

Strategic Framework for End of Life Care in Waltham Forest

END OF LIFE CARE

Strategic Framework

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What is a good death?

A good death is the best death that can be achieved in the context of the individual's clinical diagnosis and symptoms, as well as the specific social, cultural and spiritual circumstances, taking into consideration patient and carer wishes and professional expertise. (London End of Life Clinical Network 2015).

Document revision history

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1. Introduction

NHS England's Mandate from the Government for 2013-2015 includes an objective 'to pursue the long term aim of the NHS being recognised globally as having the highest standards of caring, particularly for older people and at the end of people's lives'.

Patients are generally defined as 'approaching the end of life' when they are likely to die within the next 12 months. This includes people whose death is imminent and expected within a few hours or days); and those with advance, progressive, incurable conditions, general frailty and co-existing conditions. (General Medical Council 2010).

Two-thirds of people who die are aged 75 or over. The causes of death change with increasing age at death – Alzheimer's, dementia, frailty, pneumonia and stroke becoming more common. The place of death changes too, with a higher proportion of the extreme elderly, who are more likely to be women, dying in nursing or old people's homes. This in part reflects the frailty of many elderly people before death, which often results in the need for 24-hour care; which clearly highlights the changing end of life care needs as the population ages.

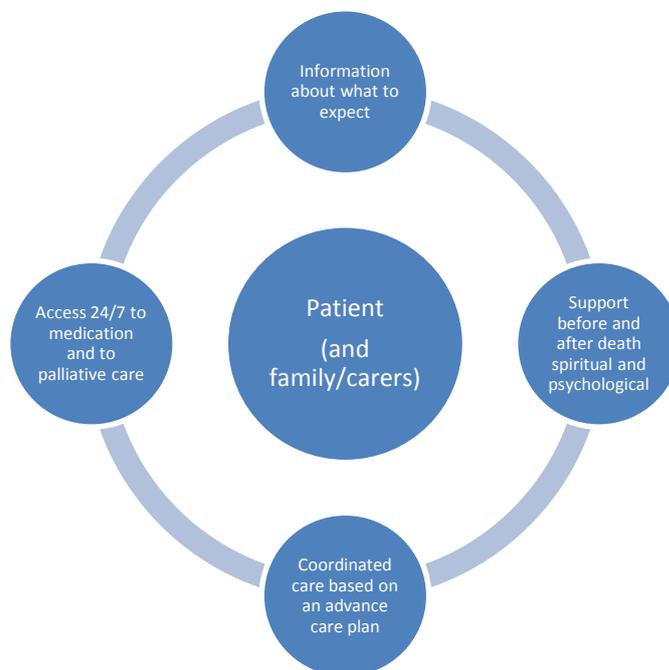
On average there are 1500 deaths in Waltham Forest each year (61% aged 75+ years). The current rate of home deaths in Waltham Forest stands at 16.4% and the majority in hospital at 75.2%, which ranks Waltham Forest as having the highest hospital death rate in London (av 63.7%) and England (av 56.7%). This is partially explained by the inclusion of deaths in the Margaret Centre Palliative Care Ward. There are only 418 patients currently recorded on the palliative care register in Waltham Forest (Health Analytics May 2015). According to the Higginson formula this figure should be nearer 1050.

The London End of Life Care Clinical Network has described a good death as being one where it is the best death that can be achieved in the context of the individual's clinical diagnosis and symptoms, as well as the specific social, cultural and spiritual circumstances, taking into consideration patient and carer wishes and professional expertise.

This would mean providing care that is competent, confident, compassionate and personalised, in line with recognised best practice standards. It will require joined up coordinated services and pathways that are easy to navigate. We should provide access to spiritual and psychological support and provide tailored pain management through access to the right medication at the right time.

2 Our vision

Our vision for End of Life Care is to enable people to die in their preferred place in a supported, safe and appropriate environment that meets the needs they have identified in advance. This will be irrespective of their medical condition.

