NHS
Calderdale and Huddersfield
NHS Foundation Trust

Living Well and Dying Well

in Calderdale and Huddersfield NHS Foundation Trust

End of Life Care Strategy 2019 - 2021

compassionate care

Contents

Mission Statement

We are clear about the responsibility Calderdale and Huddersfield Foundation Trust (CHFT) has in shaping and developing end of life care across Calderdale and Huddersfield to reduce inequality and deliver better outcomes so that people approaching the end of their life and their families are fully supported by high quality services.

We look forward to and commit to working closely with all stakeholders to enhance and develop services to ensure our patients and their families/carers receive a professional, compassionate and dignified experience.

Executive Summary

The purpose of this document is to set out Calderdale and Huddersfield NHS Foundation Trust (CHFT) two year strategy for improving the care and experience of people in the last year of their lives. We are committed to working together with all stakeholders to achieve our priorities. We encourage you to help us achieve our goals by understanding our strategy and working with us to deliver it.

- We deliver individualised care that supports the person at the end of life and their family.
- We want to develop a skilled, knowledgeable and effective workforce to deliver individualised, compassionate, person centred care for all our end of life care patients and families.
- We aim to develop partnerships resulting in improved collaboration and integrated end of life care.
- We aim for collaborative working and engagement with end of life care patients and their families resulting in better person centred care.

Context

This is a revised strategy which carries forward the 3 priorities agreed in the 2016/2017 strategy and focuses on embedding change and sustaining continuous improvement across these 3 areas. It sets out CHFT's vision and priorities for 2019 – 2021 to meet national expectations and local needs for end of life care for adults under our care.

In 2016, 45% of all deaths in Calderdale and Huddersfield locality died in hospital. In 2018 Staff in our Trust cared for 1607 patients who died in hospital and approximately 480 who died at home. End of Life Care is now one of CQCs core areas of inspection, and is also part of the Quality Improvement Framework

Introduction

Delivering compassionate care to the communities we serve is the vision for CHFT. End of life care (EOLC) is one of CHFT's key priorities within the Trust Improvement Framework. In 2016, following the visit from CQC, end of life care was rated GOOD across all 5 domains.

We need to consistently strive to deliver high quality compassionate care that meets the needs of our end of life care patients and their families both in hospital and the community.

The strategy is the means by which we will drive improvements for patients at the end of life. Successful implementation of this strategy relies on ownership at every level from individual staff members, to ward and clinical areas, to speciality and division, and Trust Board level. At CHFT we will deliver exemplary care to our EOLC patients and families, care that we will have confidence in, should our own loved ones need this help.

The aim is to continue to develop our close working relationship with local commissioning groups, Calderdale and Kirklees Councils, Overgate and Kirkwood Hospices, GPs and other voluntary organisations. This partnership will support our system wide approach to end of life care services.

The strategy for 2019-2021 will have an implementation plan which will be reviewed 2 monthly at the EOLC steering group.

The strategy covers the 3 priority areas for improvement.

- Priority 1 – Identification of patients in the last 12 months of life and high quality communication with them in order to deliver excellent care
- Priority 2 – Coordinated, timely and equitable access to good care
- Priority 3 – Exemplary care in the last hours and days of life

Supporting priority

- Education

What our patients and carers expect at CHFT

- Care that is designed around the individual's needs and also acknowledges the needs of families and friends.
- End of life care that helps you live as well as possible until you die.
- That doctors and nurse caring for them should ask about their wishes and preferences and take these into account when planning care.
- Meaningful support for family and friends.
- High quality, individualised care which addresses physical, psychological, social and spiritual needs.

End of life care definition

For the purpose of this strategy, patients are 'approaching the end of life' when they are likely to die within the next 12 months.

This definition includes those where death is expected to be imminent (hours or days).

Introduction

End of life care involves people with:

a) Advanced, progressive, incurable conditions
b) General frailty and co-existing conditions that means they are expected to die within 12 months
c) Existing conditions from which they are at risk of dying due to an acute complication
d) Life threatening acute conditions caused by sudden catastrophic events

Patient and Family Experience

What do end of life care patients say they want?

- Access to the right services when they need them so they can die where they would like to be
- Being able to maintain as normal a life as possible
- Involvement of people important to them in decisions about their care
- Being free from pain and other distressing symptoms

What families said about care at CHFT

- 'The doctors never told me how ill my mum was till it was too late'
- That staff are reluctant to be explicit in stating poor outcomes. 'These are difficult circumstances but we are in an age of openness, more capable of coming to terms with the reality of a situation'
- 'I would have been more comfortable with being informed in more direct terms'
- 'The end of life care provided by doctors and nursing staff cannot be faulted'
- 'Everyone who had any dealings with the care of my father during the last days were all compassionate and extremely helpful towards me at a difficult time'

What have we done?

Calderdale and Huddersfield NHS Foundation Trust have developed many services to improve the care of people in the last year of life within both inpatient and community settings.

- Provide comfort bags for all dying patients and their families
- Glideaway beds – 8 have been bought to enable families to stay with their loved one
- End of Life Care Facilitator
- Horizon Group – established to work collaboratively across all communities
- Education – increase in EOLC education
- Companions – EOLC companions have been trained to sit with and support dying patients on our wards
- Champions – 7 month training for colleagues to become EOLC Champions
- Individualised Care of the Dying Document (ICODD) DVD and training package is now part of essential training on ESR for clinicians.
- EOLC Steering Group to facilitate and coordinate EOLC within CHFT
- Kirklees and Calderdale EOLC Education Group – to develop and facilitate EOLC education across the area ensuring equity and quality of teaching.
- In reach projects on Medical Assessment Unit/Emergency Department and the stroke wards. The Stroke project has now been completed and has shown the benefits of in reach into this area by reducing bed days and also improved patient and family satisfaction. The MAU/ED project is currently on hold but it is hoped that it will be extended by 1 year and move into other areas of need.
- New bereavement support across the Trust

Priority One

Identification of people in the last 12 months of life and high quality communication with them.

What are we working on?

- 2 year Macmillan project working in MAU and ED at HRI with a possible 1 year extension to move into other areas of need
- Communication Skills training
- Essential EOLC training for all clinicians
- Establish EOLC champions on all areas
- EOLC education to continue on Induction training for all new staff to the trust
- Ensuring CHFT has a skilled and knowledgeable workforce to enable them to care for our EOLC patients and families.
- Red bag scheme to improve communications between Care Homes and Hospital now across all care homes in Calderdale and Huddersfield
- Enable End of Life Care Facilitator to become permanent.
- Improvements in Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) discussions and review date completion.
- IT improvements– enable staff to see SystmOne to enable collaborative working.
- Working to increase the use of Electronic Palliative Care Coordination System (EPaCCS) within acute and community settings.

What does our evidence tell us?

- The Macmillan project and Stroke in-reach project have had significant impact on patient experience and in reducing bed days, improving Advance Care Planning, enabling preferred place of death.
- Not all staff are confident and have the skills to carry out EOLC conversations.
- We don't always recognise patients in the last year of life or have the right conversations with them and their families.
- DNACPR discussions and review date compliance have significantly improved since EPR, there is still room for improvement.
- On Electronic Patient Records (EPR) you can now see 10 key points of information from SystmOne. CHFT is now working with Calderdale and Kirklees CCGs to enable access to community and palliative care information on Systmone.
- High quality, individualised care which addresses physical, psychological, social and spiritual needs.

What do we need to do?

Priority Two

Coordinated, timely and equitable access to good care

What are we working on?

- Fast Track Discharge – 5 moments of care
- Spiritual and emotional support – Faith Cards, Companions, Horizon Group
- 7 day working for the Specialist Palliative Care Team
- Companions to support dying patients
- Palliative Care Out Of Hours service continues to support EOLC patients
- Trained Hospital and Community nurses to verify death

What does our evidence tell us?

