Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**10**
Date of Meeting:	**25 September 2019**		

Title of Report:	**End of Life Care Annual Report 2018/19**
Status:	**For discussion**
Board Sponsor:	**Lisa Cheek, Director of Nursing and Midwifery**
Author:	**Helen Meehan, Lead Nurse Palliative Care and End of Life**
Appendices	**Palliative and End of Life Care Annual Report 2018/19 and summary 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 2018/19, the RUH supported 1302 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 2018/19 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
- Palliative and End of Life Care Strategy
- Care Quality Commission
- Specialist palliative care team
    - Aims of the service
    - Operational policy
    - Clinical activity
    - Business case to support 7/7 working
    - The Health Foundation grant
    - Non medical prescribing
    - Office move
    - Advance care planning clinical nurse specialist
    - Lead nurse for palliative and end of life care
- Palliative and End of Life Care Work plan
- 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 information

    - Bereavement feedback
    - Time of reflection service
    - Butterfly bereavement bag and card
- 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
RUH palliative and end of life care strategy	

8.	Freedom of Information
Public	

Royal United Hospitals Bath
NHS Foundation Trust

Palliative and End of Life Annual Report

April 2018 – March 2019

Chair, Alison Ryan
Chief Executive, James Scott

Contents

1. Executive Summary

1.1 This 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 12 months.

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.

1.3 A baseline assessment was completed in preparation for Care Quality Commission inspection in the summer.

1.4 The SPC team had 1164 referrals April 2018 – March 2018. The team supported 945 patients in 2017/18 for the full year. This represents a 23% increase in the last year.

1.5 The SPC team has received a 2 year grant from Macmillan Cancer Support to pilot 7 day working. This pilot commenced in November 2018.

1.6 The palliative and end of life care work plan for 2018/19 aligns to the national Ambitions for Palliative and End of Life Care (2015) and progress has been made on all 7 workstreams.

1.7 Quality improvement initiatives continued and included the Conversation Project CHAT Bundle, discharge planning and Priorities for Care Bundle for care of the dying patient.

1.8 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.

1.9 A 'See it My Way' event was held in May with patients living with a life-limiting condition sharing their experiences of care and support.

1.10 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.

1.11 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 continued with the Enhanced Discharge Service, Heart Failure Project Group, Macmillan Dorothy House and RUH Live Well Coordinator.

1.13 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.

1.14 Future developments will include implementing the Compassionate Companion Service, introducing bereavement bags for deceased patient's property and supporting a trust bereavement card.

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 2018/19, the RUH supported 1302 patients that died in hospital. This figure includes all deaths. This report gives an overview of the palliative and end of life care working group, the work plan for 2018/19 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 has met quarterly. The objectives of the working group included agreeing an annual work plan for end of life care for 2018/19 with workstreams aligned to the national framework Ambitions for Palliative and End of Life Care (2015), see section 7.

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 (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.

In the last year the working group has developed the RUH Palliative and End of Life Care Strategy.

4. Palliative and End of Life Care Strategy

The RUH palliative and End of Life Care Strategy was approved at trust board in December 2018.

The vision for the 5 year strategy aligns to our trust values:

To ensure that we provide the highest quality palliative and end of life care to our patients and their families, delivered by outstanding staff who live by our trust values.

We recognise that every patient and family matters, and that by working together we can make a difference to the provision of palliative and end of life care across our trust, but also across our community.

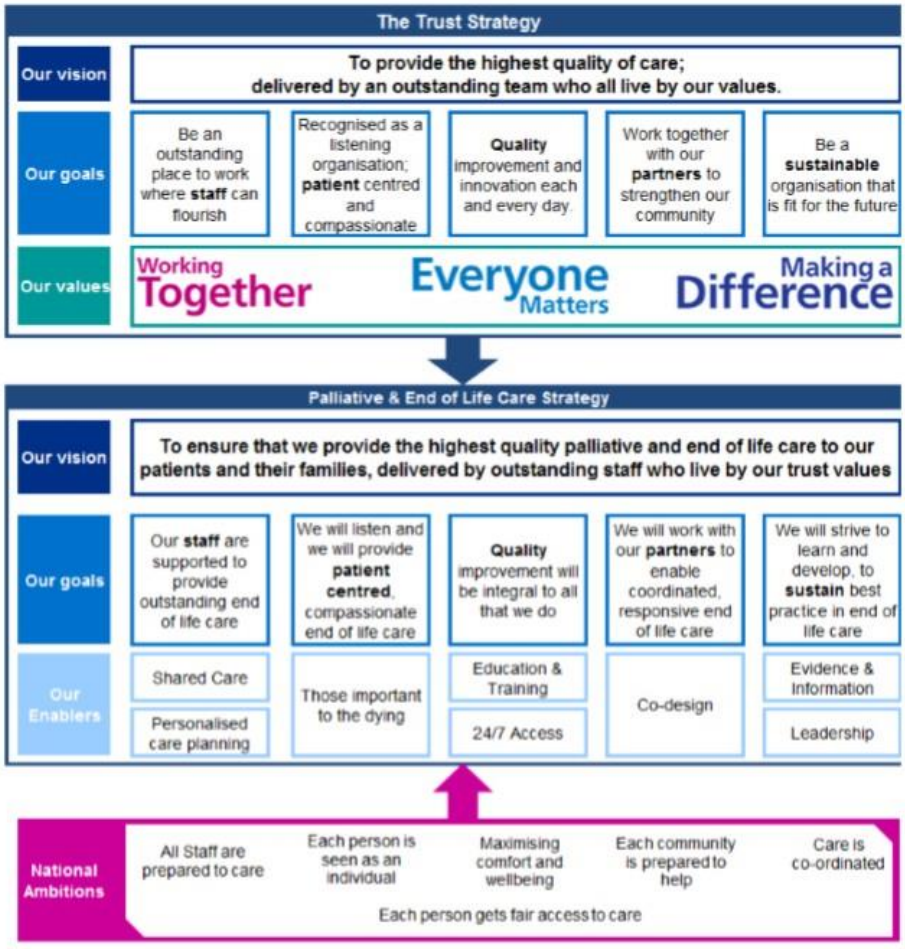
The goals set out within the strategy include:

- Our **staff** are supported to provide outstanding end of life care
- We will listen and we will provide **patient centred**, compassionate end of life care
- **Quality** improvement will be integral to all that we do
- We will work with **partners** to enable coordinated, responsive end of life care
- We will strive to learn and develop, to **sustain** best practice in end of life care

The strategy work plan outlines the actions required to deliver on these Trust goals is structured around eight foundations / enablers:

- Personalised care planning
- Shared records
- Evidence and information
- Those important to the dying person
- Education and training
- 24/7 access
- Co-design
- Leadership

Table 4.1 - to show how the palliative and end of life care strategy aligns to the trust strategy and the National Ambitions for Palliative and End of Life Care (2015)



5. Care Quality Commission (CQC)

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

Learning from the CQC inspection and recommendations were built into the palliative and end of life care work plan for 2018/19. The specialist palliative care team has continued to support quality improvement in palliative and end of life care across the trust, to support staff with maintaining high standards in patient centred, compassionate care for patients and their families.

A Key Lines of Enquiry baseline assessment was reviewed and updated in preparation for CQC inspection in 2018/19. Following CQC inspection in June 2018, end of life care remained 'outstanding.'

