Wolverhampton Integrated End of Life Care Strategy implementation plan

Is a working document which provides practical solutions to support delivery of this strategy's key recommendations; it has been developed in collaboration with our clinical advisory group and is based on learning and best practice.

** Indicates an area where a small amount of investment upfront will deliver a quick and effective result or 'quick win'

Recommendation	Action/Statement of intent	
Promoting earlier identification of patients approaching the end of life in Primary Care to support earlier advance care planning and enable choice	Programme of Primary Care education and support • GP education to include CCG supported events (Team W), RCGP events, Macmillan GPF practice visits	**
Raising awareness of EoLc and the management of this patient cohort in the Community	Raising the awareness of District Nurses to include • Initial induction • Mandatory training • Clinical teaching • Clinical reflection • Peer support	**
Raising awareness of EoLc and the management of this patient cohort in an acute setting	Programme of Secondary Care education and support including • that related to the Swan project and the rapid discharge home to die programme • Multi-disciplinary working that empowers nursing staff and allied healthcare professionals to identify patients and ensure their inclusion on EoL registers.	
Raising awareness and the management of this patient cohort in care homes	Raising awareness to include • Development of Nursing Home minimum standard • Promotion of and education related to the Integrated Care Model, ACP, Symptom Control	**
Promoting choice for all patients regarding EOLC and reducing unnecessary hospital admissions	• Education, awareness raising and debate in both Primary and Secondary care settings as above around the meaning and potential of Palliative Care. • Promotion and education related to the Advance Care Planning document • Education and Training programmes across the pathway relating	**

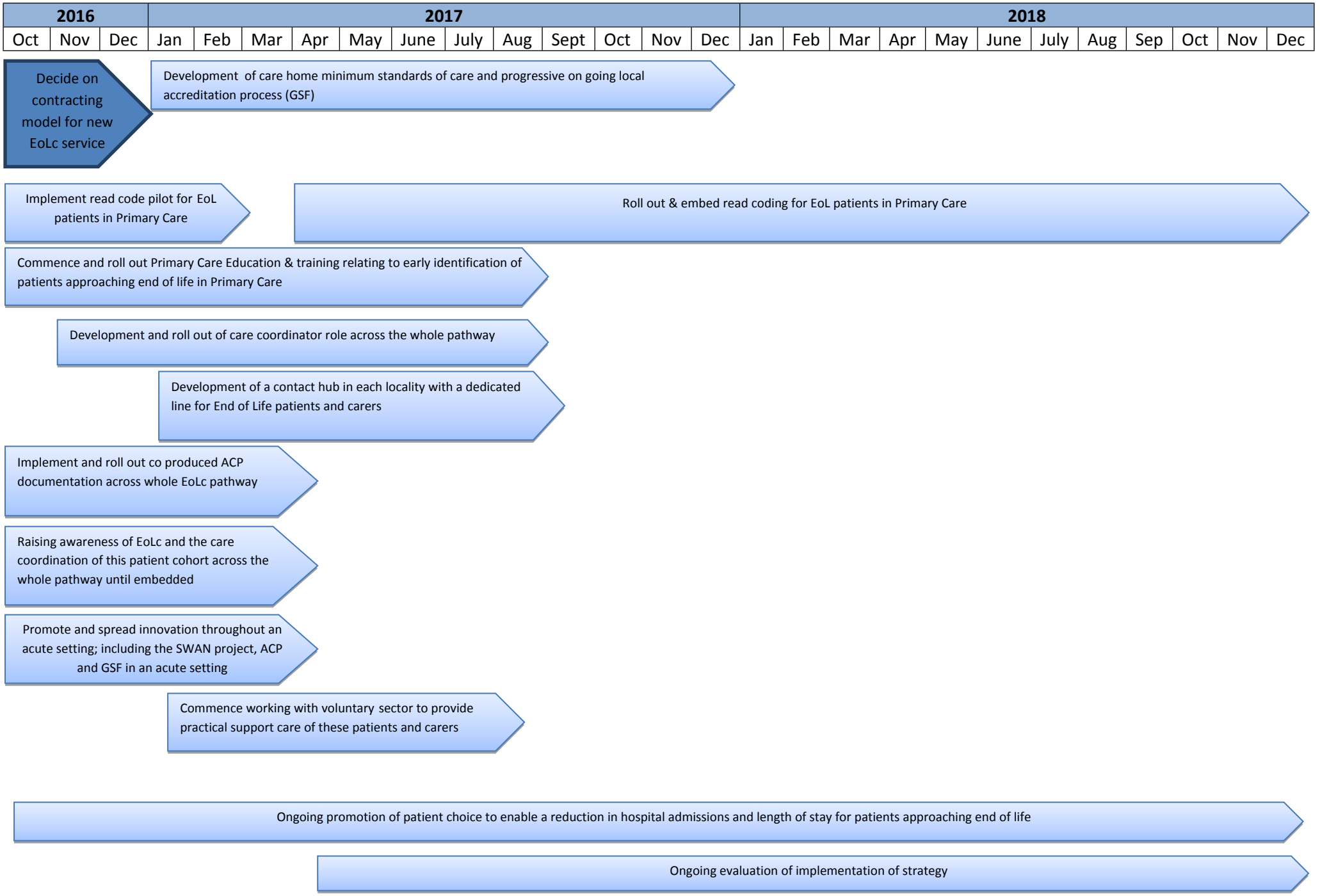
	to having difficult and sensitive conversations • Development of the holistic assessment to include physical, psychological, spiritual / cultural and social needs of patients and carers	
Ensuring patients and carers have the resources and information that they require to cope with and manage their EOLC needs	• Development of the care coordinator role • Undertake capacity & demand work in Primary and Community care (Community care links to ACC work stream Better Care Fund). • Development of a local Service Directory, (links to BCF and WIN) • Development of contact hub protected phone line for EOLC patients, their carers and professionals, 24/7, manned by qualified professionals who are able to signpost to services routinely and in the crisis situation. • Development of the third sector workforce to provide increased practical support in the home, extra support around the time of discharge from hospice or hospital, and if possible in a crisis situation. • Ensure services are responsive across the whole pathway, including equipment provision, and home oxygen • 24/7 District Nursing service across Wolverhampton • 24/7 Specialist Palliative advice available, with clear instructions around access • Development of clear processes for anticipatory prescribing • Development of a universal DNACPR policy and document that applies across the whole pathway	** **
Providing coordinated and integrated services across the whole pathway that are available to support people, including those in crisis 24/7	• Introduction of a handheld Advance Care Planning Document, with education delivered across settings • 24/7 District Nursing service across Wolverhampton • Further development and implementation of the Electronic Palliative Care Record • 24/7 Specialist Palliative Care advice available, with clear instructions around access • Development of clear processes for Anticipatory Prescribing • Development of a universal DNACPR policy and document that	** **

	applicable across the whole pathway	
Facilitation of discharge from the acute setting	• Continued promotion of rapid discharge home to die programme • Responsive services to support discharge including equipment and home oxygen • Responsive Community based services able to support the discharge of this cohort of patients	
The development and promotion of an integrated EOLc model that is universally recognised across the whole pathway and adopted by all agencies involved in the provision of care to those approaching the end of life	• On going development of the community integrated service model to include all settings (Linked to BCF). • Education and promotion of this model across all organisations and settings	**
Development of a knowledgeable and competent workforce that is trained in all aspects of EOLc as appropriate to their role and setting	• Education and training needs assessments across settings – secondary and primary / community care • Engagement with local specialist palliative care providers of education to deliver relevant, tailor-made training packages which will address the needs identified in both secondary and primary / community care. • Acknowledgement of the need for place based learning, peer review and peer support, and an option to explore external facilitation of training & support • Develop links to HEE and explore options for support in educational sessions	**
Specific consideration of EOLc needs of the residents of care homes, and their professional carers	• Development of Nursing Home minimum standard and local accreditation process • Education and Training – (Link to the PROSPER project) • Equipment (syringe drivers) training and practical support at times of need (e.g train the trainer sessions) • Implementation and adoption of standardised, whole pathway paperwork and IT solutions	** **
Specific consideration of the EOLc needs of under-represented groups	• Recruitment of Clinical Champions for each of the under represented groups to ensure that recommendations may be developed and implemented. • The recommendations and implementation plan of this strategy apply to each of the groups detailed within the glossary within the EoLc Strategy.	

Children transitioning into adult services	• Improve ethnic monitoring, include White groups and religions and provide data locally • Involve minority ethnic groups in service user events when planning future policy strategies to improve EOLc and create public awareness campaigns • Include information about available palliative care services for BAME communities in the local directory of services (WIN) • Promotion of early identification of young people with Palliative Care needs who are approaching transition within primary care and across all settings • Promotion of integration of care across settings for young people. • Development of the care coordinator role for this group • Engagement with paediatric and adult local providers addressing these issues, and with the recently established 'Transition Taskforce' (2012-2015) commissioned by Together for Short Lives.	
Development of partnerships with third sector organisations and local communities to support innovation, particularly around supporting patients and carers in the home environment, and incorporating their spiritual and cultural needs in to their care	• Development of the voluntary sector and the local volunteer workforce to provide increased practical support in the home, extra support around the time of discharge from hospice or hospital, and if possible in a crisis situation. • Engagement with local communities and projects	
Development of the IT support systems necessary to allow electronic co-ordination of patient information ensuring alignment with all agencies providing EoLc	• Further development and roll out of *'EPaCC'* system currently under development by RWT OR • Alternative option to be explored and costed • Development to ensure that local systems are aligned to enable an integrated care record	** **
Improved Bereavement care for family and carers	• People affected by bereavement should be offered appropriate support at the time of death that is culturally and spiritually appropriate, pre-bereavement, immediately and shortly afterwards and in the longer-term if necessary (to align with the	**

	wishes of the bereaved). • The development of a local model of bereavement is recommended, which could include but is not limited to: ➢ information about local support services ➢ practical support such as advice on arranging a funeral and support with cultural needs ➢ information on who to inform of a death, ➢ help with contacting other family members and information on what to do with equipment and medication ➢ general emotional and bereavement support, such as supportive conversations with generalist health and social care workers or ➢ support from the voluntary, community and faith sectors ➢ referral to more specialist support from trained bereavement counsellors or mental health workers	
On going CCG engagement with Service User and Stakeholder representatives to understand what local people want from local End of Life and Palliative care services	• Engagement with and recruitment of a range of patient champions who are currently experiencing services or carers whom have been impacted by services • Develop locality networks of patient champions to ensure a local focus on any current and future developments in End of Life and Palliative Care • Explore the opportunity for external support for this initiative (e.g Healthwatch, Macmillan)	
Defining and agreeing service outcomes, methods for the collection of baseline data, and plans for robust evaluation	• Development of robust service outcomes to support the delivery of person centred, integrated End of Life care services	

Implementation road map


2016
2017
2018
Oct Nov Dec Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec Jan Feb Mar Apr May June July Aug Sep Oct Nov Dec
Decide on contracting model for new EoLc service
Development of care home minimum standards of care and progressive on going local accreditation process (GSF)
Implement read code pilot for EoL patients in Primary Care
Roll out & embed read coding for EoL patients in Primary Care
Commence and roll out Primary Care Education & training relating to early identification of patients approaching end of life in Primary Care
Development and roll out of care coordinator role across the whole pathway
Development of a contact hub in each locality with a dedicated line for End of Life patients and carers
Implement and roll out co produced ACP documentation across whole EoLc pathway
Raising awareness of EoLc and the care coordination of this patient cohort across the whole pathway until embedded
Promote and spread innovation throughout an acute setting; including the SWAN project, ACP and GSF in an acute setting
Commence working with voluntary sector to provide practical support care of these patients and carers
Ongoing promotion of patient choice to enable a reduction in hospital admissions and length of stay for patients approaching end of life
Ongoing evaluation of implementation of strategy

2016			2017											2018											
Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec

Ensure equipment requirements of patients approaching the end of life are considered prior to procurement of service.

Ensure links are made with Equipment service following procurement to ensure responsive service for patients approaching end of life

Develop a continuous relationship with Health Education England to ensure all opportunities for education are captured and acted upon

Ongoing recruitment of patient/carer champions to ensure the patients voice is at the heart of all service redesign and enable co production

Ongoing proactive engagement with under represented groups to ensure services are fully inclusive

Develop Palliative Care and End of Life service entries on to the local directory of services (WIN)

Promote and support the development of processes to support the smoother transition into adult services for children with LLC's

Develop and roll out the care coordinator role for children transitioning to adult services

Further develop and roll out local EPaCC system across all professionals and all agencies delivering care and support to patients approaching end of life.