East Suffolk and North Essex NHS Foundation Trust

2022 – 2025

End of Life Care Strategy

Good end of life care for all

Foreword

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Chief Medical Officer

This strategy builds further on the "Ambitions for Palliative and End of Life Care: A national framework". This was refreshed in 2021. What we have learnt from the COVID-19 pandemic is that we must re-double our efforts to focus on personalised end of life care and drive down inequalities.

The Trust's philosophy is that 'Time Matters' and that we must reduce the unnecessary stress of navigating the system and free up time to focus on what matters most. It is clear that how we care for the dying is an indicator of how we care for all sick and vulnerable people.

Our patients and those important to them, should be at the centre of everything we do and we recognise that end of life care is everyone's responsibility.

This End of Life Care Strategy focuses on the care of people who are approaching the end of their life which means they are likely to die within the next 12 months. This includes care of both the patient and their loved ones during this time and when death is imminent.

East Suffolk and North Essex NHS Foundation Trust (ESNEFT) serves a population of approximately 800,000 people across East Suffolk and North Essex. We deliver care services from two main hospitals in Colchester and Ipswich, community hospitals, high street clinics and in patients' own homes.

Many of the people we serve will have progressive incurable conditions, general frailty, existing conditions with risk of dying from a sudden change in their condition or a life-threatening condition caused by sudden catastrophic events. We know that up to 10% of inpatients will die during a hospital admission and almost one in three will have died a year later, rising to one in two in those over 85.

We therefore want to provide skilled and compassionate care to our patients and those close to them. By setting out our objectives in this strategy we aim to improve identification of our patients within their last year of life, to have honest conversations with them to enable holistic care planning and management focused on what matters to them and to develop a compassionate and competent workforce to provide this care.

"End of life care affects us all, at all ages, the living, the dying and the bereaved."

Our patients' charter

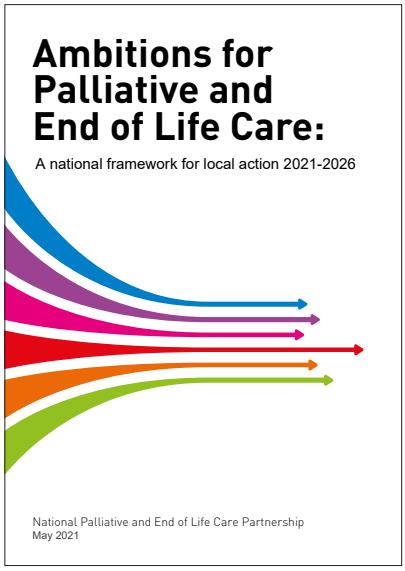
Good end of life care for all

We want to offer you the highest quality of care and support.

We wish to help you live as well as you can for as long as you can. Therefore, when you are nearing the end of life, if and when you want us to:

- We will talk with you and those identified as important to you about your future wishes.
- We will provide you with accurate and relevant information at all stages of your care from the diagnosis to death and bereavement.
- We will, where possible, ensure you are cared for in your preferred place of care.
- We will listen to your wishes about the remainder of your life, including your last days, hours and months, answer as best we can any questions that you have and provide you with the information you feel you need.
- We will work together as a multidisciplinary team to provide an individual care plan and ensure we involve and communicate sensitively with you and those identified as important to you.
- We will work with you to meet your cultural, religious, and/or spiritual needs, in appropriate ways.
- We will do our utmost to ensure that your remaining days and nights are as comfortable as possible, and that you receive all the care that you need.
- We will support those identified as important to you, both as you approach the end of your life and during their bereavement.

Our aim



Our vision for End of Life Care interlinks with the Trust's philosophy that 'Time Matters.'

Planning for care at the end of life has improved significantly however we know that more people can be given the chance to set their own goals and make choices about the end of their life.

Therefore we will improve recognition of our patients who may be in their last year of life and support those already identified as being in need of palliative and end of life care.

We will offer holistic care planning to our patients in the last year of life.

We will be aware of the pastoral, cultural and spiritual needs of those in the last year of their life.

We will have a caring, compassionate and competent workforce to deliver good end of life care for all.

The six ambitions

01 **Each person is seen as an individual**
I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what's possible.

02 **Each person gets fair access to care**
I live in a society where I get good end of life care regardless of who I am, where I live or the circumstances of my life.

03 **Maximising comfort and wellbeing**
My care is regularly reviewed and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible.

04 **Care is coordinated**
I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of the day or night.

05 **All staff are prepared to care**
Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care.

06 **Each community is prepared to help**
I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways.

01 Each person is seen as an individual

I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what's possible.

What we will do

1.1 Recognise individuals who may be in their last year of life.

1.2 Have open and honest conversations about dying and bereavement with them and those important to them, supported by the Respect tool when possible.

