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 Salim Shafeek (Clinical Director) Dr Julian Berlet (Divisional Medical Director)
Approved by:	Clinical Governance Group
Date of Approval:	7th May 2019
First Revision Due: **This is the most current document and should be used until a revised version is in place**	7th May 2021
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

Contents page:

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
EPaCCS	Electronic Palliative Care Co-ordination System
HPCT	Hospital Palliative Care Team
ICAD	Integrated Care after Death
ILDoL	Individualised Last Days of Life Care Plan for Adults
MDT	Multidisciplinary team
ReSPECT	Recommenced Summary Plan for Emergency Care and Treatment
STP	Sustainability and Transformation Partnership
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 2016, 4052 deaths occurred in Worcestershire across all care settings. Of these deaths, 43.7% of individuals died in hospital compared to the national average of 46.9% for hospital deaths. 25.7% of the deaths in Worcestershire occurred in care homes compared to the national average of 21.8%[1]. Hence, in Worcestershire the percentage of deaths occurring in hospitals is below the national average.

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 2015 – 2020 [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 pain and other 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]

Building on the Best (BOTB)
A national programme that Worcestershire Acute Hospitals Trust was selected to be involved in. The programme aimed to further improve end of life care for hospital inpatients by recognising and addressing the specific end of life care issues and needs that occur in WAHT.

Sustainability and Transformation Partnership (STP)
In response to the Five Year Forward View[8], in March 2016, NHS England divided the country into 44 footprints, bringing together NHS, local authority and other health and care organisations to collaboratively determine the future of their health and care system. These systems were first required to develop five-year, locality-based plans for the health and social care within their footprint, then referred to as Sustainability and Transformation Plans. Subsequently, as NHS England put greater emphasis on system-wide working and integration, their name and nature have changed. In March 2017, these 44 systems were renamed Sustainability and Transformation Partnerships (STPs) with the launch of Next Steps on the Five Year Forward View[9], which gave them a greater role in the planning of health and care delivery.

SystmOne
Electronic medical record system used in Worcestershire by the specialist palliative care teams, as a contemporaneous shared medical record for patients with palliative care needs.

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'.)

WHiN
Worcestershire and Herefordshire Integrated Network for palliative care education which is a project developed by the Worcestershire Palliative and End of Life Care Network in response to the STP.

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 review of care provided. 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 ensure they are confident and competent to 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 all healthcare professionals in delivering high quality end of life care. The Hospital Palliative Care Team will ensure that the End of Life Care policy is current and reflects up to date national guidance.

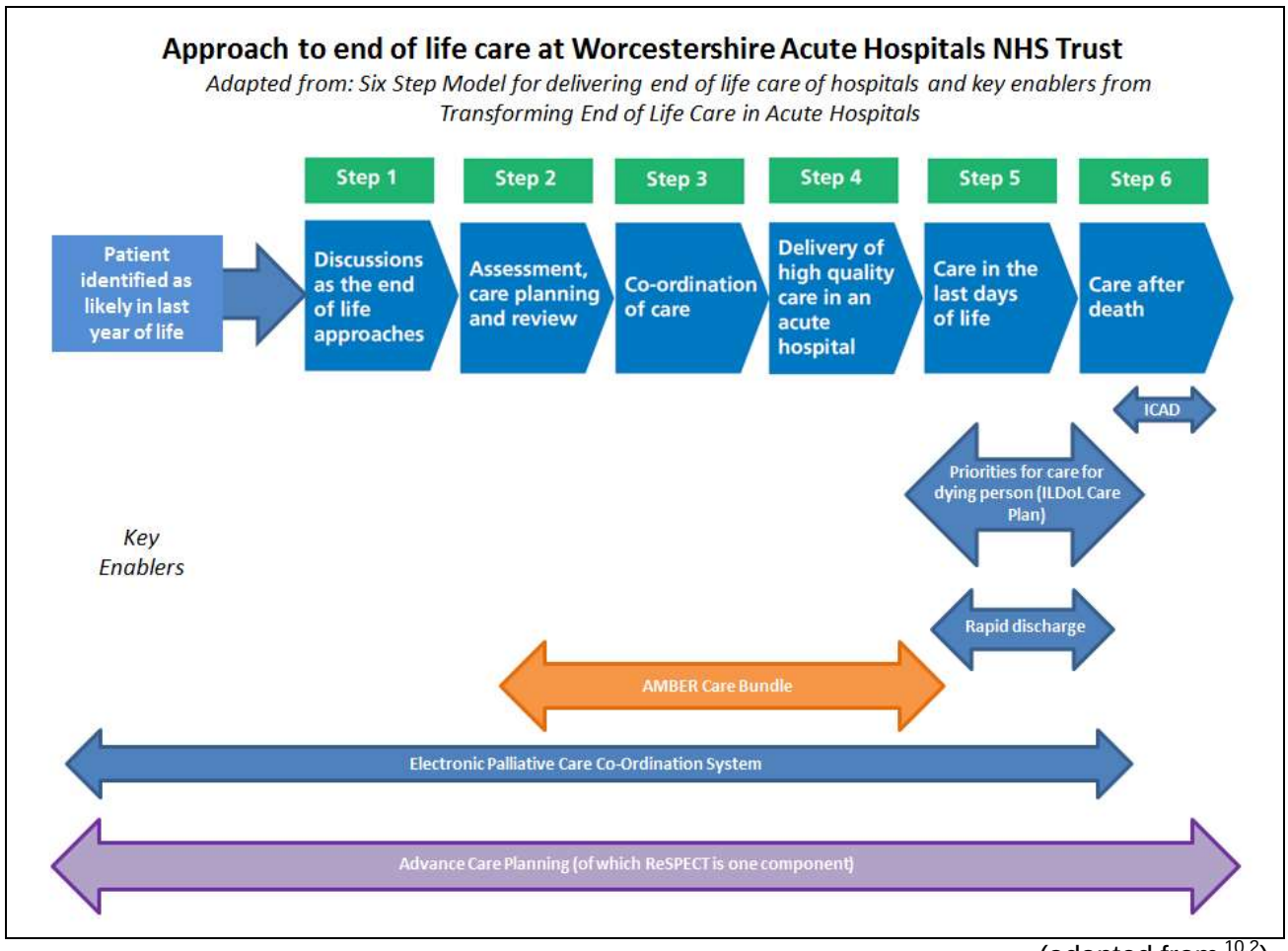
The Chief Medical Officer, Chief Nursing Officer, Divisional Directors of Nursing, Clinical Directors, Matrons and Lead Clinicians are responsible for ensuring that this policy is

implemented in a consistent manner across their areas and have a responsibility to champion high quality end of life care for all patients cared for in their clinical areas.

The Trust Board are responsible for monitoring the policy. The Hospital Palliative Care Team will provide an Annual Report and audit information to the Trust Board 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]:



(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 DNACPR are held within a patient held folder (known as a 'Greensleeve') and should accompany a patient in all places of care. During 2019, use of the Recommenced Summary Plan for Emergency Care and Treatment (ReSPECT) will be

implemented across Worcestershire. When a ReSPECT form has been completed it will provide a summary of patient preferences in the event of needing emergency care and will complement current advance care planning documents. Recommendations about cardiopulmonary resuscitation decisions will be recorded on these forms (replacing the red DNACPR forms.)

Electronic Palliative Care Co-ordination System (EPaCCS).

EPaCCS (Black Pear) is an electronic palliative care record which is available to relevant healthcare professionals, such as: ambulance crews; primary care teams; community specialist palliative care providers; care agencies; and hospital staff. This enables access to the most up-to-date summary of the patient's wishes regarding their end of life care including cardiopulmonary resuscitation status and preferred place of care and death.

AMBER Care Bundle.

This approach is used in hospitals when clinicians are uncertain whether a patient may recover and are concerned that they may only have a few months to live. 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 rapid-discharge flow chart and 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. The Discharge Liaison Nurses (DLNs) co-ordinate fast-track discharges for patients who are likely to die within the next six weeks. Referral to the DLNs should take place once the team with clinical responsibility for the patient have completed relevant Continuing Healthcare (CHC) fast-track referral forms.

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 end of life care plan for use in hospital in-patients who were in the last hours or days of life. As part of a work stream of the national Building on the Best programme, 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].'

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) Four 'Daily Review' care stickers to be added in the medical notes as prompts to ensure that the 'Five priorities of care for the dying person' are being considered on a daily basis.

The launch of the new ' 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. 'On the job' training and an online educational training package (accessed via the Hospital Palliative Care Team Intranet page) continues to be available for trust staff.

Integrated Care after Death Pathway (ICAD)

Care after death process that is used in Worcestershire Acute Hospitals NHS Trust to ensure all patients have high quality care following their death in hospital.

The 'Ambitions' framework

Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020 was published by the National Palliative and End of Life Care partnership in 2015 [3]. It sets 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. It is advised that Sustainability and Transformation Partnerships (STP) use the 'Ambitions' framework to ensure choice in end of life care is included in proposals. The 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 Worcestershire and Herefordshire STP 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 AMBER care bundle and recruitment of a dedicated AMBER care bundle support nurse to promote and facilitate its use in the trust. • Development and launch of a new 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.	• Audit of the use of the AMBER Care Bundle • Feedback from teaching on AMBER Care Bundle • Feedback from AMBER Care Bundle Facilitator • Audit of the use of the Individualised Last Days of Life Care Plan for Adults • Feedback from teaching on the Individualised Last Days of Life Care Plans for Adults. • Outcomes from NACEL (National Audit of Care at the End of Life)
Ambition Two: **Each person gets fair access to care**	• Commitment and engagement with countywide 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'. • Building on the Best programme identified areas for development to improve access to carers' facilities across the trust. • Development and introduction of Integrated Care after Death Pathway to aim to provide excellence in the care of patients and their families after death.	• 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 facilities. • Audit of the Integrated Care after Death Pathway. • Feedback from training delivered on Integrated Care after Death Pathway.
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 Specialist's 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.	• 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.

AMBITION	RESPONSE	SUPPORTING EVIDENCE
Ambition Four: **Care is Coordinated**	• Countywide electronic palliative care co-ordination system (EPaCCS) records. • Countywide use of SystmOne by all specialist palliative care teams for both medical records and to ensure timely referrals between care settings. • Working collaboratively with the ReSPECT implementation team. • 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 EPaCCS record where appropriate. • All patients discharged from the Hospital Palliative Care Team caseload have an up to date SystmOne record. • Implementation of ReSPECT countywide. • Attendance at site specific multidisciplinary care team (MDT) meetings. • Palliative Care MDT meeting outcomes included on SystmOne. • 24 hours, seven days a week on call service for specialist palliative care.
Ambition Five: **All staff are prepared to care**	• Commitment to education and upskilling all staff caring for patients at end of life. This includes engagement with WhIN (Worcestershire Herefordshire Integrated Network). • Active engagement with 4Ward programme. • Access to clinical supervision for Hospital Palliative Care Team to maintain self-care.	• Review of education training matrix to monitor training uptake by clinical staff. • Engagement with team 4ward checkpoint. • Regular clinical supervision sessions for the Hospital Palliative Care Team offered by clinical psychologist. • Feedback from teaching sessions within the trust.
Ambition Six: **Each community is prepared to help**	• Engagement with Worcestershire Palliative and End of Life Care Network community project ‘Before I die, Worcestershire’ which raises awareness of end of life care issues locally • 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, the 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 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 • AMBER Care Bundle Training • e-ELCA (eLearning on End of Life Care for All): ACP • Dementia training (developed by Dementia Team) • Individualised Last Days of Life Care Plan for adults – face to face, online and 'on the job' training.
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 Training where required • Foundation Year One/Two curriculum delivered in Junior Doctor training • Physicians Meeting • Core Medical Training teaching sessions • 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.	• AMBER Care Bundle Training • Advance Care Planning • ReSPECT training (due to commence 2019)
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.	• 4WARD Culture Training • Key Enablers Training • Preceptorship *4x 1.40 hr session includes Care after Death and Clinical Emergency Recognition Training • Care Certificate Training • Bespoke Training for Students
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) • Carers Support Training (accessed via Worcestershire Association of Carers)

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 AMBER Care Bundle across the Trust	Completion of AMBER Care Bundle audit cycle.	Annually	AMBER Care Bundle Support Nurse	High Impact Action Group Hospital Palliative Care Business Meeting Hospital Palliative Care Team annual report	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	High Impact Action Group Hospital Palliative Care Business Meeting Hospital Palliative Care Team annual report Physicians 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 Hospital and Alexandra Hospital)	End of Life Care Facilitators	High Impact Action Group Hospital 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 SystmOne 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 two 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 2015-2020 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
Tess Makinson – End of Life Care Facilitator
Rachel Hodge – End of Life Care Facilitator
Alice Ferguson – AMBER Care Support Nurse

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

Committee
Oncology, Haematology and Palliative Care Directorate Governance
SCSD Divisional Governance
Clinical Governance Group

10.4 Approval Process

This policy has been approved through the Oncology, Haematology and Palliative Care Directorate Governance meeting. SCSD Divisional Governance and the Clinical Governance Group.

10.5 Version Control

This section should contain a list of key amendments made to this document each time it is reviewed.

Date	Amendment	By:

Supporting Document 1 - Equality Impact Assessment Tool

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

		Yes/No	Comments
1.	**Does the policy / guidance affect one group less or more favourably than another on the basis of:**		
	Age	No	
	Disability	No	
	Gender reassignment	No	
	Marriage and civil partnership	No	
	Pregnancy and maternity	No	
	Race	No	
	Religion or belief	No	
	Sex	No	
	Sexual orientation	No	
2.	**Is there any evidence that some groups are affected differently?**	N/A	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and / or justifiable?**	N/A	
4.	**Is the impact of the policy / guidance likely to be negative?**	N/A	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the policy / guidance without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

If you have identified a potential discriminatory impact of this key document, please refer it to Assistant Manager of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Assistant Manager of Human Resources.

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