

ABERTAWA BRO MORGANNWG UNIVERSITY HEALTH BOARD

DELIVERY PLAN FOR END OF LIFE CARE 2013 TO 2016

1. BACKGROUND AND CONTEXT

The “Together for Health – End of Life Delivery Plan” was published by Welsh Government in 2013 and provides a framework for action by Local Health Boards and NHS Trusts working together with their partners. It sets out the Welsh Government’s expectations of the NHS in Wales in delivering high quality end of life care, regardless of diagnosis, circumstance or place of residence in Wales. The Plan sets out clear ways in which the voice of the individual, supported by those closer to them, is heard and respected at the centre of the services they need. It sets out:

- Delivery aspirations expected
- Specific priorities for 2013-2016
- Responsibility to develop and deliver actions
- Population outcome indicators and NHS performance measures

The vision:

For the people of Wales, Welsh Government wants :

- People in Wales to have a healthy, realistic approach to dying, planning appropriately for the event
- People dying in Wales to have access to high quality care wherever they live and die whatever their underlying disease or disability, devoid of any prejudice in relation to their personal situation

Welsh Government intends to use the following indicators to measure success:

- % of people dying in place of preference
- % of people with palliative needs on a primary care practice palliative care register six months prior to death
- % of people who die in usual place of care
- % of people in Wales who die intestate

The Drivers:

There are clear reasons for end of life care remaining a top priority in Wales. Everybody is affected by the death of a family member or friend who has gone through a final phase of illness. Not only do people need rapid assessment and the best possible treatment, they also need ongoing support and information about choices when treatment may no longer be effective. People must receive a clear explanation of their options and their implications. ABMU Health Board is committed to working with its partners, to deliver excellent care at every stage of the patient journey.

What do we want to achieve?

This Delivery Plan sets out the ABMU Health Board actions to improve outcomes in the following key areas between now and 2016:

1. Supporting living and dying well; informing and supporting patients to make arrangements in advance for the end of life
2. Detecting and identifying patients early; people with palliative care needs are identified early to enable the best care to be planned in advance
3. Delivering fast, effective care – Effective coordination between agencies ensures that people receive fast, effective person centred care in order to maintain quality of life for as long as possible
4. Reducing the distress of terminal illness for patients and their families; patients entering the terminal phase of their illness and their families feel well cared for
5. Improving Information
6. Targeting research

Approximately 5,000 people die in the ABMU Health Board area each year. The Board has an expectation that people with advanced life threatening illnesses and their families will receive good end of life care. It is understood that, in addition to physical symptoms such as pain, breathlessness, nausea and increasing fatigue, people who are approaching the end of life may also experience anxiety, depression, social and spiritual difficulties. ABMU Health Board, working with its partners is determined to deliver effective and collaborative, multidisciplinary services in the appropriate place. ABMU will ensure that information about people approaching the end of life, and about their needs and preferences, is captured and shared effectively with its third sector and local authority partner organisations.

In addition, ABMU is determined to help meet the needs of families, including children, close friends and informal carers, during and after the person's death.

Currently, many people within the ABMU area receive high-quality care in hospitals, hospices, care homes and in their own homes at the end of their lives, but a considerable number do not. Across the UK, around 74% of people say they would prefer to die at home, but currently 55% of people die in hospital. Within the ABMU Health Board area 66% of people die in hospital.

The End of Life Delivery Plan for ABMU Health Board sets out our commitment to provide high quality care by improving the effectiveness, safety and experience of people approaching the end of their life. This will be done by ensuring that:

- End of life care needs are identified and there is subsequent effective communication to identify needs and preferences where this is wanted by patients and their families
- The care received by people approaching the end of life is aligned to their needs and preferences.
- Increased length of time is spent in preferred place of care during the last year of life.

- There are fewer deaths following unscheduled care admissions, where death in hospital is against the stated preference.
- There are fewer deaths in inappropriate places such as on a trolley in hospital or in transit in an ambulance.

The General Medical Council definition is that 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:

- Advanced, progressive, incurable conditions
- General frailty and coexisting conditions that mean they are expected to die within 12 months
- Existing conditions if they are at risk of dying from a sudden acute crisis in their condition
- Life-threatening acute conditions caused by sudden catastrophic events.

