Clinical Governance Strategy and Work Plan – Isabel Hospice 2016-2018

Abstract

Clinical Governance is the key mechanism to support delivery of the vision outlined in ‘High Quality Care for All’ which defined quality in the NHS in terms of patient safety, clinical effectiveness and the experience of patients.

This is the two year Clinical Governance Strategy and Work Plan for the Isabel Hospice which embraces the Clinical Governance Philosophy.

Elizabeth Paske & Jill Troup
Executive Summary

1. Purpose and Key issues

To present draft Clinical Governance Strategy and Work Plan 2016-2018

Clinical Governance is essential to the delivery of high quality safe and effective patient care. It provides a framework to continuously improve the quality of hospice services.

Key issues include

- Sets out how the Isabel Hospice manages clinical governance
- Explains the Isabel Hospice principal strategic goals for clinical governance and key themes for the next 2 years
- Outlines executive and other responsibilities for leading and managing clinical governance and achieving the agenda

2. Supporting Information

The Clinical Governance Strategy and work plan 2016-2018 is attached

3. Controls and assurances

The strategy is considered by the Clinical Governance Forum. Following discussion amendments will be made as appropriate. The strategy then will be formally approved by the committee.

The Isabel Hospice clinical governance management arrangements have been developed to meet the requirements of the Litigation Standards for Hospices and the Care Quality Commission Requirements.

4. Legal Implications

The Legal implications will be considered

5. Equality and Diversity Implications

The Isabel Hospice aims to plan and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. An equality impact assessment will be carried out.

6. Patient, Public and Staff Involvement

The Isabel Hospice business planning process incorporates patient and public involvement. Robust and effective financial control and risk management systems ensure that the Isabel Hospice services can be developed to meet the needs of the patients.

7. Cost Implications

There is no additional cost over and above the normal finance for the business.

8. Potential Risk to the Organisation

If the strategy is not achieved the Hospice will be at medium risk of not achieving national requirements or acting in accordance with the Hospice standards and instructions. Risk Score 9 (consequence=3x3 Likelihood)
9. Committee Prompts
The Hospice Board need to be assured that there are effective systems for the delivery of the Clinical Governance Agenda and for keeping the Board informed

10. Strategic Objectives

<table>
<thead>
<tr>
<th>Compliance with CQC framework</th>
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<tbody>
<tr>
<td>Successful transition to System one maintaining documentation/reporting requirements</td>
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<tr>
<td>Alignment with Hospice UK standards</td>
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<tr>
<td>Implementation of National Audit Tools for Hospices</td>
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<tr>
<td>Full implementation of OACCS measures</td>
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<td>Alignment of the clinical strategy with Ambitions for Palliative Care Framework</td>
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<td>Completion of full suite of in date policies in line with CQC expectations</td>
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</table>

11. Principal Risks
The principal clinical governance risks have been identified through the Isabel Hospice risk management processes. They are updated as and when required.

<table>
<thead>
<tr>
<th>Failure to comply with the CQC standards</th>
<th>Potentially resulting in lack of organisational compliance with legislation and the reduction of reputation of Isabel Hospice.</th>
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<tbody>
<tr>
<td>Move from cross care to system one</td>
<td>Freeze on all cross care enhancements leading to potential gaps in recording of patient information whilst freeze is in place. Failure to meet national and local record keeping standards during and immediately after switch.</td>
</tr>
<tr>
<td>Quality Improvement</td>
<td>Failure to drive quality improvement across clinical and areas potentially directly affecting patient safety, patient experience and staff morale.</td>
</tr>
<tr>
<td>Policies</td>
<td>Number of policies remain out of date or not available, potentially resulting in patients being given care that is not up to date or evidence based.</td>
</tr>
<tr>
<td>Redevelopment of QE2 site</td>
<td>Disruption to service quality/continuity</td>
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# Document Control Report

**Title**  
Clinical Governance Strategy

**Authors**  
Elizabeth Paske Director of Clinical Services, Jill Troup Team Leader Clinical Governance.

<table>
<thead>
<tr>
<th>Version</th>
<th>Date Issued</th>
<th>Status</th>
<th>Comment</th>
</tr>
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<tr>
<td>1.0</td>
<td>September 2016</td>
<td>Final</td>
<td>Presented to Clinical Governance Committee for comment and approval.</td>
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Director of Clinical Services (Executive Lead for Clinical Governance)

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Clinical Governance Strategy

**Path**

**Filename**
Clinical governance is a framework through which organisations are accountable for clinical performance, underpinning quality and continuous improvement. It safeguards high standards of care and provides an environment in which excellence can flourish.

