End of Life Care Strategy
2016 to 2018

V2.0

September 2016
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1. Executive Summary

1.1. Death and dying are inevitable. 100% of us will die therefore end of life care affects us all, at all ages, the living, the dying and the bereaved.

1.2. We want to support people who choose to die in hospital but enable people to be cared for elsewhere if that is their wish. This strategy outlines our plans for the next two years to improve our end of life care and services in line with our values, operational plan and national guidance.

1.3. The first National End of Life Care Strategy was published by the Department of Health in 2008 since then numerous nation specific reports and strategies have been published including the findings from the most recent Care Quality Commission (CQC) visit to RCHT in January 2016 (and published in May 2016) which makes this an ideal time to update and revise the Trust’s End of Life Strategy which was first published in March 2014.

1.4. In developing this strategy we have reviewed the care that we deliver for dying people, have considered a broad range of national guidance and taken into account our contribution to Cornwall and the Isles of Scilly Sustainability and Transformation Plan.

1.5. This strategy is specific to adult patients approaching the end of life and who are cared for in any setting provided by Royal Cornwall Hospitals NHS Trust (RCHT).

This strategy is intended to:

- provide information about how care will be delivered to dying people using the five priorities of care set out in One Chance To Get It Right (2014)
- describe the education and training that will be provided to staff to enable them to deliver exemplary care to dying people and those identified as important to them
- raise awareness of the importance of end of life care (EoLC) within the acute hospital setting
- describe the contribution RCHT will make, working with partner agencies, to implement the Co-ordinated End of Life Pathway as part of Cornwall and the Isles of Scilly Sustainability and Transformation Plan, Priority Theme: ‘Transforming Care and Support in Communities’

1.6. In delivering this strategy we will expect to see a range of benefits including the provision of exemplary end of life care for patients choosing to die in hospital, increased staff knowledge and confidence when caring for patients approaching the end of life and better partnership working with external organisations.

1.7. The RCHT End of Life Group will oversee the implementation of this strategy.
2. **Context / Background**

2.1. The first *National End of Life Care Strategy* (Department of Health, 2008) provided three key insights: that people didn’t die in their place of choice, that preparation was needed for larger numbers of dying patients and not everybody received high quality care. Since then numerous nation specific reports and strategies have followed including, but not limited to:

a. *Treatment and Care Towards the End of Life: Good Practice in Decision Making*, General Medical Council (July 2010) sets out guidance based on long-established ethical principles, which include doctors’ obligations to show respect for human life, to protect the health of patients, to treat patients with respect and dignity and to make the care of their patients their first concern

b. National Institute for Health and Care Excellence (NICE) *Quality Standard for End of Life* (2011) which describes a comprehensive picture of what high quality care should look like for all adults approaching the end of life (EoL)

c. *More Care, Less Pathway* (2013), an independent review of the Liverpool Care Pathway (LCP) for the Dying Patient following alarming stories in the press and broadcast media, some of which appeared to have had much in common with complaints that led to the Mid Staffordshire Public Inquiry (2013) concerning the treatment of elderly patients in acute hospitals

d. *Once Chance To Get it Right* (2014), developed by the Leadership Alliance for the Care of Dying People (LACDP), an alliance established following the independent review of the LCP, which sets out the approach to caring for dying people which should be applied irrespective of the place someone is dying. *Once Chance To Get It Right* sets out five priorities of care which reinforce that the focus for care in the last few days and hours of life must be the person who is dying. Each priority is equally important and supports the primary principle that individual care must be provided according to the needs and wishes of the dying person. The priorities are set out in sequential order and will be adopted as the framework for the delivery of the Trust’s End of Life Strategy

e. NHS England’s publication *Actions for End of Life Care 2014-2016* which set out a series of commitments for adults and children informed by comments and feedback from people who have experience of end of life care - patients, carers, health professionals etc. This document signaled a shift from ‘place of death’ to the broader experience of end of life care

f. *Every Moment Counts* (2015), a publication in partnership with the National Council for Palliative Care and National Voices unequivocally sets out what person centered care means from the point of view of someone approaching the end of life:

   “I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s).”