The Board expects all clinical staff to have the values, beliefs, attitudes, training and access to resources to provide high quality end of life care. The Board employs Specialists in Palliative care who spend all or most of their time in the care of people approaching the end of life. Within ABMU, palliative care teams include:

- Palliative medicine physicians
- Palliative care specialist nurses
- Specialist Therapists

ABMU Health Board is committed to delivering the National Institute for Clinical Effectiveness (NICE) Quality Standard for End of Life Care. These require that:

- 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 are offered timely personalised support for their social, practical and emotional needs, which is appropriate to their preferences, and maximises independence and social participation for as long as possible.
- People approaching the end of life are offered spiritual and religious support appropriate to their needs and preferences.

- Families and carers of people approaching the end of life are offered comprehensive holistic assessments in response to their changing needs and preferences, and holistic support appropriate to their current needs and preferences.
- 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 experience a crisis at any time of day or night receive prompt, safe and effective urgent care appropriate to their needs 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 day or night.
- People in the last days of life are identified in a timely way and have their care coordinated and delivered in accordance with their personalised care plan, including rapid access to holistic support, equipment and administration of medication.
- The body of a person who has died is cared for in a culturally sensitive and dignified manner.
- Families and carers of people who have died receive timely verification and certification of the death.
- People closely affected by a death are communicated with in a sensitive way and are offered immediate and ongoing bereavement, emotional and spiritual support appropriate to their needs and preferences.
- Health and social care workers have the knowledge, skills and attitudes necessary to be competent to provide high-quality care and support for people approaching the end of life and their families and carers.
- Generalist and specialist services providing care for people approaching the end of life and their families and carers have a multidisciplinary workforce sufficient in number and skill mix to provide high-quality care and support.

The AMBER care bundle has been developed for use in secondary care when clinicians are uncertain whether a patient may recover and are concerned that they may only have a few months left to live.

It encourages staff, patients and families to continue with treatment in the hope of a recovery, while talking openly about people's wishes and putting plans in place should the worst happen. It consists of four elements:

- Talking to the person and their family to let them know that the healthcare team has concerns about their condition, and to establish their preferences and wishes
- Deciding together how the person will be cared for should their condition get worse
- Documenting a medical plan
- Agreeing these plans with all of the clinical team looking after the person.

The person's condition is then monitored closely and followed up on daily basis to record any changes and address any concerns that they or their family may have.

The AMBER care bundle contributes to people being treated with dignity and respect and enables them to receive consistent information from their healthcare team. It helps people and their carers to be fully involved in making decisions and knowing what is happening with their care.

By having conversations about preferences and wishes and ensuring that everyone involved is aware of care plans, people are more likely to have their needs met.

2. SUMMARY OF PALLIATIVE CARE SERVICES WITHIN ABMU

Specialist palliative care services in ABMU are delivered by a single department within the Health Board's sub-directorate of cancer services and with substantial financial support from local (and to some extent national) voluntary sector organisations. There are two inpatient units (Tŷ Olwen and Y Bwthyn Newydd) with a total of 22 specialist beds. Community palliative care services offering multi-professional domiciliary visits, outpatient assessment, day services and support in community and some mental health hospitals operate in each of the three localities (Swansea, Neath Port Talbot and Bridgend). Hospital teams offer assessment and support in each of the acute hospitals (Princess of Wales, Neath Port Talbot, Morriston and Singleton Hospitals) including mental health units on some sites. The team offer direct assessment by clinical nurse specialists 7 days a week and a palliative medicine on call rota which as well as covering the inpatient beds offers advice and support in all settings 24 hours a day, 7 days a week. The consultant tier of that rota is managed and staffed in collaboration with a neighbouring health board.

General palliative care is provided in all settings by primary and secondary health care teams with the support of specialist palliative care services.

Overview of Local Health Need and Palliative Challenge

The mixed urban & rural population in ABMU has a relatively high incidence of cancer and some other life-limiting illnesses. Specialist palliative care support has been excellent in some respects but was historically patchy with some arbitrary barriers to access, a large care home sector, a large number of long stay NHS beds in elderly mental health and a disparate range of community services inherited from predecessor organisations. Bringing a degree of harmony to these and delivering equitable care is part of the continuing challenge to be met by this delivery plan.

3. DEVELOPMENT OF THE ABMU DELIVERY PLAN FOR END OF LIFE CARE

In anticipation of the publication of the "Together for Health – End of Life Delivery Plan" by Welsh Government, an End of Life Care Group was established, chaired by a specialist in palliative medicine with Executive leadership from the Director of Therapies and Health Science. This group consists of a number of specialists in palliative medicine, specialist nurses in

palliative care, palliative care therapists, general practitioners, pharmacists, representatives of each clinical directorate and locality and other members with relevant specific expertise. The Executive Lead for End of Life Care will report progress formally to the Board against milestones in these delivery plans and publish these reports quarterly on the ABMU Health Board website.

4 SUMMARY OF THE PLAN - THE PRIORITIES FOR 2013 - 14

Following review by the End of Life Care Group, the key findings have been incorporated into our local delivery plan for palliative care. This delivery plan includes actions against each of the 2016 milestones within the Welsh Government's End of Life Plan (2013). We have set out below our review of current achievements and outstanding challenges against the key areas specified by Welsh Government :

4.1 Supporting living and dying well

Current achievements

- Royal College of General Practitioners (RCGP) audit tool sent to general practices along with further information relating to the Carers Measure to support improvements in practice systems.
- GPs encouraged to focus on the development of end of life care as a priority through QPI (Quality Performance Indicators).
- Education for all GPs through protected learning time.
- Training given to primary care pharmacy leads in each of the three localities on Paediatric palliative medicine. Individualised training provided to primary care teams when patients are identified on their case load.
- Paediatric pharmacist is a key member of the paediatric palliative care team, within secondary / tertiary services.
- Training, competency development and troubleshooting will continue to be provided throughout care homes, Social Workers, Domicillary Care teams and Supported care organisations within the locality to ensure standards are met. Communication between social care and health care is focused during this training.
- Community nursing palliative care forums will continue monthly.
- Programmes of education for palliative care are sent out via email to nominate staff within the networks to attend.
- Specialist Practitioners provide education programmes to address specific training needs of district nurses.
- An end of life education package has been developed for Health Care Support Workers (HCSW's) within the community setting to achieve expected standards of care.
- Training provided on request to GPs once or twice a year across 3 localities with Continuing Professional Development.
- Monthly education provided to with district nurses within Neath Port Talbot locality.
- Clear diagnosis of their illness is given to all patients with dementia. The effects of the diagnosis of dementia will be clearly explained to the

patients and families at different stages when appropriate, which will include the management of the End of Life Care. Throughout the patient's illness patients and their family are supported to address issues such as making a will and addressing financial matters and plan for their wishes.

Outstanding challenges to be met within Delivery Plan

- Community 'hospice at home' for children is provided, but this has not been formally commissioned. Currently there is no 24hr service for children.
- Clear funding streams have not been identified for childrens' services.
- No formal established peer review for children's palliative medicine in Wales. There is informal peer review via MCN and weekly Cardiff based ward round with teams from across South Wales.
- There is currently no specific focus on palliative care as a separate need for children.
- Patient and families Reference Group not yet established to support the work of the PCIB in overseeing the plan.
- Lack of formal training provided to primary care teams in relation to plans for end of life care.
- Patchy attendance at Integrated Care Pathway for the last days of life training and end of life study days provided by the specialist palliative care team (SPCT)
- Lack of public awareness of the need to have arrangements in place for their death, including making a will, addressing their financial matters and a plan for their wishes.

The highest priorities for supporting living and dying well from 2013 to 2016 are:

- Formal establishment of a Paediatric palliative care service. This will be taken forward in cooperation with national measures on community nursing, funding streams, peer review and transition.
- Focus on Public awareness work.
- Advance care planning training and implementation.
- Improving integration with Social Services around End of Life Care
- Establishing a Single point of contact for End of Life Care
- Improving end of life care for people within Intensive Care Units

4.2 Detecting and identifying patients early

Current achievements

- Education provided for all GPs through protected learning time.
- GP review visits to target palliative care registers for discussion as part of QOF (Quality Outcomes Framework) review.
- GPs made aware of resources for further education & training.
- ABMU paediatric palliative care monthly meeting open to primary care colleagues.

- Multi-disciplinary Teams (MDTs) are organised and led by Paediatric Palliative Medicine (PPM) team every 1-6 months according to need, for all children on case load.
- Palliative Care Teams liaise with GP practices on a case by case basis, when children with life limiting conditions are within their case load.
- Established communication between adult site specific tumour teams and GP practice to discuss whether and when palliative care should be considered.
- Training in place for nursing and allied professionals.
- As part of the training programmes the role of Specialist Teams and Support Services are highlighted with signposting when required.
- SPCT Clinical Nurse Specialists attend meetings in most GP practices to discuss patients currently being monitored via the palliative care register.
- Links between older people's mental health services and SPCT have been established across Swansea, Neath Port Talbot and Bridgend where ongoing training and development on an inter-professional level is identified and implemented.
- A named Consultant in Palliative Medicine visits Cefn Coed Hospital on a designated day on a weekly basis to meet with clinical staff to identify any issues to End of Life Care. Identified Palliative consultants have also been identified for Neath Port Talbot and Bridgend and they link with clinical colleagues in those areas.
- Dementia training is provided for Health Board staff – champions, butterfly scheme, Abbey pain scale including for care home & social care staff.

Outstanding challenges

- Medicines management & primary care are working to encourage use of audit tools and other mechanisms to support patient identification (including better identification of patients who are anticipated to die who have chronic conditions).
- Primary care are working to develop audit tools and local enhanced service to support patient identification (including better identification of patients who are anticipated to die who have chronic conditions).
- Practices are encouraged to participate in QOF.
- The Local Authority contributes to the GP network structure in Bridgend Locality and is positioned to participate in the future in work to encourage the use of palliative care registers for patients, including paediatrics, with less than one year life expectancy and in particular, non-cancer patients. There is no current work specifically with GPs on this involving the Local Authority.
- Further work needs to be developed with primary care in relation to the assessment of the need for End of Life Care for patients with Dementia that reside within nursing and residential care settings in the community.
- Capacity in general practice – community networks are experiencing significant shortfalls.

The priorities for detecting and identifying patients early from 2013 to 2016 are:

- Audit to establish the shortfalls in early identification
- QOF.
- Improvement in End of Life Care for people diagnosed with Dementia.
- Improvement in End of Life Care for people with other non cancer diagnoses such as COPD and for frail older people.
- Improved training to identify people at an early stage who would benefit from End of Life Care, particularly in dementia and in children's palliative care.
- Improving the identification and care of people at the end of life within secondary care by implementing the AMBER bundle

4.3 Delivering fast, effective care

Current achievements

- Recent audit of paediatric palliative care service (2013) confirmed good advance care planning, choice in place of care and place of death for families –as per standards.
- For adults, Swansea Locality have a community-based service. This team is able to expedite care planning and discharge planning for patients at the end stages of life to assist them to achieve their preferred place of death, whether this be at home or is a residential care environment.
- SPCT holds weekly MDTs for patients in inpatient units, hospitals and community.
- Some use of just in case boxes as part of wider moves on anticipatory prescribing.

Outstanding challenges

- Practices are being encouraged to carry out significant event analysis to enable ongoing reflection and subsequent improvements in service delivery.
- Practices are being encouraged to audit care co-ordination through Quality and Performance Indicators.
- Lead pharmacists have only been appointed to provide advice on palliative care within hospitals.. No service is currently available for: non malignant patients (eg heart failure, chronic obstructive airways disease, critical care), mental health or oncology day unit. No specific specialised palliative care medicines management support is provided for community care.
- For children, ABMU Advanced Care Plan (ACP) policy and document in place, but currently being incorporated into All-Wales Emergency Care Plan. ABMU paediatric End of Life care is delivered by a team comprising Consultants (tertiary and secondary level Paediatric Palliative Medicine) and specialist nurse. The core team are supported by a Pharmacist and have close links with the managed clinical

network, Paediatric oncology nurses, children's therapists and Community children's nurses.