- Fast Track Discharges don't always happen in a timely, well communicated manner.
- Discharges fail due to a lack of communication between patients, families hospital and community colleagues. This often results in an unnecessary readmission to hospital.
- Patients aren't being told they are dying so are unable to plan place of care or death
- The introduction of Faith Cards is now on all wards.
- CHFT now has 20 trained Companions to support patients and families in the last days of life.
- A business plan has been submitted to enable SPCT 7 day working
- There have been extra training days to complete VOED training for Community and key hospital nurses.
- Electronic Palliative Care Co-ordination System (EPaCCS) is a key platform to enable improved communication between the patient, family, hospital and community setting to improve end of life care

Priority Three

Exemplary care in the last hours and days of life

What are we working on?

- Currently in the process of adding the individualised care of the dying document (ICODD) onto EPR – We are undertaking a joint build with Bradford Trusts. This is likely to take 12 months
- ICODD and EOLC training to be part of essential skills training
- Support in bereavement, including formal surveys to assess relatives' experience and identify areas for improvement. To also maintain the close working relationship with the mortuary and general office staff who looked after our deceased patients and bereaved relatives.

The bereavement support available also includes;

- The Marigold Café has been set up to support anyone who has had a bereavement. This Café runs monthly at both Calderdale Royal Hospital and Huddersfield Royal Infirmary.
- Bereavement cards are being sent out in the surgical division to offer support and a phone number to ring with any concerns, questions or compliments. The plan is for this to be Trust wide within 2019.
- To provide cotton bags with the Marigold logo on for the relatives of the deceased patients to take their loved one's belongings home. The plan is for these to be available within 2019.
- We have improved syringe driver availability to enable excellent symptom management.
- We have trained more companions who can support patients and families in the last days of life. We now have 20 Companions available.
- The ICODD has been introduced into the community setting
- Ensuring the use of comfort bags, care of the dying leaflet and a parking permit is available to all families whose loved one is dying.

What does our evidence tell us?

- Dying is recognised very late. A recent audit highlighted that most patients were supported by the ICODD for only one day.
- Once a patient has been diagnosed as dying, families feel we look after their loved ones really well.
- Symptoms aren't always well controlled, especially respiratory distress
- Not all families receive a comfort bag, parking permit, the care of the dying leaflet, or are offered a glide away bed or a companion.
- On EPR you can now see 10 key points of information from SystmOne. CHFT is now working with Calderdale and Kirklees CCGs to enable access to community and palliative care information on Systmone.
- High quality, individualised care which addresses physical, psychological, social and spiritual needs.

In closing ...

Actions to deliver

1. Continue to train a multi professional workforce in communication skills.
2. Work with the discharge teams and Calderdale CCG integrated care model and Kirklees EOLC group to develop improved outcomes for fast track discharges.
3. Continue to participate in local and national audits
4. Collect feedback from relatives and patients and ensure any feedback is actioned
5. Continue to train and support EOLC Champions and provide EOLC training across all settings. The key themes for training across Calderdale and Kirkleesfor 2019 are 1. EPaCCs, 2. Communication, 3. Workbook implementation
6. Better IT integration betweenthe acute Trust and the community – continue to progress the work of gaining access to Systmone and EPaCCs for acute staff.
7. Add ICODD DVD onto ESR for Clinicians
8. EOLC symbol to be developed 2019/2020
9. ICODD to be added to EPR within the next year.

What will success look like?

Our progress and success must be evident to our end of life care patients and families, colleagues and commissioners. Measurable Key Performance Indicators (KPIs) relating to patient experience, safety and outcomes will be brought through the EOLC Steering Group to measure improvements and success.

Success can only be truly measured through the eyes of our patients and their families and friends. To gather this information we will send a bereavement survey following deaths in the Trust to ensure we receive family experience on what dying looks like in CHFT, both in hospital and community. Then we can better shape our services and improve the care of these patients.