Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	11
Date of Meeting:	26 September 2018		

Title of Report:	End of Life Care Annual Report 2017/18
Status:	For action/discussion
Board Sponsor:	Lisa Cheek, Acting Director of Nursing and Midwifery
Author:	Helen Meehan, Lead Nurse, Palliative Care and End of Life
Appendices	

1. Executive Summary of the Report

There continues to be a significant focus to support the delivery of high quality, timely, effective, individualised services for patients with end of life care needs, support for their families and support for staff to provide these services. This quality improvement work continues, to support staff in providing compassionate, holistic, patient centred care.

Caring for people nearing the end of life is one of the most important things we do in hospital. In 2017/18, the RUH supported 1435 patients that died. This figure includes all deaths. This report gives an overview of the end of life care working group, the work plan for 2017/18 and how this has supported local and national priorities for palliative and end of life care over the last year:

- Palliative and End of Life Care Working Group
- Care Quality Commission
- Specialist palliative care team
    - Aims
    - Operational policy
    - Clinical activity
    - Business case to support 7/7 working
    - The Health Foundation grant application
    - Lead nurse for palliative and end of life care
- Palliative and End of Life Care Work plan
    - Personalised care planning
    - Shared records
    - Evidence and information
    - Involving, supporting and caring for those important to the dying person
    - Education and training
    - 24/7 access
    - Co-design
- Quality improvement initiatives:
    - The Conversation Project
    - Discharge planning
    - Priorities for Care
    - Ambassador Badge
- NICE Guideline NG31
- National care of the dying audit for hospitals

- Care after death
    - Bereavement feedback
    - Bereavement information
    - Time of reflection service
- Support and education for staff
    - Ambassadors collaborative for end of life care
    - eLearning module
    - Essential training
- Information for the public and staff
- Partnership working with Dorothy House Hospice Care
    - Medical support
    - Enhanced Discharge Service
    - Heart Failure Working Group
    - Developing a Compassionate Companion Service
    - Developing a Partnership Live Well Coordinator role
- Future developments

2.	Recommendations (Note, Approve, Discuss)
The board is asked to note the content.	

3.	Legal / Regulatory Implications
Nil	

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
Nil	

5.	Resources Implications (Financial / staffing)
Nil	

6.	Equality and Diversity
NA	

7.	References to previous reports
NA	

8.	Freedom of Information
Public	

Royal United Hospitals Bath
NHS Foundation Trust

Palliative and End of Life Care Annual Report

April 2017 – March 2018

Chairman, Brian Stables
Chief Executive, James Scott

Contents

1. Executive Summary

1.1 This annual report gives an overview of palliative and end of life care quality improvement work at the RUH that supported the local and national priorities, over the last year.

1.2 The palliative and end of life care working group has continued to meet quarterly and oversee an annual work plan for end of life care. The group welcomed a non-executive director to the membership.

1.3 A baseline assessment has been completed in preparation for Care Quality Commission inspection in the future.

1.4 The specialist palliative care team had a total of 945 referrals in the reported year – an increase of 17.5% referrals in 2016/17 and a 45% increase since 2014/15. The team continues to provide direct clinical support to patients with complex needs, provide training in end of life and lead on quality improvement.

1.5 The palliative and end of life care work plan for 2017/18 aligns to the national Ambitions for Palliative and End of Life Care (2015) and progress has been made on all 7 workstreams.

1.6 Quality improvement initiatives continue and have included the Conversation Project, discharge planning and Priorities for Care for the dying patient.

1.7 The RUH policy for care of the dying patient and care of the deceased patient aligns to NICE Guidance NG31 and NICE Quality Standard QS144.

1.8 A ‘See it My Way’ event was held in May for bereaved families to share their experiences and a ‘Service of Reflection’ has been held for bereaved families.

1.9 All wards have an ambassador for end of life care. The elearning module to support access to ongoing learning in end of life care and end of life care has been reviewed. Compliance with ‘essential’ training for end of life care is monitored.

1.10 Intranet and internet resources and information leaflets to support end of life care have been reviewed and are being updated.

1.11 Partnership working with Dorothy House Hospice Care continues with the Enhanced Discharge Service, Heart Failure Project Group, Macmillan Dorothy House and RUH Live Well Coordinator.

1.12 Partnership working with Forever Friends Appeal and Dorothy House Hospice Care has enabled a Case for Support for funding to be developed to support a Compassionate Companions Service for patients nearing the end of life in hospital.

1.13 Future developments include embedding of the new Conversation Project CHAT Bundle, Priorities for Care Bundle, implementing 7 day working for the specialist palliative care team and implementing the Compassionate Companion Service.

2. Introduction

There continues to be a significant focus to support the delivery of high quality, timely, effective, individualised services for patients with palliative and end of life care needs, support for their families and support for staff to provide these services. This quality improvement work continues, to support staff in providing compassionate, holistic, patient centred care.

Caring for people nearing the end of life is one of the most important things we do in hospital. In 2017/18, the RUH supported 1435 patients that died. This figure includes all deaths. This report gives an overview of the palliative and end of life care working group, the work plan for 2017/18 and how this has supported local and national priorities.

3. Palliative and End of Life Care Working Group

The RUH has a palliative and end of life care working group which has met quarterly. The objectives of the working group included agreeing an annual work plan for end of life care for 2017/18 with workstreams aligned to the national framework Ambitions for Palliative and End of Life Care (2015):

- Personalised care planning
- Shared records
- Evidence and information
- Involving, supporting and caring for those important to the dying person
- Education and training
- 24/7 access
- Co-design

The purpose of the palliative and end of life care working group is to:

- To promote a compassionate approach to palliative and end of life care, that ensures respect for, and dignity of the patient and their family/ carers, through the delivery of high quality, timely, effective individualised care
- To direct and monitor the implementation of national and local policy with regard to palliative and end of life care within the RUH Trust
- To ensure the RUH Trust complies with CQC regulation in relation to end of life care in relation to the 5 domains: safe, effective, caring, responsive and well-led
- To ensure that end of life care is incorporated into the daily work of the RUH and that all employees acknowledge its importance as a part of their work
- To identify opportunities to develop and work in innovative and collaborative ways to support ongoing quality improvement in palliative and end of life care

- To identify opportunities to work collaboratively with our community partners to support coordination of care across organisational boundaries.

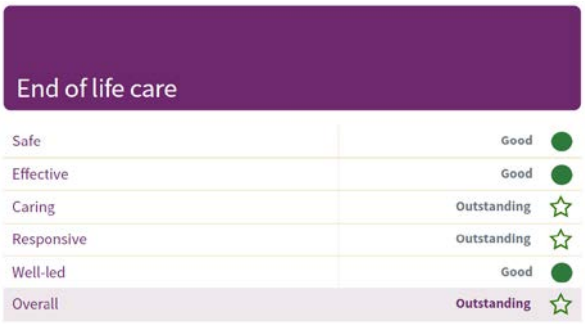
The working group has membership from medical, nursing, therapy, chaplaincy, bereavement office, specialist palliative care (SPC), discharge liaison and patient experience. There is nursing and medical representation from the hospice, community providers and commissioning, and also a lay member to represent the patient and the family view.

The working group is chaired by the Director of Nursing and Midwifery and welcomed this year a non-executive director to the membership. See appendix 1 – Terms of Reference.

The palliative and end of life care working group is accountable to the Trust Management Board and reports annually to this board, Quality Board and Governance Board.

4. Care Quality Commission (CQC)

As part of the CQC inspection in March 2016, end of life care was reviewed as a core service. The overall rating for end of life care following the inspection was 'outstanding.' The breakdown for each domain is shown below:



The learning from the CQC inspection and recommendations were built into the palliative and end of life care work plan for 2017/18. The specialist palliative care team continued to support quality improvement in palliative and end of life care across the organisation to support staff with maintaining high standards in patient centred, compassionate care for patients and their families.

In October 2017 a baseline assessment was completed using the CQC Key Lines of Inquiry framework and reviewed again in March 2018. The baseline assessment was reported to the palliative and end of life care working group. The lead nurse palliative and end of life care will take forward actions from the baseline assessment for 2018/19.

5. Specialist Palliative Care Team (SPC)

5.1 Aims of SPC team

The aim of the SPC team is to promote the best achievable quality of life for adult patients and their families facing cancer and other life-threatening illness that are not responsive to curative treatment. This may be offered at any point in the palliative care trajectory from maximising potential for rehabilitation to supporting in the dying process.

The SPC team reviews and supports patients with complex palliative care needs and provides advisory support to clinical teams for patients with palliative and end of life care needs.

The SPC aims to achieve a high standard of care through:

- Providing effective and responsive support to patients and families.
- Offering advice, support and information for healthcare professionals
- Ensuring patients experience care that is coordinated and integrated across all settings, with robust handover arrangements and communication.
- Ensuring patients are involved as much as they wish to be in making decisions about their care, with inclusion of their family, carers and those important to them if they want this.
- Providing training and opportunities for ongoing learning in palliative and end of life care for healthcare professionals
- Supporting ongoing quality improvement in end of life care, to support evidence based practice and ongoing evaluation of patient outcomes
- Directing the RUH in strategic development of end of life care
- Referring to national guidelines, policies and strategies to develop and improve services offered, including: Ambitions for Palliative and End of Life Care (2015), NICE Guideline for the Care of the Dying Adult in the Last Days of Life (2015), NICE Quality Standard End of Life Care for Adults (2011), One Chance to Get it Right (2014).

5.2. Operational policy and SPC team members

In 2017/18 the SPC continued to operate Monday to Friday 08.30-16.30. Out of Hours clinical advice was provided through the Dorothy House Hospice 24/7 advice line. The RUH SPC team members include:

- Lead nurse palliative care and end of life (1wte)
- Consultant in palliative medicine/ associate specialist sessions (5PAs) provided by Dorothy House Hospice, on an Honorary Contract
- Specialist palliative care nurses (3wte), plus an additional 0.4wte in 2017/18 with a grant from The Health Foundation
- Specialist palliative Occupational Therapist (0.4wte)
- Admin (0.69wte)

The SPC has an operational policy for 2017/18. The service supported a SPC multi-disciplinary team (MDT) meeting weekly and a pain MDT with the chronic pain service twice a month.

The SPC team has supported the RUH palliative and end of life care work plan. Unlike many other Trusts the RUH does not have an end of life care facilitator separate to the SPC, supporting quality improvement and training. End of life care quality improvement is integral to the role of the SPC team and as such the team operates as an integrated SPC and end of life care service.

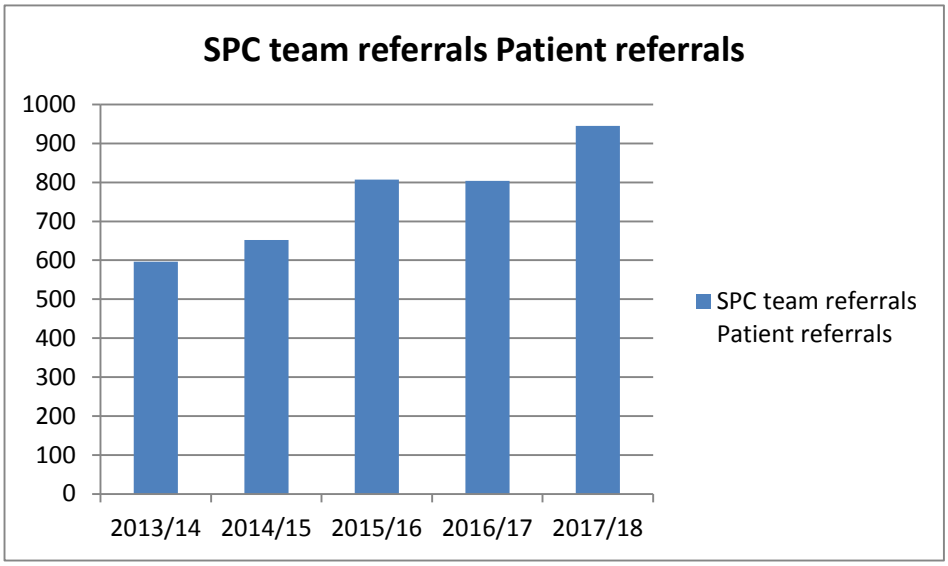
5.3. Clinical activity

The SPC team had 945 patient referrals in the reported year. This represented a 17.5% increase on total referrals in 2016/17 and a 45% increase in referrals since 2014/15.

Of the 945 patients with complex needs supported in the last year, 36% died during their admission and 64% were supported with discharge to preferred place of care.

As well as increasing referrals, there has been an increase in complexity of patient need and an increase in support for patients with a non-malignant condition. In the last year 28% of patients referred to SPC team had a non-malignant palliative diagnosis, this compares to 13% in 2013/14.

Graph 5.1 - to show increasing referrals to SPC over last 5 years



5.4 Business case to support 7/7 working

The business case to support SPC team 7/7 working was updated in 2017/18 to focus on increasing clinical nurse specialist capacity within the team to provide a robust 7 day service. This would enable:

- Timely SPC patient reviews for symptom management

- Timely access to advice and support for staff working weekends and bank holidays
- Expected reduced length of stay
- Improved flow and timely discharge to preferred place of care for patients with complex needs.

The revised business case was taken to trust investment groups and was included within submissions for MRET funding, but was not successful.

A Macmillan Cancer Support Partnership Application in February 2018 was made to seek funding for a 7/7 working pilot over 2 years to evidence the benefits of having a 7/7 SPC service. This application was successful. The grant will support an increase in clinical nurse specialist capacity in the team to enable a robust 7 day service.

The additional posts will be recruited in summer 2018.

5.5. The Health Foundation Grant

The SPC team was successful in a grant application to The Health Foundation in 2016/17 for £29,000. This grant is supporting extension of the Conversation Project and development of resources to support sustainability form April 2017 – September 2018.

The grant has funded an additional 0.4wte CNS band 7 hours within the SPC team (see section 8.1)

5.6. Lead nurse palliative and end of life care

The lead nurse palliative and end of life care manages the SPC team and is strategic lead on end of life care for the Trust.

The lead nurse leads on the palliative and end of life care work plan for the RUH and reports on progress quarterly to the RUH palliative and end of life care working group.

6. Palliative and End of Life Care Work Plan

In 2017/18 the work plan aligned to the ‘foundations’ as set out in the national framework Ambitions for Palliative and End of Life Care (2015).
The tables below give an overview from the palliative and end of life care work plan work streams:

Work Stream 1 - Personalised care planning	
Key achievements	Embedding the principles of The Conversation Project on the wards to support early identification of patients with 'prognosis uncertain' and 'end of life care needs' to support advance care planning (ACP).

	Development and launch of the Conversation Project CHAT Bundle, the new logo and 'Planning Ahead' information resources. Continued use of Priorities for Care documentation to support holistic assessment and patient centred care in the last days of life. Review of documentation and development of v3. Development and launch of the Priorities for Care Bundle and the new butterfly logo to represent compassionate care at the end of life. Development and launch of the new Badge for the Conversation Project and End of Life Care to recognise ambassadors for promoting best practice within their clinical teams. Review of Just in Case medication guidance for discharge planning and approval at BCAP of the new Just in Case Medication Prescription for discharge.
Areas to be progressed	Embedding the new resources and CHAT Bundle to support the Conversation Project on all wards. Embedding the new resources and care bundle to support the Priorities for Care on all wards.

Work Stream 2 - Shared records	
Key achievements	Engaged with Clinical Commissioning Groups (CCGs) to support information sharing in end of life care. Reviewed access to shared records to inform and support coordination of patient care across settings – access to SystmOne View. Development of Conversation Project Advance Care Planning (ACP) template on Millennium to record outcome of ACP discussions. Implemented electronic referrals through Millennium for SPC team to support development of a SPC service dataset and monitoring of patient outcomes.
Areas to be progressed	Continue to engage with CCGs and local stakeholders to work towards an integrated approach to support information sharing in relation to Treatment Escalation Plans and/or adoption of national ReSPECT form. Support use of Millennium ACP clinical template for the Conversation Project to support recording of ACP discussions and patient wishes in end of life care.

Work Stream 3 - Evidence and information	
Key achievements	Completed the Priorities for Care Audit to monitor patient outcomes for care in the last days of life. Completed the McKinley T34 Syringe Driver audit to review symptom management and policy standards for syringe driver use in palliative care. Developed an End of Life Care (EOLC) dashboard to monitor patient outcomes in EOLC across the trust from April 2017. The dashboard uses data from the Z51.5 and Z51.8 clinical codes, which include patients supported by the specialist palliative care team and patients requiring care at the end of life (expected death/patient supported on Priorities for Care). The report includes for each quarter: • Number of patient admissions • Number of patients with a cancer or non-cancer diagnosis • Number of patient deaths • Number of patient discharges • Number of patient readmissions within 30 days • Number of admissions, deaths and discharges by day of the week • Number of admissions, deaths and discharges by ward • Length of stay Commenced new process for seeking feedback from bereavement families. New bereavement feedback questionnaire implemented September 2017. Planning for quarterly reporting on bereavement feedback to the palliative and EOLC working group.
Areas to be progressed	Disseminate findings and ensure learning informs ongoing quality improvement. Finalise information to be included in the EOLC dashboard to support monitoring of patient outcomes in end of life care and review at each palliative and end of life care working group meeting. Develop quarterly reporting process for the bereavement feedback questionnaire returns and ensure this informs ongoing learning and quality improvement.

Work Stream 4 - Involving, supporting and caring for those important to the dying person	
Key achievements	'Making a difference' group led on planning for national 'Dying Matters Week,' the RUH 'Time of Reflection Service' and resources for patients and families. Reviewed access to facilities for families/carers of patients in the last days/hours of life. This included Patient and Carer Experience Group review of ward quiet rooms in September 2017. Successful funding proposal to Forever Friends Appeal in December 2017 for new sleeper chairs and zbeds for the wards to support families staying overnight.

	Reviewed and updated Comfort Boxes on all wards to support families staying overnight. Developed 'Wedding Boxes' with Forever Friends Appeal to wards with enabling a marriage under special license in hospital for patients in the last days of life. The RUH and the Forever Friends Charity held a 'Time of Reflection' service on 30th September at St Phillip and St James church in Bath. The service was well received by the bereaved families that attended. Reviewed information resources for care after death and bereavement. 'See it My Way' event for bereaved families to share their experiences of end of life care held in May 2017. Short film from the event now used in training.
Areas to be progressed	To take forward recommendations from the review of the ward quiet rooms. Planning to hold a 'Time of Reflection Service' each season in the new Spiritual Care Centre form 2018.

Work stream 5 – Education and training	
Key achievements	Using learning from the Priorities for Care audit, 'See it My Way' and Bereavement Feedback to inform training sessions, learning resources and service improvement in 2016/17. Started the review of the RUH eLearning module for end of life care. Essential training for end of life care, as 'once only' training for identified staff groups compliance 84% at 31/03/18. SPC team continued to lead on training programme for end of life care (see appendix 2). End of life care session on induction training updated to include core topics for end of life care 'essential training.' End of life care included as an annual session on Grand Round for medical division. Promoting best practice and raising awareness in end of life care: • Ambassador for end of life care study day 18/07/17 and 23/01/18 • National Dying Matters Week – specialist palliative care team visit to all wards with resources and information • Presentations given at regional and national workshops and conferences • Poster presentations at regional and national workshops and conferences • Presentation and information at trust 'Caring for You' evening 14/11/17

Areas to be progressed	To continue to use patient experience, carer experience and stories to support on-going learning in end of life care. To complete the review of the RUH eLearning module.

Work Stream 6 – 24/7 access	
Key achievements	Worked in partnership with Dorothy House Hospice Care, community providers and CCGs to define and support access to 24/7 advice line and support for patients and their families. Reviewed and updated palliative and end of life care information on the intranet and internet to support 24/7 access to information and advice. Business case developed for 7/7 working, but not approved for MRET funding. Macmillan Cancer Support Partnership Application for funding to pilot 7 day working for 2 years approved.
Areas to be progressed	Progress the palliative care team 7/7 working through the Macmillan Cancer Support Partnership Application. Commence 7/7 working in October 2018. Bring together information on the 'palliative' and 'end of life care' intranet pages to form a single access to information for staff on palliative and end of life care.

Work Stream 7 – Co-design	
Key achievements	Palliative and End of Life Care Working Group monitored progress on the work plan quarterly. Representation at the community/CCG end of life care programme board and partnership meetings to support engagement and collaborative working. Developed models with CCGs to support proactive discharge planning in end of life care. Include: • Embedding the Enhanced Discharge Service referral pathway with Dorothy House Hospice to support rapid discharge home to preferred place of care. Service now supports patients from Wiltshire, BaNES and Somerset CCGs • Development of fixed term Continuing Health Care (CHC) Fast Track specialist nurse/therapist post with BaNES CCG to support RUH Integrated Discharge Service with patient discharges through CHC Fast Track. This post finished December 2017 with the RUH Worked in partnership with Dorothy House Hospice Care to form a Heart Failure Working Group to promote collaborative working, shared learning and earlier access to hospice and community services for patients. Worked in partnership with Forever Friends Appeal and Dorothy House Hospice

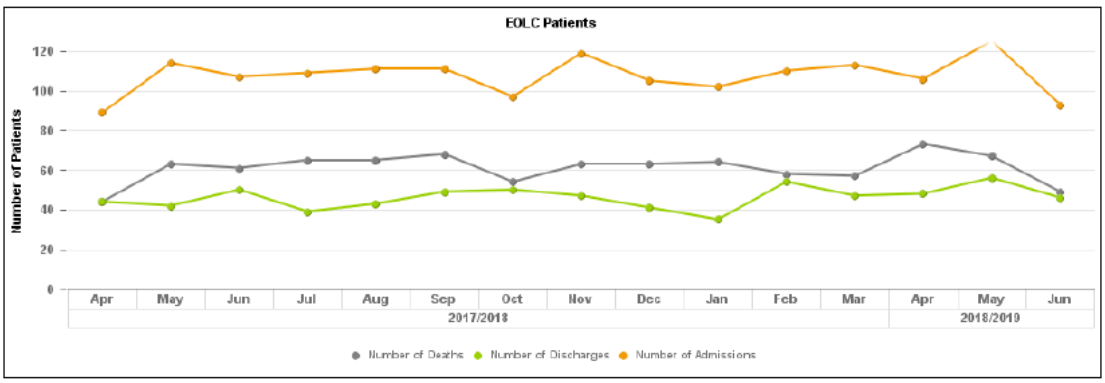
	to develop a Case for Support for funding for a new 'Compassionate Companion Service.' Worked in partnership with Macmillan Cancer Support and Dorothy House Hospice Care to develop a new Live Well Coordinator to support patients with an early palliative diagnosis and enable earlier access to hospice and community services. This new service will align to the RUH Live Well Beyond Cancer programme.
Areas to be progressed	Continue to support partnership working to benefit coordination of patient care across settings and appropriate place of care. Continue to seek funding for the Compassionate Companion Service to support dignified and compassionate care in the last days of life. To develop an end of life care strategy for the RUH.

7. End of Life Care Monitoring

The Palliative and End of Life Care working group has introduced an end of life care dashboard with the business intelligence unit (BIU), to monitor patient admissions, discharges and deaths. The dashboard is reviewed at each working group meeting.

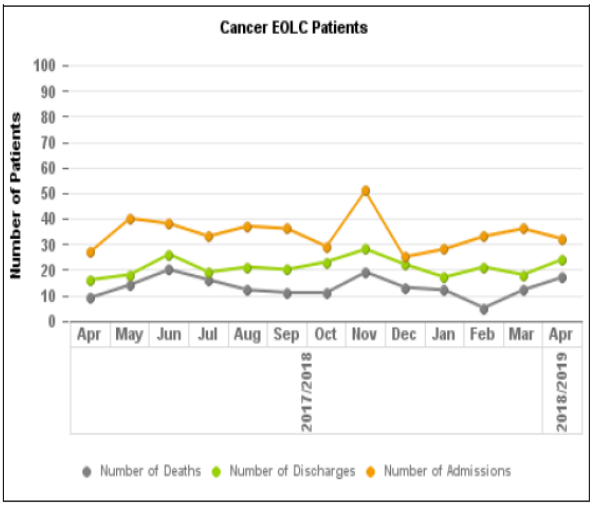
Table and graph 7.1 - number of patient admissions, discharges and deaths for clinical code Z515 (reviewed by palliative care) and Z51.8 (supported with care at the end of life)

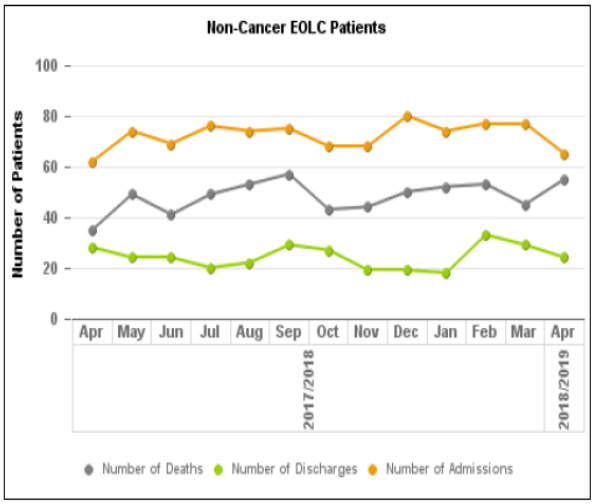
Data up until: 30/06/2018 2 month gap due to coding lag. Admissions will only appear once discharged & coded, resulting in longer lag & a drop in the latest month.	2017/2018												Total
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Deaths*	44	63	61	65	65	68	54	63	63	64	58	57	725
Discharges*	44	42	50	39	43	49	50	47	41	35	54	47	541
Admissions*	89	114	107	109	111	111	97	119	105	102	110	113	1,287
All In-Hospital Deaths	108	130	111	106	123	126	105	124	117	130	111	144	1,435
EOLC Deaths/All Deaths (%)	40.7	48.5	55.0	61.3	52.8	54.0	51.4	50.8	53.8	49.2	52.3	39.6	50.5



The data in table 7.1 indicates an increasing recognition of patients with end of life care needs over the last year. The proportion of patients dying from an expected death compared to an unexpected death has increased by 7% since 2016/17. This could be attributed to improvements in recognition of patients with end of life care needs through the Conversation Project, support from the palliative care team and use of Priorities for Care patient centred care plan.

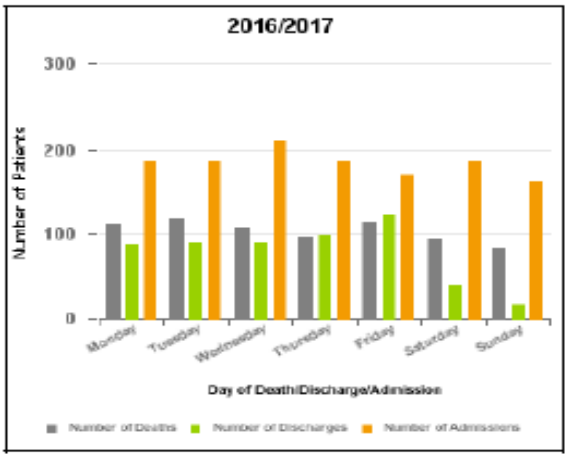
Graphs 7.2 - number of patient admissions, discharges and deaths for clinical code Z515 and Z51.8 by diagnosis (cancer or non-cancer)

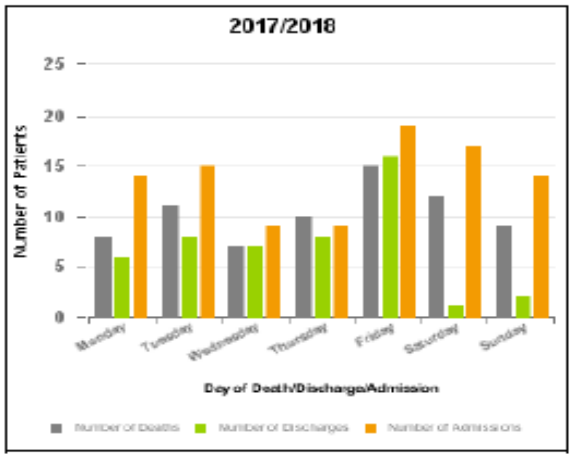




The data in graph 7.2 indicates an increasing recognition of patients with end of life care needs and a non-cancer diagnosis. This could be attributed to the Conversation Project and targeted work with OPU wards and cardiology.

Graphs 7.3 – number of patient admissions, discharges and deaths for clinical code Z515 and Z51.8 by day of the week





The data in graph 7.3 indicates a significant drop in discharges for patients with end of life care needs on Saturday and Sunday. There is currently no SPC team cover at weekends to support complex discharge planning.

The end of life care dashboard also includes information on patient admissions, discharges and deaths by ward. This information is being used to

inform targeted support for wards with the greatest number of patients with end of life care needs.

Table 7.4 – death rate compared to 2016/17 for patients with clinical code Z515 and Z51.8

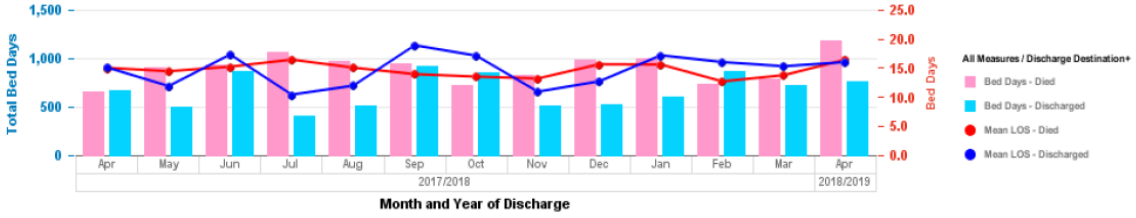
Discharge Ward	Metric	2016/2017			Total
		2	3	4	
Front Door	Deaths	21	29	46	96
	Discharges	26	17	15	58
	Death Rate	45%	63%	75%	62%
	All Deaths	66	87	110	263
Geriatric Medicine	Deaths	36	37	51	124
	Discharges	11	12	8	31
	Death Rate	77%	76%	86%	80%
	All Deaths	83	72	98	253
Medicine	Deaths	43	60	76	179
	Discharges	28	26	27	81
	Death Rate	61%	70%	74%	69%
	All Deaths	140	163	153	456
Surgery	Deaths	17	17	26	60
	Discharges	15	11	15	41
	Death Rate	53%	61%	63%	59%
	All Deaths	37	35	45	117
Oncology	Deaths	17	16	14	47
	Discharges	32	23	41	96
	Death Rate	35%	41%	25%	33%
	All Deaths	20	24	19	63
Other	Deaths	1	4	3	8
	Discharges			4	4
	Death Rate	100%	100%	43%	67%
	All Deaths	6	6	5	17

Discharge Ward	Metric	2017/2018				Total
		1	2	3	4	
Front Door	Deaths	25	28	26	41	120
	Discharges	23	17	24	17	81
	Death Rate	52%	62%	52%	71%	60%
	All Deaths	64	53	52	91	260
Geriatric Medicine	Deaths	53	48	50	42	193
	Discharges	13	19	15	10	57
	Death Rate	80%	72%	77%	81%	77%
	All Deaths	90	82	90	78	340
Medicine	Deaths	63	86	64	65	278
	Discharges	40	38	50	40	168
	Death Rate	61%	69%	56%	62%	62%
	All Deaths	145	164	148	154	611
Surgery	Deaths	13	23	23	15	74
	Discharges	19	20	20	28	87
	Death Rate	41%	53%	53%	35%	46%
	All Deaths	31	34	33	30	128
Oncology	Deaths	12	12	15	10	49
	Discharges	34	35	27	29	125
	Death Rate	26%	26%	36%	26%	28%
	All Deaths	14	14	17	14	59
Other	Deaths	2	1	2	6	11
	Discharges	7	2	2	12	23
	Death Rate	22%	33%	50%	33%	32%
	All Deaths	3	4	4	10	21

The dashboard includes information on death rate for patients with end of life care needs. For 2017/18 this rate was decreasing compared to data for 2016/17, indicating an increase in patient discharges as an outcome for patients with end of life care needs (see table 7.4).

Table and graph 7.5 – Patient length of stay for clinical codes Z515 and Z51.8

Metric		2017/2018												2018/2019
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Died	Total Bed Days	659	907	926	1,066	976	945	727	828	983	996	733	782	1,180
	Mean Length of Stay	15.0	14.4	15.2	16.4	15.0	13.9	13.5	13.1	15.6	15.6	12.6	13.7	16.4
	Median Length of Stay	11.5	9.0	9.0	11.0	12.0	9.5	9.5	9.0	11.0	12.5	9.0	9.0	11.0
Discharged	Total Bed Days	662	497	864	404	512	925	854	511	519	600	863	717	767
	Mean Length of Stay	15.0	11.8	17.3	10.4	11.9	18.9	17.1	10.9	12.7	17.1	16.0	15.3	16.0
	Median Length of Stay	9.5	10.0	13.5	7.0	9.0	13.0	12.0	9.0	12.0	13.0	12.0	12.0	14.0



The data in graph 7.5 indicates peaks in length of stay for patients being discharged in April, June, August, September, October and January. These peaks appear to align to the school holiday periods and could relate to care agency or nursing home capacity in the community being reduced.

The end of life care dashboard will be reviewed and refined at future palliative and end of life care working group meetings. The data will be used to support monitoring quantitative outcome measures for end of life care.

The BIU is currently working with the lead nurse palliative and end of life care to develop a palliative dataset to support monitoring of patient outcomes for patients supported by the specialist palliative care team, in line with the new national dataset recommendations.

8. Quality Improvement Initiatives

8.1. The Conversation Project

The RUH has developed the Conversation Project over the last 5 years to support advance care planning discussions for patients with end of life care needs. The Conversation Project was identified in the CQC inspection March 2016 as 'there was a Trust-wide approach to initiating conversations with patients and relatives who were making the transition to end of life care.'

The specialist palliative care team continue to support wards with using the principles of the Conversation Project in 2017/18:

- **Earlier recognition** of end of life or recovery uncertain for patients in acute hospital setting
- **Improving communication** and advance care planning for these patients and their families
- **Improving documentation** of conversations related to end of life care to inform management plans
- **Improve sharing of information** related to advance care planning on transfer and discharge of these patients

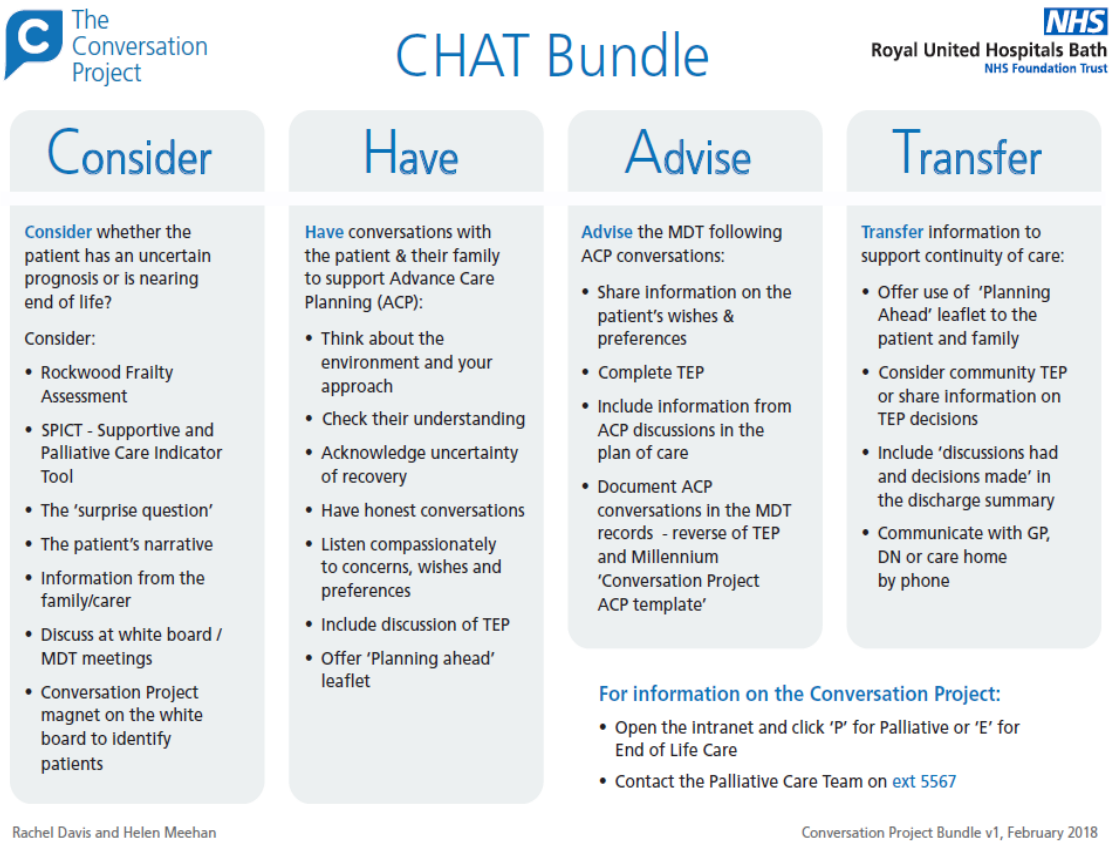
The SPC team was successful in a grant application to The Health Foundation in 2016/17 for £29,000. This grant is supporting extension of the Conversation Project and development of resources to support sustainability.

The grant has supported development of new information resources on advance care planning:

- Planning Ahead – A Guide for patients and families
- Planning Ahead – My Wishes advance care planning patient held resource
- Conversation Project CHAT Bundle
- Conversation Project logo

- Conversation Project intranet resource

The CHAT Bundle to support the principles of the Conversation Project:



The Conversation Project Magnet for ward white boards:

The new resources were launched in February 2018. The grant is also supporting the development of a series of short films to support staff with advance care planning conversations. These will be completed in September 2018.

The SPC team visited all wards in February and March to introduce the new CHAT Bundle, new 'Planning Ahead' leaflets to support advance care planning and new Conversation Project magnets for ward white boards to support recognition of advance care planning with patients during admission.

A new intranet resource has been developed to support staff with the new resources for the Conversation Project.

The SPC team continues to promote and share information on the Conversation Project on induction for new staff, ongoing training and educational sessions in end of life care.The Ambassadors for end of life care on each ward, attended a study day 18th July 2017 and 23rd January 2018 which included an update on the Conversation Project.

The SPC team continues to support a session on the 'Pulmonary Rehabilitation Programme' on advance care planning and thinking ahead for patients.

A Conversation Project Advance Care Plan (ACP) electronic assessment has been developed within Millennium to support identification of patients with end of life care needs and recording of advance care planning discussions to support patient centred care planning. This has been piloted by the SPC team. This new electronic template will also support monitoring of qualitative patient outcomes and electronic audits for the Conversation Project and advance care planning.

8.2. Continuing Health Care Fast Track and End of Life Care Discharge Planning

Choice and preferences for care are integral to quality improvement around discharge planning. In quarter 1 and 2 the trust discharge project board workstream for Continuing Health Care (CHC) Fast Track and End of Life Care supported:

- Development of a guidance and electronic checklist to support patient centred discharge planning in end of life care
- Review of patient and carer information leaflet 'Discharge to Preferred Place of Care'
- Review of the bundles of information for each CCG on the trust intranet, to support discharge through CHC Fast Track
- A Supportive Care Model, using the stages of decline for end of life care, to support proactive and coordinated patient centred care

The discharge project board was discontinued in September 2017.

8.2.1. Developing new models to support discharge planning

The trust has worked with partner CCGs to support improvements in discharge planning to preferred place of care at the end of life. These have included:

- Development of a specialist in-reach nurse/AHP for CHC Fast Track and discharge, with BaNES CCG to support coordination and proactive discharge planning. The post started April 2017 on affixed term Honorary Contract with the RUH. The post finished December 2017.

- Enhanced Discharge Service (EDS) with Dorothy House Hospice to include patients form Wiltshire and BaNES (from June) CCGs. The EDS supports rapid discharge home to preferred place of care in the

last 4 weeks of life, with a package of care through hospice at home. The care package can be for up to 24hours of care. The EDS initiative has supported ‘same day’ or ‘next day’ discharges for 97 patients in the last year. Average length of stay on EDS was 14 days for these patients.

8.3. Priorities for Care in the last days of life

In March 2018 the RUH Priorities for Care documentation version 3 was approved. The documentation was originally developed in response to the One Chance to Get it Right (2014) publication. The documentation was updated to version 3 following the trust Priorities for Care audit in 2017/18 and includes:

- Priorities for Care Initial Assessment and Guidance
- Priorities for Care Comfort Care for the Dying nursing record
- Priorities for Care Continuation Sheet
- Priorities for Care After Death
- Care at the end of life information leaflet

The documentation was developed to support decision making and identification of patients in the last days/hours of life, compassionate patient centred care, assessment of physical, psychological, social and spiritual needs, on-going review of the patient and support for the patient’s family.

The new Priorities for Care Bundle and Butterfly Logo to support patient centred compassionate care in the last days of life were developed and launched in February 2018:

Priorities for Care in the last days of life Magnet for ward white boards:

Priorities for Care in the last days of life sign for patient area or side room door:

The SPC team visited all wards in February and March to introduce the new Priorities for Care Bundle, v3 documentation to support patient centred care, new Priorities for Care Butterfly magnets for ward white boards and signs to indicate compassionate care in the last days of life.

A new intranet resource has been developed to support staff with the new resources for Priorities for Care.

8.3.1 Priorities for Care Audit

A trust audit of Priorities for Care is now undertaken 6 monthly to monitor patient outcomes in line with NICE NG31 – Care of the Dying Patient in the Last Days of Life (2015).

A small retrospective audit was completed of patient records, for patients that had died between November 2017 and January 2018. Patient records were reviewed at random each week in the bereavement office, by a specialist palliative care nurse or doctor. 21 audits were completed using the Trust Priorities for Care Audit tool.

The objectives of this audit are:

- To audit current evidence that clinicians are recognising when a patient's condition changes and that their care needs are reviewed to ensure comfort at the end of life
- To audit whether patients, and carers as appropriate, are involved in discussions about dying

- To audit whether families/carers are offered practical information on facilities at the RUH (refreshments, open visiting, car parking) and information on what to do following the death of a patient

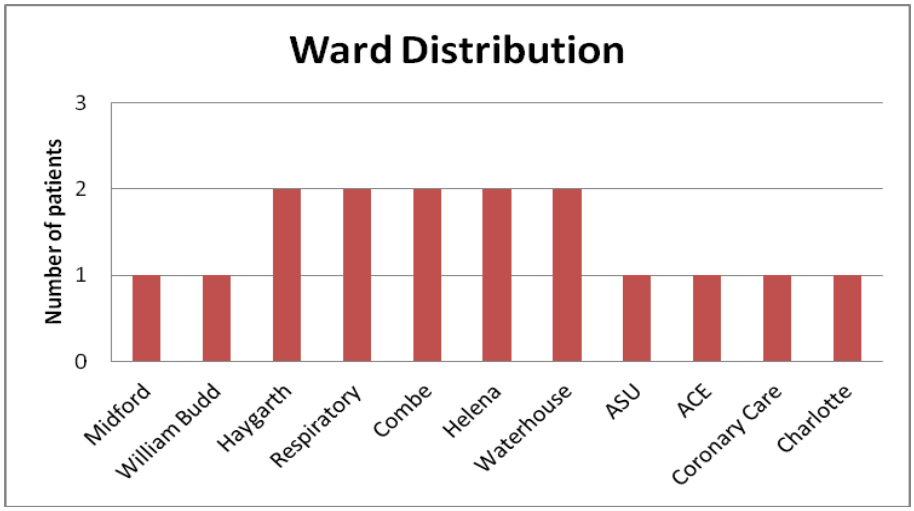
8.3.1 Key findings from the Priorities for Care audit

In this small audit of 21 patient records, 76% of patient had a non-malignant diagnosis.

Table 8.1 - Reason for admission to hospital

Reason for admission	Number of patients
Respiratory failure/breathlessness	4
Hypercalcaemia	1
Pneumonia	6
Planned admission for ERCP	1
Chest Pain	2
Fall	3
Right sided weakness	1
Cardiac Failure	1
Decompensated liver disease	1
Other	1

Table 8.2 – Ward Distribution of patients in this audit



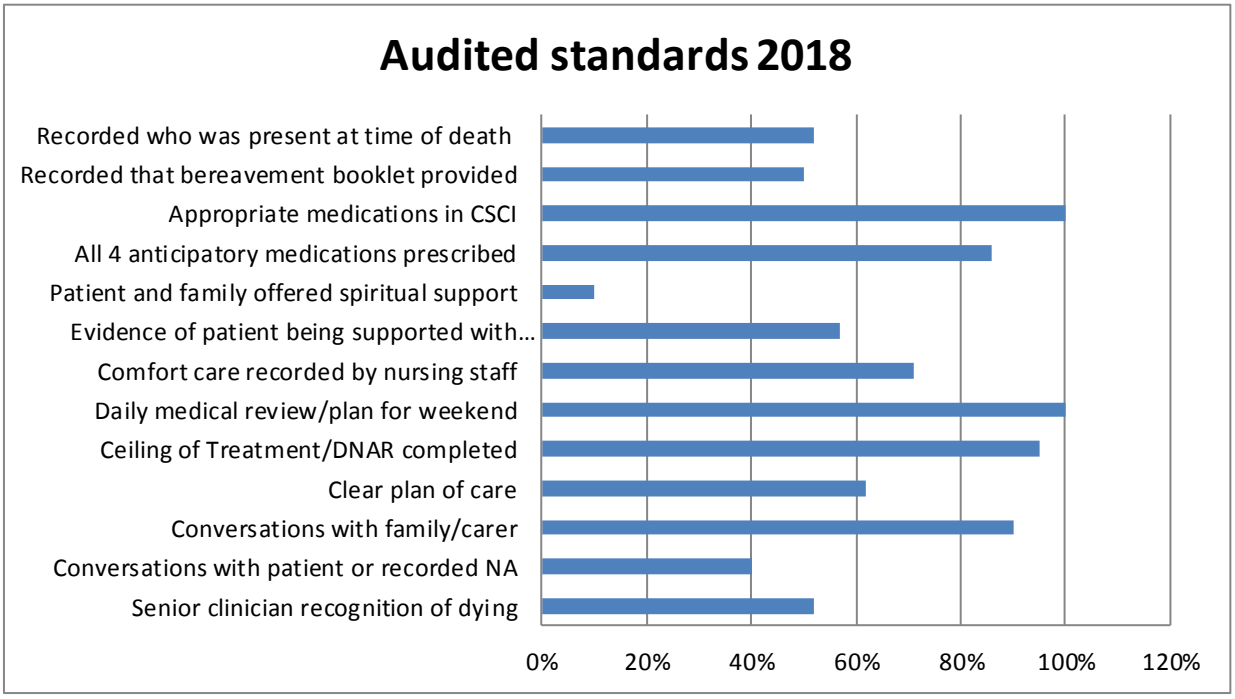
The length of stay for patient records reviewed in this audit was **1-27** days. Mean length of stay was **12.6** days. Median length of stay was 10 days.

Mean age was **84**. Median age was 86. Range 58-98.

For 17 patients there was recognition of deterioration.

The Priorities for Care documentation was used to support the care of 9 of these patients and a clear management plan for care at the end of life for 1 patient **(59%).**

Table 8.3 – Key findings from audit



8.3.2 Recommendations following Priorities for Care audit

- Senior clinician recognition that a patient is dying - New Priorities for Bundle includes need for senior clinician recognition of dying as part of MDT assessment. New Priorities for Care Bundle roll out across the trust March and April 2018.

- Conversations with the patient that they are nearing the end of life - New Conversation Project CHAT Bundle and Priorities for Care Bundle include requirement to record the outcome of conversations with patients around advance care planning wishes and priorities for care at the end of life in MDT records or reason discussions not possible. New Conversation Project CHAT Bundle and Priorities for Care Bundle roll out across the trust March and April 2018.

- Clear plan of care - New Priorities for Bundle includes requirement for holistic assessment and a patient centred plan of care or use of the Priorities for Care individualise care plan for the last days of life. New Priorities for Care Bundle roll out across the trust March and April 2018.

- Comfort care recorded by nursing staff - New Priorities for Bundle includes requirement for regular review of the patient's comfort using the Priorities for Care comfort chart. New Priorities for Care Bundle roll out across the trust March and April 2018. (NB this may be a falsely low result due to auditing methodology)

- Evidence of the patient being supported with hydration needs, comfort eating and regular mouth care – monitoring of patient being supported with hydration needs, comfort eating and mouth care included on the Priorities for Care Comfort Chart. Palliative care team to include on induction training for staff, HCA end of life care training and updated eLearning Module (NB this may be a falsely low result due to auditing methodology).

- Patient and family offered spiritual support – chaplaincy team to promote the role of the team and the new Spiritual Care Centre with ward teams. Spiritual care in the last days of life included on ward Ambassador for end of life care study day 23/01/18. Care at the end of life leaflet updated March 2018.

- Anticipatory medication prescribed for symptom management - medication was prescribed for all of the patients identified as dying in this audit, however not all patients had all 4 anticipatory medications prescribed. Anticipatory prescribing is included in the new eLearning module for end of life care and has been be included in junior doctor training sessions provided by the palliative care team January 2018.

There are plans to include Priorities for Care and the Conversation Project into ward accreditation for silver and to develop a quality mark for end of life care. This could potentially lead to a review of this audit process and potential for monthly peer review audits.

8.4 Ambassador Badge for End of Life Care

A new End of Life Care Ambassador badge has been developed and awarded to 11 staff since February 2018. The badge recognises staff that have supported quality improvement in end of life care within their clinical team and who champion best practice in compassionate care. The nominees are required to evidence their support for the Conversation Project and Priorities for Care in the last days of life. The nomination also has to be endorsed and supported the manager for the staff member.

Ambassador for End of Life Care Badge:

9. NICE Guideline NG31 and NICE Quality Standard QS144 Care of the Dying Adult in the Last Days of Life

In response to the publication of NICE NG31 and outcomes from local service improvement audits a new Trust policy 711 was developed to support ‘care of the dying patient and care of the deceased patient.’ This policy was formally

approved in January 2016. The policy includes all the recommendations from NICE NG31 and in addition includes requirements for care after death. Information about the new policy has been included in training sessions provided by the SPC team this year. The policy has been used to inform the priorities for care audit in 2017/18 and training in care of the dying patient.

The NICE QS144 was published March 2017. The trust completed a baseline review against the 4 quality standards and is compliant with all 4 standards.

10. The National Care of the Dying Audit

There has been no national end of life care audit in 2017/18. There has been confirmation from Health Quality Improvement Partnership that the NHS Benchmarking Network will lead on the next audit and will form part of the National Clinical Audit and Patient Outcomes Programme in 2018/19.

11. Care after death

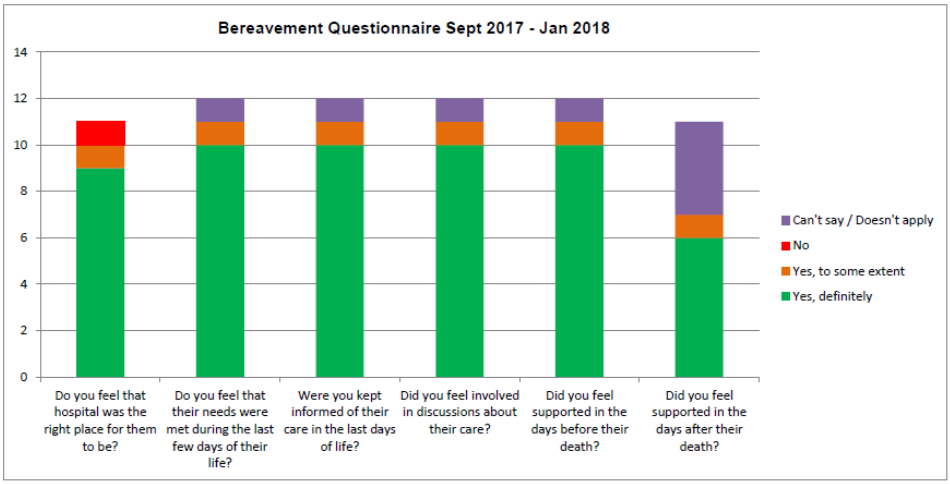
11.1. Bereavement feedback

The trust implemented a new bereavement feedback initiative to support the bereaved family/carer with providing feedback in September 2017. A quarterly report has been developed by the Patient and Carer Experience team and shared with the palliative and end of life care working group. Information from the bereavement feedback is shared with appropriated leads and used to inform ongoing quality improvement.

Table and graph 11.1 – Bereavement feedback

Bereavement Questionnaire Oct 2107 - Jan 2018

Count of ResponseText Row Labels	Column Labels Yes, definitely	Yes, to some extent	No	Can't say / Doesn't apply	Grand Total
Do you feel that hospital was the right place for them to be?	9	1	1		11
Do you feel that their needs were met during the last few days of their life?	10	1		1	12
Were you kept informed of their care in the last days of life?	10	1		1	12
Did you feel involved in discussions about their care?	10	1		1	12
Did you feel supported in the days before their death?	10	1		1	12
Did you feel supported in the days after their death?	6	1		4	11



The lead nurse palliative and end of life and Lead for Patient and Carer Experience supported a ‘See it My Way’ event 12th May 2017 for bereaved families to share their experiences of end of life care at the RUH. 4 families participated and the ward manager from Helena ward. A short 15 minute film has been developed to support ongoing learning in end of life care, using the shared experiences from the families involved.

See it My Way May 2017:

A short 15 minute film has been developed to support ongoing learning in end of life care, using the shared experiences from the families involved. This is available on the trust intranet palliative and end of life care pages.

11.2. Bereavement information

The Bereavement Booklet resource has been reviewed and updated. This booklet is offered to the family of a patient, following their death at the RUH. The booklet includes information on how to give feedback on experiences of care provided following the death of a patient at the RUH. It also includes information on bereavement and how to access advice and support.

11.3 Time of reflection service

The RUH and the Forever Friends Appeal held a ‘Time of Reflection’ Remembrance Service on 30th September at St Phillip and St James church in Bath. The service was well received by the bereaved families that attended.

With the development of the new Spiritual Care Centre, the Chaplaincy team, SPC team and Forever Friends Appeal plan to hold the Time of Reflection services every 3 months in 2018.

12. Support and education for staff

The SPC team provides a programme of education in palliative and end of life care, which includes sessions on the trust induction (see appendix 2). The team also provides ad hoc learning to staff in end of life care, symptom management, care of the dying during clinical activity on the wards. The SPC team provides placements for nursing and medical staff wishing to gain experience in palliative and end of life care.

12.1. Ambassadors - a collaborative for end of life care

This SPC team continues to support ward 'ambassadors' to champion communication, compassion and end of life care on the wards. The ambassadors are supported on the wards by the SPC team and have the opportunity to attend study days to promote and share best practice in end of life care.
Study days were held on 18th July 2017 and 23rd January 2018. The Ambassadors include registered nurses, health care assistants, an occupational therapist and a physiotherapist.

The study day on 23rd January 2018 included a registered nurse and HCA from Dorothy House Hospice Care inpatient unit. These new hospice ambassadors will now attend future study days to promote partnership working with the RUH ambassadors and shared learning.

12.2. eLearning module

An eLearning module on end of life care has been available since April 2016, with information on national and local requirements to support best practice, case studies and a self-assessment component to support self-directed learning. The eLearning module can be accessed through Electronic Staff Record. The module can be used to support ongoing learning in end of life care for doctors, registered nurses, health care assistants/assistant practitioners and therapists.

The eLearning module has continued to support access to learning in palliative and end of life care for staff across the trust.

A review of the eLearning module started in March 2018 to ensure it includes information about the new Conversation Project CHAT Bundle and Priorities for Care Bundle.

12.3. Essential training for end of life care

The RUH Mandatory Training Panel approved end of life care to be 'essential training' for identified staff groups, in 2016/17. End of life care training is identified as a requirement on 'STAR' for appropriate staff groups. The training compliance target is 90%. This was 84% at the end of March 2018.

13. Information for the public and staff

An Internet website provides information for the public around the care of the dying at the RUH. There are leaflets available for families to answer some of their concerns and questions about end of life care at the RUH and Just in Case medications. These resources are currently being reviewed and updated.

On 8th – 12th May 2017 the SPC team, Chaplaincy team, Communications team and the memory and Legacy Officer for the Forever Friends Appeal supported the 'Dying Matters' awareness week to promote and share information on quality improvement initiatives in end of life care with a resource trolley visit to all the wards. The theme this year was 'What can you do?

A 'Caring for You' evening was held with Trust Members on 14th November 2017. This outlined the key findings from CQC in relation to end of life care provided at the RUH and the quality improvement initiatives to support compassionate, patient and family centred care. Feedback from the event is being used to inform a new end of life care strategy.

An internal intranet site for palliative and end of life care provides information and guidance for staff at the RUH, on all aspects of palliative and end of life care. The intranet resource was updated in quarter 4. Each ward also has a resource folder on end of life care to support timely access to information for staff.

14. Partnership working

14.1 Dorothy House Hospice Care Medical Team support and services

Dorothy House Hospice Care continues to support the RUH with consultant/associate specialist in palliative medicine sessions. Over the last 2 quarters these continue to be 5 sessions/week (see section 5). The hospice medical team representative supports the specialist palliative care Multi-disciplinary Team (MDT) meetings with the RUH SPC team, supports assessments and reviews of patients with complex needs, provides on-going training and learning for medical students and junior doctors.

As well as the hospice medical team, other Dorothy House Hospice Care services including the inpatient unit, day patient unit, community specialist nurse teams, family support team and therapy services continue to work in partnership with the SPC team at the RUH, to support information sharing and coordination of care for patients across settings.

14.2 Dorothy House Hospice Care Enhanced Discharge Service

The SPC team, Dorothy House Hospice Care, Wiltshire CCG and BaNES CCG have worked in partnership develop further the Enhanced Discharge

Service to support rapid discharge home to preferred place of care (see section 8).

14.3 Heart Failure Working Group

The SPC team and Heart Failure Specialist Nurse have worked in partnership with Dorothy House Hospice Care to form a Heart Failure Working Group to promote collaborative working, shared learning and earlier access to hospice and community services for patients. In the last year this working group has agreed to support three areas:

- Improved access to support
- Wellbeing
- Improved symptom control through collaborative working and education

14.4. Developing a Compassionate Companion Volunteer Service

The SPC team has worked in partnership with Forever Friends Appeal and Dorothy House Hospice Care to develop a Case for Support for funding for a new 'Compassionate Companion Service.' This service would provide companionship to patients nearing the end of life in hospital, who have limited family support or to give families a break.

A patient may not have anyone to sit with them during their final days. They may have limited support from family or friends, or their family may wish to take a break and not wish to leave their loved one alone. Often the last sense patients lose during end of life care is their hearing, Compassionate Companions could read to patients, provide comforting words or be with the person and simply hold their hand.

A small working group was established in quarter 3 to scope the potential for a compassionate companion volunteer service. This group will now oversee the 'Case for Support' and potential implementation of the volunteer service in 2018/19. The Case for Support will be presented to the Sperring Trust in April 2018.

Case for Support:

14.5 Macmillan, Dorothy House Hospice Care, RUH Partnership Live Well Coordinator

The trust has worked in partnership with Macmillan Cancer Support and Dorothy House Hospice Care to develop a new Live Well Coordinator to support patients with an early palliative diagnosis and enable earlier access to hospice and community services. The project has 4 years funding from

Macmillan Cancer Support. The Live Well Coordinator will be employed by Dorothy House Hospice Care and will have an Honorary Contract to work at the RUH.

The new service will commence in 2018/19 and will align to the RUH Live Well Beyond Cancer programme.

15. Future Developments

The Palliative and End of Life Care Working Group will continue to meet quarterly to oversee continued quality improvement initiatives in end of life care.

Representatives from the Palliative and End of Life Care working group will continue support local end of life care strategy groups for the Clinical Commissioning Groups to support partnership working, shared learning and quality outcomes for care across settings for patients with end of life care needs.

The SPC team will continue to lead on The Health Foundation grant to support extension of the Conversation Project and oversee the development of resources to enable sustainability of the initiative. A final report will be drafted for the Health Foundation in October 2018.

The SPC team will lead on embedding of the new Conversation Project Bundle and Priorities for Care Bundle to support timely, coordinated and compassionate end of life care.

The SPC team will review the McKinley T34 syringe driver policy.

Feedback and consultation from the 'Caring for You' held with Trust Members on 14th November 2017, will be used to inform a new RUH end of life care strategy.

The SPC team will recruit additional clinical nurse specialists with funding through the Macmillan Cancer Support Application, to support a 2 year pilot of 7/7 working. The pilot will include evaluation after 12 months to monitor the impact of 7/7 working on patient outcomes in palliative and end of life care.

The SPC will support development of non-medical prescribing within the clinical nurse specialist role.

The lead nurse and senior specialist palliative care nurse are presenting the Conversation Project at a national EOLC conference for hospitals in London in May and June 2018.

The SPC team will hold a conference on 13th September to share learning from the Conversation Project.

The SPC team will work in partnership with Dorothy House Hospice Care and Forever Friends Appeal to develop the new Compassionate Companion Volunteer Service.

The SPC will seek opportunities to work in partnership with Dorothy House Hospice Care and partner organisations to develop services and promote best practice and support continuity of care for patients with end of life care needs and their families.

Helen Meehan
Lead Nurse Palliative and End of Life Care
September 2018

Appendix 1

Palliative and End of Life Care Working Group

Terms of Reference

1. Constitution

1.1 The RUH Management Board has authorised the establishment of this working group to oversee the delegated responsibilities outlined in these terms of reference. The group is made up of knowledgeable, experienced professionals with the ability to implement and sustain sound clinical and strategy developments in end of life care.

2. Terms of Reference

a. Purpose

- To promote a compassionate approach to palliative and end of life care, that ensures respect for, and dignity of the patient and their family/ carers, through the delivery of high quality, timely, effective individualised care
- To direct and monitor the implementation of national and local policy with regard to palliative and end of life care within the RUH Trust
- To ensure the RUH Trust complies with CQC regulation in relation to end of life care in relation to the 5 domains: safe, effective, caring, responsive and well-led
- To ensure that end of life care is incorporated into the daily work of the RUH and that all employees acknowledge its importance as a part of their work
- To identify opportunities to develop and work in innovative and collaborative ways to support ongoing quality improvement in palliative and end of life care
- To identify opportunities to work collaboratively with our community partners to support coordination of care across organisational boundaries.

b. Objectives

- To agree the work plan for palliative and end of life care
- To oversee and monitor progress of the RUH palliative and end of life care work plan
- To review and monitor compliance against National and Local targets, and regulatory standards
- To oversee plans to ensure that all staff involved in palliative and end of life care have access to relevant training and monitor compliance with essential training for end of life care
- To ensure all complaint and adverse events themes relating to palliative and end of life care are reviewed and that appropriate changes are implemented

- To ensure themes from the Bereavement Feedback are reviewed and appropriate changes are implemented
- To make a contribution and influence across boundaries commitment to respond to national developments and guidance for palliative and end of life care.

3. Membership

3.1 The Palliative and end of life care working group membership will include:

- Executive Director Lead (Chair)
- Non Executive Director lead for end of life care
- Consultant in Palliative Medicine/Associate Specialist, RUH and Dorothy House (Vice Chair)
- Lead nurse palliative and end of life care
- Palliative care nurse specialist
- Matron
- Lead for Patient and Carer Experience
- Senior chaplain
- Patient /family representative
- Medical representative from medical and surgical divisions
- Senior nursing representative from medical and surgical divisions
- Senior nursing representative from paediatric ward
- Senior midwife representative
- Senior representative from therapies
- Dementia coordinator
- Specialist nurse Long Term Conditions
- Dorothy House director of clinical services/specialist nurse
- Representative from Virgin Care
- Representative from WH&C Community
- Representative from Somerset/Mendip Community
- Discharge liaison nurse/continuing health care
- Representative from bereavement office
- Representative from Forever Friends memory and legacy officer
- Representative tissue services

a. Executive lead

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 Palliative and End of Life Care Working Group.

b. Non Executive director

The Non Executive Director is supporting the development and on-going effectiveness of end of life care and that there is regular reporting to the Board of Directors.

c. Quorum

Business will only be conducted if the meeting is quorate. The palliative and end of life care working group will be quorate with 50% RUH members, including either the Chair or Vice Chair and a palliative care representative.

d. Attendance by Members

Members are expected to attend 75% of the meetings and to send a deputy if unable to attend the meeting.

e. Attendance by Officers

Other members of staff may be invited to attend the meeting, if appropriate.

4. Accountability and Reporting Arrangements

4.1 The palliative and end of life care working group will be accountable to the Management Board. Group members will be invited to declare any issues arising in the meeting that might conflict with the business of the Trust

4.2 The palliative and end of life care working group will report to the Operational Governance Committee via the inter-committee reporting template on a six monthly (specify) basis.

5. Frequency

5.1 Meetings will be held quarterly.

6. Authority

6.1 The palliative and end of life care working group is authorised by the Board to investigate any activity within its terms of Reference

6.2 The Board will retain responsibility for all aspects of internal control, supported by the work of the palliative and end of life care working group, satisfying itself that appropriate processes are in place to provide the required assurance.

7. Monitoring Effectiveness

7.1 The palliative and end of life care working group will establish a work programme which:

- Reflects its accountabilities and responsibilities

- Reflects risks arising from the organisation-wide risk register
- Review the work plan in line with the end of life care strategy and national directives

7.2 The palliative and end of life care working group will produce an annual report in line with best practice, which sets out how the working group has met its Terms of Reference during the preceding year.

8. Other Matters

8.1 The servicing, administrative and appropriate support to the palliative and end of life care working group will be undertaken by the lead nurse palliative and end of life, who will record minutes of the meeting. The planning of the meetings is the responsibility of the lead nurse palliative care and end of life.

9. Review

9.1 The palliative and end of life care working group will review its Terms of Reference and work programme on an annual basis as a minimum.

Appendix 2 **Palliative care training annual programme 2017/18**

Session (session code for ESR reporting in bold)	Target audience	Organised by	SPC team leads	Date	Comments
Induction - Patient Care Afternoon **Introduction to palliative and EOLC**	RNs, therapists and HCAs	Training Department	Rachel, Kathy, Sue and Helen	2-3 sessions / month	45 mins
Induction – **Care of the dying patient**	HCAs	Anita Paradise	Clare and Petrena	Monthly	1 ¼ hour
Induction - McKinley T34 training	RNs	Bettina Deacon	Clare and Petrena	2 weekly	30 mins
Preceptorship - **Principles and practice in palliative and EOLC**	RNs	Training department	Kathy and Helen	Biannual	2 hours
Student Nurses - **Principles and practice in palliative and EOLC**	Student nurses – NP6-7	SPC team and Josie	Rachel and Clare	Every 6 months	½ day
Return to practice – **Principles and practice in palliative and EOLC**	RNs	SPC team	Kathy and Helen	Ad hoc	½ day
Ambassadors study day - **Principles and practice in palliative and EOLC**	RN and HCA Ambassadors for EOLC on each ward	SPCT team	Helen, Clare and David	6 monthly (July & Jan)	1 day
HCA study day – **Care of the dying patient**	HCAs	Anita Paradise	Clare, Petrena and Rachel	Yearly (June)	1 hour
Conversation Project - **Communication and ACP**	Medical teams, RNs, therapists, HCAs, admin	SPC team	Rachel, Helen and David	Ad hoc	30mins – 1 hour
Priorities for Care - **Care of the dying patient**	Medical teams, RNs, therapists, HCAs, admin	SPC team	Helen and Kathy	Ad hoc	30mins – 1 hour
Junior doctors - **Principles and practice in palliative and EOLC**	Medical teams	SPC team	Emma and Simon	Ad hoc	1 hour
Grand Round **– Principles and practice in palliative and EOLC**	Medical teams	Dr MacKenzie Ross	Emma and Helen	Yearly (September)	1 hour
E Learning module – **Principles and practice in palliative and EOLC**	Medical teams, RNs, therapists and HCAs	SPC team	Helen	Available on ESR	30-45mins
Therapists – **Principles and practice in palliative and EOLC**	Therapists	SPC team	David and Rachel	6 monthly	1 hour