- 24 hours paediatric palliative care telephone advice rota not achieved.
- The Integrated Care Priorities for Last Days of Life is included in all training. Some of the GPs within the networks will require further encouragement to adopt this tool. Acute settings are familiar with this tool and use it in a multidisciplinary context to plan care.
- Funding is in place for adult palliative care services. Staff are in place at the minimum standard advised by the palliative care implementation board for nursing and medicine. There are no recommendations for Allied Healthcare Practitioners. These levels are supported partly by annual One Wales monies.
- The Integrated community services in the Bridgend Locality use an evidenced based approach to inform the planning and organisation of network MDTs. The teams once fully integrated will be in a position to include all national guidelines in the new Standard operating procedures. Ongoing professional education and training will be designed and delivered using an inter-professional perspective.
- There is a need to put clear protocols in place for inpatient mental healthcare wards to facilitate transfer to acute general hospital settings for ongoing care where appropriate. One of the options available to patients/carers would be to be provided with appropriate End of Life Care in the current familiar setting to minimise the distress to patients and carers of any transfer..
- There are capacity constraints in General Practice.
- District Nurses are struggling with volume of palliative work & packages in all three localities.
- Concerns around sustainability of 7/7 adult SPCT Clinical Nurse Specialists.

The priorities for delivering fast, effective care from 2013 to 2016 are:

- Improved Pharmacy support
- Investment in community nursing adult & children
- Formal establishment of Paediatric 24/7 advice & support
- Integration of Health and Social Care End of Life Care services through "Changing For the Better" and the Western Bay partnership
- Rapid provision of equipment to support end of life care at home, with performance standards.
- Education and process changes with appropriate investment to help staff understand priorities and to support getting adults & children out of hospital quickly to live & to die

4.4 Reducing the distress of terminal illness for patients and their families

Current achievements

- Practices have complaints/compliments processes in place.

- Discussions around wider implementation of 'I Want Great Care' are ongoing – further analysis of palliative care responses will inform roll out.
- Ongoing training provided through All-Wales Managed clinical network for children's palliative medicine.
- Training and support for carers is provided by paediatric palliative care team on a case by case basis.
- Integrated care planning training is provided around the Integrated Priorities Approach.
- Care is accessible 24 hours, 7 days per week through the district nursing service.
- Third sector providers support families in bereavement and pre-bereavement. Sign posting is common place with service provision.
- Care planning is achieved through clear assessment with the patient and their families. Care home patients have specific end of life care plans.
- District nursing services are rapidly available throughout a 24 hour period to respond to symptomatic needs.
- Information is shared with the out of hours GP service to ensure they are aware of patients approaching the end of life patients in our community to make decisions about the necessity for hospital admission.
- Peer review of SPCT was conducted in March 2013.
- Feedback on end of life care is routinely sought from Health Board patient surveys, complaints policy, ABMU comments leaflets.
- An established practice group including specialists from Palliative Care and Older People's Mental Health Service is addressing Palliative Care best practice and inter-professional training.
- The Older People's Mental Health Services Consultants group completes mortality reviews on a three monthly basis on all deaths in and these are presented in detail to share good practice and derive learning.

Outstanding challenges

- Current lack of formal peer review of generalist palliative care services except via selected cancer MDTs.
- Opportunity to comment via IWGC (I Want Great Care) is provided to all patients and families who are referred to the SPCT service. The low level of detail usually does not allow team to act on information provided to improve services.
- User feedback is to be included in the Long term care workstream of the Integrated community services programme between ABMU & local authority.
- No patient & family reference group has been established.
- A bid has been submitted for funding to pilot an advanced communication skills programme for practitioners who work with a rehabilitation focus. If successful it is envisaged that the programme would be rolled out to include all practitioners including those who work with complex care needs.