A CQC Core service meeting with the RUH was completed 06/03/19 with two CQC inspectors. A presentation was given to update on progress made with end of life care in relation to the Key Lines of Enquiry. The CQC felt the presentation provided an impressive overview of the work being undertaken and commended the Trust.

6. Specialist Palliative Care Team (SPC)

6.1 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.

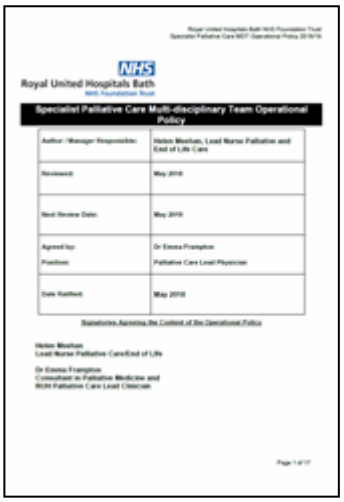
The SPC aims to achieve a high standard of care through:

- 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).

6.2. Operational policy and SPC team members


Royal United Hospitals Bath
NHS Foundation Trust

Specialist Palliative Care Multi-disciplinary Team Operational Policy

Author / Manager Responsible:	Helen Meehan, Lead Nurse Palliative and End of Life Care
Reviewed:	May 2019
Next Review Date:	May 2019
Agreed by:	Dr Emma Frampton
Position:	Palliative Care Lead Physician
Date Ratified:	May 2019

Signatories Agreeing the Content of the Operational Policy

Helen Meehan
Lead Nurse Palliative Care/End of Life

Dr Emma Frampton
Consultant in Palliative Medicine and
RUH Palliative Care Lead Clinician

The SPC team had an operational policy for 2018/19. 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 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.

From April to November 2018/19 the SPC team provided a service Monday to Friday 08.30-16.30. From November 2018/19 the SPC team commenced 7 day working, operating 08.30-16.30.

Out of Hours clinical advice was provided through the Dorothy House Hospice 24/7 advice line.

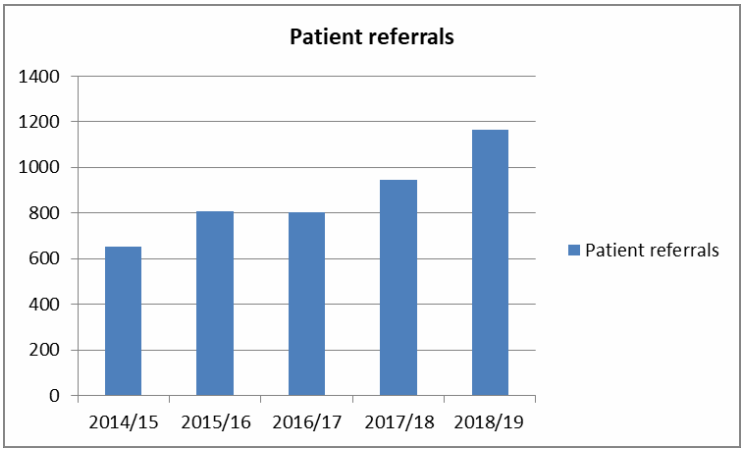
The SPC team includes:

- 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
- Clinical Nurse Specialist (CNS) palliative care (3wte), plus an additional 0.2wte in 2018/19 with a grant from The Health Foundation.
- The team recruited and additional 1.6wte palliative CNS from August with a Macmillan Cancer Support grant to enable a 2 year pilot of 7 day working
- Specialist palliative Occupational Therapist (0.4wte)
- Admin (0.69wte)

6.3. Clinical activity

The SPC team had 1164 patient referrals in 2018/19. The team had 945 patient referrals in 2017/18 for the full year. The referrals for the last year represent a 23% increase and a 79% increase in the last 5 years.

Graph 6.1 - to show increasing referrals to SPC over last 6 years



Of the 1164 patient referrals to SPC team, 34% died during their admission and 66% were supported with discharge to preferred place of care. With the 7 days working it is hoped that the SPC team will support an increasing number of discharges over the weekend and on Mondays. However, this is still dependent on community capacity to support patients out of hospital.

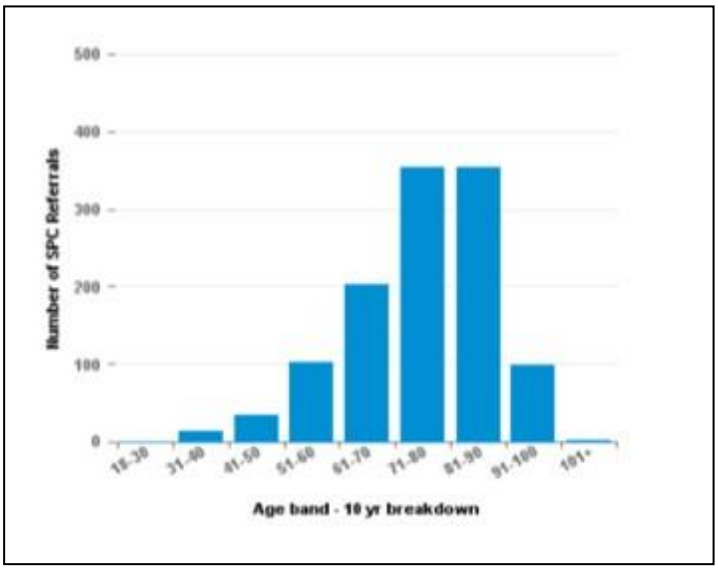
Table 6.2 – to show percentage of deaths and discharges by week day in 2018/19

Day of Discharge/Death	Died		Discharged	
Monday	55	33.7%	108	66.3%
Tuesday	64	31.4%	140	68.6%
Wednesday	45	26.6%	124	73.4%
Thursday	65	29.5%	155	70.5%
Friday	58	24.7%	177	75.3%
Saturday	52	54.2%	44	45.8%
Sunday	56	72.7%	21	27.3%

Day of Discharge/Death	Died		Discharged	
Weekday	287	29.0%	704	71.0%
Weekend	108	62.4%	65	37.6%

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 and frailty. In the last year 42% of patients referred had a primary diagnosis of malignant neoplasm.

Graph 6.3 – to show age range of patient referrals to SPC over the last year



6.4 Business case to support 7/7 working

A Macmillan Cancer Support Partnership Application was made in February 2018 to support a 2 year pilot for 7 day working. This application was successful. The team recruited of an additional 1.6wte band 7 CNS posts in August and September 2018. The increased CNS capacity has enabled the team to operate a 7 day service since November 2018. This has supported:

- Timely SPC patient reviews for symptom management
- Timely access to advice and support for staff working weekends and bank holidays
- Improved flow and timely discharge to preferred place of care for patients with complex needs.

The operational policy has been updated to include 7 day working. Team cover at weekends and Bank Holidays is reduced with 1 palliative CNS. The SPC team has introduced a 'palliative dependency rating' for the SPC caseload to support prioritization of patient being reviewed at weekends and Bank Holidays (BH). This has supported caseload management and enabled the CNS working at the weekend or BH to respond to referrals.

The service has received positive feedback since commencing 7 day working:

> *'I was on-call last weekend - we had a new patient admitted through ED on Friday night - new diagnosis of advanced metastatic disease….The Pall Care nurses were involved straight away and we got her home on the Sunday with DH support/ bed and equipment at home and everything in place.*
>
> *I was amazingly impressed by the speed at which everything was set up for her and the family in just 24 hours at the weekend!'*
>
> Consultant Oncologist

6.5. 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 has supported extension of the Conversation Project and development of resources up to March 2019.

The grant has funded an additional 0.2wte CNS band 7 hours within the SPC in 2018/19 (see section 8.1).

6.6. Non-medical Prescribing (NMP)

The SPC team has supported 1 CNS to commence the NMP course from September 2018. It is hoped that NMP will enhance the CNS role to support timely symptom management for patients with complex palliative care needs. The SPC team plans to support a minimum of 1 CNS per year to complete the NMP course.

6.7. SPC office move

In November 2018 the SPC team moved from the office in A15 to C3, as part of the cancer services redevelopment. The SPC team will now remain in C3 when the when the new cancer centre is built. The office is now much more central within the hospital site and supportive of 7 day working.

6.8. Advance Care Planning (ACP) Clinical Nurse Specialist (CNS) A

CNS from the SPC team was successfully recruited by Dorothy House Hospice Care and BaNES CCG to support advance care planning in the community and primary care. This is a 15 months secondment 3 days/week and commenced January 2019. A CNS band 7 has been recruited as backfill for the vacant hours on affixed term post.

The ACP CNS post is supporting partnership working and a shared model for ACP, using the principles form the Conversation Project and CHAT Bundle (see section 9).

6.9. Lead nurse palliative and end of life care

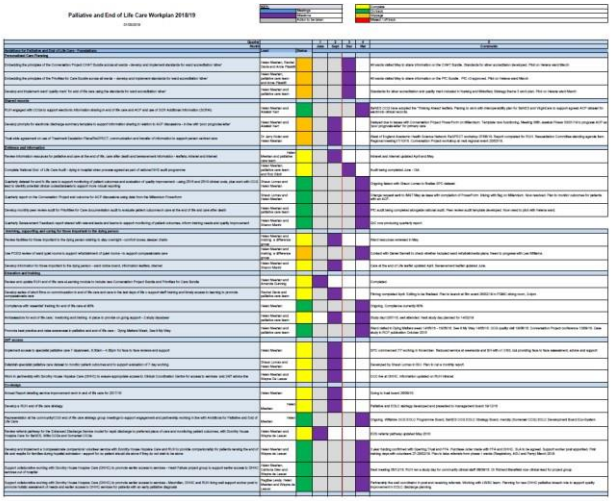
The lead nurse palliative and end of life care manages the SPC team and is strategic lead on end of life care for the Trust.

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.

7. Palliative and End of Life Care Work Plan

In 2018/19 the work plan aligned to the 'foundations' as set out in the national framework Ambitions for Palliative and End of Life Care (2015). The work plan is reviewed at every palliative and end of life care working group meeting.

Although the detail cannot be read the image below gives an indication of the work progressed over the last year.



The table below gives an overview from the palliative and end of life care work plan work streams:

Work Stream 1 - Personalised care planning	
Key achievements	Implementation of the Conversation Project CHAT Bundle 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. Implementation of the Priorities for Care Bundle and butterfly symbol to represent compassionate care at the end of life. Development of end of life care standards for silver ward accreditation aligned to Conversation Project CHAT Bundle and Priorities for Care Bundle and piloted with Helena ward. Reviewed Just in Case medication guidance for discharge planning. Developed new prescription and authorisation to administer medications for syringe driver for discharge planning.
Areas to be progressed	Continue to embed the Conversation Project CHAT Bundle on all wards. Continue to embed the Priorities for Care bundle to support compassionate care in the last days of life on all wards. Support roll out of silver accreditation standards for end of life care.

Work Stream 2 - Shared records	
Key achievements	Engaged with Clinical Commissioning Groups (CCGs) to support information sharing in end of life care. BaNES CCG adopted the RUH Advance Care Planning information leaflets 'Thinking Ahead – Guidance for Patients and Families' and 'Thinking Ahead – My Wishes.' Engaged with West of England Academic Health Science Network (AHSN) in relation to ReSPECT. SPC team ran a workshop for AHSN on the Conversation Project and ACP for the ReSPECT conference March 2019. TEP and ReSPECT Resuscitation Committee standing agenda item. Piloted Conversation Project Advance Care Planning (ACP) template on Millennium to record outcome of ACP discussions.
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. Explore potential for sharing advance care planning information electronically in line with 'poor prognosis letter' developed at University Hospitals Bristol.

Work Stream 3 - Evidence and information	
Key achievements	Completed the national audit for care at the end of life (NACEL) in hospitals. Completed the McKinley T34 Syringe Driver audit to review symptom management and policy standards for syringe driver use in palliative care. End of Life Care (EOLC) dashboard to monitor patient outcomes in EOLC across the trust reported to palliative and end of life care working group quarterly. Developed the SPC team dataset to support evaluation and monitoring of patient outcomes for patients referred to SPC team. Continued to use bereavement feedback questionnaire and developed 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.

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 Services,’ wedding boxes and ward resources. ‘Time of Reflection Service’ now held in the Spiritual Care Centre. Reviewed information resources for care after death and bereavement. Developed design for new butterfly bereavement bag for deceased patient property and agreed funding through Forever Friends Appeal. Developed design for new trust bereavement card and funding through charitable fund.
Areas to be progressed	To progress with recommendations made in PCEG review of ward quiet rooms. Implement new bereavement bags and bereavement cards.

Work stream 5 – Education and training	
Key achievements	SPC team continued to lead on training programme for end of life care (see appendix 2). Completed review of the RUH eLearning module for end of life care. Essential training for end of life care for identified staff groups, compliance monitored quarterly. End of life care included as an annual session on Grand Round. Promoting best practice and raising awareness in end of life care: • Ambassador for end of life care study day • Communication skills sessions • National Dying Matters Week – SPC team visited all wards with resources and information • Presentations given at regional and national workshops and conferences • See it My Way ‘living with a life limiting condition’ May 2018 and short film developed to support ongoing learning • 8 short films developed to support the Conversation Project and ACP conversations • Conversation Project conference September 2018 to support a shared understanding of ACP and the CHAT Bundle.
Areas to be progressed	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	Worked in partnership with Dorothy House Hospice Care, community providers and CCGs to 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. SPC team recruitment of 1.6wte palliative CNS posts through the Macmillan Cancer Support Partnership Application grant. Commenced 7 day working November 2018.
Areas to be progressed	Progress the SPC team 7 day working, monitor and use evaluation to inform business case for 7 day working.

Work Stream 7 – Co-design	
Key achievements	Representation at the community/CCG end of life care programme board and partnership meetings to support engagement and collaborative working. Reviewed the Enhanced Discharge Service referral pathway with Dorothy House Hospice to support rapid discharge home to preferred place of care. Worked in partnership with Dorothy House Hospice Care to promote collaborative working, shared learning and earlier access to hospice and community services for patients with heart failure. Worked in partnership with Forever Friends Appeal and Dorothy House Hospice to develop a 'Compassionate Companion Service.' Successful funding application with the Sperring Trust (see section) Worked in partnership with Macmillan Cancer Support and Dorothy House Hospice Care to enable a new Live Well Coordinator post to support patients with an early palliative diagnosis and enable earlier access to hospice services. Worked in partnership with VirginCare and Dorothy House Hospice Care with grant application to Health Education England to support the 'One Survey One Voice' project, developing a shared model for seeking feedback from bereaved families.
Areas to be progressed	Continue to support partnership working to benefit coordination of patient care across settings and appropriate place of care. Implement the new Compassionate Companion Service to support dignified and compassionate care in the last days of life. Implement the 'One Survey, One Voice' project to support shared learning from family experience.