   Every moment counts because, once passed, it can never be regained.

g. *Ambitions for Palliative and End of Life Care: a national framework for local action 2015-2020* which sets out six ambitions focussing not only on the experience of the dying person
but also carers, families, those important to the dying person and, where appropriate, people who have been bereaved.

h. NICE Care of Dying Adults in the Last Days of Life (2015) provides an evidence based approach to the clinical care of the dying adult and is focussed on care needed when a person is judged by the multi-professional team to be within a few (2 to 3) days of death

i. ‘Transforming end of life care in acute hospitals: The route to success ‘how to’ guide” (revised December 2015) provides practical advice and support for front-line clinicians and leaders for the work required to transform end of life care in acute hospitals

j. ‘Delivering the Forward View: NHS Shared Planning Guidance 2016/17-2020/21’ (December 2015) outlines a new approach to building health and care systems around the needs of local populations showing how local services will evolve and become sustainable over the next five years

k. Each Community is Prepared to Help: Community Development in End of Life Care (July 2016) provides advice and practical suggestions for organisations that are keen to stimulate and extend partnerships with communities and, in particular, describes the important role hospitals have to play in the broader context of supporting a compassionate communities programme for end of life care.

2.2. New national publications, including the findings from the most recent Care Quality Commission (CQC) visit to RCHT in January and published in May 2016, make this an ideal time to update and revise the Trust’s End of Life Strategy which was first published in March 2014.

2.3. This version superseded any previous versions of this document.

3. Objectives of this Strategy

3.1. In developing this strategy we have reviewed the care that we deliver for dying people, have considered a broad range of national guidance and taken into account our contribution to Cornwall and the Isles of Scilly Sustainability and Transformation Plan.

3.2. This strategy is intended to:

l. provide information about how care will be delivered to dying people using the five priorities of care set out in One Chance To Get It Right (2014)

m. describe the education and training that will be provided to staff to enable them to deliver exemplary care to dying people and those identified as important to them

n. raise awareness of the importance of end of life care within the acute hospital setting

o. describe the contribution RCHT will make, working with partner agencies, to implement the Co-ordinated EoL Pathway which is one element or ‘building block’ of Cornwall and the Isles of Scilly Sustainability and Transformation Plan, Priority Theme ‘Transforming Care and Support in Communities’

4. Scope

4.1. This strategy is specific to adult patients. and those identified as important to them, who are approaching the end of life i.e. are expected to die within 12 months and who are cared for in any setting provided by RCHT; this includes adults who die suddenly or
after a very brief illness, have dementia (and may need to participate in advance care planning significantly earlier than patients with cancer for instance) or have been diagnosed with frailty syndrome as well as those patients known to have advanced, progressive, incurable illnesses e.g. heart failure, chronic obstructive pulmonary disease etc.

4.2. The strategy does not cover condition-specific management and care, clinical management of specific physical symptoms or mass casualty incidents.

4.3. The strategy sets out standards for the high-quality care of patients, aged 16 years and older (i.e. cared for in an adult environment) who are approaching the end of life. It also covers support for the families, carers and those identified as important to this group of patients.

4.4. The strategy has relevance to all members of RCHT staff who may, in the course of their daily working life, encounter patients who are approaching the end of life. It also applies to ‘back office’ staff as it is recognised that death and dying are inevitable and end of life care affects us all, at all ages, the living, the dying and the bereaved.

4.5. Children’s end of life care needs are excluded from this strategy and will be addressed separately.

5. Definitions / Glossary

5.1. **End of Life Care** – patients are ‘approaching the end of life’ when they are likely to die within the next 12 months. This includes patients whose death is imminent (expected within a few hours or days) and those with:

- advanced, progressive, incurable conditions
- general fraility and co-existing conditions that mean they are expected to die within 12 months
- existing conditions if they are at risk of dying from a sudden acute crisis in their condition
- life threatening acute conditions caused by catastrophic events.

5.2. **Gold Standard Framework** – is a programme of training and support that brings about individual and organisational transformation, enabling a ‘gold standard’ of care for all people nearing the end of life.

