

Palliative and End of Life Care Strategy

1 April 2019

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Agenda Item No:11.6

Trust Board Report

Meeting Date:	01 April 2019
Title:	Palliative & End-of-Life Care Strategy
Executive Summary:	<p>The purpose of this document is to set out the Royal Wolverhampton NHS Trust's strategy for palliative & end-of-life care provided by the Royal Wolverhampton NHS Trust. It is informed by the Ambitions for Palliative & End-of-Life Care national framework and other national directives.</p> <p>The strategic objectives for care delivery, based on the Ambitions for Palliative & End-of-Life Care national framework, are:</p> <ol style="list-style-type: none"> 1. Each person is seen as an individual. 2. Each person gets fair access to care. 3. Maximising comfort and wellbeing. 4. Care is coordinated. 5. All staff are prepared to care. 6. Each community is prepared to help. <p>These objectives are driven by the vision to become an organisation where palliative & end-of-life care is everyone's business. Everyone will feel responsible for playing a positive part in delivering and achieving high-quality, personalised care and support for every individual approaching the end of their life and those important to them.</p> <p>A key part of this vision is the partnership working between the Clinical Commissioning Group (CCG) and other providers, both statutory and voluntary.</p> <p>Trust Policy Group approval 01 March 2019. Trust Management Committee approval 22 March 2019.</p>
Action Requested:	Receive and note Approve
For the attention of the Board	<p>In line with the Trust's Visions and Values, there is a desire to continuously improve delivery of palliative and end-of-life care.</p> <p>This strategy is specific to patients, and those identified as important to them, who have a life-threatening illness or are approaching the end of their lives. It also includes care given in bereavement. It is applicable to all Trust employees.</p> <p>It will involve collaborative working with local partner organisations, including the CCG, primary care services, local authority, care homes and hospices.</p>
Assure	N/A
Advise	N/A

Alert	N/A
Author + Contact Details:	Tel 01902 695212 Email clare.marlow@nhs.net
Links to Trust Strategic Objectives	<ol style="list-style-type: none"> 1. Create a culture of compassion, safety and quality 2. Proactively seek opportunities to develop our services 3. To have an effective and well integrated local health and care system that operates efficiently 4. Attract, retain and develop our staff, and improve employee engagement 5. Maintain financial health – Appropriate investment to patient services 6. Be in the top 25% of all key performance indicators
Resource Implications:	Revenue: No (acute); Yes (community) Capital: None Workforce: None Funding Source: At the present time the resources are in place. Actions may result in future business cases to deliver on the National Ambitions.
Report Data Caveats	N/A
CQC Domains	<p>Safe: patients, staff and the public are protected from abuse and avoidable harm.</p> <p>Effective: care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence.</p> <p>Caring: staff involve and treat everyone with compassion, kindness, dignity and respect.</p> <p>Responsive: services are organised so that they meet people's needs.</p> <p>Well-led: the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.</p>
Equality and Diversity Impact	The initial screening of the Strategy did not identify any adverse / negative impact and therefore a full equality analysis was not required.
Risks: BAF/ TRR	N/A
Risk: Appetite	N/A
Public or Private:	Public
Other formal bodies involved:	N/A
References	National Palliative and End of Life Care Partnership. Ambitions for palliative and end of life care: A national framework for local action 2015-20. 2015. http://endoflifecareambitions.org.uk/wpcontent/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: <ul style="list-style-type: none"> • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Document Control – Strategy Template

