Trust Policy	Worcestershire Acute Hospitals NHS Trust

End of Life Care Policy

Department / Service:	Hospital Palliative Care Team
Originator:	Dr Nicola Heron, Dr Mandeep Uppal and Dr Rachel Bullock
Accountable Director:	Dr Juliet Mills (Clinical Director) Dr Julian Berlet (Divisional Medical Director)
Approved by:	Trust Management Executive
Date of approval:	17th July 2024
First Revision Due This is the most current document and should be used until a revised version is in place :	17th July 2027
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All
Target staff categories	All

Policy Overview:

This policy outlines the values, principles and practices that underpin the delivery of high quality end of life care across Worcestershire Acute Hospitals NHS Trust.

This policy is to assist all healthcare professionals who have responsibility for the care of patients the last 12 months of life. This policy identifies the key responsibilities and duties of the providers of care and managers/staff in relation to end of life care across the Trust.

In addition, this policy is designed to ensure that all staff who are involved in the care of patients at the end of life can do so in a safe and effective manner, appropriate to their role and that training, education and support is available from the Hospital Palliative Care Team.

Latest Amendments to this policy:

7th May 2019 – New document approved at Clinical Governance Group
30th June 2021- Revision of version undertaken. Document approved for 3 years at

TME
13th May 2024 - Document extended until end of September 2024 whilst discussed at Palliative Care business Meeting and DREAMS meeting
Revision of version undertaken: 30/06/21/ 28/06/24

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Contents page:

Appendices

Glossary of Terms or Abbreviations Used

ACP	Advance Care Planning
BOTB	Building on the Best
CHC	Continuing Healthcare Checklist
CNS	Clinical Nurse Specialist
DNACPR	Do not attempt cardiopulmonary resuscitation
DLN	Discharge Liaison Nurse
EOLC	End of Life Care
HPCT	Hospital Palliative Care Team
ICAD	Integrated Care after Death
ICB	Integrated care board
ILDoL	Individualised Last Days of Life Care Plan for Adults
MDT	Multidisciplinary team
ReSPECT	Recommenced Summary Plan for Emergency Care and Treatment
WAHT	Worcestershire Acute Hospitals NHS Trust

1. Introduction

The purpose of this policy is to ensure the provision of consistently high standards of care for patients assessed as being in the last 12 months of life including those in the last hours to days of life.

This is of key importance as:

- One in three hospital inpatients are in the last 12 months of life and one in three inpatients will die on that admission.
- In 2020, 6865 deaths occurred in Worcestershire across all care settings. In 2022 38.9%% of individuals died in hospital compared to the national average of 43.4% for hospital deaths. 24.6% of the deaths in Worcestershire occurred in care homes compared to the national average of 20.5%[1]. In Worcestershire the percentage of deaths occurring in hospitals is below the national average, with an above national average of deaths occurring at home (30.5% compared to 28.7% nationally).

This policy has been developed in accordance with national guidance around end of life care in hospitals. The principles of the Transforming End of Life Care in Acute Hospitals Programme[2], the Ambitions for Palliative and End of life Care: A National Framework for Local Action 2021 – 2026 [3] and National Institute for Health and Care Excellence Care of dying adults in the last days of life [4] form the foundation on which this policy is based.

2. Scope of this document

This policy refers to the care of all adult patients who have been assessed as being in the last 12 months of life and are receiving care at Worcestershire Acute Hospitals NHS Trust. It is intended for use by all multidisciplinary healthcare professionals in the hospital environment who are involved in caring for these patients. This policy should be used in conjunction with other related policies in order to ensure a holistic and integrated approach to care.