5.3. **Liverpool Care Pathway** - developed during the late 1990s at the Royal Liverpool University Hospital, in conjunction with Marie Curie Palliative Care Institute, was intended to provide the best possible quality of care for dying patients, and was seen as a way of transferring best practice from hospices into other care settings such as hospitals. Its aim was to ensure that everyone expected to die within hours or days received the same high standard of care, regardless of where they were being cared for.

5.4. **Mental Capacity (lack of)** - for the purposes of this Mental Capacity Act 2005, a person lacks capacity in relation to a matter if at the material time he/she is unable to make a decision for him/herself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

5.5. **National Council for Palliative Care** - is the umbrella charity for all those involved in palliative, end of life and hospice care in England, Wales and Northern Ireland.
5.6. **National Voices** - National Voices is the coalition of health and social care charities in England and works for a strong patient and citizen voice and services built around people.

5.7. **Sustainability and Transformation Plans** – are place-based, multi-year plans built around the needs of local populations between 2016-2021 and are seen as the blueprints for accelerating the ambitions set out in the Department of Health’s strategy *Five Year Forward View (5YFV)*

5.8. **Specialist Palliative Care Team** is a multi-professional team, comprising specialist nurses and doctors who provide assessment, advice and support to patients and staff for patients with illnesses that are not curable or who are approaching the end of life.

6. **Ownership and Responsibilities**

6.1. The **Nurse Executive** is the Trust Board Lead for End of Life Care and a member of the End of Life Care group.

6.2. The **End of Life Lead** chairs the End of Life Care Group and acts as a champion to secure the engagement of clinical and non-clinical staff in taking the strategy forward.

6.3. The **End of Life Programme Facilitator** is an evolving role and will include a review of end of life care documentation, provision of ward based training to staff, development of new models of training and education and the launch of the ‘How To Guide’ in clinical areas as a minimum. A progress report will be provided to each End of Life Care Group meeting.

6.4. The **End of Life Care Group** meets bi-monthly, is chaired by the End of Life Care Lead, has broad membership and clearly defined Terms of Reference and will oversee the implementation of this strategy.

6.5. The **Specialist Palliative Care Team** will work closely with the End of Life Programme Facilitator and will be actively involved in implementing key aspects of this policy e.g. raising awareness, contributing to how care is provided and delivering training and education to staff.

6.6. The **Specialist Palliative and End of Life Link Nurses** act as a link between specialist services and the staff of the clinical areas where they work distributing information, improving awareness of policies and procedures specific to Palliative/End of Life Care and promoting best practice in Palliative/End of Life Care.

6.7. **Line Managers** will ensure staff are emotionally supported staff and ensure staff are released for the education and training necessary to fulfill their role and other duties (e.g. link nurses), monitor and investigate complaints and incidents related to end of life care, ensure end of life care is delivered to the highest standard (including audit of documentation) and use the ‘How To Guide’ to transform end of life care in their clinical areas.

6.8. **Clinical and Non-Clinical Staff** delivering any aspect of end of life care have a responsibility to ensure that they have the necessary skills and competences to provide care to the standard required and in compliance with the five priorities of care. If they are
registered with an appropriate professional body, they should also ensure that they can demonstrate this for the purposes of revalidation/recertification.

6.9. **Chaplains** provide spiritual support in the hospital environment to patients, hospital staff, and family members and will be actively involved in end of life care training.

7. **Benefits**

7.1. In delivering this strategy we will expect to see the following benefits:

- An improved patient experience evidenced through a reduction in complaints/incidents
- An increase in positive feedback from patients and those who have been bereaved
- Individual end of life care plans in place for every patient approaching the end of life with all aspects completed, and reviewed regularly, as evidenced through audit of documentation
- Patients achieving their preferred place of dying
- Increased staff knowledge and confidence in caring for end of life patients and those identified as important to them as reported by staff
- Increased attendance at end of life training
- Active link nurse group with good attendance and representation from clinical areas
- Better partnership working with external organisations resulting in reduced admissions/beds days in the last year of life
- Compliance with national standards e.g. NICE
- Improved CQC rating

