CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

16 July 2015

Report title	The end of life strategy update report of The Royal Wolverhampton NHS Trust (RWT)
Cabinet member with lead responsibility	Councillor Sandra Samuels, Health and Wellbeing
Wards affected	All
Accountable director	Gwen Nuttall, Chief Operating Officer (RWT)
Originating service	Royal Wolverhampton NHS Trust (RWT)
Accountable employee(s)	Clair Hobbs — Senior Matron – Adult Community Services Tel 01902 442590 Email Clair.hobbs@nhs.net
Report to be/has been considered by	

Recommendation(s) for action or decision:

The Panel is recommended to comment on the content of the report and provide feedback to the reporting organisation (RWT).

1.0 Purpose

1.1 This report is a scheduled update of the progress made by The Royal Wolverhampton NHS Trust in regards to the end of life strategy.

2.0 Background

2.1 End of life care is one of The Trust's three overarching priorities. Since 2013 there have been significant local and national documents about end of life care. The marking of the 2013 halfway point of the Department of Health's 10-year end of life care strategy; the demise of the Liverpool Pathway (2013); the Francis Report (2013) about the failures in care at the Mid-Staffordshire Foundation Trust that led to hundreds of deaths that were potentially avoidable; the publication of the Leadership Alliance for Care of Dying People (LACDP), 'One chance to get it right: Improving people's experience of care in the last few days and hours of life *(*2014); The National Institute for Health and Care Excellence document, Quality standard for end of life care for adults (2011); What We Know Now 2013, National End of Life Care Intelligence Network (2013); Emergency admissions to hospital: managing the demand, National Audit Office (2013); Wolverhampton Clinical Commissioning Group End of Life Care Strategy (2014); and the 2013 CQC RWT inspection made it imperative that the Trust take every opportunity to ensure that end of life care and bereavement care remains a core priority. It is important to note that the term 'end of life care' in this document refers to patients in the last 12 months of life.

2.2 The Trust's vision is to *'continually strive to improve patients' experiences and outcomes'*. With this in mind, the Trust launched a project known as Creating Best Practice with a sole aim to improve the experience of patients in the last days of their lives. This project ensures that learning and change happens across the organisation and not just in certain areas, it has a robust governance framework and is championed by the Chief Nurse.

2.3 With end of life and bereavement high on the Trust agenda, a Creating Best Practice work stream was set up to review and overhaul end of life and bereavement care across all services including community.

2.4 This work stream aimed to implement services that will meet the recommendations of The Leadership Alliance for Care of Dying People following their response to the independent review of the Liverpool Care Pathway that took place in 2014. This detailed clear recommendations for care in the last days and hours of life which included the now nationally recognised five priorities of the dying person; these priorities come into play when it is thought that a person may die within the next few days or hours:

- This possibility is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.
- Sensitive communication takes place between staff and the dying person, and those identified as important to them.
- The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.

- The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.
- An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

In cases of sudden, unexpected death these priorities can expect to be accelerated.

2.5 Other work streams within the Trust are further developing services to improve patient experience and support patient choice in the last twelve months of their lives. These include:

- Development of a Rapid Discharge process and supporting information to facilitate patients in the last days of life being discharged home to die if that is their wish.
- Development of a local electronic palliative care co-ordination system (EPaCCS) that will enable the safe sharing of palliative patient's key information that aims to prevent unnecessary admissions and/or inappropriate treatment decisions and support the patient's wishes regarding their care. This information will meet the needs of the National Information Standard for End of Life Care.
- Piloting of the Gold Standards Framework in Acute Hospitals, which aims to improve recognition of patients in the last 12 months of their lives and facilitate communication between hospital and community teams.
- A single Do Not Attempt Cardiopulmonary Resuscitation form that follows the patient and is accepted across the local health economy, preventing multiple distressing conversations with patients and families within different care environments.
- Piloting of a patient held document that details their wishes around future care, including where they want to be cared for and what is most important to them.
- Successful implementation of a Consultant Nurse led Homes In-reach Team (HIT) that supports end of life care patients in nursing homes, avoiding unnecessary hospital admissions.
- Joint working between Adult and Paediatric Community Nursing services to extend end of life care at home to transitional patients aged 16-18 years old.

3.0 Progress, options, discussion, etc.

3.1 The Creating Best Practice group have developed a new health economy wide document for staff to use when patients are in the last few days or hours of life, which is based on the five priorities. This document was launched in April 2015 and is now in use within all inpatient areas and at Compton Hospice.

3.2 The document encompasses all recommendations from the Leadership Alliance review including meeting the dying person's own needs and wishes in relation to how their care should be managed and any treatment preferences they may want to express. The plan also includes attention to symptom control (e.g. relief of pain and other discomforts) and the person's physical, emotional, psychological, social, spiritual, cultural and religious needs. The person is supported to eat and drink as long as they wish to do so, and their comfort and dignity prioritised.

3.3 This plan of care stays with the patient so that consistent information about the person's needs and wishes is shared with those involved in the person's care and be available at the time this information is needed, for example a patient who is discharged from New Cross to the care of the District Nursing Service for end of life care.

3.4 Part of the document also has a perforated page called the 'one page profile' where the patient and their loved ones can document personalised information about the patient such as 'what is important to me', 'how to support my family' which stays with the patient and is displayed in wards next to the patient's bed so it is clear for all staff to see.

3.5 The group has developed a new intranet site for staff to gain information and details regarding end of life and bereavement care.

3.6 A Trust wide launch day was held in April 2015 to introduce the Trust philosophy and new ways of working to as many staff as possible. A total of eight teaching days are also arranged at the Molineux for 50 staff on each day to fully embed the Trust's new approach. The training days are then set to continue on a monthly basis at New Cross. They are designed to be interactive with staff from all disciplines not just healthcare workers, so that the whole Trust culture and approach will transform.

3.7 The teaching days aim to:

- Raise awareness across the Trust
- Increase knowledge of Trust priorities
- Learn from each other
- Empower staff to provide a truly patient centred approach

Discussions also take place around religious and spiritual care so that staff gain greater insight into the differences between these two areas so that neither is forgotten.

3.8 As part of the development, members of the group visited Salford hospital to observe how they had successfully changed their culture and practice and embedded the five priorities. The Trust has taken some of the excellent work already achieved in Salford and utilised or adopted some of their approaches including the recognised swan symbol, which is a discreet visual aid for all staff to note when a patient is nearing the end of their life or a recently bereaved person. The swan motif is used on all new documentation and as a discreet sign next to the patients bed to assist staff visiting the ward. It also gives staff permission to think outside of the box and ensure they fully utilise a person centred approach. The motif has also been used as a print on canvas bags that will now be utilised by the bereavement office for handing over the deceased person's belongings to their loved ones rather than a generic plastic carrier bag from the Trust.

3.9 Each area including community areas are to be presented with a swan resource box to utilise, which includes all documentation that may be required, silk pouches for bereaved ones to take home the deceased persons jewellery or locks of hair. The Trust is supporting photographs being taken if bereaved loved ones should wish to do so and hand prints.

3.10 Each area across the organisation including areas such as Estates, Pharmacy and theatres are also involved in the promotion of the new approach and have identified

along with clinical areas ‘swan champions’ from their patches that will promote and communicate end of life and bereavement within their departments.

3.11 There has been a full refurbishment of the Mortuary department at New Cross Hospital and this re-opened in April 2015. The viewing area for the bereaved has also been refurbished as part of this project.

3.12 To ensure the motivation with this is not lost, quarterly meetings are to be held with the swan champions for the Trust and information from these meetings will be fed back across all departments.

3.13 There will continue to be an end of life and bereavement working group for the Trust which will involve the members of the Creating Best Practice group. This will continue to develop and steer this priority within the organisation.

3.14 Currently individual services carry out their own bereavement survey. To avoid unnecessary burden to bereaved relatives, a bereavement survey is in development that can be utilised across the Trust for inpatient and community areas. It will be co-ordinated by the Patient Advisory and Liaison service and will enable the Trust to monitor and gain valuable insight into the care it is providing to the dying person and their loved ones.

3.15 The Trust has undergone a CQC inspection in June 2015 and is voluntarily taking part in the National End of Life Care audit for inpatient areas later this year. It is hoped that this will give positive feedback to the changes that have been made and embedded.

3.16 In addition to the implementation of these services, the Creating Best Practice group will widen to support and monitor the implementation of end of life care service developments. Progress so far is:

- Rapid Discharge Home – the pilot project is well underway and its efficacy will be evaluated by the end of 2015.
- EPaCCS – Phase one of the development to identify IT requirements is completed, with phase two underway determining practical application via the trusts existing electronic clinical information system.
- Implementation of the Gold Standard Framework in Acute Hospitals pilot is underway on two hospital wards. A pre and post implementation audit will assess efficacy by March 2016.
- The health economy wide Do Not Attempt Resuscitation form is now well embedded and is working well. A bespoke e-learning package and face to face training has been developed to support its use.
- An advance care planning document called ‘My Care’ is being piloted initially at Compton Hospice and roll out across the health economy is planned, subject to successful outcome of the pilot.
- The HIT team is now well established and has proved extremely effective at helping patients achieve care and death in their normal place of residence, and reducing acute admissions. Following there great success, plans to expand the team are underway.

- In terms of the number of referrals, the demand for Transitional end of life care services is low, but when required, the positive impact on their care is very significant for patients and their families.

4.0 Financial implications

4.1 There are no financial implications arising from this report.

5.0 Legal implications

5.1 There are no legal implications arising from this report.

6.0 Equalities implications

6.1 There are no equalities implications arising from this report.

7.0 Environmental implications

7.1 There are no environmental implications arising from this report.