3. Definitions/Explanations of Terms used

End Of Life Care

- *What is end of life care?* A working definition of end of life care is care that helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes management of physical symptoms and provision of psychological, social, spiritual and practical support.[5,6]

- *Which patient groups?* For the purposes of this policy people are 'approaching the end of life' when they are likely to die within the next 12 months. This includes people whose death is imminent (expected within a few hours or days) and those with:
  (a) advanced, progressive, incurable conditions
  (b) general frailty and co-existing conditions that mean they are expected to die within 12 months
  (c) existing conditions if they are at risk of dying from a sudden acute crisis in their condition

(d) life-threatening acute conditions caused by sudden catastrophic events. [7]

Sustainability and Transformation Partnership (STP)

Herefordshire and Worcestershire NHS Joint forward plan

The Health and Care Act 2022 established Integrated Care Boards (ICBs). These are statutory organisations which commission services for their area and work with local services, including local authorities and wider partners, to improve population health and establish shared strategic priorities. This is done in the form of a Integrated Care Partnership (ICP) The Joint Forward Plan has been created by NHS partners across Herefordshire and Worcestershire and it describes shared priorities that partners will work on collectively over the next five years in response to the integrated care strategy and Joint Local Health and Wellbeing strategies. Palliative and End of Life care forms one of the core service areas of this plan.

Electronic Patient record

Sunrise is the new electronic patient patient record (EPR) system used across WAHT. The HPCT also dual record notes onto SystmOne which is an electronic patient record system shared with community palliative care services in South Worcestershire This allows the patients electronic record to be shared between the acute and South Worcestershire community Palliative care services and St Richards Hospice as the patient moves between care settings. North Worcestershire Community Palliative services are now using a different electronic patient record system which medical staff in the HPCT can access.

4Ward

Worcestershire Acute Hospitals NHS Trust culture programme's four signature behaviours (including: 'Do as we say we will do'; 'No delays everyday'; 'We listen, we learn, we lead'; 'Work together, celebrate together'.)

4. Responsibility and Duties

All trust healthcare professionals have a duty of care to ensure patients, who require it, receive appropriate, high quality end of life care, which encompasses systematic and holistic assessment, treatment and regular review of the plan of care.. Care must be provided in a timely manner following discussion with the clinician responsible for the patient's care. All healthcare professionals have a duty to ensure they are up to date with this policy and engage with appropriate training to enable them to confidently and competently deliver end of life care. They must also seek advice where it is needed.

The Hospital Palliative Care Team have a responsibility to offer support and training to healthcare professionals across WAHT involved in delivering high quality end of life care. At present this training is not mandatory and therefore healthcare professionals have a responsibility to access this education. The Hospital Palliative Care Team will ensure that the End of Life Care policy is current and reflects up to date national guidance.