Clinical Governance is the key mechanism to support delivery of the vision outlined in ‘High Quality Care for All’ which defined quality in the NHS in terms of patient safety, clinical effectiveness and the experience of patients. The framework for delivery of this vision and the first year of the NHS Five Year Plan is set out in the Operating Framework for the NHS in England 2010-11.

Clinical Governance is a complex movement with many elements, strategies and initiatives to support patient safety and quality improvement.

Clinical Governance underpins quality and continuous improvement. It is an integral part of the Isabel Hospice vision, systems and processes in which to deliver excellent care and services. It should therefore help to support system design and re-design. The strategy builds on the quality improvement that exists at the Isabel Hospice.

At the Isabel hospice we employ robust systems of clinical governance for accountability, continuous improvement and excellence, including:

- Ensuring that we are complying with Care Quality Commission outcomes and regulations
- Monitoring care through the use of Help the Hospice audit tools and other measures to ensure best practice
• Monitoring patient and carer satisfaction by responding promptly to comments and complaints and conducting an audit of patient and carer satisfaction surveys
• Rigorously reviewing reports of incidents and near misses and putting in place appropriate action plans
• Development of clinical guidelines based on the most up to date evidence.

The Isabel Hospice is registered and inspected by the Care Quality Commission, which is the independent regulator of care in England.

Aims and Objectives

Clinical Governance requires organisations to develop a culture where staff are supported to work safely and can utilise the best evidence available to guide and help them reflect on practice. This is also reliant on a strong leadership structure, effective partnership, continuous learning to aid delivery of safe and effective care. The continuous improvement cycle is integral to this.

All organisations must have a top-level strategy for managing clinical governance. This strategy sets out how the Isabel Hospice manages clinical governance. It clarifies the organisation’s strategic goals for clinical governance and key themes for the next two years. It also defines executive and other responsibilities for leading, managing and driving forward the clinical governance agenda.

This strategy builds on work that has already commenced to develop systems for managing quality and safety.

Accountability and Assurance

There are clear lines of responsibility for clinical governance in the Isabel Hospice. It is important that there is clarity in terms of overseeing, delivery and supportive roles.

This section details and identifies the systems for governance, assurance and operational responsibilities.

Board Level Accountability

The overall responsibility for delivery of the clinical governance strategy and agenda rests with the Chief Executive. This responsibility is delegated to the Director of Clinical Services who is a Nurse and has executive responsibility for ensuring that clinical governance is delivered throughout the organisation and remains a priority, thus becoming an integral part of the Isabel Hospice Policies and Procedures.

The Team Leader for Clinical Governance (who reports directly to the Clinical Director), Chairs the Clinical Governance Forum which monitors this strategy, through regular reports, an annual plan and clinical governance reports to the Director of Clinical Services who attends the meeting.
The Board has appointed one lead Non–Executive Director who take a special interest in Clinical Governance Board Assurance.

The Board is responsible for ensuring that adequate resources are committed to deliver the strategic goals for clinical governance.