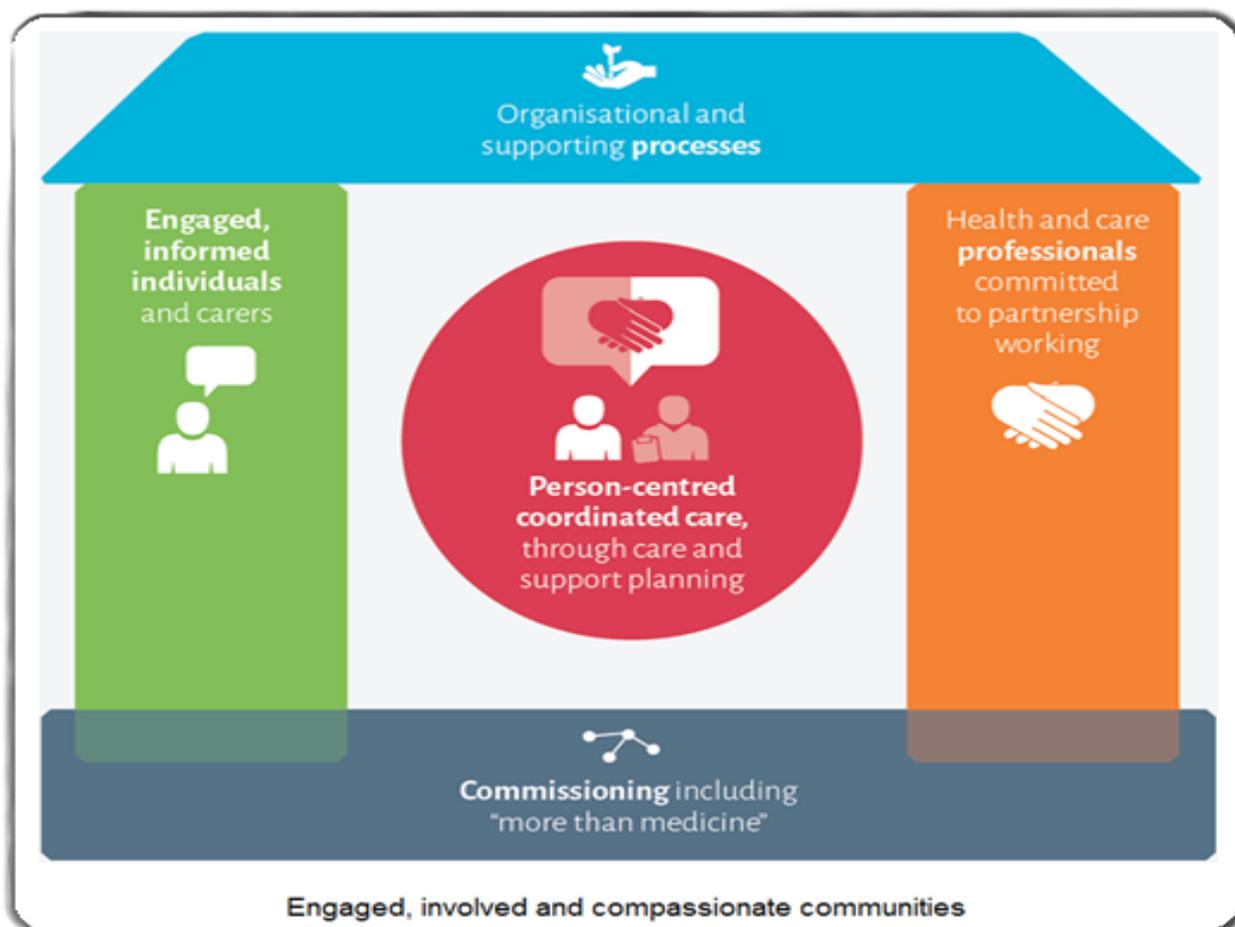


The National End of Life Care Strategy (Department of Health 2008) adopts a whole systems approach by outlining an end-of-life care pathway, which is intended to guide both the commissioning and delivery of end-of-life care.