1.3 Offer holistic assessment and advance care planning using My Care Choices Register (MCCR) in North East Essex and My Care Wishes in Ipswich and East Suffolk.

1.4 Develop mechanisms to support bereaved relatives immediately after death and ensure signposting to bereavement services where appropriate.

02 Each person gets fair access to care

I live in a society where I get good end of life care regardless of who I am, where I live or the circumstances of my life.

What we will do

2.1 Increase the use of electronic palliative care registers and systems for communication of advance care planning.

2.2 Increase identification of patients in their last year of life with diseases other than cancer.

2.3 Identify and address inequalities in access to palliative and end of life care for those communities who have been previously underserved, in conjunction with partner organisations.

2.4 Improve recognition of those individuals thought to be in the last days of life and ensure that symptoms are addressed and eating and drinking supported, in line with National Institute for Health and Care Excellence (NICE) guidance.

2.5 Ensure there is equitable access to Palliative Care Services for all, including improved access at weekends.

03 Maximising comfort and wellbeing

My care is regularly reviewed and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible.

What we will do

3.1 Educate our workforce in line with the ESNEFT EOL Education Strategy, to be able to identify those who are dying and improve symptom control and provide skilled and compassionate care.

3.2 Improve individual care planning by increasing the use of the Individualised Care Plan for the last days of life.

3.3 Ensure an adequately staffed Specialist Palliative Care Team to provide support in complex situations including 7 day a week face to face service.

3.4 Provide improved care environments, including appropriate areas for breaking bad news.

3.5 Provide access for emotional, spiritual, and religious care from Chaplaincy teams.

04 Care is coordinated

I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of the day or night.

What we will do

4.1 Work closely with our community partners to ensure timely discharge of our patients to enable them to die in their preferred place.

4.2 In North East Essex promote the use of the My Care Choices Register as a shared record within the hospital and the community. We will support hospital healthcare professionals to learn how to access and add patients to this register (a record of all deteriorating patients in the locality).

4.3 In Ipswich and East Suffolk, encourage use of My Care Wishes and work with community partners to promote and develop an electronic palliative care register to improve the sharing of people's end of life wishes.

4.4 Contribute to and support a system-wide approach to end of life care, including access to 24/7 helplines.

05

All staff are prepared to care

Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care.

What we will do

5.1 Ensure that we have a well-trained, competent and confident workforce in line with our Education Strategy.

5.2 Have clear governance from ward to board level for high-quality palliative and end of life care.

5.3 Trust-wide engagement with end of life care, ensuring it is everybody's business.

5.4 Continue development of the hospital's End of Life Care Champions.

5.5 Optimise the wellbeing of our workforce through support networks, training and supervision.

06

Each community is prepared to help

I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways.

What we will do

6.1 Engage with our community to improve public awareness of death and dying and services available in support of this.

6.2 Develop and increase the volunteer service to support patients and their families within the hospital, by increasing the support from Butterfly Volunteers in the acute and community hospitals. Work closely with other charitable partners to support our patients and carers.

Implementation of the Strategy

Operational progress with the implementation of the strategy will be overseen through the Trust's End of Life Steering Group, which has representation from a Non-Executive Director, patient representatives and Governors.

There will be a quarterly report to the Patient Experience Group. The Quality and Patient Safety Committee will also report to the Trust Board of Directors.

We will continue to work closely with our community partners to improve integrated care for our patients and carers to include our local Hospices, Clinical Commissioning Groups (CCG), local County Councils, GPs, voluntary groups and care home representatives, as well as patient representatives.

Relevant information

Ambitions for Palliative and End of Life Care 2021-2026. https://www.england.nhs.uk/publication/ambitions-for-palliative-and-end-of-life-care-a-national-framework-for-local-action-2021-2026/

Department of Health (2008). End of Life Care Strategy: Promoting high quality care for all adults at the end of life. London: HMSO

Parliamentary and Health Service Ombudsman (PHSO) (2015). Dying without dignity. Investigations by the Parliamentary and Health Service Ombudsman into complaints about end of life care. PHSO: London: 2015

The Independent Review of the Liverpool Care Pathway. (2013). More Care, Less Pathway: A Review Of The Liverpool Care Pathway. Available at: www.gov.uk/ government/ publications/review-of-liverpool- care-pathway-for-dying-patients

Clark et al (2014) Imminence of death amongst a cohort of hospital in- patients: prevalent cohort study. Pal Med DOI: 10.1177/0269216314526443

The Leadership Alliance for the Care of Dying People. (2014). One Chance to Get it Right: Improving people's experience of care in the last few days and hours of life. London: LACDP

NICE National Institute for Health and Care Excellence (NICE) (2011 modified 2013). Quality standard for end of life care for adults. NICE Quality Standard 13. London: