End of life Care Strategy 2022-2026

This strategy builds further on our previous strategies setting out our vision and ambitions for the end of life care we provide at Chesterfield Royal Hospital NHS Trust. It provides us with the opportunity to refocus our efforts and improve end of life care for our patients and those important to them, ensuring they are, at the centre of everything we do.

Our Ambitions

1. **Each Person Seen as an Individual**
2. **Each person gets fair access to care**
3. **Maximising comfort and wellbeing**
4. **Care is coordinated**
5. **All staff are prepared to care**
6. **Each community is prepared to help**

The achievement of our ambitions we will ensure our patients are supported to have/be:

1. Involvement in, and have control over, decisions about their care.
2. Access to high quality care given by well trained staff.
3. Access to the right services when they need them
4. Support for their physical, emotional, social, and spiritual needs.
5. The right people aware of their wishes at the right time.
6. Cared for and die in a place of their choice.
7. The people who are important to them supported and involved in their care.

How will we get there?

To help us to get there, this strategy outlines our plans over the next four years to improve our end of life care and services in line with our Care values. It sets out our ambitions for improving the experience of patients who are at the end of life, as well as improving the support and care we give to families, friends and/or their loved ones

What do we want to be?

We want to be the hospital that our patients, their loved ones, and staff would want to be in if they had to be cared for in hospital at the end of their lives. We also want to do everything we can to enable people to be cared for elsewhere (such as in their home) if that is their wish.

NHS
Chesterfield Royal Hospital
NHS Foundation Trust

NB This strategy was developed in alignment with Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2025, End of Life Care for Adults: Service Delivery (NG142 Oct 2019) and End of Life Care for Adults, NICE Quality standard (QS13 Sept 2021).

What will we do to achieve our Ambitions?

1-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.

- Continue to educate our staff in and promote shared decision making
- Further develop uncertain recovery programme, to enable early, proactive identification of those with chronic illnesses and potential palliative care need.
- Promote open, honest, sensitive, and well-informed conversations about dying, death and bereavement, through the provision of a programme of communication training, at foundation, intermediate and advanced levels.
- We will work in partnership with JUCD (Joined Up Care Derbyshire) end of life work streams to develop and implement a locality wide approach to a personalised care planning shared digitally across all providers, rapid access to health and social care and systems for person centered care.
- Develop an improvement plan to promote the use of advance care planning tools to help identify a person's wishes and priorities.

2-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.

- Ensure when reviewing or developing policy /procedure that consideration is given to specific needs, e.g., children & young adults, mental health, learning disabilities, autism, dementia.
- Continue to monitor and improve the rapid discharge process so that where it is possible patients are always supported to achieve their wishes surrounding place of care at the end of life
- Utilise existing data and examine any opportunities to gather new data that is robust and useful in the development of improvement plans, this will include the development of person centred outcome measures
- Foster a culture of unwavering commitment to ensure there is equitable access to ensure the right care at the right time is provided for all, this will include the development of inclusive cross-cultural training.

3-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.

- Continue ongoing development of the Supportive care model to ensure the service remains responsive to service users, this will include improving integrated working between specialist palliative care and other specialties for non-malignant long-term conditions.
- Current EOL documentation will be reviewed, and a holistic assessment and care management tools will be developed, along with point of care education on their use to facilitate:
  -a skilled assessment performed by the most appropriate healthcare professional,
  -Assessment and management of symptoms
  -Recognising and manging all forms of distress
  -Supporting patients expressed wishes about eating and drinking
  -Regular evaluation of care and ongoing review
  -Referral to appropriate palliative services as required
- Further development of the SWAN model and "#it starts with a yes", promoting personalised end-of-life care, including delivering care that matches the person's preferences and needs as closely as possible.

4-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.

- Continue our focus on the rapid discharge process ensuring there are improvements in coordination of care that enable patients to remain at home
- We will work in partnership with JUCD (Joined Up Care Derbyshire) end of life work streams to develop new models of care and implement a locality wide approach to the provision of a single point of access, shared care records ensuring the patient experience perspective is used in design of services.
- Cross-boundary care, continuing to work in partnership with all stakeholders to ensure the delivery of high-quality end-of-life care, ensuring clear channels of communication to facilitate a seamless transition of care.

5-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.

- Further develop and implement our EOL training strategy to ensure that staff have access to a diverse and comprehensive range of education and training opportunities to ensure they have the appropriate knowledge, skills, competences, attitudes, and behaviours.
- Continue to develop and implement improvements that foster an organisational and professional environment that ensures psychological safety, support, and resilience amongst our staff
- Ensure that clear governance structures, strong clinical leadership including executive support are in place throughout the organisation that ensures EOL care is considered as everybody's business and supports the provision of high-quality palliative and end-of-life care.
- Examine the use of new technology and consider the development of innovative training methods

6-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

- Expand of companion volunteer programme, so all adult inpatient wards have input
- Continue to develop our SWAN model and "#it starts with a yes" programme to ensure we provide the highest level of involvement and support possible to those important to the patient including carers
- Build on existing working relationships with local health and social care providers and voluntary organisations, working together to foster compassionate and resilient communities
- Improve public awareness about the difficulties people face when nearing the end of life and create a better understanding of the help that is available.
- Continue to develop our Always event programme working with patients/ families to co-design service improvements
- Improve access to pre-bereavement and bereavement support, including children and young people and those affected by sudden/traumatic death.
- Build on existing links with CRHFT carer liaison service to better support families who have caring responsibilities