The pathway outlines six steps, identifying the services and support that patients should be able to access during the course of their illness, from the identification of their palliative and supportive care needs through to care after their death. These steps are underpinned by support for carers both during the illness and after death, information for patients and carers, and access to spiritual care.

NHS England and its partners are using a simple organising framework to deliver person-centred coordinated care for people with long-term conditions. This model has been adopted as the framework for End of Life Care because this framework helps to focus attention on the elements that need to be in place to enable high quality person-centred end of life care to be experienced, and it provides a continuum from long term conditions through to end of life care.

The 'walls', 'roof', and 'foundation' of the House of Care represent four interdependent components which, if present, provide the greatest opportunity for person-centred and coordinated care. The framework assumes an active role for patients and carers in individual care planning, working with health and social care staff, services and other support agencies.



3 Strategic approach

This framework will allow us to focus work methodically given the amount of change that needs to happen in a relatively short period of time. It will provide a platform to develop the quick wins, identify gaps in provision and ensure we have a firm community offering in line with national standards for end of life care.

It will lead to delivery of comprehensive end of life care services in Waltham Forest that enable our vision to be achieved. The framework will also start the process of a fully developed wider End of Life Care strategy that will encompass our longer term ambitions.

4 Priorities to improve end of life care in Waltham Forest

Commissioning

As a CCG we are aware of a number of limitations to our End of Life Care provision in Waltham Forest. We do not have a hospice at home service, we do not have dedicated palliative nursing support in the community 24 hours a day 7 days a week and we do not have a hospice available 24 hours a day 7 days a week within Waltham Forest. Margaret Centre is a palliative care ward based at Whipps Cross. However, we are aware that 80% of patients access the ward through the hospital and only 20% from the community. The service operates 9.00 to 5.00 Monday to Friday and although it provides community palliative care support this has not been clearly defined or commissioned. Due to its location the ward sometimes has patients who are not palliative placed there and this may affect the ability for patients who need the provision to be denied it. We do not have day hospice services and there is little to support anyone dying at home who experiences problematic pain and symptom control in the later stages. During 2013/2014

Data

It has been difficult establishing baseline data for many of the areas we would like to improve. Some resource into measuring a baseline so we can be confident of the impact of implementing this framework will be required. Much of the analysis is based on data from 2012 which is already 5 years out of date and does not include a significant older people population increase that will in effect significantly increase the number of people approaching the end of their lives.

Primary Care/Difficult conversations

A key to improving end of life care will be the ability to both identify and inform patients who are approaching the end of life. Although this is not solely the domain of GPs this is where the conversation should start and GPs must ensure they coordinate the community aspect of care for the patient through to the end. This will require a programme of training and support to ensure GPs feel able to have these conversations and that the preferences of patients are documented and available wherever they are in the care pathway.

Medication

One of the ways that care at home during the end stages becomes impossible is due to the lack of access to palliative care medication that can alleviate the uncontrollable pain or other symptoms that occur in the final stages. *Marie Curie/London School of Economics and Political Sciences April 2015 Management of a loved one's pain, not having access to 24/7 care and strains on finances are the top concerns UK people would have if faced with looking after a loved one with terminal illness.'*

It may be necessary to change medication during this stage and it is necessary to have both the ability to identify this and access the medication. One of our case studies describes a family member running around trying to find the end of life care medication prescribed. We need systems in place so that the drugs and access to them are in place well before those end stages which are fairly similar regardless of medical condition. Our medicines management team are currently working on developing a network of community pharmacists to supply this medication

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in the community as well as protocols to ensure patients are discharged with the right palliative care medication or at least access to this when they need it.

GPs need support to confidently prescribe these medications as well as have systems in place to ensure authorisation for DNs to administer the drugs and stock is held in local pharmacies so they can be accessed quickly.

EOL Documentation

We believe patients are being taken to A & E by London Ambulance Service despite having a Do Not Attempt Resuscitation Record (DNAR) in place. A DNAR is not transferable from one place to another so if one is signed in hospital it will not be valid if copied for the patient to have at home. A new DNAR would need to be signed for at home. Equally the one that may be at home cannot be used in the hospital. Clearly systems need to be in place to alert the existence of a DNAR and then ensure it is regularly reviewed with the patient. We will look into how this is managed in other areas as we currently do not have an agreed Electronic Palliative Care Coordination System (EPACC) that would enable this information to be held on a system. Further analysis of this issue needs to take place as it is believed that it is partly due to inoperability of IT systems. We have trialled Coordinate My Care as an EPACC in Waltham Forest and it has not been popular being described as 'clunky'. The latest version may be more palatable. Health Analytics is also being looked at to hold care plans but again its use is not universal across Waltham Forest. This stream will need to be picked up to ensure we have a system that allows the whole system to view advance care plans DNARs and other end of life care documentation to ensure we comply with the patient's wishes.

The End of Life Care Clinical Network is currently looking at adoption and implementation across London of standardised end of life care documentation.

Linking with wider initiatives

The Integrated Care Management stream of Transforming Services Together is looking at how patients within Integrated Care are managed during the last year of life. Whilst not all patients who are in the last year months of life would be picked up by the algorithm used to select patients there will be a number who have conditions which shorten their lifespan and in the end stage they should be managed in the same way as any other person approaching the end of life. GPs are able to use their clinical judgement to refer patients into the integrated care pathway but this does not seem to be happening.

Communications

Irrespective of disease, care pathway or length of time a patient and their family/carers are aware of them approaching the end of life they must have access to information about their options and what to expect. We will need to ensure there are communications available in a variety of formats signposting people to the support to help them to understand what to expect. This will enable families and carers to more easily cope with the end stages and to understand aspects such as why a GP may be prescribing certain drugs or why the patient is no longer being given food.

Partnership working

It is important to recognise that not all support needed for people approaching the end of their lives and their families will be health related. Voluntary agencies and faith groups may be where they will feel able to find spiritual, culturally sensitive and practical support.

Local Authority

People approaching the end of their lives and their families often have practical issues that need to be addressed either before during or after the death. Religious needs in relation to burial are tied to access to death certificates therefore access to the coroner's office and funeral directors will need to be a part of planning. The local authority may well be the landlord of a person wishing to die at home and issues such as ending tenancies upon the death of a family member can be difficult particularly where the person died at home. Agreeing protocols and having these in place can ensure this does not add to the burden of bereavement.

Families can sometimes for their own reasons not wish to follow through with the needs of the person who is approaching the end of their life. This may well lead to safeguarding and DOLs concerns which need to be handled sensitively but appropriately.

Care Homes

Care homes need to be better supported to ensure patients who are end of life and choose to stay in their care home are supported in the same way as they would if they were in hospital or in the community. The Care Home is the home that some people may wish to choose to die in and staff should equally feel supported to manage the end stage according to the wishes of the person approaching the end of their life. There will need to be a training programme and to ensure the pathways to support care home staff are clear and provide the level of support to prevent unnecessary hospital admissions. They will need to access palliative care support and medication to achieve this.

Education and training

Staff across the whole system will need to undergo palliative care training in order to ensure they feel competent and able to care for people approaching the end of their lives. A training proposal across care homes, primary, secondary and acute care will be developed to ensure that as a minimum they undertake some palliative care training with view to GPs and care homes achieving GSF accreditation.