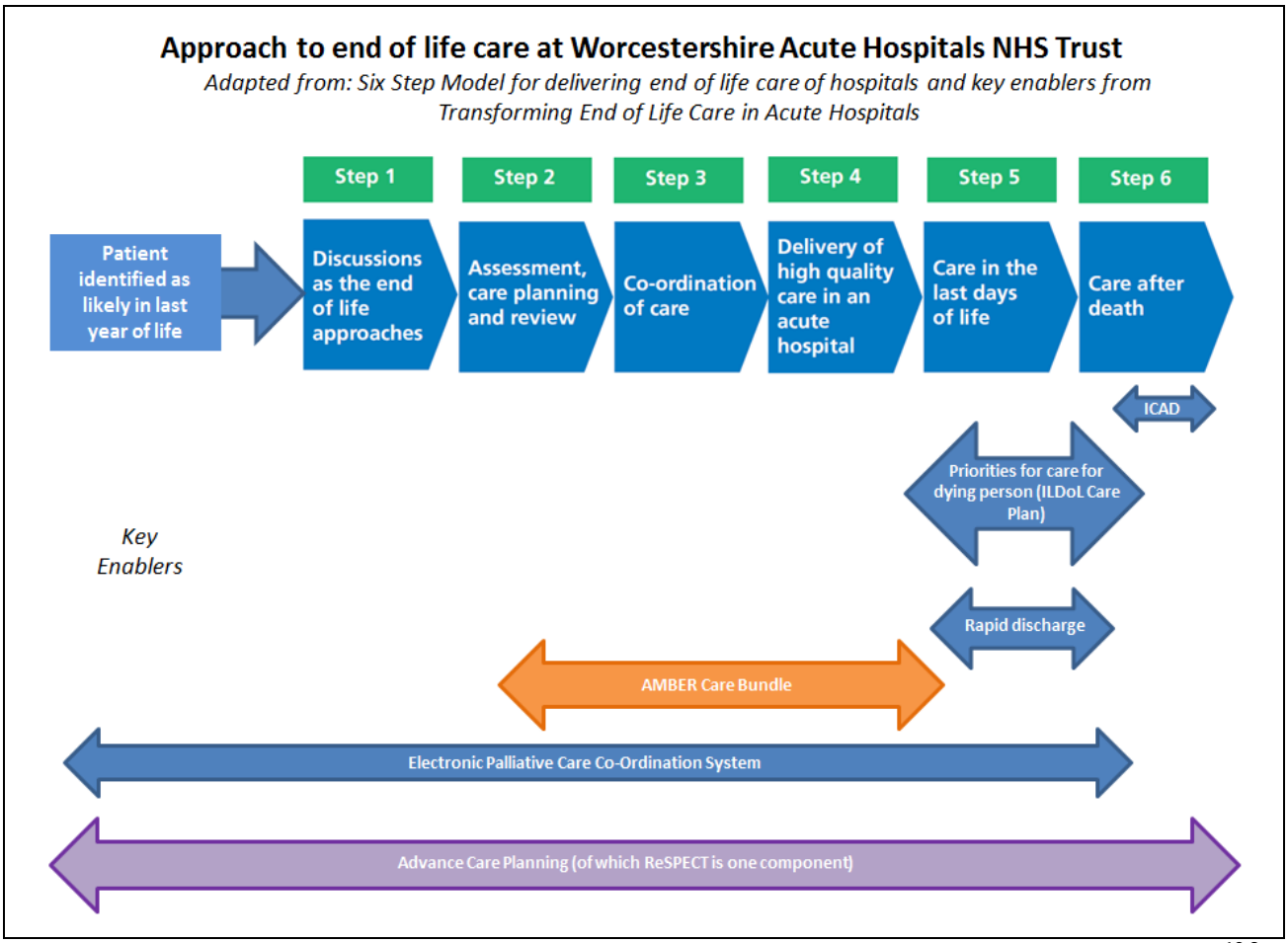
Within Worcestershire Acute Hospital Trust the recently established DREAMS (deterioration, resuscitation, end of life and mortality studies) group provides senior level leadership for End of Life Care approaches at the Trust.

The Chief Medical Officer is responsible for ensuring that this policy is implemented in a consistent manner across all clinical areas and has a responsibility to champion high quality end of life care for all patients.

The Trust Management Executive (TME) are responsible for monitoring the policy. The Hospital Palliative Care Team will provide an Annual Report and audit information to the TME to assist with this process.

5. Policy detail

In 2010, the NHS National End of Life Care Programme promoted a six-step model for delivering high quality end of life care in hospitals[10], underpinned by key enablers from the Transforming End of Life Care in Acute Hospitals[2]: These formed the basis for the 2019 – 2021 End of Life Policy and continues to provide the basis for this revised 2024policy;



(adapted from [10,2])

These key enablers have been developed locally in Worcestershire as follows:

Advance Care Planning (ACP)

Advance Care Planning is the term used to describe the conversation between people, their families and carers and those looking after them about their future wishes, preferences and priorities for care. In Worcestershire documents for Advance Care Planning, Advance Decisions to Refuse Treatment and resuscitation decisions are held within a patient held folder and should accompany a patient in all places of care. Since 2019, the Recommenced Summary Plan for Emergency Care and Treatment (ReSPECT) has been implemented across Worcestershire. The ReSPECT form provides a summary of patient preferences and treatment escalation decisions and guidance in the event of the patient requiring emergency care. It complements other advance care planning documents. Recommendations about cardiopulmonary resuscitation decisions are recorded on the ReSPECT form

Uncertain recovery plan (previously known as AMBER Care Bundle This approach is used for hospital in-patients who have an uncertain recovery from their current illness and may have a limited prognosis. It encourages continuation of treatment in the hope of recovery whilst talking openly about patient's wishes and putting plans in place in the event of their deterioration.