Strategy Name: ST01 Palliative & End-of-Life Care Strategy (2019-2022)	Version: V1 March 2019	Status: Final	Author: Trust Clinical Lead for End-of-Life Care Director Sponsor: Chief Nurse	
Version / Amendment History	Version	Date	Author	Reason
	V1	March 2019	Clare Marlow	New Strategy
Intended Recipients: Applicable to all Trust staff				
Consultation Group / Role titles and Date: Trust End-of-Life Steering Group – June 2018 Consultation via Trust intranet – December 2018				
Name and date of Trust level committee where reviewed			Trust Policy Group – March 2019	
Name and date of final approval committee			March 2019	
Date of Policy issue			March 2019	
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated)			March 2022 3 yearly (or sooner dependent on revised national guidance)	
Training and Dissemination: The Trust End-of-Life Steering Group will be responsible for communication and facilitation of the strategy.				
To be read in conjunction with: Wolverhampton Integrated End of Life Care Strategy (2016-2020) The Royal Wolverhampton NHS Trust Strategy (2018-2021) The Royal Wolverhampton Mortality Strategy (2018-2019) OP 87 Death Certification & Learning from Deaths Policy (inc OP 89)				
Equality Impact (initial) Assessment (all policies):			Completed Yes	
Full Equality Impact assessment (as required):			Completed NA	
If you require this document in an alternative format e.g., larger print please contact				

Central Governance Department on Ext 5114.	
Contact for Review	Dr Clare Marlow Trust Clinical Lead for End-of-Life Care
Implementation plan / arrangements (Title of Implementation Lead)	Trust Clinical Lead for End-of-Life Care in conjunction with the Trust End-of-Life Steering Group
Monitoring arrangements and Committee	Compliance Oversight Group (COG) and Quality Governance Assurance Committee (QGAC) – 6 monthly Trust Board – 12 monthly
<p>Document summary / key issues covered:</p> <p>The purpose of this document is to set out the Royal Wolverhampton NHS Trust's strategy for palliative & end-of-life care provided by the Royal Wolverhampton NHS Trust. It is informed by the Ambitions for Palliative & End-of-Life Care national framework and other national directives.</p> <p>The strategic objectives for care delivery, based on the Ambitions for Palliative & End-of-Life Care national framework, are:</p> <ol style="list-style-type: none"> 1. Each person is seen as an individual. 2. Each person gets fair access to care. 3. Maximising comfort and wellbeing. 4. Care is coordinated. 5. All staff are prepared to care. 6. Each community is prepared to help. <p>These objectives are driven by the vision to become an organisation where palliative & end-of-life care is everyone's business. Everyone will feel responsible for playing a positive part in delivering and achieving high-quality, personalised care and support for every individual approaching the end of their life and those important to them.</p> <p>A key part of this vision is the partnership working between the Clinical Commissioning Group (CCG) and other providers, both statutory and voluntary.</p>	

VALIDITY STATEMENT

This document is due for review on the latest date shown above. After this date, policy and process documents may become invalid. The electronic copy of this document is the only version that is maintained. Printed copies must not be relied upon to contain the latest updates and amendments.

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Glossary

DoH	Department of Health
ONS	Office for National Statistics
Poppi	Projecting Older People Population Information System
PHE NEoLCIN	Public Health England National End of Life Care Intelligence Network

Widely accepted definitions of end of life, palliative care, specialist level palliative care provision and core level palliative care provision are used within the strategy, as detailed here:

End of Life: 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:

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

(Treatment and care towards the end of life: good practice in decision making. General Medical Council, 2010)

Palliative Care: Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care: provides relief from pain and other distressing symptoms; affirms life and regards dying as a normal process; intends neither to hasten or postpone death; integrates the psychological and spiritual aspects of patient care; offers a support system to help patients live as actively as possible until death; offers a support system to help the family cope during the patient’s illness and in their own bereavement; uses a team approach to address the needs of patients and their families; enhances quality of life and may also positively influence the course of illness; is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, and includes those investigations needed to

better understand and manage clinical complications.

Palliative care can be provided by a range of health and social care staff and may be done alongside treatment intended to reverse particular conditions.

(World Health Organisation)

Specialist Level
Palliative Care
(SLPC) Services:

Specialist level palliative care is required by people with progressive life-limiting illness, with or without comorbidities, where the focus of care is on quality of life and who have unresolved complex needs that cannot be met by the capability of their current care team. These needs may be physical, psychological, social and/or spiritual. Examples include complex symptom, rehabilitation or family situations and ethical dilemmas regarding treatment and other decisions.

