **Public** ☐ **Organisation** ☐	
2ii	How are they likely to benefit?		Improved and consistent care at end of life	
2iii	What outcomes are wanted from this policy or function?		High quality and consistent care for people who are at end of life within the hospital	
For Questions 3-11 below, please specify whether the policy/function does or could have an impact in relation to each of the nine equality strand headings:				
3.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **race/ethnicity?**	**Y**	**N x**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
4.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **gender?**	**Y**	**N x**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
5.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **disability?** Consider Physical, Mental and Social disabilities (e.g. Learning Disability or Autism).	**Y**	**Nx**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
6.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **sexual orientation?**	**Y**	**Nx**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data

7.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **pregnancy or maternity?**	**Y**	**Nx**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
8.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **religion/belief?**	**Y**	**Nx**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
9.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **transgender?**	**Y**	**Nx**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
10.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **age?**	**Y**	**Nx**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
11.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **marriage or civil partnership?**	**Y**	**Nx**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
12.	Could the impact identified in Q.3-11 above, amount to there being the potential for a disadvantage and/or detrimental impact in this policy/function?	**Y**	**Nx**	*Where the detrimental impact is unlawful, the policy/function or the element of it that is unlawful must be changed or abandoned. If a detrimental impact is unavoidable, then it must be justified, as outlined in the question above.*
13.	Can this detrimental impact on one or more of the above groups be justified on the grounds of promoting equality of opportunity for another group? Or for any other reason? E.g. providing specific training to a particular group.	**Y**	**Nx**	*Where the detrimental impact is unlawful, the policy/function or the element of it that is unlawful must be changed or abandoned. If a detrimental impact is unavoidable, then it must be justified, as outlined in the question above.*
14.	**Specific Issues Identified**			
	Please list the specific issues that have been identified as being discriminatory/promoting detrimental treatment			Page/paragraph/section of policy/function that the issue relates to
	1. None			**1.**
	2.			**2**

	3. INSERT HERE		**3**
15.	**Proposals**		
	How could the identified detrimental impact be minimised or eradicated?	N/A	
	If such changes were made, would this have repercussions/negative effects on other groups as detailed in Q. 3-11?	**Y**	**N**
16.	Given this Equality Impact Assessment, does the policy/function need to be reconsidered/redrafted?	**Y**	**N**
17.	**Policy/Function Implementation**		
	Upon consideration of the information gathered within the equality impact assessment, the Director/Head of Service agrees that the policy/function should be adopted by the Trust. Please print: **Name of Director/Head of Service:** Liz Libiszewski **Title:** Director of Nursing and Workforce **Date:** February 2016 **Name of Policy/function Author:** Director of Nursing and workforce **Title:** Director of Nursing and workforce **Date:** February 2016 (A paper copy of the EIA which has been signed is available on request).		
18.	**Proposed Date for Policy/Function Review** January 2017		
	Please detail the date for policy/function review (3 yearly): January 2019		
19.	**Explain how you plan to publish the result of the assessment?** *(Completed E.I.A's must be published on the Equality pages of the*		

	Trust's website).
	Standard Trust process
20.	**The Trust Values**
	In addition to the Equality and Diversity considerations detailed above, I can confirm that the four core Trust Values are embedded in all policies and procedures. They are that all staff intend to do their best by: Putting patients first, and they will: Provide the best possible care in a safe clean and friendly environment, Treat everybody with courtesy and respect, Act appropriately with everyone. Aiming to get it right, and they will: Commit to their own personal development, Understand theirs and others roles and responsibilities, Contribute to the development of services Recognising that everyone counts, and they will: Value the contribution and skills of others, Treat everyone fairly, Support the development of colleagues. Doing everything openly and honestly, and they will: Be clear about what they are trying to achieve, Share information appropriately and effectively, Admit to and learn from mistakes. I confirm that this policy/function does not conflict with these values. ☑