The priorities for reducing the distress of terminal illness for patients and their families from 2013 to 2016 are:

- Review of generalist palliative care
- Provide more comprehensive user feedback and involvement in service co-design
- Improve communication skills support & training

4.5 Improving Information

Current achievements

- Paediatric palliative care team support Consultant colleagues with End of life plans on individual case basis.
- Site specific cancer Clinical Nurse Specialists support communication.
- Macmillan information coordinator in post and based in South West Wales Cancer Centre.
- Regular presentations by Paediatric Palliative Medicine team to medical, nursing and AHPs throughout health board on a variety of topics. PPM toolkits, for each ward area are in development. Information is shared via letter / email and telephone with secure email to police and ambulance for ACP sharing.
- Gaps addressed through a problem solving approach with good networking links with senior nurses in both community and secondary care. This ensures that locality teams are able to improve services in response to experiences learned.
- Promotion of the All-Wales Palliative Care site as a Resource to support good End of Life Care.
- Referral guidance and referral forms for adult palliative care provided electronically..
- Verbal information provided by palliative care team in respect of processes.
- Written discharge information is provided in a timely way by SPCT.
- There are Local Authority representatives on the Interface Meeting between Bridgend Locality Integrated Services and Palliative Care group. This strategic group focuses on the planning and delivery options for the local integration of palliative care services.
- There is a dedicated specialist sensory team within the Bridgend community resource team, the Community Independence and Wellbeing Team. This integrated team is well placed to include the focus on information needs in its current development work.

Outstanding challenges

- Primary Care Practices are encouraged to carry out audits designed to drive better co-ordination of care and effective communication, including audit through QPI.

- Royal College of General Practitioners (RCGP) audit tool provided to general practices along with further information relating to Carers measure to support improvements in practice systems.
- More timely information sharing would be facilitated by secure email / online data sharing across Wales. IT links are currently suboptimal, with a lack of clinical information system. Consequently, timely access to information across Wales is compromised.
- Lack of regular and easy to understand information about the effectiveness of end of life care services for children
- Where the locality has capacity issues with end of life care, the lead nurse raises this with the locality management team who look for solutions to ensure patients are able to come home to die in the preferred place. There are many examples where resources have been pooled together to achieve this. There is also evidence that short term funding increases have been made available to support the wishes of patients. However, the longstanding capacity issues require resolution.

The priorities for Improving Information from 2013 to 2016 are:

- Improved participation in national audit of ICP(LDL).
- Audit of information provision.
- Improved IT provision and appropriate levels of information sharing including linking primary and secondary care IT systems.
- Evaluation of electronic palliative care coordination system.
- Developing public information about children's services.
- Overcoming barriers to information provision to patients and families.
- Resolution of issues with implementation of DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation policy. Redesign of the DNACPR consent form.

4.6 Targeting Research

Current achievements

- There is a virtual research group in place within the adult palliative care department.

Outstanding challenges

- Research trials are limited in paediatric palliative medicine outside of Oncology.
- Need for support and encouragement of protected research time for clinically active staff. This is currently not achieved in adult or paediatric palliative care since clinical commitments are too high to allow lead clinician and specialist nurse research time.
- Engagement with NISCHR (National Institute for social Care Health Research) is developing among palliative medicine doctors although not the wider SPCT as yet.
- Few clinical trials are available to recruit patients in to.
- There is a need for the Integrated Network teams (between health & social care) to develop a focus on research as they bed in and mature.

- There is a need to build links with units in Swansea university. A number of these have been identified and need development.

The priorities for targeting research from 2013 to 2016 are:

- Building a research culture within end of life care
- Identifying research trials
- Making links between clinicians and research units
- Building time for research into job plans
- Growing research capacity

5.0 PERFORMANCE MEASURES/MANAGEMENT

The Welsh Government's 'Delivery Plan for End of Life' (2013) contained an outline description of the national metrics that LHBs and other organisations will publish:

- Outcome indicators which will demonstrate success in delivering positive changes in outcome for the population of Wales.
- National performance measures which will quantify an organisation's progress with implementing key areas of the delivery plan.

Progress with these outcome indicators will form the basis of ABMU HB's annual report on end of life care. They will be calculated on behalf of the NHS annually at both a national and local Health Board population level. The Health Board will produce its first annual report on end of life care in March 2014.