Rapid discharge home.

A number of helpful resources (such as, community prescription charts) can be found on the Hospital Palliative Care Team Intranet site. This resource can help ensuring a well-managed hospital discharge for end of life care patients. Fast-track discharges can be facilitated for patients who are likely to die within the next four weeks via referral to the Onward Care Team. Referral should take place once the team with clinical responsibility for the patient have completed relevant Continuing Healthcare (CHC) fast-track referral process.

Priorities of Care for the Dying Person

In response to the 'More Care, Less Pathway' report[11], the WAHT Hospital Palliative Care Team developed an individualised end of life care plan for use in hospital in-patients who were in the last hours or days of life. During 2018, this end of life care plan underwent review and after extensive consultation with healthcare professionals across the trust a new 'Individualised Last Days of Life Care Plan for Adults' has been developed explicitly based on the 'Five Priorities of Care for the Dying Person[12].' This plan has now been launched in an electronic version on Sunrise to form part of the electronic patient record.

Priorities for the care of the dying person [2]
• The possibility that the person may die within the next few days or hours is recognised and communicated clearly, decision made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed. • 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 decision about treatment and care to the extent that the dying person wants • The needs of families and other 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, coordinated and delivered with compassion.

The Individualised Last Days of Life Care Plan for Adults consists of the following components:

a) Assessment of the dying person based on the 'Five Priorities of Care for the Dying Person';
b) Algorithm for prescribing opioid analgesia at the end of life;
c) Guidance on anticipatory medication prescribing (incorporating new guidance for patients with renal impairment) and basic pharmacological considerations at the end of life chart that outlines syringe driver drug compatibility;
d) Palliative Care Symptom Observation Chart (National Early Warning System (NEWS) style observation chart to assess symptoms);
e) Guidance on the use of Palliative Care Symptom Observation chart and outline of Abbey Pain Scale Tool. (The Abbey Pain Scale can be used to assess pain in patients with dementia, delirium or who cannot communicate.);
f) Electronic daily review form on Sunrise to be completed by the medical team to ensure the individualised end of life care plan is reviewed each day and required changes to the plan made as needed.

The launch of the 'Individualised Last Days of Life Care Plan for Adults' occurred in December 2018 and included a package of face-to face training sessions offered to all healthcare professionals across the trust. The 'Individualised Last Days of Life Care Plan for Adults' has undergone revisions in response to the outcome from user feedback and trustwide audit. This includes changes to prescribing recommendations and the plan layout. It now exists in its fourth version and in April 2024 was launched in an electronic format on the WAHT electronic patient record system (Sunrise).

Revised versions of the Individualised Last Days of Life Care Plan will be promoted within Worcestershire Acute Hospitals NHS Trust via trust wide communication and be accompanied by relevant online educational resources. Online training is currently being updated, as the plan has now been launched in an electronic format on Sunrise.

Integrated Care after Death Pathway (ICAD)

This is a care after death pathway that is used in Worcestershire Acute Hospitals NHS Trust to ensure all patients have high quality care following their death in hospital. This document is now also available to complete electronically on Sunrise EPR.

The 'Ambitions' framework

Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020 was initially published by the National Palliative and End of Life Care partnership in 2015 [3]. The Ambitions for Palliative and End of Life Care Framework was extended in its current form from 2021 – 2026.It set out the collective vision of the 'Ambitions' partnership to improve end of life care in England and the framework for local action that is required to achieve that. The six Ambitions for Palliative and End of Life Care are outlined below, with the descriptions of each 'Ambition' detailed from a patient's perspective:

The Ambitions Framework for Palliative and End of Life Care was also further endorsed nationally in 'Our Commitment to you for End Life Care: the government response to the review of choice in

end of life care' [13] published in July 2016. The Herfordshire and Worcestershire Palliative and End of Life Care Network have actively engaged with the 'Ambitions' document and have developed a local strategy in response to this. This network is also collaborating with the Herefordshire and Worcestershire Joint Forward Plan to ensure palliative and end of life care remains on the strategic agenda across all care settings.

6. Implementation

6.1 Plan for implementation

The table below demonstrates the response of the Hospital Palliative Care Team and its involvement in wider palliative care services in order to implement each of the six 'Ambitions' for end of life care that underpin this policy.

AMBITION	RESPONSE	SUPPORTING EVIDENCE
Ambition One: **Each Person is seen as an Individual**	• Continued clinical use of the Uncertain recovery plan (previously known as the AMBER care bundle) and recruitment of a dedicated AMBER care bundle support nurse to promote and facilitate its use in the trust. This document also now exists in a digital format on the WAHT digital electronic patient record system (Sunrise).Ongoing use of latest version of the Individualised Last Days of Life Care Plan for Adults. This allows a personalised end of life care plan to be created for each patient based on their individual needs and circumstances and includes a new symptom control observation chart. This document now also exists in a digital format on the WAHT digital electronic patient record system (Sunrise).	• Audit of the use of the Uncertain recovery plan (previously know as the AMBER Care Bundle) • Feedback from teaching on AMBER Care Bundle • Feedback from AMBER Care Bundle Facilitate • Audit of the use of the Individualised Last Days of Life Care Plan for Adults • Outcomes from NACEL (National Audit of Care at the End of Life), the national benchmarking audit.
Ambition Two: **Each person gets fair access to care**	• Commitment and engagement with Hereford and Worcestershire Palliative and End of Life Care Network and commissioners to improve equity in quality and access to end of life care including 'harder to reach groups'. • Ongoing use of the Integrated Care after Death Pathway to aim to provide excellence in the care of patients and their families after death. • Launch of SUPPORT initiative to ensure all families/carers have access to EOLC support.	• Review of agreed and completed actions from Palliative and End of Life Care Network meetings. • Access to fully functioning carers' facilities at Worcestershire Acute Hospitals. • Feedback from families/carers who have accessed SUPPORT facilities. • Audit of the Integrated Care after Death Pathway. • Feedback from training delivered on Integrated Care after Death Pathway. • Feedback from bereavement survey
Ambition Three: **Maximising Comfort and Wellbeing**	• Access to a seven-day face to face hospital palliative care Clinical Nurse Specialist service. • Dedicated End of Life Care Facilitators, Clinical Nurse Specialists' and Palliative Medicine doctors providing end of life care education to clinical staff at all levels. • Holistic needs assessment of all patients referred to the Hospital Palliative Care Team. • Access to spiritual and psychological support. • Launch of SUPPORT programme trustwide to ensure all	• Monitoring of referral rates across a seven-day service. • Review of training matrix to monitor training uptake by clinical staff.????? • Access to inpatient assessment and support by clinical psychologist. • Support from chaplaincy team

	families/carers have access to EOLC support.	
AMBITION	**RESPONSE**	**SUPPORTING EVIDENCE**
Ambition Four: **Care is Coordinated**	• Use of a shared electronic palliative care record by specialist palliative care teams in South Worcestersh helps to ensure continuity and timely referrals between care settings. • Working collaboratively with the ReSPECT lead as part for the DREAMS network, • Involvement of members of the Hospital Palliative Care Team at site-specific multidisciplinary team cancer meetings (such as, Upper GI, Lung) • Regular palliative care multidisciplinary team discussions regarding patients on the Hospital Palliative Care Team caseload. • Healthcare professionals will be able to access advice and support at any time of day or night from someone from specialist palliative care.	• All patients discharged from the Hospital Palliative Care Team caseload have an up to date a shared electronic palliative care record in South Worcestershire. • Ongoing use of and engagement with ReSPECT countywide. • Attendance at site specific multidisciplinary care team (MDT) meetings. • Palliative Care MDT meeting outcomes included on a shared electronic palliative care record in South Worcestershire. • 24 hour, seven days a week on call service for specialist palliative care for HeatlhCare Professionals to access.
Ambition Five: **All staff are prepared to care**	• Commitment to education and upskilling all staff caring for patients at end of life. • Active engagement with 4Ward programme. • Access to clinical supervision for Hospital Palliative Care Team to maintain self-care. • Inclusion of End of Life Care and Uncertain recovery in the Fundamentals of Care programme	• Review of education training matrix to monitor training uptake by clinical staff. Feedback from palliative care teaching sessions within the trust.Engagement with team 4ward checkpoint. • Regular clinical supervision sessions for the Hospital Palliative Care Team offered by clinical psychologist. • Feedback from bereavement app data • Feedback from NACEL • Review of Uncertain recovery key performance indicators •