8. End of Life Care Monitoring

The business intelligence unit (BIU) provides an end of life care dataset for the palliative and end of life care working group. The dataset uses the Z515 (reviewed by SPC) and Z51.8 (supported with care at the end of life) clinical codes. The dataset includes:

- Patient admissions, discharges and deaths
- Patients admission, discharge and death trends across wards
- Patients admission, discharge and death trends by day of the week
- Patient admission, discharge and death trends for malignant and non-malignant conditions
- Length of stay
- Readmission within 30 days of discharge and the patient died

The dataset is reviewed at each working group meeting.

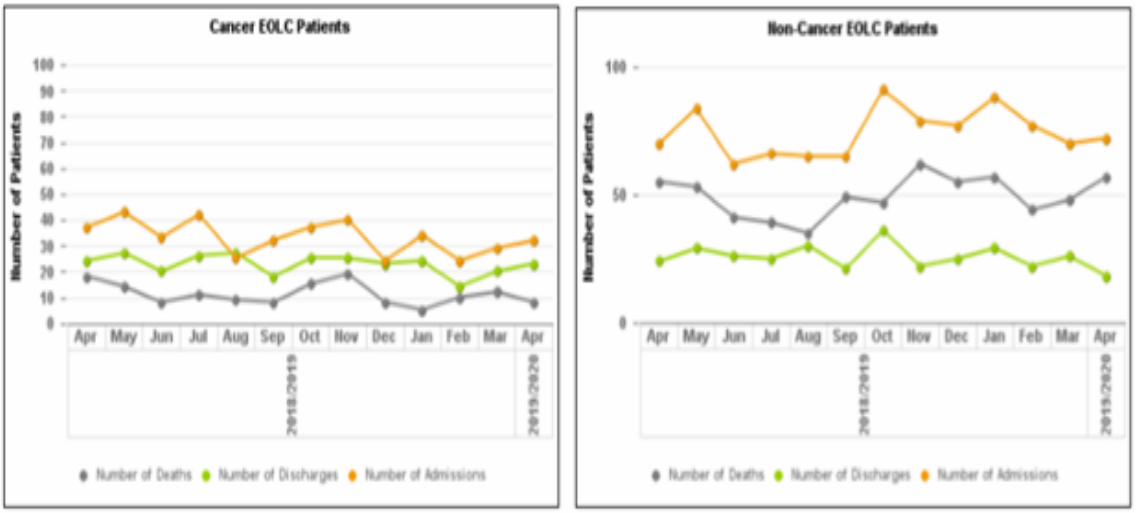
Table and graph 8.1 - number of patient admissions, discharges and deaths for clinical code Z515 (reviewed by palliative care) and Z51.8 (supported with care at the end of life)

Data up until: 31/01/2019 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	58	726
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	114	1,288
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	40.3	50.6

Data up until: 30/04/2019 2 month gap due to coding lag. Admissions will only appear once discharged & coded, resulting in longer lag & a drop in the latest month.	2018/2019												Total
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Deaths*	73	67	49	50	44	57	62	81	63	62	54	60	722
Discharges*	48	56	46	51	57	39	61	47	48	53	36	46	588
Admissions*	107	127	95	108	90	97	128	119	101	122	101	99	1,294
All In-Hospital Deaths	128	112	86	92	89	107	108	130	113	128	107	103	1,303
EOLC Deaths/All Deaths (%)	57.0	59.8	57.0	54.3	49.4	53.3	57.4	62.3	55.8	48.4	50.5	58.3	55.4

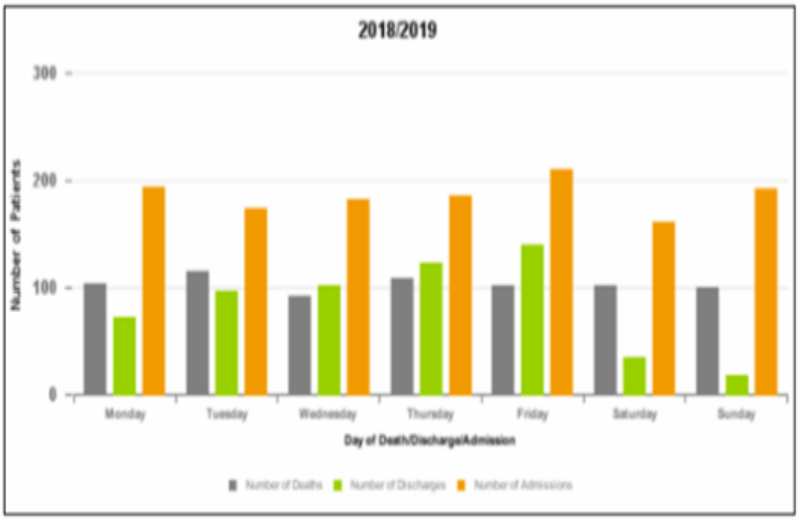
The data in table 8.1 indicates an increasing recognition of patients with end of life care needs (dying from an expected death). 55.4% of all deaths in 2018/19 were expected deaths, compared to 50.6% in the previous year.

Graphs 8.2 - number of patient admissions, discharges and deaths for clinical code Z515 and Z51.8 by diagnosis (cancer or non-cancer)



The data in graph 8.2 indicates trends for patients with a cancer or non-cancer diagnosis. In the last year there has been an increasing admission rate for patients with a non-cancer diagnosis.

Graphs 8.3 – number of patient admissions, discharges and deaths for clinical code Z515 and Z51.8 by day of the week



The data in graph 8.3 indicates a significant drop in discharges for patients with end of life care needs on Saturday, Sunday and Monday. There is no significant increase in deaths over the weekend period. There is an increase in admissions for Monday, Friday and Sundays.

Table and graph 8.4 – Patient length of stay for clinical codes Z515 and Z51.8

Metric		2018/2019												2019/2020	
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Died	Total Bed Days	1,194	816	748	726	568	747	648	1,204	783	781	694	899	922	729
	Mean Length of Stay	16.4	12.2	15.3	14.5	12.9	13.1	10.5	14.9	12.4	12.6	12.9	15.0	14.0	11.4
	Median Length of Stay	11.0	8.0	10.0	10.5	8.5	9.0	8.5	10.0	9.0	8.0	8.0	10.5	9.0	8.5
Discharged	Total Bed Days	767	1,144	605	1,156	1,064	636	861	640	688	824	449	702	617	844
	Mean Length of Stay	16.0	20.4	13.2	22.7	18.7	16.3	14.1	13.6	14.3	15.5	12.5	15.3	15.0	14.8
	Median Length of Stay	14.0	13.0	11.0	16.0	16.0	11.0	10.0	11.0	12.0	8.0	9.5	13.0	11.0	11.0

The data in graph 8.4 indicates peaks in length of stay for patients being discharged in May, July, August 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 greatest peak can be seen in the summer holiday period.