**Management responsibilities.**

<table>
<thead>
<tr>
<th>Area of responsibility</th>
<th>Lead Executive Director</th>
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<tbody>
<tr>
<td>External Responsibility</td>
<td>Chief Executive</td>
</tr>
<tr>
<td>Internal Communication</td>
<td>Chief Executive</td>
</tr>
<tr>
<td>Clinical Audit &amp; Effectiveness</td>
<td>Director of Clinical Services</td>
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<tr>
<td>Clinical Governance &amp; Quality Assurance</td>
<td>Director of Clinical Services</td>
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<tr>
<td>Patient Experience/ Customer Relations</td>
<td>Director of Clinical Services</td>
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<tr>
<td>Patient Focus and Public Involvement</td>
<td>Director of Clinical Services</td>
</tr>
<tr>
<td>Patient Safety Improvement</td>
<td>Director of Clinical Services</td>
</tr>
<tr>
<td>Research and development</td>
<td>Director of Clinical Services, Medical Director</td>
</tr>
<tr>
<td>Safeguarding Adults and Children</td>
<td>Director of Clinical Services, Medical Director</td>
</tr>
<tr>
<td>Access, Referral, Treatment and Discharge</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Emergency and Contingency Planning</td>
<td>Director of Clinical Services</td>
</tr>
<tr>
<td>Continuous Professional Development</td>
<td>Head of Human Resources</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>Head of Human Resources</td>
</tr>
<tr>
<td>Fitness to Practice</td>
<td>Head of Human Resources</td>
</tr>
<tr>
<td>Information Governance</td>
<td>Head of IMT</td>
</tr>
<tr>
<td>Performance Management</td>
<td>Head Of Finance</td>
</tr>
<tr>
<td>Risk Management</td>
<td>Director of Clinical Services, Head of Finance</td>
</tr>
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</table>

**Operational delivery**

In order for Clinical Governance to be significant it must be linked to the development of the multidisciplinary clinical teams and services who are responsible for the continuous improvement of the care they deliver with support from the embedded clinical governance structures.

There are also internal links and partnership working to support the clinical governance structure there is a weekly clinical incident group where clinical incidents are discussed in depth and then further investigated or closed. The meeting also explores complaints and drives dissemination of learning from incidents/complaints. The Director of Clinical Services chairs this meeting.

**Support for Clinical governance**

The primary support services for clinical governance are the clinical governance team. They support the development and implementation of clinical governance processes and provide advice on all aspects of clinical governance. It is the responsibility of the Team Leader Clinical governance to co-ordinate the work of this service.

**Acting on the Clinical Governance Strategy**

The aims of the Isabel Hospice are to ensure mechanisms are in place to:-

- Deliver safe and effective care based on available evidence and best practice.
• Achieve demonstrable improvements in patient outcomes
• Increase the involvement of staff, patients, carers and the public in clinical governance and quality improvement activities
• Provide assurance to patients and the public who are involved with the Isabel Hospice, and our commissioners on our systems for safety and quality of care

The Care Quality Commission, our regulators, ask the same five questions of all care services which are consistent with our aims.

Are they safe?
Are they effective?
Are they caring?
Are they responsive to people’s needs?
Are they well led?

There is a strong Clinical Governance Structure supporting the Isabel Hospice and closure of the incident reporting loop is enabled with Learning Outcomes which infiltrates through all the Team Meetings. Therefore the five questions asked by the Care Quality Commission are continually evaluated through this structure.

**Monitoring and Review of Strategy**

Work plans will be in place for delivery of the key components of clinical governance and will support the following:

Patient Safety, Quality and Experience
Information Governance
Clinical Audit & Effectiveness
Education and Training
Risk Management
Workforce Development
Central Alerts
Key challenges and proposed work plan at the Isabel Hospice 2016-2018

1. **Care Quality Commission**

   The last two CQC visit were carried out in June 2013 and August 2014. They were both unannounced routine inspections to check that the essential standards of quality and safety were being met. The Isabel Hospice received an overall ‘Good’. The Isabel Hospice was again assessed in January 2016. A work plan was developed using the gaps from the analysis carried out by the CQC (verbal feedback), in particular the way that some Nursing Staff assess and report Pressure Ulcers. Following the CQC visit it was found that the correct process was in place as per NICE Guidance but not always being followed. This is ongoing work.

2. **Information Governance**

   We are changing to Systemone to be aligned with other health providers in the county to increase access to patient related communication which will support safety in practice, particularly after hours.

   There is a project plan in development and we will be working with the developers to ensure a smooth transition.