Specialist level palliative care is delivered by a multidisciplinary team (MDT) of staff with the requisite qualifications, expertise and experience in offering care for this group of people, to support them to live as well as possible during their illness ensuring their comfort and dignity are maintained as they come to the end of their lives. Input from specialist level palliative care professionals to the care of a person must be based on the needs of the person and not the illness they have.

(NHS England Specialist Level Palliative Care: Information for commissioners. April 2016)

Core level
palliative care
provision:

All professionals and staff in health and social care have a role in the effective provision of palliative and end of life care services across all care settings. The SLPC MDT are expected to proactively support, advise, assist and guide education and training to these staff.

Professionals and staff working in services providing core level palliative and end of life care make an important contribution and may be specialists in other disciplines and services; however unless they are led by a SLPC MDT they cannot be considered to provide a specialist level palliative care service.

(NHS England Specialist Level Palliative Care: Information for commissioners. April 2016)

Palliative & End-of-Life Care Strategy

1.0 Aim / Objectives

This strategy sets out the vision and ambitions for palliative & end-of-life care provided by the Royal Wolverhampton NHS Trust. It is informed by the Ambitions for Palliative & End-of-Life Care national framework and other national directives.

1.1 Vision

An organisation where palliative & end-of-life care is everyone's business. Everyone will feel responsible for playing a positive part in delivering and achieving high-quality, personalised care and support for every individual approaching the end of their life and those important to them.

A key part of this vision is the partnership working between the Clinical Commissioning Group (CCG) and other providers, both statutory and voluntary.

1.2 Objectives

The framework for action developed by the National Palliative and End-of-Life Care Partnership 'Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020' identifies six ambitions for care delivered at a local level:

1. Each person is seen as an individual.
2. Each person gets fair access to care.
3. Maximising comfort and wellbeing.
4. Care is coordinated.
5. All staff are prepared to care.
6. Each community is prepared to help.

The Trust is fully supportive of the six ambitions as a framework to see fulfilment of the overarching vision.

2.0 Scope

2.1 This strategy is specific to patients, and those identified as important to them, who have a life-threatening illness or are approaching the end of their lives. It also includes care given in bereavement. It is applicable to all Trust employees.

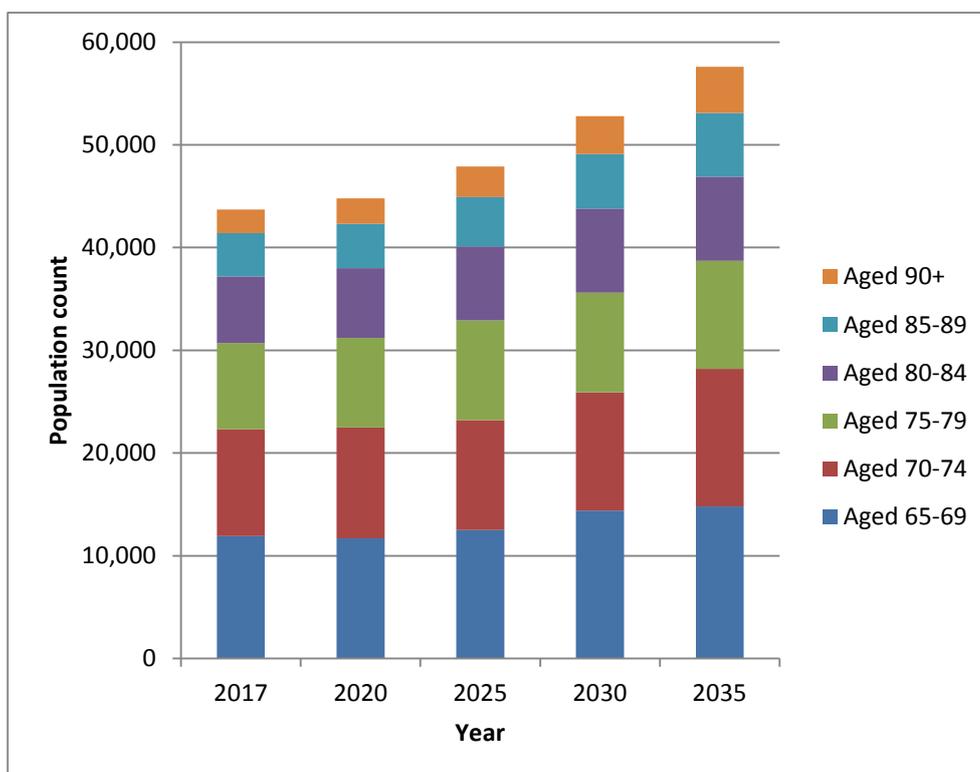
2.2 It will involve collaborative working with local partner organisations, including the CCG, primary care services, local authority, care homes and hospices.

3.0 Strategic Context / Background

3.1 Care for people at the end of their lives is receiving increasing attention.

- 3.2 Each year about 500,000 people in England die and there are many around them who are affected by caring, loss and grief. In 2008 the first national strategy for end-of-life care in England highlighted three key insights: that people didn't die in their place of choice; that we needed to prepare for larger numbers of dying people and that not everybody received high-quality care. Since then a number of reports have followed. More recently the Ambitions for Palliative and End-of-Life Care, a National Framework for local action 2015-2020 is a continuation of this work.
- 3.3 There has been a rapid increase in population ageing. The average life span has almost doubled in the UK over the past 150 years. It has been predicted that there will be 57,600 people age 65 and over living in Wolverhampton by 2035 (figure 1).

Figure 1. Wolverhampton population projection to 2035 for people aged 65+ (Source: ONS/Poppi)



- 3.4 With ageing, inevitably there is physiological decline and a rising prevalence of frailty and multi-morbidities. Now the majority of people die in older age following a period of chronic illness (e.g. organ failure, stroke, cancer and dementia).
- 3.5 People dying of chronic illnesses are very likely to have complex physical, psychological, spiritual and/or social problems that could be improved by a palliative care approach, the specific duration of any one person's end-of-life care varying depending on their circumstances. Consequently, the demand for palliative and end-of-life care is set to substantially increase over the next

20 years, placing further pressure on currently stretched health and care services.

- 3.6 The last few months of life can often involve multiple hospital admissions, extended stays and numerous consultations and referrals. This activity can be very significant in terms of its costs and has been estimated to account for as much as 15-20% of total health costs. Around 30% of adult hospital inpatients at any one time are likely to be in their last year of life. Nearly half of all deaths occur in hospital, although we know that for people approaching the end of life, being cared for and dying in their usual place of residence, surrounded by loved ones, is often the preferred choice.
- 3.7 According to Public Health England End of Life Care Profile data, in 2016 52.5% (1349) of all deaths in Wolverhampton were in hospital. This is higher than both the West Midlands (49.3%) and England (46.9%) average. Correspondingly there were fewer home, care home and hospice deaths (figure 2).

Figure 2. End of Life Care Profile for Wolverhampton, with comparative data from the West Midlands and England (Source: PHE NEoLCIN, 2016)

Compared with benchmark ● Better ● Similar ● Worse ● Lower ● Similar ● Higher ○ Not Compared



Indicator	Period	Wolves		Region England		England			
		Count	Value	Value	Value	Worst/Lowest	Range	Best/Highest	
Hospital deaths (%), Persons, Aged 0 - 64 years.	2016	267	56.3%	48.4%	45.6%	32.1%		60.3%	
Hospital deaths (%), Persons, Aged 65 - 74 years.	2016	228	54.0%	50.6%	49.2%	35.2%		64.5%	
Hospital deaths (%), Persons, Aged 75 - 84 years.	2016	382	53.9%	53.1%	50.5%	40.6%		67.4%	
Hospital deaths (%), Persons, Aged 85 years and over.	2016	472	48.9%	46.3%	43.8%	29.8%		66.3%	
Hospital deaths (%), Persons, All Ages.	2016	1,349	52.5%	49.3%	46.9%	38.3%		63.1%	
Care home deaths (%), Persons, Aged 0 - 64 years.	2016	18	3.8%	2.5%	2.9%	0.7%		13.0%	
Care home deaths (%), Persons, Aged 65 - 74 years.	2016	33	7.8%	7.9%	8.6%	2.6%		19.2%	
Care home deaths (%), Persons, Aged 75 - 84 years.	2016	110	15.5%	17.2%	18.7%	4.1%		27.8%	
Care home deaths (%), Persons, Aged 85 years and over.	2016	309	32.0%	34.7%	36.7%	11.2%		50.9%	
Care home deaths (%), Persons, All Ages.	2016	470	18.3%	20.1%	21.8%	5.2%		32.8%	
Home deaths (%), Persons, Aged 0 - 64 years.	2016	142	30.0%	32.4%	33.9%	21.8%		44.7%	
Home deaths (%), Persons, Aged 65 - 74 years.	2016	113	26.8%	29.4%	30.3%	19.7%		39.7%	
Home deaths (%), Persons, Aged 75 - 84 years.	2016	167	23.6%	23.0%	23.8%	17.4%		30.7%	
Home deaths (%), Persons, Aged 85 years and over.	2016	155	16.1%	15.9%	16.4%	10.0%		28.4%	
Home deaths (%), Persons, All Ages.	2016	577	22.5%	22.8%	23.5%	17.1%		29.7%	
Deaths in Other Places (%), Persons, Aged 0 - 64 years.	2016	27	5.7%	6.7%	7.2%	2.6%		13.9%	
Deaths in Other Places (%), Persons Aged 65 - 74 years.	2016	6	1.4%	1.8%	2.0%	0.6%		9.7%	
Deaths in Other Places (%), Persons, Aged 75 - 84 years	2016	11	1.55%	1.17%	1.36%	0.44%		4.94%	
Deaths in Other Places (%), Persons, Aged 85 years and over.	2016	5	0.52%	0.79%	1.01%	0.25%		6.52%	
Deaths in Other Places (%), Persons, All Ages.	2016	49	1.91%	1.98%	2.20%	1.11%		6.66%	
Hospice deaths (%), Persons, Aged 0 - 64 years.	2016	20	4.2%	10.1%	10.4%	0.9%		18.5%	
Hospice deaths (%), Persons, Aged 65 - 74 years.	2016	42	10.0%	10.2%	10.0%	1.1%		31.9%	
Hospice deaths (%), Persons, Aged 75 - 84 years.	2016	39	5.5%	5.5%	5.6%	0.8%		18.1%	
Hospice deaths (%), Persons, Aged 85 years and over.	2016	24	2.49%	2.23%	2.08%	0.35%		8.38%	
Hospice deaths (%), Persons, All Ages.	2016	125	4.9%	5.8%	5.7%	0.2%		14.3%	

3.8 The Trust received a 'good' rating for end-of-life care following the Care Quality Commission (CQC) inspections in 2015 and 2018. Positive findings in the report included the implementation of the SWAN service as an integrated approach to end of life and bereavement care, with use of the SWAN logo to trigger a compassionate response from any staff member, promoting and encouraging personalised care; the Rapid Home to Die Care Bundle documentation to facilitate a rapid discharge of a dying person and the responsive and easily accessible hospital specialist level palliative care team.

3.9 Since 2016, the Trust has been implementing the Gold Standards Framework Acute Hospitals (GSFAH) programme, with the aim of training and supporting staff delivering core level palliative care to provide high quality end-of-life care in a structured approach, including:

- Identifying patients thought to be in the last year of life.

- Initiating advance care planning discussions and planning ongoing care accordingly.
 - Increasing confidence in delivering care at the end of life, linking with and supporting ongoing education in relation to other end-of-life initiatives already in place, e.g. SWAN end-of-life and bereavement service, rapid discharge home care bundle, development of electronic palliative care co-ordination system (EPaCCS).
- 3.10 The overall Summary Hospital-level Mortality Indicator (SHMI) for the Trust has been rising for nearly four years due to a combination of a wide range of factors. An interim report to the Trust Board (January 2019), assessing the clinical and governance aspects of mortality in response to the rising SHMI, noted that changes have been made to the mortality review process. The potential for clinical reviews on mortality to feed into overall quality improvement was highlighted. Clear links are being established between the Trust's mortality and end-of-life care oversight groups to ensure findings from these reviews are considered in relation to ongoing quality improvement in palliative and end-of-life care. This includes cross representation at the Trusts End of Life and Mortality Review Groups.
- 3.11 In line with the Trust's Visions and Values, there is a desire to continuously improve delivery of palliative and end-of-life care.
- 3.12 The Trust is committed to ensuring that the six ambitions (figure 3) become a reality, through strong leadership, commitment and empowerment.

Figure 3. Ambitions and local priorities

National Ambition	Local Priorities
<p>1. Each person is seen as an individual.</p> <p><i>“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.</i></p>	<ul style="list-style-type: none"> • Early, proactive identification of those with chronic illnesses and potential palliative care need. • Enable and offer opportunities for honest, sensitive and well-informed conversations about dying, death and bereavement. • Embedding advance care planning tools to help identify a person’s wishes and priorities.
<p>2. Each person gets fair access to care.</p> <p><i>“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”</i></p>	<ul style="list-style-type: none"> • Equitable access to ensure the right care at the right time, regardless of diagnosis or setting, using data to understand and remedy any partial reach of services. • Consider specific needs, e.g. children & young adults, mental health, learning disabilities, autism, dementia. • Greater integrated working between specialist level palliative care and other specialties in relation to non-malignant long term conditions (e.g. building on links already established with respiratory, renal, cardiology).
<p>3. Maximising comfort and wellbeing.</p> <p><i>“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”</i></p>	<ul style="list-style-type: none"> • 24/7 access to specialist level palliative care advice. • 7-day face-to-face specialist level palliative care service assessing care needs in any setting. • Appropriate access to allied health care professionals and equipment / resources. • Carer support: giving care and support to families, friends, carers and all those who are important to the person. • Personalised end-of-life care, including SWAN (last days of life) delivering care that matches the person’s preferences

		and needs as closely as possible.
4.	<p>Care is coordinated.</p> <p><i>“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”</i></p>	<ul style="list-style-type: none"> • Cross-boundary care, continuing to work in partnership with all stakeholders to ensure the delivery of high quality end-of-life care, ensuring clear channels of communication to facilitate a seamless transition of care. • Implementation of a locality-wide electronic palliative care co-ordination system (EPaCCS), working with partners to determine the most appropriate electronic communication system.
5.	<p>All staff are prepared to care.</p> <p><i>“Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care”</i></p>	<ul style="list-style-type: none"> • End-of-life care considered as everybody’s business. • The majority of end-of-life care is provided by core level staff and it is therefore important to ensure a framework for appropriate education and training so that all staff have the appropriate knowledge, skills, competences, attitudes and behaviours. • Strong clinical leadership; clear support at Board level for high-quality palliative and end-of-life care.
6.	<p>Each community is prepared to help.</p> <p><i>“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”</i></p>	<ul style="list-style-type: none"> • Access to pre-bereavement and bereavement support, including children and young people and those affected by sudden or traumatic death. • Compassionate communities: support for people and communities who can provide practical help and compassion. • Improve public awareness about the difficulties people face when nearing the end of life and create a better understanding of the help that is available.

3.12 To demonstrate the delivery of high quality end-of-life care, taking into consideration the local priorities (figure 3), the identified indicators of success are:

- Increase in earlier identification of patients who will benefit from end-of-life care.
- Increased engagement with advance care planning and achievement of documented wishes and preferences.
- Improvement in identification of a person's preferred place of care when dying.
- Increase in the percentage of people dying in their preferred setting.
- Increase in number of individuals identified as being in the last days of life with implementation of SWAN resources to support individualised care.
- Reduced unnecessary hospital admissions.
- Increased positive feedback from bereaved relatives and those identified as important to the patient.
- Reduction in end-of-life care related complaints.
- Development and implementation of a framework for education and training to ensure an appropriately skilled workforce, with confirmation that all relevant health care professionals have undertaken training in end-of-life care where it is role specific.

The above data are not routinely recorded and reported and therefore a key outcome for the strategy will be the development of robust mechanisms for data collection related to end-of-life care activity. These will need to be implemented before realistic quantitative goals can be determined and agreed (see [Appendix 1](#)).

4.0 Staff Requirements

Delivering palliative and end-of-life care is a core part of the roles and responsibilities of nursing, medical and allied health professionals (DoH 2008).

It is therefore imperative that all these staff groups access palliative and end-of-life care training that builds their knowledge and skills around this highly sensitive area of care delivery.

5.0 Roles and responsibilities

The Chief Nurse is the Executive Lead for end-of-life care and will maintain oversight of end-of-life care issues within the organisation, oversee the implementation of the Palliative & End-of-Life Care Strategy and ensure clinical staff are aware of their responsibilities and the requirement to conform to the strategy

The Medical Director has responsibility for the learning from deaths agenda, participates in the Mortality Review Group (MRG), oversees the implementation of the Mortality Strategy and Policy, and ensures clinical staff are aware of their responsibilities and the requirement to conform to the strategy and policy.

The Trust Specialist Palliative Care Team is a multidisciplinary team, responsible for providing specialist level palliative care to patients cared for within the Trust. They work collaboratively within the acute hospital setting, working with, and supporting other health professionals in delivering high quality palliative care. The team is responsible for providing professional guidance around palliative and end-of-life care issues to staff delivering core level palliative care across the Trust.

Specialist level palliative care services for patients in the community setting are provided by the local hospices.

Managers, matrons, and clinical directors will be responsible for ensuring the communication of the strategy within their directorates.

All staff working within the Trust are responsible for providing high quality palliative and end-of-life care.

6.0 Structure and Approach

In order to achieve the commitments set out in this strategy an outline action plan has been developed ([Appendix 1](#); Strategy Action Plan).

A detailed implementation plan will subsequently be produced, through consultation across the Royal Wolverhampton NHS Trust and with partners, overseen by the Trust End-of-Life Steering Group ([Appendix 2](#); Trust End-of-Life Steering Group terms of reference).

7.0 Communication of Strategy

The Trust End-of-Life Steering Group will be integral to successful communication and facilitation of the strategy. Trust employees at all levels must be aware of the strategy and their associated individual and team responsibilities.

The strategy will be launched and promoted internally via local governance networks and the normal communication channels through the communications team. It will be available on the Trust intranet for staff to access. A special launch day will be an opportunity to showcase our strategic ambitions.

8.0 Evaluation and Review

Implementation of the strategy will be overseen and monitored by the Trust End-of-Life Steering Group.

The timescales for this work are outlined in the action plan ([Appendix 1](#)). A detailed implementation plan will be developed through consultation across the Royal Wolverhampton NHS Trust and with partners to ensure it meets the needs of patients, those identified as important to patients and staff.

The strategy will be reviewed on a regular basis to ensure that it remains true to the vision and objectives. It will be updated with any changes in National policy or local circumstances.

9.0 Equality statement

This document complies with the Royal Wolverhampton Trust's Equality & Diversity statement.

The initial screening of this Strategy did not identify any adverse / negative impact and therefore a full equality analysis was not required.

10.0 Resource assessment

1	Does the implementation of this policy require any additional Capital resources	No
2	Does the implementation of this policy require additional revenue resources	No (acute) Yes (community)
3	Does the implementation of this policy require additional manpower	No
4	Does the implementation of this policy release any manpower costs through a change in practice	Yes (reduced bed days)
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff.	No
	Other comments At the present time the resources are in place. Actions may result in future business cases to deliver on the National Ambitions.	

11.0 References

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12.0 Appendices

[Appendix 1. Strategy Action plan](#)

[Appendix 2. Trust End-of-Life Steering Group Terms of Reference](#)