9. Quality Improvement Initiatives

9.1. The Conversation Project

The SPC team continued to support wards with using the principles of the Conversation Project in 2018/19:

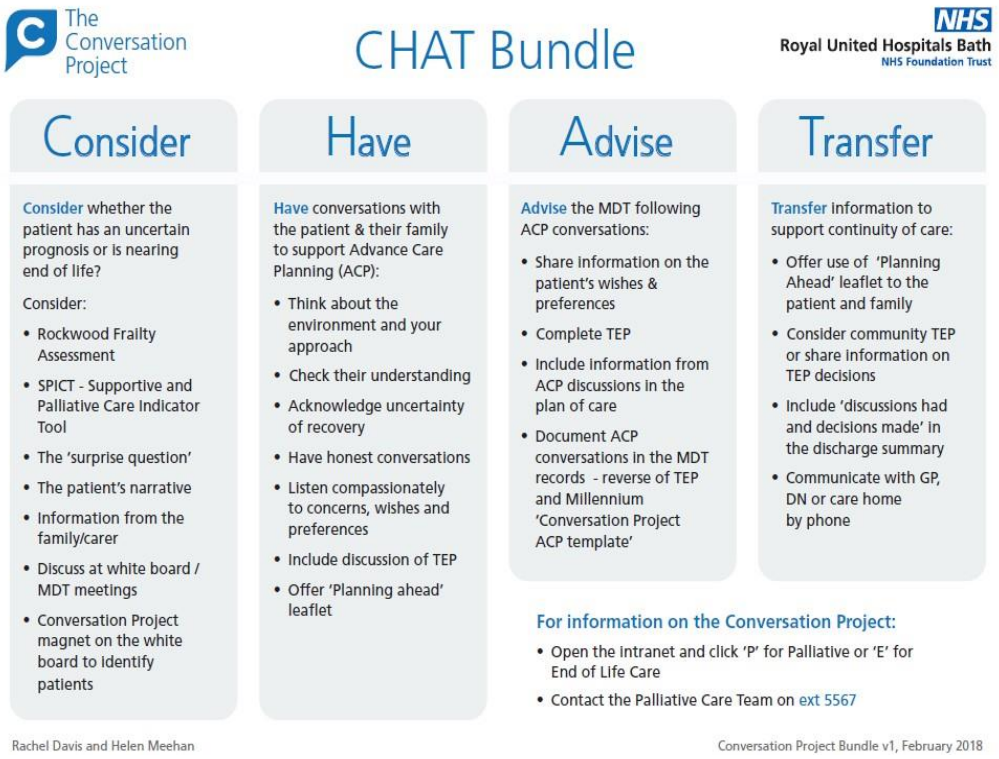
- **Earlier recognition** of end of life or recovery uncertain for patients in acute hospital setting
- **Improving communication** and advance care planning (ACP) for these patients and their families
- **Improving documentation** of conversations related to end of life care to inform management plans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

The successful grant application to The Health Foundation in 2016/17 for £29,000 continued to support extension of the Conversation Project in 2018/19 and development of resources to support sustainability. The grant supported an increase of 0.2wte CNS band 7 capacity within the SPC in the last year.

The grant has supported development of new information resources:

- Planning Ahead – A Guide for patients and families leaflet
- Planning Ahead – My Wishes leaflet
- Conversation Project CHAT Bundle
- Conversation Project intranet resource

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



The grant also supported the development of a series of short films to support staff with advance care planning conversations. The short films were launched in February 2019 and have been used in training to support compassionate conversation in end of life care and ACP.

The films include:

- Supporting a relative – nurse and patient's husband
- Thinking ahead – occupational therapist and patient
- Listening to distress – healthcare assistant and patient
- Addressing the future – doctor and patient
- Resuscitation conversation – doctor, patient and her husband
- Wishes and preferences – nurse, patient and her daughter
- A family adjusting – nurse, occupational therapist, patient and her family
- A life behind the illness – a patient story

The SPC team will develop an intranet and web based learning resource for the films in the next year with a successful NHS Health Education England grant.

The SPC team held a 'Let's CHAT Conversation Project' Conference 13th September with delegates form the RUH and partner organisations to share learning on the Conversation Project. The conference was fully booked with 80 delegates attending.

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.

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.

9.2. End of Life Care Discharge Planning

9.2.1. A Continuing Health Care (CHC) Fast Track Best Practice Group

A CHC Fast Track Best Practice group was established in June 2018 with representation from Wiltshire, BaNES CCG CHC teams, VirginCare CHC leads, Somerset in-reach Discharge Liaison Nurses (DLN), RUH Integrated Discharge Service (IDS) lead, RUH DLNs and SPC team.

The group has mapped best practice and identified challenges in CHC Fast Track discharge planning. The group has developed and tested new ways of working to support improvements in discharge planning for patients nearing end of life. This has included adding prompts to the CHC Fast Track documentation to improve the quality of applications for funding and improve timeliness of decision to fund.

9.2.2. Rapid Discharge Pathway to Preferred Place of Care

The Enhanced Discharge Service (EDS) with Dorothy House Hospice Care 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 103 patients in the last year. Average length of stay on EDS was 14 days for these patients.

9.3. 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 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, 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 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 and implemented throughout the last year:

Priorities for Care

Priorities for Care in the Last Days of Life Bundle

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Recognise

The possibility that the patient may die in the next few days or hours is recognised and communicated clearly:

- Consultant or Spr decision
- Commence Priorities for Care person centred care plan
- Review TEP
- Use of the butterfly magnet on the white board

Communicate

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

- Consider environment and manner
- Check their understanding
- Acknowledge uncertainty
- Have honest conversations
- Listen with compassion to concerns, wishes and preferences
- Consider use of 'care at the end of life in hospital' leaflet

Involve

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

- Consider physical, social, psychological and spiritual needs
- Consider side room or position in ward bay to support dignity
- Encourage the family to bring in items of importance from home

Support

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

- Support with open visiting
- Support with car parking
- Comfort Box
- Use of sleeper chair/ z bed if staying overnight
- Consider Chaplaincy support
- Consider 'companion' volunteer support
- Consider palliative care team support

Plan and Do

An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support is agreed, coordinated and delivered with compassion:

- Ongoing senior review of holistic needs of the patient daily or weekend plan using Priorities for Care
- Ongoing nursing review of comfort needs of the patient using Priorities for Care Comfort Chart

Further information on the intranet under 'P' for Palliative or 'E' for End of Life Care.