8. **Risks**

8.1. The risks of not implementing this strategy will vary dependent on what is, and is not, achieved but may include:

- Reported poor patient experience evidenced through patient feedback
- Increased number of complaints and incidents
- Low staff morale as evidenced through the annual staff survey and local ‘pulse checks’
- Continued poor CQC rating with resultant adverse publicity

8.2. Potential risks/barriers to implementation of this strategy, in part or in entirety, include:

- Lack of funding to support the appointment of a substantive End of Life Programme Facilitator
- Poor staff engagement/staff resistance
- Lack of training and education resource to develop the necessary skills and competencies of staff
- Limited access to charitable funds to allow the implementation of the Gold Standard Framework

9. **The Strategy**

9.1. Death and dying are inevitable. 100% of us will die therefore end of life care affects us all, at all ages, the living, the dying and the bereaved.
Providing exemplary care to dying people requires collaboration and cooperation between individual health professionals, the teams within which they work and between organisations in the wider health and social care system however, improving the care that dying people receive will only improve when each and every one us makes the commitment to act in the right way, at the right time, using the five priorities of care as the ‘way we do things around here’.

We want to support people who choose to die in hospital but enable people to be cared for elsewhere if that is their wish. This strategy outlines our plans for the next two years to improve our end of life care and services in line with our values, operational plan and national guidance.

How Care will be Delivered to Dying People

RCHT has a clearly defined set of values which reflect our commitment to the provision of exemplary care to the dying person, and those identified as important to them.

We will deliver care in the following ways:

Priority One: the 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.

Every patient whose condition deteriorates and it is thought they may die within a few days or hours will be assessed, by a doctor competent to judge, whether the change is potentially reversible or the person is likely to die.

If the patient is likely to die, taking into account the views of others caring for the person, this will be clearly and sensitively explained to the patient in a way that is appropriate to their circumstances (if conscious and they have not indicated that they would not wish to know), and their family and others identified as important to them.

The doctor and/or senior nurse will explain to the patient, clearly and sensitively, why they think the patient is dying, when and how death might be expected to occur, what this is likely to entail and the uncertainties around this; this explanation/discussion will be documented in the patient’s medical records by the doctor. The patient must be given the opportunity to ask questions.

The same communication (explanation and opportunities for questions) will take place with those identified as important to the patient. Euphemisms e.g. ‘TLC’ will be avoided.

Changes to a patient’s condition will be a ‘trigger’ for making decisions to change care and treatment or review the position again later. Changes to care and treatment or ‘review later’ will be documented in the patient’s medical recorded, including the time the review took, or will take place.

The patient’s views and preferences will be taken into account, and those identified as important to them will be involved in decisions in accordance with the patient’s wishes; these views and preferences will be documented in the patient’s medical records by the doctor or nurse caring for the patient.
The Chaplaincy is available to advise and support those who wish to get married or have a civil ceremony whilst in hospital, providing they meet the criteria set out in national guidelines. Marriage/civil ceremonies may only be carried out by registered persons or by a priest through the obtaining of a bishop’s licence.

An individual plan of care will be developed and the patient will be regularly reviewed, at least daily or when the patient’s condition deteriorates, to check that the plan of care remains appropriate and to respond to changes in the person’s condition, needs and preferences.

A fast track system of discharge/transfer will be introduced to support the patient’s wish in preferred place of death.

**Priority Two: sensitive communication takes place between staff and the dying person, and those identified as important to them**

Clear, understandable and plain language will be used verbally, and in all other forms of communication, with the dying patient and those identified as important to the patient.

Staff will actively seek to communicate with, and listen to, the patient and those identified as important to the patient, and not wait to be asked questions or just provide information.

Communication will take place in a way that maximises privacy to patients and will be sensitive, respectful in pace and tone and take account of what the patient and those important to the patient, want to, and feel able to discuss, at any given point in time.

Staff will check the patient’s, and those identified as important to the patient, understanding of what has been discussed and document any discussion in the patient’s medical records.

**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**

Staff will involve patients in decisions about their treatment and the care, including day to day decisions about food, drink and personal care to the extent to which the patient, and those important to the patient, wish to be involved.

Staff will communicate sensitively to ascertain the wishes of the dying patient and their wishes will be respected.