3. **Ambitions for End of Life Care**

   The National Framework for local action set out the Ambitions for Palliative and End of Life Care 2015-2020. Six ambitions and eight foundations were summarised to achieve this vision – they are:

   **Six Ambitions**
   - Each person is seen as an individual
   - Each person gets fair access to care
   - Maximising comfort and wellbeing
   - Care is co-ordinated
   - All staff are prepared to care
   - Each Community is prepared to help

   **Eight Foundations**
   - Personalised care planning
   - Shared Records
   - Evidence and Information
   - Education and Training
   - 24/7 Access
   - Involving, supporting and caring for those important to the dying person
   - Co-design
   - Leadership

   The IH has committed to using the ambitions as the structure for our clinical services and developmental activity going forwards. This is ongoing work. See appendix 1.

4. **Development of an Isabel Hospice User Group**

   Part of the work plan will be to set up a user Group for the Hospice as part of this Clinical Governance Strategy. The plan is for it to be comprised of self-selected representatives from patients, carers, volunteers and staff. Members of the Group will be representatives of all those involved in the Hospice.
Discussions will take place around provision of different perspectives day to day and longer term issues relating to the services provided by the hospice. Then relate these to the planning, developing, monitoring and fundraising of the services.

Objectives:-

To improve the services offered by the Isabel Hospice for patients, carers and their families
To identify and address issues as they arise, which may affect people using the services.
To evaluate the progress and impact of the group

This is ongoing work.

5. Policies in Development

There are a number of policies, being written, reviewed and updated. A number of these policies remain out of date or not available. Policies are reviewed usually two yearly. This is ongoing work.

6. Revalidation work

Revalidation for nurses and midwives, which starts from April 2016, is a process in which all qualified nurses will need to engage in order to demonstrate that they practise safely and effectively throughout their career. All nurses and midwives are required currently to renew their registration every three years. Revalidation will strengthen the renewal process by introducing new requirements that focus on:

- Up-to-date practice and professional development
- Reflection on the professional standards of practice and behaviour as set out in the new code
- Engagement in professional discussions with other registered nurses and midwives

Guidance has been given to the Isabel Hospice Nursing Staff and support in the form of workshops presentations and discussions on the paperwork. This has been advertised on the Isabel Hospice Intranet. Contact names have been given for ongoing/ further support. This is ongoing work.

7. Controlled Drug Assessment

Each year Isabel Hospice is required to undertake two audits in relation to controlled drugs. One which provides assurance that the Controlled Drugs Accountable officer is undertaking the role effectively and one that assesses the organisations compliance with the effective management of controlled drugs. Both audits are retrospective and use the ‘Help the Hospices’ audit tools.

The Accountable Officer audit assesses that the CDAO:

- Has been correctly appointed and holds an appropriate level of seniority in the organisation
- Liaises closely with partners and stakeholders and has ensured that the organisation has done all it should to meet legislative requirements
- Has undertaken an annual review
- Is satisfied that continuous quality monitoring is in place.

The Controlled Drugs audit assesses:

- Adequacy of the premises
- Procurement
- Examination of stock held
The CD register, audit and records
Prescribing
Administration of CDs
Destruction of CDs

Whilst the audit in August 2015 evidenced a high level of compliance with legal requirements and best practice, there were some recommendations that needed to be taken forward with an improvement plan. These improvements were carried out however re-audit needs to be carried out to monitor compliance.

8. Audit Programme

There is an audit programme in place in which we have a number of audit tools and this enables us to benchmark against other hospices in line with Hospice UK standards. This is ongoing.