Contact the Palliative Care Team on ext 5567

Helen Meehan and Rachel Davis

Priorities for Care Bundle v1, 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:

9.3.1 Priorities for Care Audit

A trust audit of Priorities for Care is undertaken 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 in April 2018. Patient records were reviewed as part the national care at the end of life audit. 10 of these records were also audited the Trust Priorities for Care Audit tool. The objectives of this audit are:

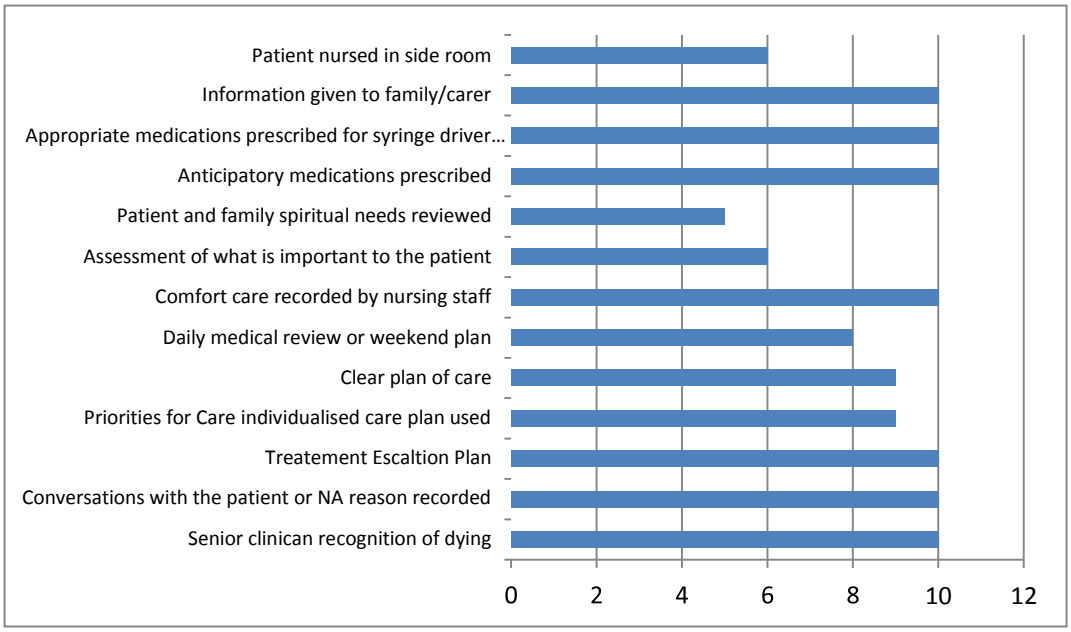
- To audit current evidence that clinicians are recognising when a patient's condition changes and that their care needs are reviewed to ensure comfort at the end of life
- To audit whether patients, and carers as appropriate, are involved in discussions about dying
- To audit whether families/carers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

9.3.2 Key findings from the Priorities for Care audit

In this small audit of 10 patient records, 80% of patient had a non-malignant diagnosis. The patient age range was 67 – 91 years. The audit included 5 female and 5 male patients.

For all 10 patients there was recognition of deterioration. The Priorities for Care documentation was used to support 9 patients.

Table 9.1 – Key findings from audit



9.3.3 Recommendations following Priorities for Care audit

- The specialist palliative care team will support the ward teams with embedding the Priorities for Care Bundle. This 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.

- The essential training elearning module has been updated and includes the new Priorities for Care Bundle.

- Assessment of spiritual needs in end of life care was included in the Ambassadors for end of life care study day 12/07/18.
- The specialist palliative care team has been working with senior nurse Quality Improvement to include standards for Priorities for Care as part of ward silver accreditation and to develop a peer audit for Priorities for Care. This will be piloted with one ward initially and will hopefully replace retrospective audit.

9.4 Ambassador Badge for End of Life Care

A new End of Life Care Ambassador badge has been developed and awarded to 11 staff since March 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:

10. 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 policy is due for review March 2019.

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.

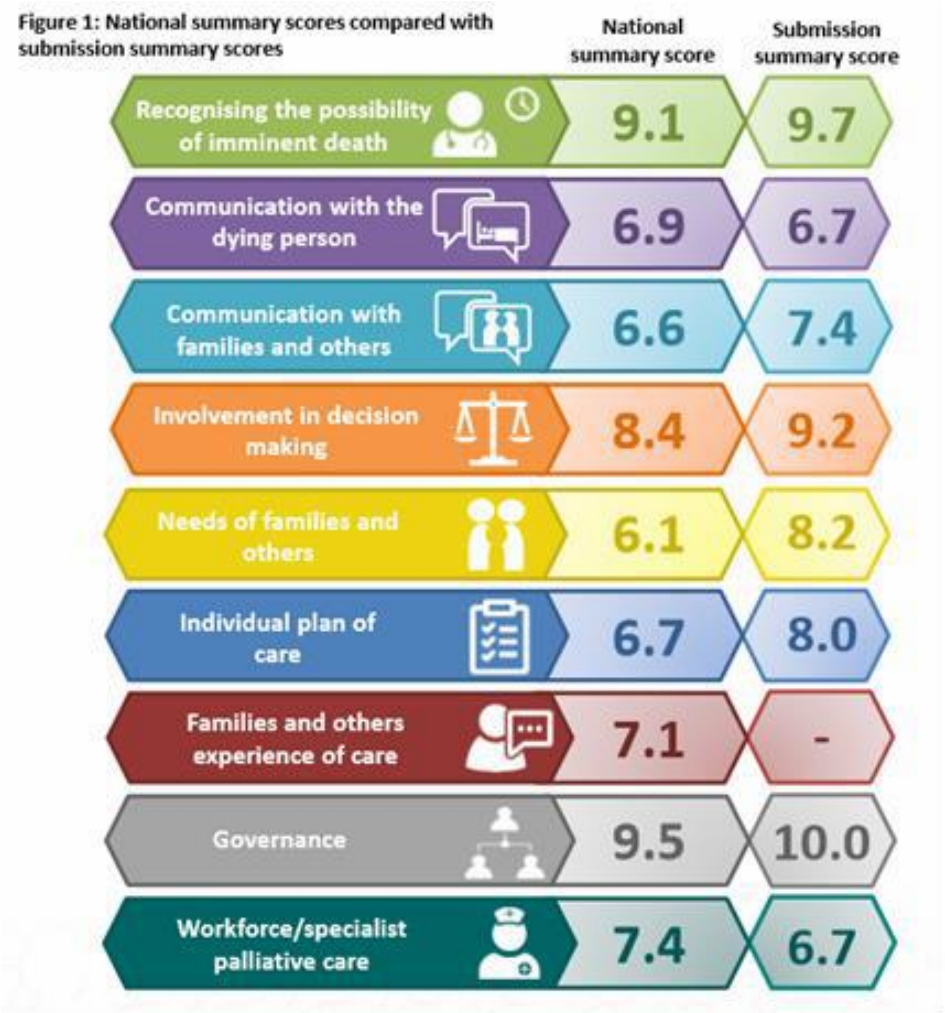
11. National Audit of Care at the End of Life (NACEL)

The trust completed the national care at the end of life audit for hospitals August to October 2018. The audit included:

- Organisation audit
- Clinical audit of 60 patient records for patients that died 01/04/18 – 30/04/18

- Quality audit – feedback questionnaire completed by bereaved families.

Table 11.1 – to show findings from NACEL 2018/19



The trust presented as above the national average across most of the standards within the NACEL audit.

Communication with the dying person score also included evidence of discussions relating to hydration and nutrition, rather than just advance care planning and recognition of dying. Communication with the family and others also included evidence of discussion around the care plan for the dying person.

Within the palliative and EOLC work plan for 2019/20 embedding the CHAT Bundle and Priorities for Care Bundle, and implementing v4 of Priorities for Care should support the improvements around recording the outcome of discussions around the dying person's care plan.

The organisational audit timeframe pre-dated SPC team 7 day working. The standard for 7 day working will improve with the next audit, with the implementation of SPCT 7 day working.

Feedback from bereaved families nationally was low in numbers and therefore data was not benchmarked for individual trusts.

The trust will be completing the NACEL audit again in 2019/20.

12. Care after death

12.1. Bereavement information

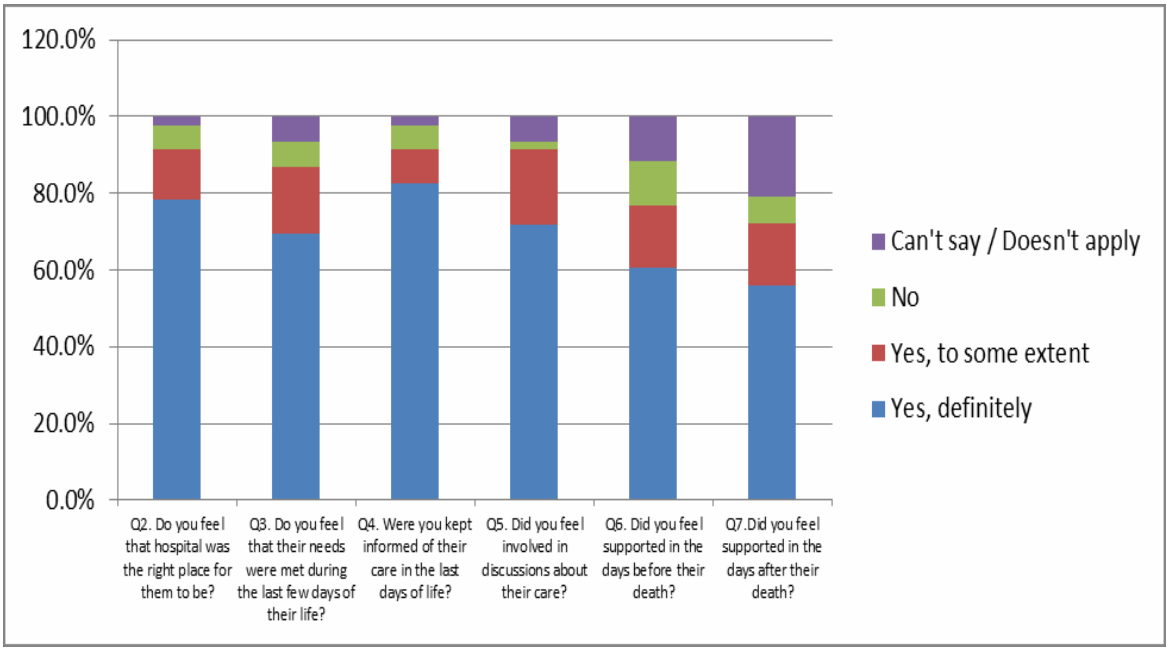
The Bereavement Booklet resource has been reviewed and updated. This booklet is offered to the family of a patient, following their death at the RUH. The booklet includes information on how to give feedback on experiences of care provided following the death of a patient at the RUH. It also includes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

12.2 Bereavement feedback

An annual report is produced 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, ward senior sisters and used to inform ongoing quality improvement.

The report below is for the full year. 46 bereavement feedback questionnaires were completed and returned. The bereavement feedback audit was suspended for the period of the NACEL bereavement questionnaires last year, so that bereaved families were not offered 2 questionnaires to complete.

Table and graph 12.1 – Bereavement feedback 2018/19



12.3 Time of reflection service

The RUH and the Forever Friends Appeal now hold ‘Time of Reflection Services’ more frequently in the Spiritual Care Centre. In September 2018 the service included bulb planting in memory of love ones, in the Spiritual Care Centre garden.

12.4. Development of new butterfly bereavement bag and bereavement card

A new butterfly bereavement bag design has been agreed and funding confirmed through Forever Friends Appeal to support delivery of 2000 bags. The butterfly bereavement bag has the Priorities for Care butterfly symbol and will be made from unbleached cotton. The bags will be used for deceased patient’s property and will be launched in Dying Matters week 2019.

The design for a new trust bereavement card has been agreed and support for 1000 cards to be printed confirmed. The cards will be launched in 2019/20.

13. 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.

13.1. Ambassadors - a collaborative for end of life care

This SPC team continues to support ward 'ambassadors for end of life care' 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 12th July 2018 and 14th February 2019. The Ambassadors include RUH registered nurses, health care assistants, an occupational therapist and a physiotherapist. A registered nurse and HCA from Dorothy House Hospice Care inpatient unit now also attend the study days. These new hospice ambassadors attend to promote partnership working with the RUH ambassadors and shared learning.

In 2018/19 at each study day the Ambassadors shared quality improvement work that they had supported on the wards and completed action plans for quality improvement in end of life care.

13.2. 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 was completed in the last year to ensure it included information about the new Conversation Project CHAT Bundle and Priorities for Care Bundle.

13.3. 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%. Trust compliance was 80% at year end.

A review of end of life care ‘essential training’ was completed and presented to the mandatory training panel in February 2019. The panel approved end of life care to continue as essential training.

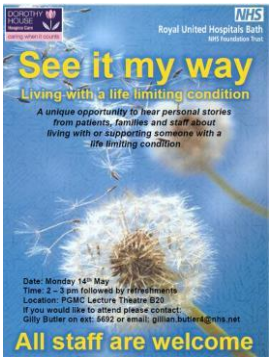
14. Information for the public and staff

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, including: advance care planning, the role of the SPC team, using McKinley T34 syringe drivers, Just in Case medications and care at the end of life in hospital. These resources have been reviewed and updated. The Priorities for Care Butterfly symbol is now added to all information resources supporting care of patients in the last days of life.

The trust 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 the last year.

On 14th – 18th May 2018 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?

During Dying Matters Week the SPC team and lead for patient and carer experience worked in partnership with Dorothy House Hospice Care to support a ‘See it My Way’ event with patients sharing their experiences of living with a life limiting condition. The ‘See it My Way’ was well attended with staff from RUH and the hospice. A short film from the event is now also available on the intranet for staff to access and support ongoing learning.



15. Partnership working

15.1 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.

15.2 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).

15.3 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

The RUH Heart Failure Specialist Nurse, Lead Nurse Palliative and End of Life Care and cardiologist provided a 'Heart Failure study day' on 6th September at DHHC for hospice and community staff.

15.4. 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 will provide companionship to patients nearing the end of life in hospital, who have limited family support or to give families a break.

In April 2018 the case for support was presented to the Sperring Trust, a charitable organisation from Midsomer Norton. The Speering Trust agreed to fund the full 3 year pilot for the Compassionate Companion Service.

The Compassionate Companion steering group was established in April and has overseen the work plan for the new volunteer project. The volunteer service will be coordinated through the existing Dorothy House Hospice Care companion service. The funding supported recruitment of a support worker in November 2018 to increase the coordination capacity of the service.

12 compassionate companion volunteers were recruited in December 2018 and January 2019. In February 2019 the volunteers completed 2 days training specific to their role as compassionate companions supporting patients in the last days of life.

Following completion of recruitment checks and mandatory training, the compassionate companions will commence volunteering in April 2019.

Information resources and referral pathway have been developed to support the new service.

The service will support 3 wards initially – respiratory, acute stroke unit and Parry ward. The service will extend to another 3 wards after 3 months, when recruitment of the second cohort of volunteers is completed. The service will operate 9am – 9pm, with volunteers supporting 3 hour shifts.

The service will be officially launched 15th May 2019, during Dying Matters Awareness Week.

A quarterly report will be produced and presented to the palliative and end of life care working group, detailing outcomes from the volunteer support

provided, number of referrals received and number of volunteer hours provided.

15.5 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 has been employed by Dorothy House Hospice Care and has an Honorary Contract to work at the RUH.

The new Partnership Live Well Coordinator was appointed in April 2018 and aligns to the RUH Live Well Beyond Cancer programme. Referrals to the Partnership Live Well Coordinator have been triaged through the RUH Live Well Beyond Cancer service. The post holder is supported by the therapy team lead for oncology and palliative care.

Despite awareness raising and communication about the new Partnership Live Well Coordinator post the referrals over the last year have been lower than expected. The RUH Live Well Beyond Cancer team is also now well established and completing holistic reviews for patients with a new diagnosis of metastatic disease and supporting them with information on services for early palliative care. The project steering group will complete a review of the partnership post early in 2019/20.

16. Future Developments

The Palliative and End of Life Care Working Group will change to a steering group to oversee implementation of the new palliative and end of life care strategy. The steering 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 steering 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, including engagement with ACP, TEP and ReSPECT.

The SPC team will continue to embed the Conversation Project Bundle and Priorities for Care Bundle to support timely, coordinated and compassionate end of life care.

The SPC team will support wards with preparing for silver accreditation standards for end of life care.

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

The SPC team will review and update the care of the dying and deceased patient policy.

The SPC team will review the 7 day working pilot to evaluate the impact of 7day working on patient outcomes in palliative and end of life care. A business case will be developed to support the increased and expected increased need for patients with complex palliative care needs. This will include continuation of 7 day working to support timely symptom management, discharge planning to preferred place of care and reduced length of stay for patients with palliative and end of life care needs.

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

The SPC team will work in partnership with Dorothy House Hospice Care implement the new Compassionate Companion Volunteer Service and support rollout across all the wards in the next 2 years.

The SPC team will work in partnership with VirginCare and Dorothy House Hospice Care to support the 'One Survey One Voice' project developing a shared model for bereavement feedback and information.

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.

The SPC team and making a difference group will implement the new RUH bereavement bag and bereavement card during Dying Matters Week 2019.

The SPC will seek charitable funding to support the refurbishment of the side lobby to the team office to create a family quiet room.

Helen Meehan
Lead Nurse Palliative and End of Life Care
August 2019

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 2018/19**

Session (session code for ESR reporting in bold)	Target audience	Organised by	SPC team leads	Date	Comments
Induction - Patient Care Afternoon **Introduction to principles and practice in palliative and EOLC**	RNs, therapists and HCAs	Training Department	Rachel, Kathy and Helen	2-3 sessions / month	45 mins
Induction Care Certificate – **Care of the dying patient**	HCAs	Anita Paradise	Clare and Annie	Monthly	1 ¼ hour
Induction - McKinley T34 training	RNs	Bettina Deaco	Clare and Annie	2 weekly	30 mins
Preceptorship – **Principles and practice in palliative and EOLC**	RNs and associate nurses	Linda Chapman	Kathy and Helen	Biannual	2 hours
Student Nurse study day - **Principles and practice in palliative and EOLC**	Student nurses – NP6-7	SPC team and Josie	Rachel and Clare	Every 6 month	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
Bands 1-4 study day – **Principles and practice in palliative and EOLC**	HCAs	Anita Paradise	Clare, Annie and Rachel	Yearly (June	1 day
Conversation Project – **Communication and ACP**	Medical teams, RNs, therapists, HCAs,	SPC team	Rachel, Helen and	Ad hoc	30mins – 1 hour
Priorities for Care - **Care of the dying patient**	Medical teams, RNs, therapists, HCAs,	SPC team	Petrena 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 (Sept/Oct)	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
Communication Skills session - **Communication and ACP**	Medical teams, RNs, therapists and HCAs	SPC team	Rachel and Helen	6 monthly	2 hours

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Caring for people nearing the end of life is one of the most important things we do in hospital. In 2018/19, the RUH supported 1302 patients that died.

- The Palliative and EOLC Working Group - oversaw the annual work plan for quality improvement
- Palliative and EOLC Strategy - approved at trust board December 2018
- Care Quality Commission (CQC) Outstanding ☆
  Baseline assessment completed. Core service meeting March 2019
- Specialist Palliative Care (SPC) Team
  - 1164 patient referrals – 23% increase in a year, 79% over last 5 years
  - 66% of patients were supported with discharge
  - 7/7 working pilot commenced – improving timely symptom management
  - Developing NMP role
  - Office move to C3
  - ACP specialist nurse BaNES CCG
- Palliative and End of Life Care Work Plan – aligned to national framework Ambitions for Palliative and EOLC (2015). Progress on all work streams.
- End of life care monitoring - Dashboard developed with BIU to monitor admissions, discharges and deaths. Improved recognition of EOLC. Trends in admissions and discharges, and peaks with LoS
- Quality Improvement Initiatives led by SPC team:
  - Conversation Project
    - Embedding CHAT Bundle and 'Thinking Ahead' resources
    - Developed series of short films
    - Conference 13/09/18
  - CHC Fast Track and EOLC Discharge Planning
    - CHC Fast Track best practice group
    - Enhanced Discharge Service supported 103 patients
  - Priorities for Care in the Last Days of Life
    - Embedding Priorities for Care Bundle and butterfly resources
    - Audit completed to monitor patient outcomes
  - Ambassador badge

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- NICE Guideline NG31 and NICE Quality Standard QS144 Care of the Dying Adult - Trust Policy 711 in line with NICE NG31. Completed review for QS144.
- National Care of the Dying Adult in Hospital Audit - Benched marked well for majority of standards. Audit pre-dated palliative team 7/7 working
- Care After Death
  - Bereavement information - updated
  - Bereavement Feedback - 46 feedback questionnaires received. Learning shared with ward sisters
  - Time of Reflection Service - Service for bereaved families held in September with bulb planting
  - Bereavement butterfly bag and card – developed and funding agreed
- Support and Education for Staff
  - The SPC team provided a programme of education in palliative and EOLC
  - SPC team supported ward 'ambassadors' to champion communication, compassion and EOLC on the wards
  - Reviewed eLearning module for EOLC
  - Essential training for EOLC reviewed
- Information for public and staff
  - Intranet and internet resources updated
  - Supported Dying Matters Week 8th – 12th May
  - See it My Way – living with a life limiting condition
- Partnership working with Dorothy House Hospice Care (DHHC)
  - Medical team 5 consultant PAs/week
  - Enhanced Discharge Service
  - Heart Failure working group
  - Case for Support with Forever Friends and funding granted through The Sperring Trust.. Steering group established and work plan.
  - Macmillan, DHHC and RUH partnership live well coordinator to enable earlier referral to DHHC
- Future Developments
  - Palliative and EOLC steering group to lead on implementation of the strategy
  - Embed CHAT Bundle and Priorities for Care Bundle
  - Support EOLC standards in silver accreditation
  - Sustain SPC team 7/7 working
  - Implement Compassionate Companion Service
  - Support quality improvement and partnership working with One Survey One Voice project