Every patient, and those important to the patient, will know which senior doctor has responsibility for their treatment and care and the nurse leading and co-ordinating their care whilst in hospital; these names will be clearly displayed above the patient’s bed.

Every patient will also have an assigned nurse on each shift with responsibility to meet the needs of the patient and those identified as important to them. Introductions will be made at the start of every shift and this fact will be documented in the nursing care plan.
Where it is established that the dying patient lacks the mental capacity to make a particular decision, the decision made, or action taken on their behalf, must be in their best interests, and they should still be involved as far as possible in that decision.

The timing of the decisions to withdraw, or not to start potentially life-prolonging treatments, especially when made overnight, will be carefully considered and made only by doctors and nurses with the requisite training and competence; this will include decisions which can, and must wait, for a review of the person’s condition by the senior doctor who has responsibility for the patient’s treatment and care (and who may know the patient better and/or have relevant competence and training to inform treatment decisions) or a clinician with the appropriate and training and competence to whom the responsibility has been delegated.

Professionals will comply with legal requirements in relation to representation or advocacy for patients who lack capacity to consent and will have had the necessary training in this aspect of care.

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

Families and those identified as important to the dying patient, have their own needs which can be overlooked at this time of distress. An appreciation or acknowledgement that the imminent death of somebody they love is hard and that they have a role in ensuring that their loved one receives a good standard of care as they near the end of life will be offered. Where they have particular needs for support or information, these will be met as far as possible.

If the patient lacks capacity to make a decision, the decision-making process should be explained to those people who are supporting the person and they should be involved as much as possible.

Feedback from people who are bereaved will be sought sensitively, and at an appropriate time, and this will be used to inform service developments/improvements and the training provided to staff.

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

An individual end of life care plan will be developed to meet the dying patient’s own needs and wishes in relation to how their care should be managed and any treatment preferences they may want to express; this plan will include attention to symptom control e.g. relief of pain and other discomforts (although pain killers and tranquillisers must be given appropriately for symptom relief, rather than as a matter of course) and the person’s physical, emotional, psychological, social, spiritual, cultural and religious needs.

Individualised end of life care plans will be regularly reviewed and updated, so that consistent information about the person’s needs and wishes is shared with those involved in the person’s care and available at the time this information is needed.
Food and drink will continue to be offered to every patient providing this will not harm the patient, and nursing and support staff will ensure the patient receives the necessary help to do this.

Prompt referral to, and input from, the specialist palliative care team for any patient and situation that requires this will be made. Staff will know how and when to make a referral and referrals to the team will be audited to ensure that referrals are appropriate and patients are referred in a timely way.

The reason for the use of syringe drivers will be explained to the dying person, and those identified as important, before it is used, unless the circumstances are exceptional. The likely effects of specific interventions, especially those that make the person sleepy, will be discussed with the dying patient to enable them to make informed decisions and explained to those important to the dying person. Advice may be sought from the palliative care team during normal working hours and the Cornwall Hospice out of hours.

Privacy and dignity will be maintained whenever possible e.g. allocation of side room, reduced multiple transfers between wards except an initial move from the ‘point of entry’ to the Trust or from the ward the patient is on when end of life needs are recognised, to the ward identified as most appropriate to meet that patient’s end of life care needs.

Patients’ wishes with regard to preferred place of dying will be respected and every effort will be made to ensure that this is achieved, including adopting a ‘fast track’ approach to discharge/transfers between organisations.

9.5. Education and Training

9.5.1. All staff who have contact with dying people must have the skills to do this effectively and compassionately, this includes clinical and non-clinical staff i.e. those not usually identified as being central to the provision of care e.g. porters, reception staff and ward clerks.

9.5.2. Training and education of staff will therefore be designed to support and empower staff, giving them the confidence to identify and care for those at the end of their lives and the tools to communicate clearly and sensitively.

9.5.3. Development of the workforce with regard to end of life care will take time, but is not an excuse for inaction.

9.5.4. The following steps outlines the broad programme of workforce development that will be instigated to ensure that all staff caring for people approaching the end of life, both clinical and non-clinical staff, have the necessary knowledge, skills, competencies and attitudes.