Hospice Provision

Currently for adult provision the only contract is with St Joseph's Hospice. In 2014/15 there were a total of 42 referrals to St Joseph's and of these 4 patients died in the hospice. With children the service is different, children with life limiting conditions can be referred to a hospice but this is usually for respite. We contract with both Haven House and Richard House. Children who are continuing healthcare can have direct access to Haven House. We may however need to ensure that children who are transitioning into adults are not missed out as service offerings change drastically.

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Margaret Centre, the palliative care ward in Whipps Cross Hospital provide inpatient palliative care. This is however not a hospice and not staffed as one with access from the community restricted to 9.00 to 5.00 Monday to Friday. Of the 386 admissions in 2014/15, 271 were from the acute trust (this will include patients from the community who are admitted from A & E), 11 from the patient's home, 3 from Hospice/Specialist Palliative Care and 1 from a Care Home. Figures for the past three years show a small reduction of patients year on year with an average of 356 new patients each year, 283 deaths and about 60% of those patients having a cancer diagnosis. On average 75.5% of patients admitted died at Margaret Centre.

Community Palliative Care Support

Currently Margaret Centre provide some community palliative care support. This service is not commissioned therefore there is no current service specification.

The community palliative team has seen a more stable number of patients with an increase in 2014/15. On average they see 255 new patients a year an average of 60 (40%) die at home. In 2014/15 of the 200 patients who died 23 died in acute hospital, 73 died but not at home and for 10 the place of death was not recorded.

Margaret Centre additionally provide telephone support to patients and health care professionals which forms a larger part of its activity.

Patient Representation

Much of the influence and representation in end of life care planning will be those bereaved family members who have experienced poor care of their family member. We have chosen to use two case studies to look at where we have not got things right to provide us with a focus from a patient perspective. We will also use nationally available data and reference key guidance such as:

- NICE, Quality Standard/Guidance QS13 (updated August 2013)
- National Bereavement Survey (VOICES) 2012
- National Centre for the Dying,
- One chance to get it right (Improving people's experience of the last few days and hours of life) Leadership Alliance for the Care of Dying People
- Actions for End of Life Care 2014 – 2016 NHS England
- The End of Life Care Strategy : New ambitions The National Council for Palliative Care
- Everyone Counts Planning for Patients 2014/15 to 2018/19 NHS England
- Guide for commissioners on end of life care for adults. NICE 2011
- Namaste Care – End of life Care Program for people with Dementia 2013
- Equity in the Provision of Palliative and End Of Life Care in the UK LSEPS April 2015
- London End Of Life Care Clinical network definition of a good death May 2015

5. What we must learn from the case studies

Both case studies reviewed highlight poor coordination of care in both the acute and community setting. In neither case did professionals appear to be referring to the wishes of the person approaching the end of life. Basic care appeared to have been missed with even the provision of comfort in the form of pillows being too much.

The GP should play a coordination role in the care of patients approaching the end of their lives in the community. Initiating care through the GP to District Nurses was missed and this highlights a lack of clarity as to their role in end of life care. Constant referral to A & E rather than Rapid Response resulted in ten bed days in Whipps Cross for one patient.

Access to medication proved a challenge with issues around the actual prescribing, stocks of the medication and access to the medication. Finally in both cases the family member relating the incident said they had no information or knowledge of how things should work but they clearly fell short of acceptable standards.

In both cases the patient wished to die at home. One succeeded but it was not how we wish to leave patients, unsupported, not knowing what to expect and expecting them to do the coordination.

NICE Standards that specifically relate to these case studies:

- People approaching the end of life are identified in a timely way.
- People approaching the end of life and their families and carers are communicated with, and offered information, in an accessible and sensitive way in response to their needs and preferences
- People approaching the end of life are offered comprehensive holistic assessments in response to their changing needs and preferences, with the opportunity to discuss, develop and review a personalised care plan for current and future support and treatment.
- People approaching the end of life have their physical and specific psychological needs safely, effectively and appropriately met at any time of day or night, including access to medicines and equipment
- People approaching the end of life receive consistent care that is coordinated effectively across all relevant settings and services at any time of day or night and delivered by practitioners who are aware of the person's current medical condition, care plan and preferences
- People approaching the end of life who may benefit from specialist palliative care, are offered this care in a timely way appropriate to their needs and preferences, at any time of the day and night.

6. Measuring Impact

To achieve our aim of increasing the number of people who die in their preferred place we must recognise patients approaching the end of life, record their wishes and provide care to enable those wishes to be met. There are numerous problems with getting data to count many of these areas but this will be worked on and should not deter us. End of life is not a condition and measurements of cause of death have to be interpreted from conditions that you would expect to be palliative towards the end.

To determine whether we are achieving this we will need to measure progress by the following performance indicators:

- Increase in advance care plans
- Increase in patients registered on GPs palliative care register
- Reduction in emergency admissions to hospital of people who are approaching end of life care
- Increase in satisfaction of bereaved families
- Increase in people who die in their preferred place
- Reduction in emergency admissions of people who are approaching the end of their lives from Care Homes
- Reduction in number of bed days of patients wishing to die at home.
- Reduction in cost of emergency admission of end of life patients

End of Life Care is a cross cutting theme in the CCG's strategic objectives. In addition to working across all other programmes there is a substantial piece of work to be done in order to ensure we can deliver a comprehensive end of life care provision in Waltham Forest. This will require investment both in the short and longer term.

7. Drivers for action; Case studies

Case Study 1.

A perspective from the daughter of an 83 year old woman who died in hospital of multiple primary cancers of the same sites, as well as different sites.

Following a series of repeated Urinary Tract Infections, my mother's GP referred her for a scan. The scan revealed a mass in the womb. A hysterectomy and radiotherapy followed. About 18 months later she complained about still not feeling right. At this stage cancer of the cervix was diagnosed. Her GP was never again involved.

Her gradual deterioration led to a decision to perform a colostomy. However during surgery it was identified that there was a further mass between the bladder and bowel. The surgery was cancelled and a prognosis of six months was given to my mother.

On discharge the hospital sent my mother to a nursing home for two weeks convalescence. They refused to let her travel by car and insisted she travelled in an ambulance which we were left to pay for privately. On her return home she needed regular blood tests as her potassium levels kept falling. Each journey to hospital was becoming more difficult as she now had a growth that extended out externally making sitting and laying down difficult. I asked that the bloods to be taken at home in future but this was refused.

About five months before her death my mother complained of passing faeces when she urinated. She was taken to the hospital where they advised the growth had broken through and she would contract septicaemia and die soon. She was then discharged home with no advance care plan or support.

About three months later the pungent smell from the growth had become increasingly unbearable. A month later my mother was admitted to hospital as she was struggling to breathe. She was admitted to a chest ward. At no stage did they ask her or any of our family about her wishes and she was placed at the furthest end of the ward due to the pungent smell, leaving her isolated and uncared for. She was agitated and disorientated and would often pull out tubes and try to go to the toilet on her own. She was often left unclean after toileting accidents and was very uncomfortable as she needed several pillows so that she could lay down due to the growth. She was refused additional pillows as they had a shortage!

She was assessed for NHS Continuing Healthcare but did not meet the criteria. As she had her own house and savings she was told that support at home could only be given if the house was sold. We refused to have her sent home at this stage and requested she be placed in the onsite palliative care ward due to her palliative condition. This was refused as we were told that the criteria for admission was that the person needed to have no more than two weeks left to live. They regularly assessed my mother and kept telling us she did not meet the criteria which we found this most distressing.

Following a formal complaint to the hospital about the lack of basic care my mother received, a grade D nurse was allocated to her. Then four days before my mother's death the hospital were on red alert and wanted to move her to the palliative care ward. This was because they needed her to be discharged and not because she was identified as being at end stage. They told me they would move her back again after a few days which we refused. Four days after she was moved to the palliative care ward she

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deteriorated and died a couple of days later. My mother spent thirty one days on an acute chest ward and six days on a palliative care ward at the end of her life. It had been her wish to die at home.

Case Study 2:

Coordination of care at the end of life: a carer's view.

A patient with prostate cancer and his wife experienced numerous problems with his care in the last months of life, mostly due to the lack of coordination and communication between professionals.

My husband wanted to die at home. His cancer was 'managed' by a number of professionals. In the community, he was looked after by his GP, the District Nurses and a Palliative nurse who was supervised by a Palliative Consultant. He had three hospital Consultants: an Oncologist, an Urologist, and a Vascular Consultant. There was a serious lack of co-ordination both within the hospital, between services in the community, and between hospital and community. On each step of my husband's journey he needed access to advice, treatments and pain-relieving drugs. In a palliative situation, you would hope that a suitably qualified person would take an overall view and co-ordinate the necessary services. No one did that for us: we had to do it for ourselves.

When my husband developed a problem of haematuria in his catheter, irrigation of the catheter could not be undertaken in the community. The only advice the GP could give, was that my husband should go to A&E. The GP seemed to have no way of influencing the situation. There was a yawning gap between hospital and community services, a gap into which a patient could all too readily fall.

Haematuria in the urine was a recurring problem for my husband. In A & E each time he was subjected to a full assessment before urologists were called and irrigation was undertaken. He had to lie on a hard trolley without pillows. On one visit to A& E, my husband was there for seven hours, yelping with pain if anyone moved him. After this, he had to be admitted to a ward. Three times he was admitted to a ward, and he spent a total of ten nights in hospital. This was traumatic for my husband and expensive for the NHS.

What was needed, was a dose of palliative radiotherapy, which the Oncologist could provide. As there was a failure of communication between the Urology and the Oncology consultants, the urologists could only 'patch' my husband up, and the problem kept recurring.

I had had enough, and I put in a formal complaint on my husband's behalf. That same week he was given a palliative dose of radiotherapy and thereafter the worst of the bleeding was over. Two months earlier, he had asked for a suprapubic catheter but his request was ignored. Ten days after I handed in my complaint he was given one.

In the community, communication and co-ordination between professionals was no better. There was a division of labour and responsibilities between District Nurses, GP and the Palliative Nurse which at times had an element of farce. For example; the palliative nurse faxed urgent requests to the GP to authorise prescriptions, but the fax machine was 'outside and upstairs', so urgent drug requests could go unnoticed.

Towards the end of my husband's life, a request for oxygen was processed by the GP receptionist on Friday evening, just before the surgery closed. The company supplying the oxygen found fault with the way the form had been filled in and faxed it back to a closed surgery. When the oxygen did not arrive, we had to ring the emergency GP to sort out the problem. The oxygen eventually came on Saturday morning. As it happened, the oxygen didn't make any difference to my husband's breathing.

Now came the point at which a syringe driver was needed. Here, there was a tripartite division of labour between GP, palliative nurse and district nurses, further complicated by needing to use the emergency

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GP service. That evening, we had to call out the emergency GP. He gave my husband an injection against pain, and left prescriptions for the three drugs that had to be used in a syringe driver. On Sunday morning we began the task of finding the drugs. When the district nurse arrived to set up the syringe driver, not only was one drug out of stock locally, but there was also no authorization to administer them. Another emergency GP had to be called to authorise the drugs and supplement the syringe driver with an injection.

Next day there was a dispute between the district nurse and the GP as the GP was not happy to prescribe the drugs used by the emergency GP and the palliative nurse was not on duty. One of her colleagues intervened at my request and we had the prescription. Once again we had to go in search of the drugs.

The same day there was haematuria in the urine. The district nurse attempted a washout, which was unsuccessful so she decided to change the catheter. The spares that had been delivered were 12mm rather than the 16mm she would have preferred to use.

On Tuesday when the district nurse came to refuel the syringe driver there weren't enough drugs. Once again a prescription had to be obtained and we had to go out to get what was needed. The GP visited and we expostulated with him that we shouldn't be the ones doing the running around. What would happen to someone who didn't have any family support? Shortly before midnight on that Tuesday my husband died peacefully at home surrounded by all the people he loved.

I was lucky to have a close friend who happened to be a district nurse who stayed with us in the last few days of my husband's life. She was able to guide us through the process and give us a professional perspective on what was going on. Research indicates that two out of three people would prefer to die at home, yet only one in three succeed in doing so. Given our experiences of services in the community, I can begin to understand why this should be so. Although we met some excellent practitioners, we found that they were greatly disadvantaged by the systems and procedures that had been set up.

This is an edited version of an article by Nicki Cornwell, published in the European Journal of Palliative Care 2014 (www.ejpc.eu.com), edited by the author herself.

8. End of Life Care Action Plan

	Actions	Milestones/ Timescales
<ul style="list-style-type: none"> • Mapping exercise 	<ul style="list-style-type: none"> • Gap analysis to determine areas of priority 	By end of July 2015
<ul style="list-style-type: none"> • Data 	<ul style="list-style-type: none"> • Develop baseline data for the measures within the strategy.(currently little data available beyond 2012.) Work with CSU to deliver clear baselines so that measurement of progress is possible. 	July – September 2015
<ul style="list-style-type: none"> • Pathway 	<ul style="list-style-type: none"> • Identify the pathways to end of life care and identify any blockages 	By end of June 2015
<ul style="list-style-type: none"> • End of life care documentation 	<ul style="list-style-type: none"> • Work with End of Life Care Clinical network to agree End of Life care documentation for London. • Task and finish group to agree implementation and adoption within Waltham Forest. To include protocols for primary, secondary and acute care. • To determine the EPACC to be adopted throughout Waltham Forest and ensure its implementation dovetails into any education and training programme. 	June 2015 – November 2015 June 2015 – November 2015 January – March 2016
<ul style="list-style-type: none"> • Education/training 	<ul style="list-style-type: none"> • Bid for HENCEL funding to provide GSF training for all GPs in Waltham Forest • Along with providers draw up a further bid to complete training across care homes, secondary care and acute trust. • Utilise education sessions with primary care to address concerns, educate in relation to management of end of life care in Waltham Forest and to help to develop champions • Business case to fund training in 2015/16 and 2016/17. 	May 2015 July 2015 July 2015 June 2015 – March 2016
<ul style="list-style-type: none"> • Medication 	<ul style="list-style-type: none"> • Develop project plan for medication for end of life care. • Discussions with key stakeholders • Business case for commissioning of service to support medication for end of life care • Launch of service to provide medication out of hours from pharmacies in each of the localities 	June 2015 June 2015 June 2015 October 2015
<ul style="list-style-type: none"> • Communication 	<ul style="list-style-type: none"> • Communications plan to draw together range of information for people approaching the end of their lives and their families. To be provided as leaflets 	September 2015 – March 2016

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	and online and to include pre and post bereavement support	
• Community Support	<ul style="list-style-type: none"> • Business case to support additional community palliative nurses. • 	July 2015
• Commissioning/business case	<ul style="list-style-type: none"> • Review of funding to switch some acute and inpatient funding to community provision. 	July – September 2015
•	•	
• Acute	<ul style="list-style-type: none"> • Define the Margaret Centre support required externally with new service specification drafted and agreed. • Agree any additional funding requirements for the above 	June – August 2015
• Primary Care	<ul style="list-style-type: none"> • Review and recommend funding for blockages to GP support of end of life care patients. 	August 2015
• Dementia	<ul style="list-style-type: none"> • Develop clear end of life care pathways for people with dementia that take into account longer timeframe but the need to incorporate people’s wishes while they still have capacity. 	September – October 2015