Ambition Six: **Each community is prepared to help**	• Engagement with Hereford and Worcestershire Palliative and End of Life Care. Involvement in national 'Dying Matters' week which raises awareness of end of life care issues nationally.	• Information events for 'Dying Matters' week.

6.2 Dissemination

The Palliative Medicine Consultants and Lead Nurse for Palliative and End of Life Care will oversee the effective communication of this approved policy to all relevant staff. This includes highlighting this policy and its information at training sessions to relevant staff and teams. This policy is also accessible via the Hospital Palliative Care Team intranet pages and WAHT Key Documents webpage.

Staff and ward teams may use this policy as needed but must be aware it is only valid on the day of printing and must refer to the Intranet for the latest version. Hard copies must not be stored for local use as this undermines the effectiveness of an intranet based system.

Individual members of staff have a responsibility to ensure they are familiar with all key documents that impact on their work and must ensure that they are working with the current version of a key document. Therefore, WAHT intranet must be the primary resource that staff use when locating documents relevant to their work.

Across the Trust, line managers are responsible for ensuring that a system is in place for their area of responsibility that keeps staff up to date with new key documents and policy changes.

This policy will be discussed at key meetings for approval and to support dissemination. The Chief Nursing Officer, matrons and ward managers will be notified electronically that this policy is available on the Intranet. It will be requested that they disseminate this information to their wards and departmental staff.

The Hospital Palliative Care Team will actively encourage implementation of the policy at ward level. They will assist with monitoring practice as outlined in the section 7 (monitoring and compliance) below and disseminating information, which will be a two-way process between the Hospital Palliative Care Team and the ward teams.

The Hospital Palliative Care Team Annual Report will be sent to Matrons, via the Chief Nursing Officer, which will highlight the implementation of the policy.

6.3 Training and awareness

The training matrix, as mapped against the six ‘Ambitions’ is outlined in the table below. Information about Palliative Care educational events and opportunities can be found on the Trust Intranet on the Learning and Development page and the Hospital Palliative Care Team page.

Ambition	Priorities for EOLC Education	Education/Training Available
Ambition One: **Each Person is seen as an Individual**	The Hospital Palliative Care Team will encourage all staff to recognise when the end of life is approaching for all conditions, including severe frailty. This will enable staff to have honest conversations with patients and their loved ones and carers. This will lead to development of shared expectations and a clear individualised care plan for every patient approaching the end of their life.	• Sage & Thyme (communications skills based course) • Palliative & End of Life Care Workshops • Uncertain recovery plan (previously AMBER Care Bundle) Training • e-ELCA (eLearning on End of Life Care for All) • Dementia training (developed by Dementia Team) • Individualised Last Days of Life Care Plan for adults – face to face, online and 'on the job' training. • Inclusion of End of Life Care in the Fundamentals of Care trustwide programme • Palliative and EOLC teaching programme for Foundation and Internal medicine trainees.
Ambition Two: **Each person gets fair access to care**	The Hospital Palliative Care Team will encourage all staff to engage with the relevant education so that patients and their carers will have access to the same quality of service. The Hospital Palliative Care Team will highlight the accessibility for healthcare professionals of any time access to speciality palliative care advice.	• Discharge Planning • Trust Induction • Informal training 'on the job' • Integrated Care After Death Pathway training • Countywide End of Life Network quarterly meetings /education • Contact details for the Hospital Palliative Care Team, including out of hours advice, included in teaching sessions and on intranet.