The Executive lead will also report progress against the local delivery plan milestones to the Health Board at least annually and to the public via the website. The Local Delivery Plan and milestones will be reviewed and updated annually from March 2014.

1.0 DETAILED DELIVERY PLAN

Details of the narrative delivery plan are given in the following pages. A detailed operational delivery plan will be developed by the ABMU End of Life Care group with timescales for implementation together with process and outcome measures. This will be aligned with the Board's Strategic Direction and Planning Cycle and contain detailed costings. Partnership working with Local Authority and Third Sector organisations will underpin delivery and these relationships will be developed over the period of the plan. Dr Idris Baker, Consultant in Palliative care medicine will chair this group, with Executive leadership provided by the Director of Therapies and Health Science, to whom questions on the plan should be addressed.

4.1 Supporting living and dying well

Objectives	Actions	Expected outcome	Risks to delivery	Timescales	Lead
Paediatric palliative care – cooperation with national measures on community nursing, funding streams, peer review and transition.	Active engagement with Health Boards across Wales as opportunities arise. This to be taken forward by the Palliative Care Implementation Board	Improved palliative care for children, particularly those dying at home. Security of funding	Uncertainty on national progress. Funding	End of 2016	Consultant Child Health Paeds Palliative Care
Improve Public awareness of death and dying.	Active engagement with public health colleagues within ABMU & nationally	Healthier attitudes to death and dying	Uncertainty on national progress	End of 2016	Director of Public Health
Advance care planning training and implementation.	Adopt appropriate documentation Training of staff in administering documentation	Better anticipatory decision making with people nearing end of life	Patient and family willingness to participate. Training capacity	End of 2014 End of 2016	Consultant Palliative Care
Improved engagement of Social workers in End of Life Care	In partnership with Western Bay and Macmillan, Gain funding for innovative SW posts to support EOLC	Better assessment of need and support for people approaching the end of life	Funding	2014	Consultant Palliative Care
Implement Single point of contact for end of life care	Embed EOLC needs in discussions about single point of contact in health & social care	Improved care and reduced distress through better coordination of assessment and support	Failure to prioritise Communications Hub development	2014	Asst Dir Primary Care/ Asst Director Informatics

4.2 Detecting and identifying patients early

Objectives	Actions	Expected outcome	Risks to delivery	Timescales	Lead
Audit the shortfalls in early identification, specifically in primary care	Audit palliative care registers in Primary Care as part of Frailty LES	Understanding of why people don't get put on register or if put on register too late to be of benefit	Capacity of GPs to participate	2014	Associate Medical Director – Bridgend Locality / Asst Director Primary Care
Using QOF to drive improvements in early detection	Primary Care Managers to	improvements in early detection	Failure to engage primary care managers	2016	Primary Care Managers
Improve end of life care for Dementia population – specific challenges and a paradigm for other non cancer including frail elderly.	Develop and apply evidence base for identification which people nearing end of life	Improve end of life care for Dementia population	Inherent Uncertainty about process Lack of engagement with patients, carers, families, care homes, GPs, Acute hospitals	2016	Director of Therapies
Developing access to training about identification – for instance in dementia and in children's palliative care.	Provide training	Better training for non-specialists in current knowledge	Lack of training capacity	2016	Old age psychiatrists

Improving end of life care in secondary care by implementing the AMBER bundle	Redesign of work processes, communication strategies, and infrastructure, along with sustained measurement and vigilance.	Better training for secondary care staff in assessment and communicating with patients and families	Lack of training capacity Engagement in secondary care	2016	Medical Director Director of Nursing Director of Therapies and Health Science
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4.3 Delivering fast, effective care					
Objectives	Actions	Expected outcome	Risks to delivery	Timescales	Lead
Improved Pharmacy support	National work to agree with community pharmacies Gain investment	Deliver improved access to basic drugs and specialist advice including out of hours	Lack of engagement with community pharmacies Funding	2016	Palliative Care Implementation Board
Gain Investment for community nursing for adults & children	Develop business case for investment	Better support fore people dying at home Better achievement of preferred place of care	Funding	2014	Asst Director Primary Care
Provide Paediatric end of life care advice & support, 24 hours a day, 7 days a week	Develop medical on call rota	Better support for children dying at home Better achievement of preferred place of care	Funding. Engagement of Paediatricians.	2016	Consultant Child Health