We will:
- Undertake a comprehensive training needs analysis which sets out the skills and competencies required according to the following principles:
Level 1 - non clinical staff working in health care settings (e.g. ward clerks, porters etc.) will need a basic knowledge and awareness of end of life care needs with an emphasis on communication e.g. as part of customer care training

Level 2 - clinical staff who have some degree of contact with people approaching the end of life (e.g. ED staff, pharmacists etc.) will need a good basic knowledge of the principles and practice of end of life care including knowing when to refer or seek expert advice or information

Level 3 - clinical staff who contribute to the assessment, planning, intervention and evaluation of the needs of people approaching the end of life (e.g. staff working in acute medicine, oncology etc.) and are likely to be involved in ‘trigger’ discussions will need an enhanced knowledge to include advanced communication skills, assessment of the dying person’s needs and preferences, advanced care planning and symptom management as they relate to end of life care. This group of staff are identified as having the greatest potential training need and will hold competency passports to evidence that they have received the requisite training and development

Level 4 – specialist palliative and end of life care staff

- Develop and deliver the training programmes outlined above. Delivery of the training programmes will be a collective responsibility and will be delivered by staff from training and development, the specialist palliative and end of life care team, senior medical staff, matrons, specialist nurses, ward managers and external experts as required
- Maximise the use of e-learning as, given the number of staff involved, this will be key to delivering training
- Provide one day educational workshops for staff requiring Level 3 training at least twice per year
- Provide training for the assessment, and meeting of, spiritual needs of dying people, and those identified as important to them; this will be provided by the chaplaincy team
- Utilise ‘tool box talks’ and other models of informing and communicating with staff to complement the training already provided
- Evaluate and review all training programmes annually to ensure that they are fit for purpose, meet local need and are based on best practice and emerging guidance

9.6. Raising Awareness of the Importance of End of Life Care Within the Acute Hospital Setting

9.6.1. In order to raise awareness across the organisation about the importance of end of life care within our hospitals and building on work previously undertaken, as described in the last strategy, we will:

- Publish this strategy in an abridged form, making it available in all public, clinical and ‘back office’ areas and on the Trust’s website
- The full strategy will be available via the Trust Document Library and circulated via the Policies and Guidelines bulletin
- Appoint a substantive End of Life Programme Facilitator
- Use Trust wide communication including ‘One and All’ Daily to communicate about issues relating to end of life care
- Create new, individualised, end of life care plans for patients to ensure all patients receive exemplary care by setting out all the elements staff need to consider when caring for the dying person
- Provide End of Life training to staff at induction and on mandatory training programmes
including maximising the use of e learning opportunities
- Refresh membership of the link nurse group and combine the link nurse groups for Palliative Care and End of Life to share expertise and make the best use of resource
- Use the *Transforming Care at the End of Life How to Guide* on the seven wards identified as having the highest number of deaths to improve the quality of end of life care for dying patients and those identified as important to them
- Roll out the *Transforming Care at the End of Life How to Guide* to other wards across the Trust using a planned, systematic approach
- Identify End of Life Care Champions (clinical and non-clinical) across the organisation from ward to board and in ‘back office’ areas
- Refresh the Terms of Reference for the End of Life Group and extend membership to include, for example, the Nurse Consultant for Older People and the Children’s Lead Nurse
- Introduce the gold butterfly scheme to support patients, and those identified as important to them, and to make it easier for staff to identify people approaching the end of life
- Host an annual end of life care conference bringing together staff from all levels and specialties and from different organisations
- Introduce a bi-monthly end of life newsletter to keep staff informed of developments and initiatives relating to end of life care
- Develop a concise resource folder of information regarding end of life care which is available both electronically and in hard copy in all clinical areas which provide care to end of life patients
- Provide quarterly reports to the Quality and Safety Committee and an annual report to Trust Board
- Implement the Gold Standard Framework across the organisation (subject to funding)

### 9.7. Partnership Working

9.7.1. Improving end of life care involves a wide range of people and organisations, across the health and social care, professional and public, and statutory and voluntary, spectrum. The aim should be to provide a seamless service addressing end of life care needs of patients, and those identified as important to them, to provide the right care in the right place at the right time by the right people therefore, RCHT will explore opportunities to actively collaborate with other organisations by:

- Being an active member of the Cornwall and Isles of Scilly End of Life Strategy Board and the project and work streams that emerge from this
- Extending membership of the RCHT End of Life Group to representatives of external organisations e.g. Cornwall Hospice
- Contributing to the development of multi-agency, multi-disciplinary training and education programmes across all settings of care in Cornwall
- Working alongside providers across all health and social care settings in Cornwall to develop robust systems of information sharing and joint working e.g. shared end of life care plans to provide the best possible individualised care to patients approaching the end of life
- Exploring opportunities to collaborate with other health, social care or voluntary organisations e.g. via the community development in end of life care programme
10. Implementation and Action Plan

10.1. Implementation of this strategy will be monitored by the End of Life Care Group which will review and update the related action plan at each meeting. Reports and verbal updates will also be received by the End of Life Care Group.

10.2. This strategy will be available on the Trust Documents Library and circulated via the Policies and Guidelines Bulletin. An abridged form will be available in all public, clinical and ‘back office’ areas and on the Trust’s website.

11. Monitoring Compliance and Effectiveness

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<tbody>
<tr>
<td>Patient experience</td>
<td>End of Life Lead supported by the End of Life Programme Facilitator, the Specialist Palliative Care Team, Learning and Development Department, Complaints and Quality Team, members of the End of Life Care Group</td>
<td></td>
</tr>
<tr>
<td>Quality of care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients preferred place of dying</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff knowledge/confidence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attendance at training/conferences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Better Partnership working</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compliance with NICE standard (2001)</td>
<td></td>
<td>CQC rating is improved</td>
</tr>
<tr>
<td>Patient Experience - complaints, feedback, incidents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of Care - audit of documentation, complaints, feedback, incidents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred place of dying – audit of documentation, incidents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff knowledge and confidence - evaluation of training, audit of documentation, reduction in complaints &amp; incidents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training compliance - training records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partnership working - representation on key committees across the county NICE standard (2011) - audit of documentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CQC rating - review of service</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reporting Arrangements: Quarterly reports on progress will be submitted to the Quality and Safety Committee and an annual report will be submitted to Trust Board.

Acting on recommendations and Lead(s): The End of Life Group will monitor the work plan associated with this strategy and ensure that any deviations from the plan are identified in a timely manner and remedial action taken to ensure the work plan delivers against its objectives.

Change in practice and lessons to be shared: Changes in practice/lessons learned, as a result of the implementation of this strategy, will be communicated to the wider organisation using established Trust wide communication e.g. One and All Daily, via the link nurse forum, in the newsletter and incorporated in training programmes. They will also be described in reports provided to the Quality and Safety Committee and Trust Board.
12. Updating and Review

12.1. This Strategy will be reviewed annually by the End of Life Care Group to ensure that it remains relevant and up to date with local issues and emerging guidance and will be reviewed and formally updated in 2018.

13. Equality and Diversity

13.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website.
## Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>RCHT End of Life Care Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>September 2016</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>September 2016</td>
</tr>
<tr>
<td>Date for Review:</td>
<td>September 2018</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Service: Clinical Support Services and Cancer Division Authors: Jan Walters, End of Life Care Lead</td>
</tr>
<tr>
<td>Contact details:</td>
<td>Via switchboard: 01872 250000</td>
</tr>
</tbody>
</table>

### Brief summary of contents

This is a strategy to support the delivery of high quality end of life care by raising awareness of end of life care in an acute hospital setting, describing how care will be delivered to patients approaching the end of life, describing the education and training that will be provided to staff and the contribution RCHT will make to partnership working.

### Suggested Keywords:

End of Life, Five Priorities of Care, Raising Awareness, Education and Training, Partnership Working

### Target Audience

<table>
<thead>
<tr>
<th>RCHT</th>
<th>PCT</th>
<th>CFT</th>
<th>KCCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Executive Director responsible for Policy:

Nurse Executive

### Date revised:

September 2016

### This document replaces (exact title of previous version):

RCHT End of Life Care Strategy v1.0 (March 2014)

### Approval route (names of committees)/consultation:

RCHT End of Life Care and Executive End of Life Care Lead Clinical Support Services and Cancer Divisional Governance Board

### Divisional Manager confirming approval processes

Karen Jarvill, Associate Director, Clinical Support Services and Cancer Division
### Name and Post Title of additional signatories
Not required

### Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings
{Original Copy Signed}

Name: Karen Jarvill

### Signature of Executive Director giving approval
{Original Copy Signed}

### Publication Location (refer to Policy on Policies – Approvals and Ratification):
Internet & Intranet

- Intranet Only

### Document Library Folder/Sub Folder
Clinical / Palliative Care

### Links to key external standards
- NICE Quality Standard for End of Life Care (2011)
- Once Chance To Get It Right (2014)
- NICE Care of Dying Adults in the Last Days of Life (2015)

### Related Documents:

RCHT Guidelines Discharges and Transfers in the Last Few Weeks of Life (revised July 14)

### Training Need Identified?
Learning and Development Department are informed.

Training and development needs of staff are set out in the strategy (Section 9.5)

### Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 14</td>
<td>V1.0</td>
<td>Initial issue.</td>
<td>Dr Rachel Newman, Chair of RCHT End of Life Care Group</td>
</tr>
<tr>
<td>September 16</td>
<td>V2.0</td>
<td>Revised / updated.</td>
<td>Jan Walters, Interim End of Life Care Lead</td>
</tr>
</tbody>
</table>

All or part of this document can be released under the Freedom of Information Act 2000. This document is to be retained for 10 years from the date of expiry. This document is only valid on the day of printing.

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Appendix 2

Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as policy) (Provide brief description):</th>
<th>RCHT End of Life Care Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate and service area: Relevant organisation wide, produced via Cancer and Support Services Division</td>
<td>Is this a new or existing Policy? Existing</td>
</tr>
<tr>
<td>Name of individual completing assessment: Jan Walters, Interim End of Life Care Lead</td>
<td>Telephone: 01872 253471</td>
</tr>
</tbody>
</table>

1. Policy Aim* Who is the strategy / policy / proposal / service function aimed at? All members of RCHT staff

2. Policy Objectives* To raise awareness of the importance of end of life care within the acute hospital setting To provide information about how care will be delivered to dying people using the five priorities of care set out in One Chance To Get It Right (2014) To describe the education and training that will be provided to staff to enable them to deliver exemplary care to dying people and those identified as important to them To describe the contribution RCHT will make, working with partner agencies, to implement the Co-ordinated End of Life Pathway which is one element or ‘building block’ of Cornwall and the Isles of Scilly Sustainability and Transformation Plan Priority Theme ‘Transforming Care and Support in Communities’

3. Policy – intended Outcomes* To ensure the delivery of exemplary care to patients who are dying, and those identified as important, by raising awareness of end of life care in an acute hospital setting and by supporting staff through training and development to ensure they have the right skills, competencies and attitude.

4. *How will you measure the outcome? Complaints, patient feedback, incidents, audit of documentation, evaluation of training, training records, CQC rating

5. Who is intended to benefit from the policy? Patients approaching the end of life, and those identified as important to them, staff providing end of life care, the Trust and the wider community.

6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy? Yes

   b) If yes, have these *groups been consulted? Yes

   c) Please list any groups who have been consulted about this RCHT End of Life Care Group
7. The Impact
Please complete the following table.

Are there concerns that the policy could have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex (male, female, transgender / gender / gender reassignment)</td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Disability - Learning disability, physical disability, sensory impairment and mental health problems</td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Religion / other beliefs</td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td></td>
<td>√</td>
<td></td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation- this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended. Yes No √

9. If you are not recommending a Full Impact assessment please explain why.

The strategy objectives are based on nationally recognised best practice standards. The End of Life Care Group has been consulted and the strategy discussed at length and the strategy has been ratified by the Clinical Support Services and Cancer Division. There are no members of staff or patients / families who would experience a differential impact by the implementation of this policy.

Signature of policy developer / lead manager / director Date of completion and submission

Names and signatures of members carrying out the Screening Assessment 1. 2.

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead,