Royal United Hospitals Bath
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Report to:** | **Public Board of Directors** | **Agenda item:** | **9** |
| **Date of Meeting:** | **27 September 2017** | | |

| | |
|---|---|
| **Title of Report:** | **End of Life Care Annual Report 2016/17** |
| **Status:** | **For Information** |
| **Board Sponsor:** | **Helen Blanchard, Director of Nursing and Midwifery** |
| **Author:** | **Helen Meehan, Lead Nurse Palliative Care and End of Life** |
| **Appendices** | **End of Life Care Annual Report 2016/17, End of Life Care Annual Report 2016/17 slides** |

## 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 2016/17, the RUH supported 1497 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 2016/17 and how this has supported local and national priorities for palliative and end of life care over the last year:

- End of Life Care Working Group
- Care Quality Commission
- Specialist palliative care team
    - Aims
    - Operational policy
    - Clinical activity
    - Macmillan Cancer Support Review
    - Business case to support 7/7 working
    - The Health Foundation grant application
    - Lead nurse for palliative and end of life care
- 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
- NICE Guideline NG31 Care of the Dying Adult
- 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
- 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

**Appendix 1**

# RUH End of Life Care Annual Report

## April 2016 - March 2017

## Contents

Chairman, Brian Stables
Chief Executive, James Scott

# 1. Executive Summary

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

1.2 The end of life care working group has continued to meet quarterly and oversee an annual work plan for end of life care.

1.3 End of life care was rated as outstanding in August following the Care Quality Commission inspection in March 2016.

1.4 The specialist palliative care team had a total of 804 referrals in the reported year – a 23% increase since 2014/15 and a 35% increase since 2013/14. 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 end of life care work plan for 2016/17 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 new RUH policy for care of the dying patient and care of the deceased patient has been implemented.

1.8 The action plan from the national end of life care in hospitals audit completed in 2015/16 has been implemented.

1.9 The bereavement booklet has been reviewed, a patient story from a bereaved daughter has been shared at trust board and used in training, and a 'Service of Reflection' has been held for bereaved families.

1.10 All wards have an ambassador for end of life care. An elearning module has been developed to support access to ongoing learning in end of life care and end of life care has been approved as 'essential' training for identified staff groups.

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

1.12 Partnership working with Dorothy House Hospice Care continues. The hospice medical team provide 5 sessions per week with the RUH palliative care team and provide 24/7 out of hours advice line. This year a new Enhanced Discharge Service has been developed to support rapid discharge to preferred place of care with the hospice and Wiltshire CCG.

1.13 Future developments include developing Conversation Project resources and sharing knowledge through the successful grant to The Health Foundation.

## 2. Introduction

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 2016/17, the RUH supported 1497 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 2016/17 and how this has supported local and national priorities.

## 3. End of Life Care Working Group

The RUH has an 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 2016/17 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 end of life care working group is to:

- To promote a compassionate approach to 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 end of life care within the RUH Trust
- To ensure the RUH Trust complies with Care Quality Commission (CQC regulation in relation to end of life care
- 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 ways to support quality improvement in end of life care.

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

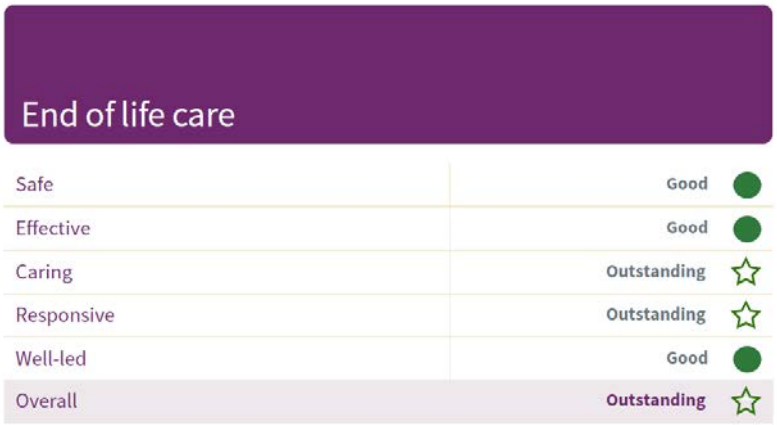
from the hospice and community providers and also a lay member to represent the patient and the family view. The working group is chaired by the Director of Nursing. See appendix 1 – Terms of Reference.

The end of life care working group is accountable to the Trust Management Board and reports annually to this board, Quality Board and Governance Board, with an End of Life Care Annual Report. The EOLC annual report 2015/16 was presented to the Trust Board 28th September 2016.

The lead nurse palliative and end of life care and senior specialist palliative care nurse gave a presentation called 'Let's talk about end of life care' at the Trust Annual General Meeting on 28th September 2016. This outlined the key findings from CQC in relation to end of life care provided at the RUH and the service improvement initiatives to support compassionate, patient and family centred care.

## 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 CQC findings were reported in August 2016. The overall rating for end of life care following the inspection was 'outstanding.' The breakdown for each domain is shown below:




The CQC inspection for end of life care included a review of the care of patients in the last 12 months of life as well as patients in the last days of life, and includes the care after death. The inspection included review and observation of services provided by the specialist palliative care team, observation of care and discussions with staff across 16 wards, critical care and emergency department. The inspection team also met with the discharge liaison nurses, bereavement office, mortuary service and chaplaincy service. The inspection team also met with patients and their relatives.

Some of the key findings from the CQC inspection included:

- *People's care and treatment was planned and delivered in line with the latest guidance, standards and legislation.*
- *Patients were respected and valued as individuals and were empowered as partners in their care.*
- *People's individual needs and preferences were central to the planning and delivery of end of life care.*
- *The trust worked with services in the local community to provide continuity of care where possible and engaged with commissioners and community services to drive improvements.*
- *Staff were proactive in their approach to understanding individual patients' needs and wishes and in their approach to meeting the needs.*
- *Some aspects of leadership, particularly that of the palliative care team was outstanding. Nursing, medical and healthcare staff across the hospital were being engaged and motivated to improve the service they provided in respect of end of life care.*
- *There were clear governance structures for end of life care with the objectives of the end of life working group being clearly laid out and monitored. There was positive leadership at board level for end of life care.*

The learning from the CQC inspection and recommendations were built into the end of life care work plan for 2016/17. 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.

## 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 aims to achieve a high standard of care through:

- Providing safe, effective and responsive support to patients and families.
- Offering advice, support and information for healthcare professionals involved in the palliative care of people with cancer or other life-threatening illnesses.
- Ensuring patients experience care that is coordinated and integrated across all settings, with robust handover arrangements and communication between generalist and specialist healthcare professionals.
- 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 involved in supporting and caring for patients with end of life care need.
- Supporting ongoing quality improvement in end of life care, to support evidence based practice and ongoing evaluation of patient outcomes in end of life care.
- Directing the RUH in strategic development of end of life care, though ongoing quality improvement initiatives, supporting evidence based practice and development of an annual work plan for end of life care.
- Monitoring key quality indicators, training and education provision, service improvement initiatives and evaluation of patient outcomes in 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 2016/17 the SPC has operated 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)
- Specialist palliative Occupational Therapist (0.4wte)
- Admin (0.69wte)

The SPC had an operational policy for 2016/17 and completed an annual report for SPC services in 2016/17. The service supports a SPC multi-disciplinary team (MDT) meeting weekly, and a pain MDT with the chronic pain service twice a month.

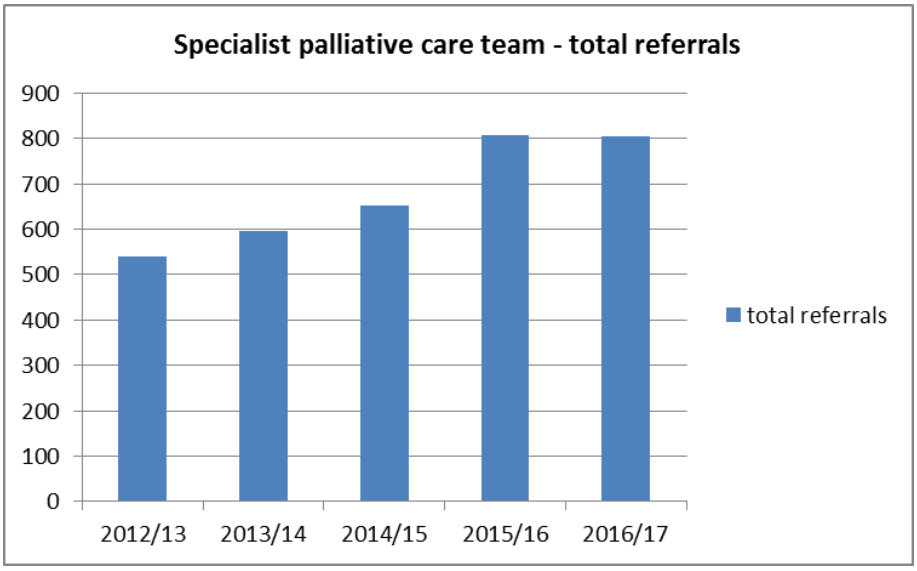
The SPC team supports the work set out in the RUH end of life care work plan. Unlike many other Trusts the RUH does not have an end of life care facilitator separate to the SPC, supporting quality improvement and training. End of life care quality improvement is integral to the role of the SPC team and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

**5.3. Clinical activity**

The SPC team had a total of 804 patient referrals in the reported year. This represented a 23% increase on total referrals since 2014/15 and a 35% increase in referrals since 2013/14. Of the 804 patients supported in the last year, 35% died during their admission and 63% 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 20% of patients referred to SPC team had a non-malignant palliative diagnosis, this compares to 13% in 2013/14.

**Graph to show increasing referrals to SPC over last 5 years**




**5.4. Macmillan Cancer Support Service Review**
The SPC team participated in a Macmillan Cancer Support review October 2016. Feedback from this review included:

> *'It has been very exciting to spend time with a team that is so committed to excellence in practice and is not content to rest on their laurels. Under inspiring leadership, the team continues to push forward with the underlying philosophy that they will reach the widest possible patient population requiring skilled end of life care.'*
>
> *'There is an awareness that the generalist staff can work in partnership with them if suitably knowledgeable so the training programme has been impressive and very appropriate.'*

**5.5 Business case to support 7/7 working**
The business case to support SPC team 7/7 working was updated in 2016/17 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 and timely discharge to preferred place of care for patients with complex needs.

Access to SPC services providing face to face assessment of patients, 9am – 5pm, 7 days per week is a national KPI for SPC and is included within the CQC inspections as a quality indicator. For the last CQC inspection it was

recognized that the trust was developing a business case for SPC 7/7 working.

The revised business case was taken to trust investment group November 2016 with agreement to progress and medical division executive performance meeting in December 2016. The business case did not progress further in 2016/17, but has been included in the end of life care work plan for 2017/18.

### 5.6. The Health Foundation Bid

The SPC team was successful with a grant application to The Health Foundation in October 2016 for £29,700, to be awarded April 2017 – October 2018. The grant will support project lead funding to develop extension of the Conversation Project and a suite of resources. These will include a series of short films to support ongoing learning for staff in advance care planning and communication with patients and their families.

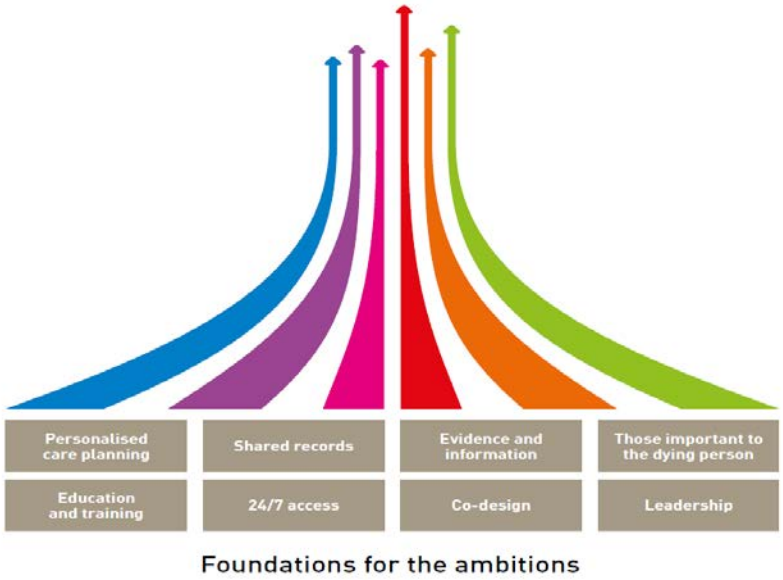
The project lead was appointed from the SPC team and will commence the project in April 2017. Backfill clinical nurse specialist hours for the project lead have also been appointed and will commence April 2017.

### 5.7. 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 end of life care work plan for the RUH.

## 6. End of Life Care Work Plan

In 2016/17 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 work plan work streams to date:

| **Work Stream 1 - Personalised care planning** | |
|---|---|
| Key achievements | Continued roll out 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). Principles shared across all wards.<br><br>Trust wide agreement on use of Treatment Escalation Plans (TEP) and piloting completion of Community TEP for BaNES and Wiltshire CCG to support information sharing and continuity as part of discharge planning.<br><br>Continued use of Priorities for Care documentation to support holistic assessment and patient centred care in the last days of life.<br><br>Developed and piloted discharge planning resources to support discharge to preferred place of care at the end of life. Development of an information leaflet to support patients and their families when being discharged to preferred place of care at the end of life. |
| Areas to be progressed | Embedding the principles of the Conversation Project on all wards in the RUH.<br><br>Review of Priorities for care documentation in 2017/18. |

| Work Stream 2 - Shared records | |
|---|---|
| Key achievements | Engaged with Clinical Commissioning Groups (CCGs) to support information sharing in end of life care, Advance Care Planning and Treatment Escalation Plan.<br><br>Reviewed access to shared records to inform and support coordination of patient care across settings – access to SystmOne View.<br><br>Development of Conversation Project template on Millennium to record outcome of ACP discussions. Developed February 2017 for implementation 2017/18.<br><br>Development of electronic referrals through Millennium for SPC team from February 2017, to support monitoring of patient outcomes and reporting requirements for new national minimum data set for SPC. |
| 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.<br><br>Support use of Millennium clinical template for the Conversation project to support recording of advance care planning discussions and patient wishes in end of life care. |

| Work Stream 3 - Evidence and information | |
|---|---|
| Key achievements | Developed action plan following publication of the National End of Life Care Audit 'dying in hospital' March 2016 and RUH outcomes.<br><br>Audited patient outcomes in relation to ACP with the Conversation Project Audit.<br><br>Audited patient outcomes in care at the end of life with the Priorities for Care Audit.<br><br>Commenced biannual McKinley T34 Syringe Driver audit January 2017 to review symptom management and policy standards for syringe driver use in palliative care.<br><br>Developed an EOLC dashboard to monitor patient outcomes in EOLC across the trust from April 2017. Dashboard will include for each quarter:<br><br>• Number of admissions for patients with EOLC needs<br>• Number of patient deaths<br>• Number of patient discharges for patients with EOLC needs<br>• Number of discharges through CHC Fast Track: including KPIs for the Discharge Project Board<br>• Number of discharges through Enhanced Discharge Service<br>• Number of patients referred to SPC<br>• Training compliance for EOLC<br>• Bereavement feedback |

| | |
|---|---|
| Areas to be progressed | Disseminate findings and ensure learning informs ongoing service improvement.<br><br>Finalise end of life care dashboard to support monitoring of patient outcomes in end of life care and review at each end of life care working group meeting. |

| **Work Stream 4 - Involving, supporting and caring for those important to the dying person** | |
|---|---|
| Key achievements | Reviewed access to facilities for families/carers of patients in the last days/hours of life. Held consultation event 12th January 2017 to review potential sleeper chairs to support family members staying overnight.<br><br>Reviewed information resources for care at the end of life, care after death and bereavement information.<br><br>Reviewed process for access to free car parking for families of patients receiving care at the end of life.<br><br>Reviewed the bereavement feedback process. Planning for 'See it My Way' event for bereaved families to share their experiences of end of life care in May 2017. Planning for bereavement feedback process through paper questionnaire and freepost returns for 2017/18.<br><br>The RUH and the Forever Friends Charity held a 'Time of Reflection' service on 24th September at St Phillip and St James church in Bath. The service was well received by the bereaved families that attended.<br><br>Planning for new 'making a difference' group to oversee planning for national 'Dying Matters Week,' the RUH 'Time of Reflection Service' and resources for patients and families. The group will meet from April 2017. |
| Areas to be progressed | To implement new process for bereavement feedback through questionnaire and freepost returns.<br><br>Business case to Forever Friends Appeal to purchase sleeper chairs for wards to support family members staying overnight. |

| **Work stream 5 – Education and training** | |
|---|---|
| Key achievements | Used learning from Conversation Project audit, Priorities for Care audit, Bereavement Feedback and National End of Life Care Audit to inform training sessions, learning resources and service improvement in 2016/17.<br><br>Implemented the RUH eLearning module for end of life care.<br><br>Essential training for end of life care, as 'once only' training for identified staff groups, approved by the mandatory training committee. Training needs analysis completed and trajectory agreed for 90% compliance by September 2017.<br><br>SPC team continue to lead on training programme for end of life care (see appendix 2).<br><br>End of life care session on induction training updated to include core topics for end of life care 'essential training.' |

| | |
|---|---|
| | End of life care now included as an annual session on Grand Round for medical division.<br><br>Promoting best practice and raising awareness in end of life care:<br>• ambassador for end of life care study days x2<br>• national Dying Matters Week information stand in May<br>• presentations given at regional and national workshops and conferences<br>• poster presentations at regional and national workshops and conferences<br>• presentation at trust AGM in September |
| Areas to be progressed | Review content of the eLearning module and update as required.<br><br>To continue to use patient experience, carer experience and stories to support on-going learning in end of life care. |

| **Work Stream 6 – 24/7 access** | |
|---|---|
| Key achievements | Developed business case to support specialist palliative care team 7/7 working, face to face assessments 8.30am - 4.30pm. Presented to Trust Investment Group, Medical Division Executive Performance meeting and now to go to Trust Management Board in 2017.<br><br>Working in partnership with Dorothy House Hospice Care, community providers and CCGs to define and support access to 24/7 advice and support for patients and their families.<br><br>Reviewing palliative and end of life care information on the intranet and internet to support 24/7 access to information and advice. |
| Areas to be progressed | Progress the palliative care team 7/7 working business case.<br><br>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 | End of Life Care Working Group monitoring progress on end of life care work plan quarterly.<br><br>Established 'Forget Me Not' group December 2016 to review guidance, protocols and bereavement resources for stillbirth, neonate, infant and child death.<br><br>Representation at the community/CCG end of life care strategy group meetings to support engagement and partnership working.<br><br>Developed models with CCGs to support proactive discharge planning in end of life care. Include:<br>• Development of Enhanced Discharge Service with Dorothy House Hospice and Wiltshire CCG to support rapid discharge home to preferred place of care |

| | |
|---|---|
| | • Development of 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. |
| Areas to be progressed | Review and evaluate patient outcomes through the Enhanced Discharge Service to inform future commissioning intentions. Review and evaluate the CHC Fast Track specialist nurse/therapist post to inform future commissioning intentions.<br><br>To develop an end of life care strategy for the RUH. |

# 7. Quality Improvement Initiatives

## 7.1 The Conversation Project

The RUH has developed the Conversation Project over the last 4 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 continued to support wards with using the principles of the Conversation Project in 2016/17:

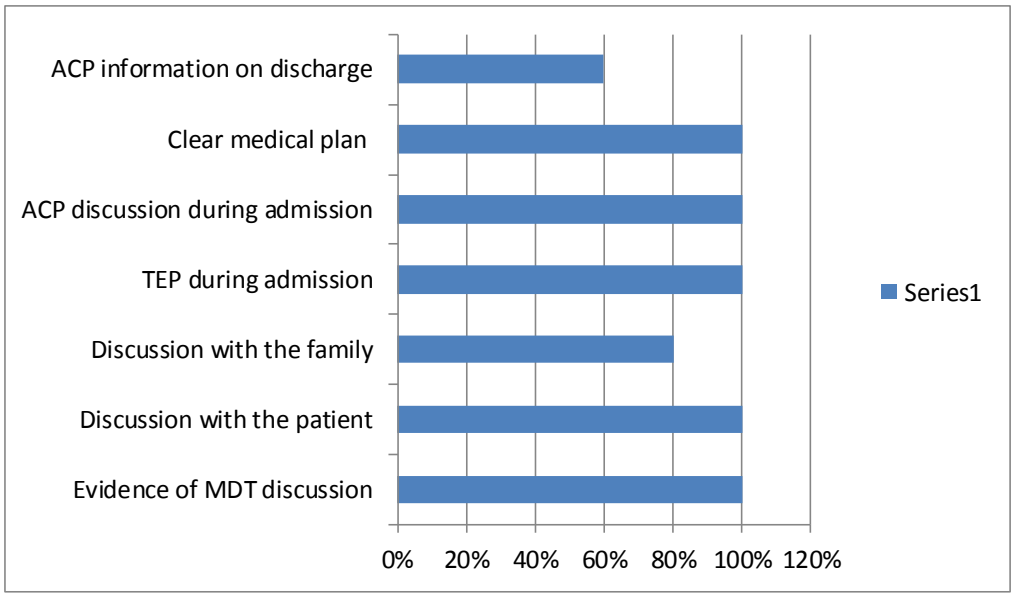
- Earlier identification of patients approaching end of life
- Supporting clinicians to have conversations with these patients and their families about their end of life care wishes or with managing uncertainty
- Documenting conversations about end of life care, ensuring these are visible to all health and social care professionals involved
- Ensuring that there is a clear medical plan in the clinical notes, that this is regularly reviewed, and that family/carers are involved
- Relaying all relevant discussions and decisions made to appropriate healthcare professionals in any transfer of care
- Education for healthcare staff about communication, advance care planning and end of life care.

### 7.1.1 Conversation Project audit

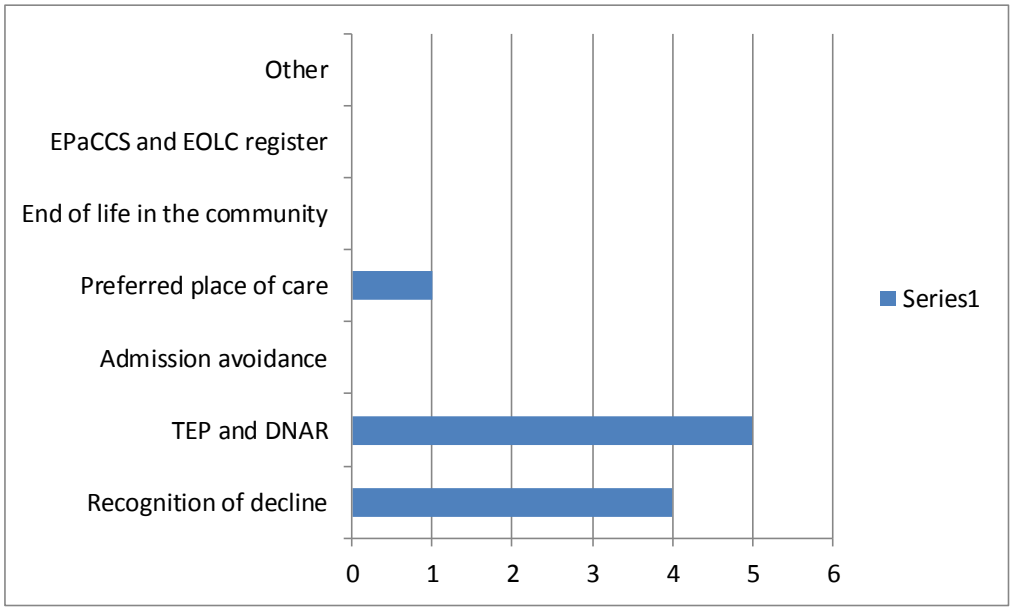
During quarter 1 an audit was completed of patient records, for patients that had been identified as having end of life care needs/ recovery uncertain. 5 audits were completed using the trust Conversation Project Audit tool (see appendix 2). The objectives of the audit tool are:

- To audit recognition of end of life care needs
- To audit conversations and discussions with the patient and their family to support advance care planning
- To audit documentation and recorded content of the conversations
- To audit sharing of information related to ACP on transfer or discharge

Graph to show outcomes form the Conversation Project audit:




Graph to show the focus of ACP discussions during admission:




From the small audit there was evidence or recognition of patients with end of life care needs and/or uncertainty of recovery during the admission. There was evidence of conversations with the patient and where appropriate with their family to support ACP and planning for future care needs. The audit did highlight a need to improve information provided on discharge in relation to ACP, including information on discussions relating to ACP during admission.

On this audit there was no evidence of patients having a community treatment escalation plan or advance decision to refuse treatment on admission.

However, in previous audits there has been evidence of a community treatment escalation plan or DNAR on admission.

Due to clinical workload within the specialist palliative care team an audit was not completed in quarter 3.

### 7.1.2 Recommendations following the Conversation Project audit

The principles of the Conversation project have been built into the eLearning module for end of life care. The module includes 2 case studies of patients with end of life care needs and the discussions required to support an understanding of patient wishes: one relating to discharge planning and one relating to the care of a dying patient.

End of life care has been approved by the mandatory training panel as 'essential training' for specified staff groups and includes the principles of the Conversation Project

### 7.1.3 Building on the Conversation Project

The SPC team will continue to support the wards using the Conversation Project, attending white board/MDT meetings to promote identification of patients, advance care planning discussions, recording of conversations in patient records and communication on advance care planning on transfer of care.

The specialist palliative care team will continue 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 20th September which included an update on the Conversation Project and resources to support the wards.

The specialist palliative care team in partnership with the respiratory nurse specialists at the RUH, now support a session on the 'Pulmonary Rehabilitation Programme' on advance care planning and thinking ahead for patients.

An information leaflet for patients and families has been developed called 'Thinking Ahead and Planning for Your Future' to support advance care planning.

The lead nurse palliative and end of life care is working with the Information Management and Technology team to develop a Conversation Project electronic assessment 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 will also support monitoring of patient outcomes and electronic audits for the Conversation Project in 2017/18.

### 7.2 Continuing Health Care Fast Track and End of Life Care Workstream

Choice and preferences for care are integral to the service improvement around discharge planning. The trust discharge project board has a workstream for Continuing Health Care (CHC) Fast Track and End of Life Care. This work stream has supported:

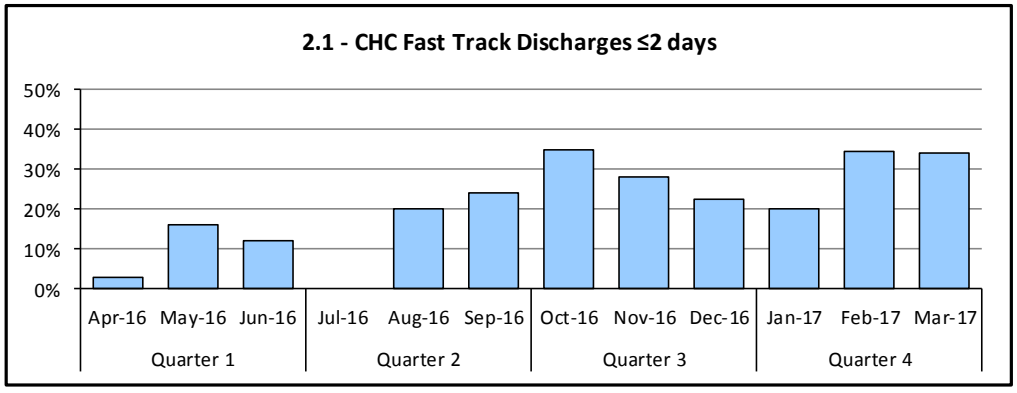
- Development of a guidance and checklist to support patient centred discharge planning in end of life care
- Development of a patient and carer information leaflet 'Discharge to Preferred Place of Care'
- Bundles of information for each CCG on the trust intranet, to support discharge through CHC Fast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

### 7.2.1 CHC Fast Track key performance indicators

This workstream reports on Key Performance Indicators (KPIs) for discharge planning to the trust discharge project board:

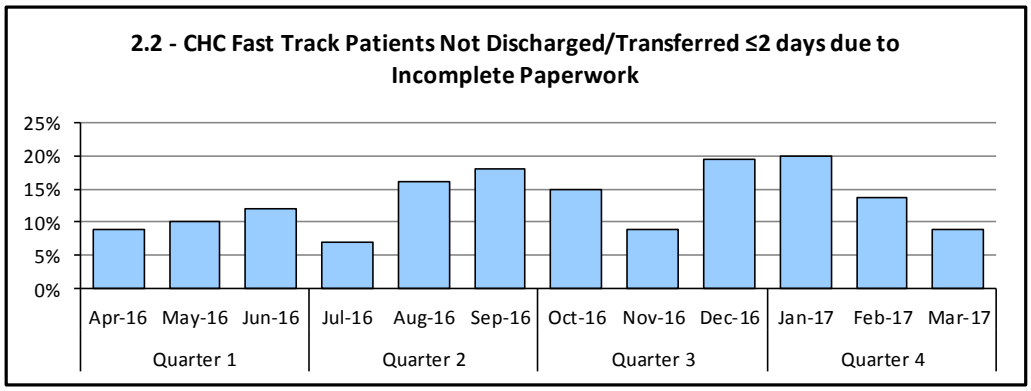
- KPI 2.1 - percentage of CHC Fast Track patient discharges within 2 days of funding approval. This KPI will be affected by available capacity within the community for packages of care and nursing home beds.

  Graph to show KPI 2.1




- KPI 2.2 - percentage of CHC Fast Track patient discharges not discharged in 2 days due to incomplete paperwork. This KPI relates to delay with internal processes.

Graph to show KPI 2.2




- KPI 2.3 – number of discharges through the Enhanced Discharge Service (see section 7.2.2).

In August 2016 a new Millennium clinical template was developed to record outcomes in discharge planning through CHC Fast Track. The data pre August 2016 was not recorded consistently so accuracy was limited. The KPIs for the workstream are reported to trust discharge project board monthly.

### 7.2.2. Developing new models to support discharge planning

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

- Developing a specialist nurse/AHP for CHC Fast Track and discharge, with BaNES CCG to support coordination and proactive discharge planning. The post will commence April 2017 on an Honorary Contract with the RUH. The post has been funded by the CCG on a fixed term for 2 years.

- Development of an Enhanced Discharge Service (EDS) with Dorothy House Hospice and Wiltshire CCG. 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 started in July and supported ‘same day’ or ‘next day’ discharges for 42 patients, from July 2016 to March 2017. Average length of stay on EDS was 14 days for these patients.

  Funding for EDS has been confirmed by Wiltshire CCG for 2017/18 to support continuation of the service.

### 7.3. Priorities for Care Documentation

In March 2016 the RUH Priorities for Care documentation version 2 was implemented across all the wards. The documentation was originally developed in response to the One Chance to Get it Right (2014) publication.

The documentation was updated to version 2 following the trust Priorities for Care audit in 2015/16 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

The documentation was developed to support decision making and identification of patients in the last days/hours of life, patient centred care, assessment of physical, psychological, social and spiritual needs, on-going review of the patient and support for the patient's family.
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 retrospective audit was completed in quarter 2 and quarter 4 of patient records, for patients that had died. Patient records were reviewed at random for 2 weeks in each quarter, in the bereavement office, by a specialist palliative care nurse and specialist teaching fellow. 28 audits were completed using the trust Priorities for Care Audit tool (see appendix 1). The objectives of this tool 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

### 7.3.1 Key findings from the Priorities for Care audit

Two small audits were undertaken in quarter 1 (8 patient records) and quarter 2 (20 patient records), using the priorities for care audit tool. These were retrospective audits of patient records in the bereavement office, of patients that had died. Patient records were chosen at random. The findings from these 2 audits are combined for this annual report. In the small sample of 28 patients, 75% of had a non-malignant diagnosis.

Table 1 - Recorded diagnosis for each patient

| Diagnosis on admission | Number of patients |
|---|---|
| Bowel cancer | 2 |
| Breast cancer | 2 |
| Cancer of unknown primary | 1 |
| Lung cancer | 2 |
| Myeloma | 1 |
| Chronic Kidney Disease | 1 |
| COPD/non-malignant respiratory disease | 7 |
| Dementia | 3 |
| Diabetes/morbid obesity | 1 |
| Heart Failure | 8 |

Table 2 - Reason for admission to hospital

| Reason for admission | Number of patients |
|---|---|
| Shortness of breath /respiratory failure | 5 |
| Pneumonia | 9 |
| Seizures | 2 |
| Sepsis | 1 |
| Acute kidney injury | 5 |
| Deterioration | 4 |
| Delirium | 1 |
| Planned admission | 1 |

Table 3 – Recognition of dying before death

| When deterioration recognised | Number of patients |
|---|---|
| 1 day before or on day of death | 10 |
| 2 days before death | 5 |
| 3 days before death | 4 |
| 4 days before death | 2 |
| 5 days before death | 3 |
| 7 days before death | 2 |
| 12 days before death | 1 |
| 13 days before death | 1 |

The length of stay for patient records reviewed in this audit was 1 – 23 days. Mean length of stay was 9 days.

Table 4 – Key findings from audit 2016/17

| | Evidence of quality of care or service (criterion) | Standard % compliance | Priorities for Care Audit findings |
|---|---|---|---|
| 1 | Evidence that that clinicians have recognised that a patient is dying. | 100% | 100% recognition and decision made by a senior clinician (consultant or SpR) |
| 2. | Evidence that conversations have been had or attempted with patient | 100% | Yes - 40%<br>NA – 60% (records state patient semiconscious, lacked capacity or too unwell) |
| 3 | Evidence that conversations have been had or attempted with family/NOK | 100% | Yes – 100% |
| 4 | Evidence of clear plan in medical records regarding goals of care including treatment escalation plan (TEP) and DNAR | 100% | Yes – 100% clear plan of care<br>Yes – 100% DNAR status recorded<br><br>20% of patients had a community TEP or DNAR form |
| 5 | Daily medical review once a decision has been made that patient is dying | 100% | Yes – 100% daily review recorded or review and plan for the weekend |
| 6 | Evidence of nursing staff attending to patient comfort and holistic needs | 100% | Yes – 100% |

| | | | |
|---|---|---|---|
| | | | |
| 7 | Evidence of patient being supported with hydration needs, comfort drinking and regular mouth care | 100% | 100% regular review of hydration needs |
| 8 | Evidence that patients and family have had opportunity to discuss spiritual needs | 35% | Yes – 35%<br>No – 65% |
| 9 | Evidence that family have been offered practical information about RUH (verbal and written) | 88% | 88% verbal information given<br>77% bereavement booklet<br>88% recorded who was present at time of death |
| 10 | Evidence of anticipatory prescribing for patient symptom control | 98% | 94% anxiolytic<br>98% analgesia<br>85% anti-secretory<br>75% antiemetic |
| 11 | Appropriate administration of medication via Continuous Subcutaneous Infusion | 100% | Yes 100% (9 patients) |

**Key:** Adherence ⩾ 80% | Adherence 60% – 79% | Adherence ⩽ 59%

### 7.3.2 Recommendations following Priorities for Care audit

The spiritual needs of the patient have been included within the new eLearning module for end of life care and were included in the Ambassadors for end of life care study day in September 2016.

Anticipatory medication was prescribed for all of the patients 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 included in junior doctor training sessions provided by the palliative care team.

The findings of the audit were discussed at the SPC team meeting October 2016 and March 2017. The findings from quarter 1 audit were presented at the RUH End of Life Care Working Group October 2016.

The Priorities for Care audit will continue in 2017/18, and findings used to inform quality improvement in care of the dying patient and their family, and training for staff.

## 8. NICE Guideline NG31 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 was used to inform the priorities for care audit in 2016/17 and training in care of the dying patient.

An action plan has been developed to monitor compliance with the new NICE NG31 and sets out plans for ongoing local audits to monitor patient outcomes in care at the end of life. This action plan was reviewed in December 2016 and continues on track.

## 9. The National Care of the Dying Audit

The national end of life care audit for hospitals is completed every 2 years. The audit was last completed in 2015/16 included a retrospective review of 80 patient records, for patients that had died in May 2015, and an organisational audit of key quality indicators.

Since the national audit was completed the RUH Priorities for Care Documentation has been reviewed and updated, and a new Trust Policy for Care of the Dying Patient and Care of the Deceased Patient developed and formally approved.

Many of the quality indicators included within the national audit, are now included within the new documentation as guidance and within the new RUH 'policy for care of the dying patient and care of the deceased patient.' A detailed action plan was developed in response to the national audit, which has been monitored by the End of Life Care steering group. The majority of actions were included within the annual workplan for 2016/17, on which progress has been made in all workstreams.

## 10. Care after death

### 10.1. Bereavement feedback

The trust had implemented a bereavement feedback initiative to support the bereaved family/carer with providing feedback. There has been no access to a website based feedback questionnaire in 2016/17, due to access issues with eQuest. A new paper feedback format has been developed and freepost returns process agreed, which will commence in 2017/18.

A 'patient story' was presented to trust board 27th July. This was a reflection from a daughter of a patient that had died at the RUH on her experience of care given to her father and her family. The reflection highlighted the importance of the 'little things that make such a difference' and which are remembered by those that are bereaved. The daughter's reflection has now also been used at the Ambassadors for end of life care training day in September and will be used in future training sessions.

The lead nurse palliative and end of life and head of patient experience have planned for a 'See it My Way' event in May 2017 for bereaved families to share their experiences of end of life care at the RUH.

### 10.2. Bereavement information

The Bereavement Booklet resource has been reviewed again this year. 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.

Information and guidance has been developed and shared with ward managers on sending a bereavement card/letter to the bereaved family following the death of a patient on the ward. The card or letter offers condolences from the ward team and offers the opportunity for the bereaved family to contact the ward team if they have any unanswered questions.

### 10.3 Time of reflection service

The RUH and the Forever Friends Charity held a 'Time of Reflection' remembrance service on 24th September at St Phillip and St James church in Bath. The service was well received by the bereaved families that attended. The RUH end of life care working group has agreed to support the planning for remembrance service annually to support bereaved families of patients that have died at the RUH.

## 11. 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 1). 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 also provide placements and training for medical students Monday afternoons and Friday mornings, during oncology placement.

### 11.1 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. The last study day was held on 20/09/16. The Ambassadors include registered nurses, health care assistants, an occupational therapist and a physiotherapist.

### 11.2 eLearning module

An eLearning module on end of life care was developed in 2015/16 and has been available to use from 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.

### 11.3 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. A training needs analysis was completed in September. End of life care training is now identified as a requirement on 'STAR' for appropriate staff groups. A training compliance trajectory for 90% has been agreed for September 2017.

Table to show end of life care training compliance March 2017

| Trust Compliance Level | | 68.7% |
|---|---|---|
| 427 Bank | | 63.6% |
| 427 Corporate Division | | 44.0% |
| 427 Medical Division | | 72.8% |
| 427 Surgical Division | | 67.1% |
| 427 Women and Children's Division | | 67.7% |

## 12. 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 were reviewed and updated.

On 9th – 13th 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 service improvement initiatives in end of life care with a stand and resources in the Lansdown foyer.

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. Each ward also has a resource folder on end of life care to support timely access to information for staff.

## 13. Partnership working with Dorothy House Hospice Care

Dorothy House Hospice Care continues to support the RUH with consultant/associate specialist in palliative medicine sessions. Over the last year these have been 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.

The RUH, Dorothy House Hospice Care and Wiltshire CCG worked in partnership in 2016/17 to develop the Enhanced Discharge Service to support rapid discharge home to preferred place of care (see section 7).

## 14. Future Developments

The End of Life Care Working Group will continue to meet quarterly in 2017/18 and have agreed a work plan for 2017/18 to oversee continued quality improvement initiatives in end of life care.

Representatives from the 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. This will include exploring the potential to develop a volunteer model for ‘compassionate companions’ for patients at the end of life in hospital, with Dorothy House Hospice Care.

The SPC team will 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.

The SPC team will continue to support progress of the business case to support the service to cover 7 days/week, 8.30-16.30, in line with national guidance.

Helen Meehan
Lead Nurse Palliative and End of Life Care
August 2017

Appendix 1

# 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 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 End of Life Care (EOLC) within the RUH Trust
- To ensure the RUH Trust complies with CQC regulation in relation to end of life care (add regulation section)
- To ensure that EOLC 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 ways to support service improvement in EOLC.

#### b. Objectives

- To agree the work plan for end of life care
- To oversee and monitor progress of RUH EOLC work stream activity
- To review and monitor compliance against National and Local targets, and regulatory standards
- To oversee plans to ensure that all staff involved in EOLC have access to relevant training
- To ensure all complaint and adverse events themes relating to EOLC 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 end of life care.

## 3. Membership

3.1 The EOLC working group membership will include:

- Executive Lead (Chair)
- Consultant in Palliative Medicine/Associate Specialist, RUH and Dorothy House (Vice Chair)

- Lead nurse palliative and end of life care
- Senior 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
- Dementia coordinator
- Specialist nurse Long Term Conditions
- Dorothy House director of clinical services/specialist nurse
- Representative from Sirona
- Representative from WH&C Community
- Representative from Somerset/Mendip Community
- Discharge liaison nurse/continuing health care
- Representative from bereavement office
- Representative from memory and legacy officer

### a. Quorum

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

### b. Attendance by Members

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

### c. Attendance by Officers

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

## 4. Accountability and Reporting Arrangements

4.1 The EOLC 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 EOLC 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 EOLC working group is authorized 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 EOLC working group, satisfying itself that appropriate processes are in place to provide the required assurance.

## 7. Monitoring Effectiveness

7.1 The EOLC 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 EOLC working group will produce an annual report in line with best practice, which sets out how the EOLC 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 Chair and EOLC 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/ end of life.

## 9. Review

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

Appendix 2 **Palliative care training annual** Royal United Hospitals Bath NHS Foundation Trust **programme 2016/17**

| 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 and Kathy | 2-3 sessions / month | 45 mins |
| Induction – **Care of the dying patient** | HCAs | Anita Paradise | Clare and Helen | Monthly | 1 ¼ hour |
| Induction - McKinley T34 training | RNs | Bettina Deacon | Annie and Clare | 2 weekly | 30 mins |
| Preceptorship - **Principles and practice in palliative and EOLC** | RNs | Training department | Annie, Kathy and Jane | Biannual | 2 hours |
| Student Nurses - **Principles and practice in palliative and EOLC** | Student nurses – NP6-7 | SPC team and Josie | Annie, Kathy and Clare | Every 6 months | ½ day |
| Return to practice – **Principles and practice in palliative and EOLC** | RNs | SPC team | Annie, 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 | SPC team | Helen, Clare and Jane | June and January | 1 day |
| HCA study day – **Care of the dying patient** | HCAs | Anita Paradise | Clare, Annie and Rachel | Yearly (June) | 1 hour |
| Conversation Project - **Communication and ACP** | Medical teams, RNs, therapists, HCAs, admin | SPC team | Rachel, Helen and Jane | 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 | | 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 | Jane and Rachel | 6 monthly | 1 hour |
| Overseas nursing – **Principles and practice in palliative and EOLC** | RNs | Lisa Foxwell | Annie, Rachel and Helen | Ad hoc | 1-2hours |

# End of Life Care Annual Report 2016/17

Caring for people nearing the end of life is one of the most important things we do in hospital. In 2016/17, the RUH supported 1497 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 2016/17 and how this has supported local and national priorities

The End of Life Care (EOLC) Working Group The group met quarterly and was chaired by the director of nursing. The group oversaw and monitored an annual work plan for quality improvement in EOLC.

## Care Quality Commission (CQC)

Outstanding ☆

Learning from the CQC inspection March 2016 were built into the end of life care work plan for 2016/17, to maintain high standards of patient centred, compassionate care.

## Specialist Palliative Care Team

- The team supported 804 patient referrals – a 23% increase on 2014/15
- 63% of patients were supported with discharge to preferred place of care
- The business case for 7/7 working did not progress
- The team had a successful bid to The Health Foundation for a grant of £29,700 to be awarded April 2017-October 2018 for the Conversation Project.

## End of Life Care Work Plan

The work plan aligned to the foundations as set out in the national framework Ambitions for Palliative and End of Life Care (2015).

## Quality Improvement Initiatives

- Conversation Project
  - SPC team continues to support wards with using the principles of the Conversation Project and audit
- CHC Fast Track and EOLC Workstream
  - Reported to RUH Discharge Project Board
  - Developed new in-reach CHC specialist nurse/therapist with BaNES CCG
  - Developed and implemented new Enhanced Discharge Service with Wiltshire CCG and Dorothy House to support rapid discharge to preferred place of care at the end of life
- Priorities for Care
  - Version 2 documentation implemented and audited

# End of Life Care Annual Report 2016/17 – slide 2

## NICE Guideline NG31 Care of the Dying Adult

Trust Policy 711 implemented and in line with NICE NG31

## National Care of the Dying Adult in Hospital Audit

Biannual national audit last completed in 2015/16. The actions form the audit were include in the 2016/17 EOLC work plan.

## Care After Death

- Bereavement Feedback
  - Patient story presented to trust board July
  - See it My Way event planning for May 2017
  - Reviewed bereavement feedback process
- Bereavement information
  - Updated RUH bereavement booklet
  - Reviewed ward team contact with families through bereavement card or bereavement letter
- Time of Reflection Service
  - Service for bereaved families held 24th September

## Support and Education for Staff

- The SPC team provided a programme of education in palliative and end of life care
- SPC team supported ward 'ambassadors' to champion communication, compassion and end of life care on the wards
- The new RUH eLearning module for EOLC was implemented
- EOLC was approved by the mandatory training panel as 'essential training' for identified staff.

## Information for public and staff

Intranet and internet resources updated. Information leaflet reviewed. Information and resources shared with staff during Dying Matters Week in May.

## Partnership working with Dorothy House Hospice

Dorothy House Hospice provided consultant in palliative care medical sessions, 5/week and 24/7 tel advice line. Partnership working has included development of EDS and supporting rapid discharge to preferred place of care.

## Future Developments

- Extending the Conversation Project through The Health Foundation Grant in 2017/18
- Progressing the business case for 7/7 working
- Continuing to support quality improvement and partnership working