Appendix 1. Strategy Action Plan

Action	Ambition(s)	How will we measure success?	Lead	Timescale
<p>Systematically utilise data, in conjunction with clinical experience, to aid proactive identification of those people who may be approaching the end of life.</p> <p>A 'system driven end-of-life care model' to be developed in conjunction with RWT Clinical Informatics Operational Group.</p>	1	<p>Number and percentage of people identified as likely to be in the last year of life (in line with local mortality rate).</p> <p>Percentage of dying persons who had been identified as likely to be in the last year of life.</p>	Trust Clinical Lead for End-of-Life Care	February 2021
<p>Ensure personalised care planning for the care of dying adults (last days and hours of life) in line with Five Priorities for Care and NICE guidance 'Care of dying adults in the last days of life'.</p> <p>SWAN individual plan of care for dying adults and associated resources to be consistently used across all settings.</p>	1,3	<p>Percentage of dying persons who had SWAN individual plan of care documentation completed.</p> <p>National Audit of Care at the End of Life (NACEL) findings.</p>	Chair of Trust End-of-Life Steering Group	February 2020
<p>Ensure identification of a person's wishes and preferences regarding their end-of-life care.</p> <p>Locality wide advance care planning documentation ('My care' and 'Me')</p>	1	<p>Percentage of people identified as likely to be in the last year of life who have had initial advance care planning discussions.</p> <p>Percentage of people identified as likely to be in the last year of life who have completed</p>	Chair of Trust End-of-Life Steering Group	February 2021

documents) to be used across all settings.		advance care planning documentation.		
Improve access to bereavement and pre-bereavement services, including children and young people and those affected by sudden or traumatic death.	1,6	Scoping of current provision and determining actions to address gaps.	Trust Bereavement nurse	February 2022
Develop robust mechanisms for accurately capturing and reporting patients receiving end-of-life care at any point in time. Utilise date to facilitate seamless information transfer as patients' transition between care environments.	2,4	The reach of palliative and end-of-life care services (across different diseases, social and ethnic groups and considering specific needs, e.g. children and young adults, mental health, learning disabilities, autism and dementia) routinely monitored and reviewed. Implementation of a locality-wide electronic palliative care co-ordination system (EPaCCS) working in conjunction with partners via the Wolverhampton Integrated Care Alliance end-of-life subgroup. Percentage of dying persons who had an EPaCCS completed. Percentage of dying persons who had preferred place of death recorded and percentage dying in their preferred setting.	Trust Clinical Lead for End-of-Life Care	February 2021
Greater integrated working between specialist level palliative care and other specialties, including a 7-day specialist level palliative care face-to-face service within the acute hospital setting.	2,3	Increase the acute hospital specialist level palliative care team staffing (business case approved November 2018). Percentage of people identified as likely to be in the last year of life who have been seen by the acute hospital specialist level palliative care	Trust Clinical Lead for End-of-Life Care	February 2020 (increased staffing) February

		team (or integrated supportive care team) during inpatient admission.		2021 (7-day service)
Clear education framework in place for developing a skilled and competent workforce in the assessment and management of people approaching the end of life.	3,4,5	<p>Training needs analysis conducted, with comprehensive education programme to address every level of expertise.</p> <p>Collaboration with other palliative care providers to develop education across all settings, promoting shared learning initiatives across boundaries.</p> <p>Feedback from bereaved relatives and those important to them routinely sought, with clear mechanisms for ongoing learning in relation to any actions required.</p> <p>End-of-life care related complaints monitored, with clear mechanisms for ongoing learning in relation to any actions required.</p>	<p>Head of Education</p> <p>and</p> <p>Head of Patient Experience</p> <p>and</p> <p>Trust Bereavement nurse</p>	February 2020
Support the promotion of the public discussion around death, dying and bereavement. Improve public awareness about the difficulties people face when nearing the end of life and create a better understanding of the help that is available, taking particular account of the diverse community within the locality of Wolverhampton and the surrounding areas.	1,6	<p>Established links with Compton Care Compassionate Communities and other organisations supporting public awareness via the Wolverhampton Integrated Care Alliance end-of-life subgroup.</p> <p>Central information point where people can easily access clear information about local palliative and end-of-life care services, including details about the level of service that they should expect and what they are entitled to.</p>	<p>Head of Communications in conjunction with Trust End-of-Life Steering Group</p>	<p>February 2020</p> <p>February 2021</p>



The Royal Wolverhampton
NHS Trust

Appendix 2. Trust End-of-Life Steering Group Terms of Reference

(hyperlink to be added)