Ambition Three: **Maximising Comfort and Wellbeing**	The Hospital Palliative Care Team is committed to training and supporting staff in all environments to deliver patient centred high quality end of life care.	• Bespoke and collaborative training where required • Foundation Year One/Two and Internal medicine curriculum delivered in Junior Doctor training • Physicians Meeting • End of life care simulation scenario for medical students • Seven day a week Clinical Nurse Specialist visiting service and access to a Palliative Medicine Consultant to support 'on the job' training for all healthcare professionals
Ambition	**Priorities for EOLC Education**	**Education/Training Available**
Ambition Four: **Care is Coordinated**	The Hospital Palliative Care team will contribute to the development process of new approaches to co-ordinated care. The Hospital Palliative Care Team will support and encourage staff to ensure patients and records are shared in a timely manner.	• Recovery uncertain (previously AMBER Care Bundle) Training • Advance Care Planning • ReSPECT training inclusion in mandatory training • Individualised Last Days of Life Care plan for adults online videos • End of life care workshops • Inclusion of End of Life Care in the Fundamentals of Care trustwide programme

Ambition Five: **All staff are prepared to care**	The Hospital Palliative Care Team will raise awareness of end of life care issues by offering appropriate training to all staff coming into contact with patients' at the end of life.	• Inclusion of end of life care in trust induction material • Preceptorship *4x 1.30 hr session including recognising signs of dying, Five priorities of care for the dying person and care after death • Health care assistant certificate programme • Spoke placement days for nursing students • RN verification of an expected death
Ambition Six: **Each community is prepared to help**	The Hospital Palliative care team will engage with volunteers and staff who support those at the end of life to help develop communities will be well informed and confident in the support they offer.	• 'Dying Matters' Week events • Chaplaincy training (available from Chaplaincy team) •

7. Monitoring and compliance

Monitoring and compliance is outlined below:

Key control:	**Checks to be carried out to confirm compliance with the Policy:**	**How often the check will be carried out:**	**Responsible for carrying out the check:**	**Results of check reported to:** ***(Responsible for also ensuring actions are developed to address any areas of non-compliance*****)**	**Frequency of reporting:**
WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
Use of the Recovery uncertain (previously AMBER Care Bundle) across the Trust	Completion of AMBER Care Bundle audit cycle.	Annually	AMBER Care Bundle Support Nurse	DREAMS group Hospital Palliative Care Business Meeting Hospital Palliative Care Team annual report Directorate Governance Meeting	Annually
Use of the Individualised Last Days of Life Care Plan for Adults across the Trust	Completion of audit cycle for Individualised Last Days of Life Care Plan for Adults	Biannually	End of Life Care Facilitators and Palliative Medicine doctors	DREAMS Palliative Care Business Meeting Hospital Palliative Care Team annual report Directorate Governance Meeting	Annually
Use of the Integrated Care after Death Pathway across the trust	Completion of audit cycle for Integrated Care after Death Pathway.	Annually at each site (Worcestershire Royal and Alexandra Hospital)	End of Life Care Facilitators	DREAMS Palliative Care Business Meeting Hospital Palliative Care Team annual report Bereavement services	Annually
Training uptake by clinical staff.	Review of the training matrix to ascertain level of attendance as sessions.	Annually	End of Life Care Facilitators	Hospital Palliative Care Business Meeting Hospital Palliative Care Team annual report Learning and Development team	Annually

Patients discharged from the Hospital Palliative Care Team caseload have an up to date electronic palliative care record	Review at Palliative Care Team MDT meeting.	Weekly	All Hospital Palliative Care Team staff	Hospital Palliative Care Team annual report	Annually

8. Policy Review

This policy will be reviewed every three years. This policy may be reviewed earlier if there are significant changes to the national strategies that underpin this policy.