Part of the plan for the audit programme is to survey health professionals annually about the Isabel Hospice. This will be carried out July 2016. This is ongoing.
<table>
<thead>
<tr>
<th>Target Area</th>
<th>Objectives</th>
<th>Lead</th>
<th>Activity</th>
<th>By when</th>
<th>Outcomes</th>
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<tr>
<td>CQC</td>
<td>Continue with ongoing work to establish robust mechanisms to maintain CQC assessment at good working towards excellence.</td>
<td>EP/JT</td>
<td>Identify key objectives from assessment and analysis carried out by CQC January 2016</td>
<td>August 2016</td>
<td>All key areas will be monitored continuously through the Clinical Governance structure. NB Report delayed</td>
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<td>JT</td>
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<td></td>
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<td></td>
<td>Develop Action Plan to ensure delivery.</td>
<td>August 2016</td>
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<tr>
<td>Information Governance</td>
<td>Crosscare Patient Records being changed to system one</td>
<td>SQ/EP</td>
<td>Being project managed by CCG</td>
<td>July 2016</td>
<td>Safe implementation and crossover from cross care to systemone.</td>
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<td>SQ/EP</td>
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<td></td>
<td>Introduction, Implementation, Training and Education of System one.</td>
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<td>SQ/EP</td>
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<td></td>
<td>Develop Action Plan to ensure delivery.</td>
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<tr>
<td>Ambitions for End of life Care</td>
<td>Establish structures and partnerships to underpin work to be implemented for Ambitions for End of Life Care</td>
<td>PA/EP</td>
<td>Develop an action plan to ensure delivery of work to be completed using both NICE and National guidance</td>
<td>April 2016-2017</td>
<td>There will be evidence of ongoing work and care pathways to support NICE and National Guidance.</td>
</tr>
<tr>
<td>Date</td>
<td>Description</td>
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<tr>
<td>April 2016-2017</td>
<td>Engage clinicians in the process of implementation, monitoring and audit of Ambitions for End of life Care.</td>
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<td>March 2016</td>
<td>Develop an action plan to ensure delivery.</td>
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<td>Policies will be written to an agreed standard and continue to go through correct ratification procedure.</td>
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<tr>
<td>January 2016</td>
<td>All Registered Nurses will revalidate on time.</td>
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**Development of IH User Group**
- Establish structure and process to support the development and continuity of Isabel Hospice User Group
- Determine the structure and process to support the development and continuity of Isabel Hospice User Group
- Develop an action plan to ensure delivery.
- Policies will be written to an agreed standard and continue to go through correct ratification procedure.
- All Registered Nurses will revalidate on time.

**Re-validation Work**
- Establish structure that supports all Registered Nurses going through revalidation within the Isabel Hospice
- Set up workshops for Registered Nurses
- Mentor names given to nurses to ensure support through process.
- HR process set up
- Complete
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<tbody>
<tr>
<td>Audit programme</td>
<td>Continue with ongoing work as per audit programme and robust process.</td>
<td>KH</td>
<td>Ongoing Audit Plan to be followed</td>
<td>Ongoing</td>
<td>Evidence of ongoing audit and re-audit.</td>
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<tr>
<td></td>
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<td></td>
<td>Audit external Health Care Professional on how they perceive the Isabel Hospice</td>
<td>December 2016</td>
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Appendix 1

Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020
A summary

2008 1st National strategy for End of Life care concluded three key insights:

- People don’t die in preferred place
- Need to prepare for increased numbers of dying
- Not everyone receives high quality care (significant variation)

This document was produced by alliance of multiple organisations to try to target these areas, producing person-centred and coordinated care, and eliminating variation in quality of care experienced nationally.

They summarise six ambitions to achieve this vision and eight foundations to help achieve this
Six ambitions to bring that vision about

01. Each person is seen as an individual
02. Each person gets fair access to care
03. Maximising comfort and wellbeing
04. Care is coordinated
05. All staff are prepared to care
06. Each community is prepared to help

“I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer[s].”
The six ambitions in more detail

Building blocks:

- Honest conversations - everyone has opportunity for honest discussion about dying
- Clear expectations - people should know what they are entitled to expect as they reach EOL
- Helping people take control (person budgets for social care)
- Systems for person centred care (care coordination, care planning and care delivery)
- Access to social care
- Integrated care (between health and social care)
- Good EOLC includes bereavement (care of the family in both preparing and after loss)

How Isabel is meeting these/working further towards:

- Staff trained in communication skills and advance care planning
- Working closely with CHC and adult care services to provide longer term care for patients
- Hospice at home team providing short term practical care solutions, in liaison with Marie Curie services
- Bereavement service including child bereavement available, even for those relatives whose loved one was not cared for by Isabel

Building blocks:

- Using existing data (using this locally, to remedy the partial reach of some services)
- Generating new data (generating robust useful data to guide care and development)
- Population based needs assessment (commissioners should use data to commission equitable services)
• Community partnerships (building partnership with faith groups & diverse organisations locally)
• Unwavering commitment (for equity of care, embedded in local contracts)
• Person centred outcome measurement (tracking services to ensure and guide equity and quality)

How Isabel is meeting these/working further towards:
• OACC projects to gain new patient-focussed and centred data to inform decisions about directions of services
• Encouraging closer work with commissioners

Maximising comfort and wellbeing

Building blocks:
• Recognising distress whatever the cause
• Addressing all forms of distress (holistic approach)
• Skilled assessment and symptom management
• Specialist palliative care - all who need should have access
• Priorities for the care of the dying person - patients should expect local services to reflect these
• Rehabilitative palliative care - maximising function and independence key part of palliative care

How Isabel is meeting these/working towards meeting these:
• Holistic approach, demonstrated in holistic needs assessment
• Multiprofessional teams - including therapy teams and family support teams for holistic approach
• Encouraging access for patients with non malignant disease?
• Training and education programmes internally
Building blocks:

- Shared records (records encompassing needs and preferences, and shared between providers)
- Clear roles and responsibilities (patients have oversight of roles of providers)
- A system-wide approach (coordination of services)
- Everyone matters (needs of all at centre of organisations thoughts)
- Continuity in partnership (joined up care)

How Isabel is meeting these/working towards meeting these:

- Information governance targets to allow closer sharing of information
- Transfer to system one to allow closer work with local general practitioners and other services involved in care
- Specialist MDT allowing coordination of services between IPU, community and hospital services.
- Training and education - to expand externally?

Building blocks:

- Professional ethos (all trained and supported to bring professional ethos to care)
- Support and resilience (work environments ensuring psychological support and resilience)
- Knowledge based judgement (well trained competent staff)
- Using new technology (to enhance professionals learning and development)
- Awareness of legislation (all staff understanding and complying with legislation)
- Executive governance (all organisations have clear governance at board level)

How Isabel is meeting these/working towards meeting these:

- Training, education and appraisal
- Systems for cascading new legislation and incorporating into practice
• Psychological support available for staff - Schwartz rounds, clinical supervision, and reviews.

Building blocks:

• Compassionate resilient communities (public health approaches to ensure public involvement)
• Public awareness (those sharing ambitions work towards enhanced public awareness)
• Practical support (local organisations should find 'new ways' of providing support information and training to families neighbours and community organisations)
• Volunteers (more to be done nationally to recruit, train and value volunteers)

How Isabel is meeting these/working towards meeting these:

• Isabel volunteers comprise significant proportion of work force
• How to expand our vision and expertise into the community?
The eight foundations

Foundations for the ambitions

- Personalised care planning
- Shared records
- Evidence and information
- Those important to the dying person
- Education and training
- 24/7 access
- Co-design
- Leadership
1. Personalised care planning
All patients approaching EOL should be offered the chance to create a personalised care plan (the opportunity should be universal, though participation clearly must be voluntary). Such conversations should be ongoing with options reviewed revisited and revised.

2. Shared records
To ensure the plan can guide a person centred approach, it has to be available to that person, so that they can review, change and update it themselves. All electronic systems for sharing health preferences must encompass the recording and sharing of EOL preferences. There should be ambitious local targets for the rollout of systems for sharing digital records.

3. Evidence and information
Local care organisations need up to date information to help improve services. These data should inform judgements about the quality and accessibility of services and support quality improvement.

4. Involving supporting and caring for those important to the dying patient
As well as caring for individuals who are facing or have experienced loss and grief, there needs to be recognition and support for their role as part of the person’s caring team, if they and the dying person wish them to be regarded in that way.

5. Education and training
All professionals competent and up to date. Every locality must have a framework for their education training and CPD to achieve and maintain competence.

6. 24 hour access
Every person at the EOL should have access to 24/7 services as needed as a matter of course. All commissioners and providers have to engage in defining how their services will operate to ensure this.

7. Co-design
Systems for EOLC are best designed in collaboration with people who have personal and professional experience of palliative and end of life care. Care organisations should have these connections, including patients and relatives.

8. Leadership
The leadership of CCGs and Local Authorities and, in particular Health and Wellbeing Boards, is needed to create the circumstances necessary for action.
References

Lord Darzi’s *NHS Next Stage Review*, Department of Health, June 2008


Department of Health, December 2009

Adapted from North Devon Healthcare Clinical Governance and Quality Strategy 2010-13