			Collaboration between HBs for on call rotas.		
Integration of Health and Social Care – Western Bay Collaboration, frailty LES	Develop Frailty LES Wider integration eg frailty and dementia workstreams	Better, more cost effective, more joined up care	Engagement Funding	2016	Western Bay Collaboration,
Rapid equipment provision to support end of life care in preferred place	Provide transport and access at least 7/7 to equipment	Better achievement of preferred place of care and improved quality of care	Risk averse approach currently	2014	Director of Therapies
Improved Education (& for children, process change) to help staff understand priorities and to support getting adults & children out of hospital quickly to live & to die	Provide training and develop a process for children possibly modelled on fast track processes for adults	Better achievement of preferred place of care and improved quality of care for adults and children	Risk averse approach currently	2014	Director of Primary Care/ Consultant Child Health
Development of more consistent anticipatory prescribing	Education, training and listening to concerns so as to overcome barriers	More consistent anticipatory prescribing	Lack of engagement	2014	Dan Harris EOLCG

4.4 Reducing the distress of terminal illness for patients and their families

Objectives	Actions	Expected outcome	Risks to delivery	Timescales	Lead
Peer Review of generalist palliative care	Commission Peer Review	External objective measure of performance leading to resolution of gaps and improved performance through sharing knowledge	Lack of prioritisation by PCIB	2016	Palliative Care Implementation Board
Better user feedback and involvement in service development	Need to develop process for systematic collection of feedback from people receiving end of life care and their families. Need to develop partnership with patients to co-design services	Service improvement and person centred care from feedback and codesign	Lack of prioritisation by PCIB	2016	Asst Director of Nursing/ Head of Patient Experience/ Palliative Care Implementation Board
Improve Communication skills support & training	Deliver training in communication skills	Better care and reduced incidence of distress through poor communication	Funding for large scale training	2015	Director of Workforce & OD

4.5 Improving information					
Objectives	Actions	Expected outcome	Risks to delivery	Timescales	Lead
Improved participation in national audit of ICP(LDL).	Ensure clinical teams complete and submit audit proformae	Improved rate of participation in National audit	Engagement of clinical teams	2013	Director of Nursing/ Interim Medical Director
Improved information provision.	Review of existing written information provided and development of improved	More consistent provision of information and possibly better information. People better informed about choices	Engagement/Time	2014	Asst Director of Nursing/ Head of Patient Experience
IT provision and appropriate levels of information sharing including linking primary and secondary care IT systems.	National Programme required to integrate systems	Fewer gaps in patient care due to lack of timely, up to date information	Engagement of National IT Funding	2016	NWIS/ Asst Director of Informatics/ Palliative Care Implementation Board
Provide better public information about children's services.	Review of existing written information provided and development of improved for children and parents	More consistent provision of information and possibly better information. People better informed about choices Reduced distress	Engagement/Time	2014	Child Health Consultant
Progress on DNACPR policy & form.	Participation in national project	National policy	Lack of Agreement	2014	Externally led

4.6 Targeting research

Objectives	Actions	Expected outcome	Risks to delivery	Timescales	Lead
Building the culture				2016	End of Life Care Delivery Group
Finding the studies	Engagement with NISCHR	Having studies to recruit patients to	Dearth of suitable Studies, particularly in children. Reluctance of staff to engage	2016	End of Life Care Delivery Group
Making the links	Develop links with Universities	Having the confidence and networks to engage in collaborative research	Time of clinical staff to engage	2016	End of Life Care Delivery Group
Finding the time	Grant Applications/Job Planning/	Funding for research	Time of clinical staff to engage	2016	End of Life Care Delivery Group
Growing the capacity	After developing links and funding, commitment of time to research	More time spent on research for end of life care	Time of clinical staff to engage, research skills/interest	2016	End of Life Care Delivery Group