9. References

1) Public Health England End Of Life Care Profiles –https://fingertips.phe.org.uk/profile/end-of-life/data#page/0/gid/1938132883/pat/6/par/E12000005/ati/102/are/E10000034 (accessed on 5/4/19)

2) NHS England (2015) Transforming end of life care in acute hospitals: the route to success 'how to' guide. https://www.england.nhs.uk/wp-content/uploads/2016/01/transforming-end-of-life-care-acute-hospitals.pdf *(accessed on 5/4/19)*

3) National Palliative and End of Life Care Partnership (2015) Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026 http://endoflifecareambitions.org.uk/ *(accessed on 5/4/19)*

4) National Institute for Health and Care Excellence (NICE) (2015) Care of dying adults in the last days of life [NG31] NICE Guideline [NG31] https://www.nice.org.uk/guidance/ng31/resources/care-of-dying-adults-in-the-last-days-of-life-pdf-1837387324357 *(accessed on 5/4/19)*

5) National Council for Palliative Care 2006 referenced in: Commissioning End of Life Care June 2011 http://www.ncpc.org.uk/sites/default/files/AandE.pdf (accessed on 5/4/19)

6) Department of Health and Social Care (2008) End of life care strategy: promoting high quality care for adults at the end of their life. https://www.gov.uk/government/publications/end-of-life-care-strategy-promoting-high-quality-care-for-adults-at-the-end-of-their-life(accessed on 5/4/19)

7) Adapted from Treatment and care towards the end of life: good practice in decision making, the General Medical Council 2010(accessed on 5/4/19)https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/treatment-and-care-towards-the-end-of-life (accessed on 5/4/19)

8) NHS England (2014) Five Year Forward View. https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf *(accessed on 5/4/19)*

9) NHS England (March 2017) Next Steps on the NHS Five Year Forward View. https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf *(accessed on 5/4/19)*

10) NHS, National End of Life Care Programme (2010) The route to success in end of life care: achieving quality in acute hospitals. https://webarchive.nationalarchives.gov.uk/20130718121857/http://www.endoflifecare.nhs.uk/search-resources/resources-search/publications/imported-publications/the-route-to-success-in-end-of-life-care-achieving-quality-in-acute-hospitals.aspx (accessed on 5/4/19)

11) Independent review of the Liverpool Care pathway (2013). More Care, Less Pathway: a review of the Liverpool Care pathway. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/212450/Liverpool_Care_Pathway.pdf *(accessed on 5/4/19)*

12) Leadership Alliance for the Care of Dying People (2014) One chance to get it right – Improving people's experience of care in the last few days and hours of life. https://www.gov.uk/government/publications/liverpool-care-pathway-review-response-to-recommendations *(accessed on 5/4/19)*

13) Department of Health (2016) Our Commitment to you for End Life Care: the government response to

the review of choice in EOLC. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/536326/choice-response.pdf(*accessed 5/4/19)*

10. Background

10.1 Equality requirements

There are no equality issues in regard to this policy (see Supporting Document 1)

10.2 Financial risk assessment

Currently there is sufficient resource to support this policy for the next 12 months, so there is no financial risk associated with the policy. (See Supporting Document 1)

10.3 Consultation

This key document has been circulated to the following individuals for consultation;

Designation
Dr Nicola Heron – Lead Consultant in Palliative Medicine
Dr Rachel Bullock – Consultant in Palliative Medicine
Dr Mandeep Uppal - Consultant in Palliative Medicine
Avril Adams – Lead Nurse Palliative and End of Life Care
AMBER Care Support Nurse
End of Life Care facilitators

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
DREAMS meeting

10.4 Approval Process

This section should describe the internal process for the approval and ratification of this Policy.

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

Please complete assessment form on next page;

NHS Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	x	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Dr Mandeep Uppal**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Dr Mandeep Uppal	**Consultant in palliative Medicine**	mandeep.uppal@nhs.net
Date assessment completed			

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** End of Life Care Policy			
What is the aim, purpose and/or intended outcomes of this Activity?				
Who will be affected by the development & implementation of this activity?	❑ x ❑ ❑	Service User Patient Carers Visitors	x ❑ ❑ ❑	Staff Communities Other _____

Is this:	❑ Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	
Summary of relevant findings	

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age				
Disability				
Gender Reassignment				
Marriage & Civil Partnerships				
Pregnancy & Maternity				
Race including Traveling Communities				
Religion & Belief				
Sex				

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Sexual Orientation				
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)				
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)				

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)				

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	
Date signed	
Comments:	
Signature of person the Leader Person for this activity	
Date signed	
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	No

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval

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