

End of Life Care

Everyone's business in
Gloucestershire



October 2011

Issue 12

Welcome to issue twelve of Gloucestershire's newsletter *End of Life Care*.

The purpose of this newsletter is to raise the profile of end of life care by informing you about local and national end of life care issues and developments, promoting the message that end of life care is *everyone's business*.

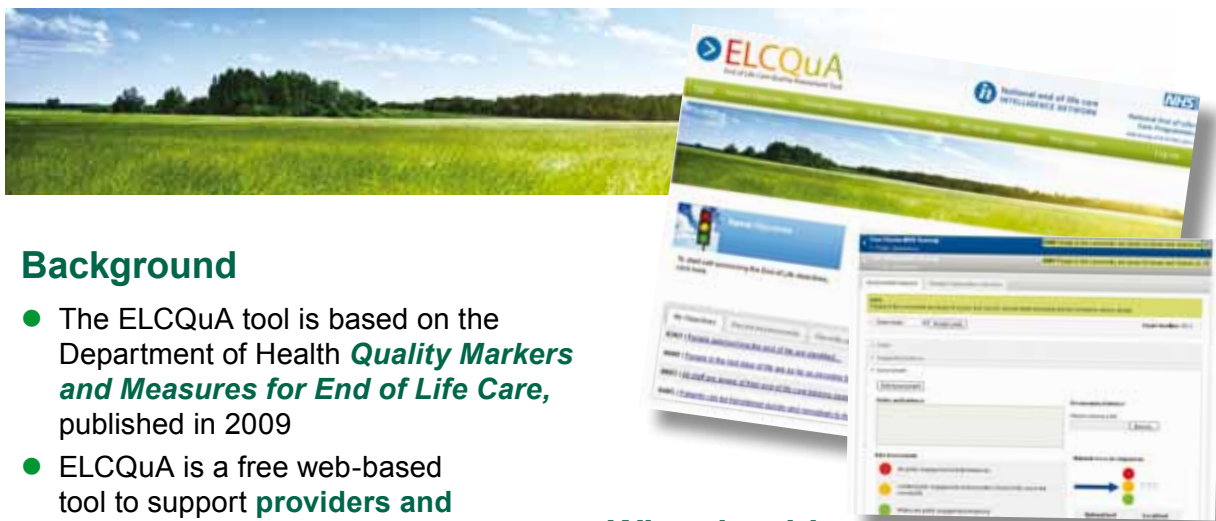
Through the sharing of best practice, together we can achieve high quality care for patients and their carers.

In this issue:

- National and Regional Updates
End of Life Care Quality Assessment Tool
- Updates on activity in Gloucestershire
 - Aداstra Electronic End of Life Care Register
 - Summary of local service updates
- Education and training
- The Mental Capacity Act supporting ACP
- Raising awareness
- Co-ordination of care
- Measurement and research



National & Regional News



Background

- The ELCQuA tool is based on the Department of Health **Quality Markers and Measures for End of Life Care**, published in 2009
- ELCQuA is a free web-based tool to support **providers and commissioners of end of life care** applying the Quality Markers in practice
- The Quality Markers describe the structures and processes leading to high quality care for people who are approaching the end of life
- The ELCQuA tool will develop and expand based on feedback and future development of the national end of life care Quality Markers

What does the ELCQuA tool look like?

- Quality Markers are listed against each organisation for selfassessment
- Options to complete a full or summary self-assessment
- Top ten Quality Markers highlighted for high level reports
- Opportunity for reports and evidence to be uploaded and shared
- Assessments are given a red/amber/green rating, for measuring improvement & benchmarking
- Captures numerical as well as qualitative evidence
- Highlights where Quality Markers link to national Key Performance
- Indicators and Care Quality Commission regulation standards

Why should I use the ELCQuA tool?

You can use the ELCQuA tool to:

- assess performance against the national end of life care Quality Markers
- identify and share areas of best practice and highlight areas for improvement
- benchmark against other similar services throughout the country
- provide evidence for CQC assessment, contracting and
- commissioning end of life care services
- ensure the relevant key questions are asked when planning or evaluating the end of life care delivered in your area

ELCQuA is user-friendly, easy to update, personalised to each user and free to users

What supporting materials are available?

- An **ELCQuA guide and overview sheets** are available to introduce the tool for providers and commissioners
- More information can be found on the website www.elcqua.nhs.uk
- Users of the tool have available **technical guidance** and a **dedicated help and support system**

Updates on activity in Gloucestershire



Supporting patient preferences through improving communication: Adastra End of Life Care Register

NHS Gloucestershire and NHS South West will be supporting the implementation of the Adastra End of Life Care Register during 2011. Many thanks to those who have already given support, expressed an interest or concern and identified risks.

A stakeholder meeting was held on the 6th and 13th June and provided the opportunity to view the content of the register template, share, review and develop the plans, identify risks and address any initial concerns.

The date for the system to 'Go Live' at selected sites was on the 30th September 2011. Priority areas include GP surgeries, Out of Hours and Ambulance Service.

Many staff already use Adastra as a patient care record system.

The EOLC Steering Group operates on a quarterly basis and is commissioning led. Membership aims to be representative of a wide variety of key stakeholders to provide the following:

- Equal engagement and collaborative partnership working
- Continued commitment to develop and deliver an EOL strategy for Gloucestershire
- Leadership and sponsorship
- Robust systems for evaluation and reporting
- Coordination and direction for effective cross-boundary working
- Establish and support sub-groups to ensure all associated work streams are fully implemented and sustainable

- It is a web based application and this register has been designed and added to the system to support the delivery of improved end of life care and patients achieving their preferred place of care.
- It will allow clinicians to access relevant information to guide their decision-making when called upon for help in a crisis.
- It links to the Operational Plan and QIPP and meets the requirements of the National End of Life Care Strategy.
- It also has the advantage of a reporting function which means that audits related to end of life care performance are possible.

Membership includes leading representatives from a wide range of sectors at both commissioning and provider level: primary care, secondary care, social services, specialist palliative care, hospices and other charitable organisations, mental health and learning disabilities, clinical networks, ambulance, Out of Hours, service users, Higher Education Institutions, private and independent partners.

The importance of involvement from organisations and departments with specific disease areas is recognised and representatives will be invited to attend for specific agenda items. Circulation of minutes will be widespread.

The next Steering Group Meeting will be held on 5th December

Please do not hesitate to contact Gina King (Tel: **08454 221845** or email georgina.king@glos.king) for further information.

Updates for Gloucestershire

Summary of Local Service Updates

Gloucestershire Hospitals NHS Foundation Trust EoLC Steering Group

60% people die in hospital nationally – this is also reflected in Gloucestershire. Membership of the steering group includes Renal, Oncology, palliative Care, ITU, CNS and Consultants. It is chaired by Dr. Janet Ropner. Meetings are quarterly and it has five sub-groups:

1. Discharge Home to Die

A ward template to support discharge has been developed but is currently on hold due to imminent changes with Continuing Health Care fast-tracking systems.

2. Diagnosing Dying

A consultant led group. Has developed a successful 'Purple Form' for the Unwell patient which has been piloted and rolled out to wards to assist decision-making for supporting appropriate care during ward rounds.

3. Advance Care Planning Group

Advertising ACP to consultants rounds, sisters, A&E.

4. Bereavement Group

Development of support packages for bereavement in ITU and Neo-natal Care.

5. Education Group

Macmillan has also funded a project with UWE to support a Link worker project with Clive Warne. There will be minimal face to face training but Action learning sets and tutorial support. The aim is to find 40 link workers in identified areas. The start date was 24 October but due to the quick turn around this has been postponed until 9 November 9.

3 Counties Cancer Network

The 3 Counties Cancer Network are pleased to welcome Megan Willsher who started in post at the end of June 2011. Megan is based at Cheltenham General Hospital and covers the whole of Gloucestershire. She also links in with colleagues in Herefordshire and Worcestershire, Bristol (the Principle Treatment Centre for Teenage and Young Adults with Cancer for the South West Region) and Birmingham where patients will be referred to from Gloucestershire for treatment. Megan's role is one of five Specialist Nursing Post for TYA patients in the South West Region.

Megan's role covers cancer patients from 15 – 24 inclusive, and predominately involves supporting, referring, liaising, educational, and ensuring they get the best possible care and treatment throughout their cancer journey.

Addressing psychosocial and life stage issues is also big part of Megan's role in this age group, and enhancing and complementing what already is provided by site specific teams. Communication and collaboration with other members of the health team in relation to individual's patient care is also paramount to provide a seamless service, and positive cancer experience, and is a big part of Megan's role.

Megan works closely with TCT (the Teenage Cancer Trust) Clic Sargent for Children and Young Adults with Cancer, and Macmillan, to provide patients with the required support: finance, education, peer and recreational support being vital. Consequently, Megan is working closely with these organisations to improve and develop existing facilities for this age group across the Trust.

Community Specialist Palliative Care Nurses (Macmillan)

The Community Specialist Palliative Care Team are no longer based at Wheatstone, Barnwood and are now settling in to their new bases. There are 3 teams of Clinical Nurse Specialists now locality based at Beacon House Gloucester Royal Hospital, Sue Ryder Day Hospice Leckhampton and Cotswold Care Hospice Minchinhampton to cover the whole of Gloucestershire.

There is a single point of access (SPA) based in the Palliative Care offices in Beacon House manned by an administrator and a Clinical Nurse Specialist from 09.00-17.00 Monday to Friday to receive all referrals and answer enquiries and clinical questions/advice. The number of new referrals received to the SPA in August 2011 was 127.

Tel: **08454 225370** Fax: **08454 225125**

All the Clinical Nurse Specialists in the community and hospital provide an out of hours advice telephone service for professionals which is supported by on-call Palliative Medicine Consultants. The number of calls is increasing; during 2010 we received 622 calls and we will exceed these numbers in 2011. The Clinical Nurse Specialists have an annual continuing professional development day where we receive updates on current provision of palliative care services, new information and discuss case studies from calls received that

we can all learn from. This year the day will be held at the 'Manor by the Lake' Cheltenham on 4th October and the programme includes information on out of hours community nursing, hospice at home, the out of hours Hub, mental health services, ICD deactivation, haematology update and case studies.

The Pager number for me or call service is **07659 119458**

Helen Roberts
Clinical Nurse Manager for the Community Palliative Care Team. **01452-371022.**

Update on Pain Assessment Tools

Although the working group has now concluded, members have continued to promote the use of pain assessment tools in their own organisations:

Gloucestershire Hospitals NHSFT have launched the use of Abbey Tool through workshops at both Gloucestershire Royal and Cheltenham General, and have developed an accessible micro-teach session for staff.

2gether NHSFT have run a number of workshops on pain assessment for staff, supported by GHNHSFT colleagues.

Pain Assessment is incorporated into the training provided by the Gloucestershire Dementia Education Nurses.



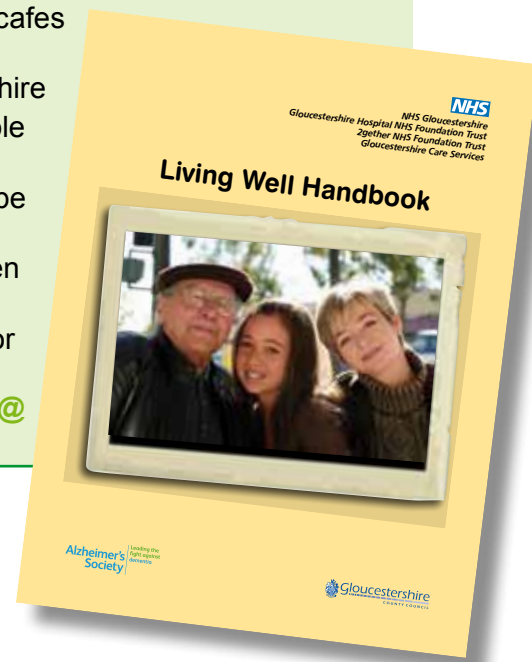
The resources and tools that have informed the Pain Assessment flyer can be accessed on www.gloucestershire.gov.uk/dementiatraining or by contacting Helen Vaughan on **08454 221947** or emailing helen.vaughan@glos.nhs.uk

Updated Living Well Handbook

1000 copies of the Living Well Handbook are now in circulation and the updated 2nd edition will be available shortly. The updated LWH includes:

- The Pain Assessment guide
- Carers Top Tips written by carers for carers
- Guide to peer support such as memory cafes around Gloucestershire

Single or multiple copies of the handbook can be requested by contacting Helen Vaughan on **08454 221947** or emailing helen.vaughan@glos.nhs.uk



follow us on **twitter**

Just a reminder that you can now find the EOLCP on Twitter, where they are tweeting the latest website updates and other news and information relevant to end of life care – and we now have over 200 followers! We're **@NEoLCP** (the link is <http://twitter.com/neolcp>). Do follow us and tweet a hello.

Education and Training

EoLC Support Forums

Do you work with people approaching the end of their life? It can be such a privilege to be involved at this very intimate time in people's lives. The experience inspires and enhances professional practice that then benefits others requiring similar care and support. Yet, how often do we talk about these experiences with our colleagues? When do we share good practice? How do we germinate new ideas into practical solutions for more complex and individual needs?

There are also times when such care and support can be particularly intense and our involvement leaves us feeling drained, weary, possibly even vulnerable and exposed. Have you come away from a dying patient wondering whether you could have done better? Or frustrated that there does not seem to be the capacity in the health care system to ensure true individualised care? How often have you reflected on a case when you feel that it would have been so much better managed if you could have gone that extra mile?

So how do you cope both professional and personally? Do you have someone to whom you can safely off-load? Where do you go to gain ideas of how to deal with specific issues? And remember that family who were so grateful for the innovative care and commitment you gave them that made all the difference? It would be so helpful to your colleagues if you could pass on the expertise gained.

The District Nurses in the Forest of Dean have held regular forums for the last 7 years to be able to do all of the above.

Every month, on the same day, at the same time, in the same place, they meet and share. Often there is a speaker, invited by the group, to talk about their own specific speciality within the EoLC field. This could be the Consultant discussing pain management.

It could be the Macmillan Welfare Benefits Adviser giving information about available financial support. Or maybe the manager from The Haven Breast Care Support Centre coming to talk about the service they offer. A local funeral director has given interesting talks about what actually happens to a body after death and the role of a funeral director – much wider than you might imagine! At each forum, there is always time for people to chat, to support, to share, and to care for each other.

Now these forums are being developed across Gloucestershire. They will be open to anyone working with people with EoLC needs. They will operate on a "drop in" basis with posters sent out to workplaces each month to advertise who is speaking at the next local forum.

Are you interested? Would you like to be sent ongoing information and receive notification of your local forums? If so, please get in touch with:

Jane Hamilton: **01594 811910** or jane.hamilton@great-oaks.org.uk
Sue Goold by email: sue.goold@nhs.org.uk

There is so much expertise and talent within EoLC – let's share that through these forums.

EoLC training

To find out more about EoLC education opportunities visit:

www.nhsglos.nhs.uk/your-services/help-for-those-with-a-long-term-condition/eolc-training/



County EoLC Education Facilitators



End of Life Care Education Facilitator Hospitals

- End of Life Link Workers or champions have been identified within each community hospital. A confidence questionnaire has been distributed throughout each hospital and the results are helping to shape end of life education action plans for each site.
- Acute trust – Glos. Hospitals have been successful in obtaining Macmillan funding to employ 2 part time EoLC education facilitators. The funding has also helped them to work with UWE on a project to develop around 40 link workers.
- **Monthly free workshops** have continued and available via the education page with address
- Don't forget that **free workbooks** can also help where staff release is difficult.
- Launch of New End of Life Care Resources
- Accessing the 155 free e learning sessions all related to End of Life Care has now been made easier!! There have been some difficulties in some NHS trusts accessing these. We have now been assured that anyone with an NHS e mail address should now be able to access them.
www.endoflifecareforall.com

Education and Training

Social Care Framework Project: update

In April 2011 in this newsletter, we reported on the first wave of mentoring workshops held for social workers and fieldwork support assessors in March-April this year. It is exciting to report that Gloucestershire County Council has confirmed funding to support three follow on workshops, to be held this autumn, in order to build on and sustain the skills of staff who have already participated in one of the first workshops.

The style of the sessions will be highly interactive, facilitated by specialist palliative care social workers and using participants' own real practice examples to discuss and explore challenging issues in end of life care, including communication in families and across multi-professional teams.

For further information on the project, contact Felicity Hearn, Head of Family Support, Leckhampton Court Hospice
felicity.hearn@sueryder.org

Palliative Care Education also offered by the following local providers (list not exclusive):

- Gloucestershire Acute NHS Trust
 - Adult Social Care Services
 - University of West of England
 - University of Gloucestershire
 - Sue Ryder Care
 - Cotswold Care Hospice
- Please contact organisation directly for further details.

County EoLC Education Facilitators

Community and Care Homes

Link Workers

Currently the work within Care Homes and the Community is moving forwards and importantly enthusiastic individuals are putting their names forward to become End of Life Care Link Workers. Please see the flyer and if interested please contact me for further information.



Confidence Assessment Questionnaire (CAQ)

The team has developed a 'confidence assessment questionnaire' (CAQ!!) in relation to end of life care, which will help to channel training to individual needs whether it be teams or individuals,

therefore ensuring training is tailored to needs. My role is to facilitate this training includes:

1. Providing action plans resulting from the CAQs and sharing these with team leaders/individuals to ensure the training accessed is appropriate and at the right level
2. Working closely with Alison Bradshaw, Care Home Support Team Manager and her team to sustainable plans and support engage with core training.
3. Working closely with Helen Ballinger, NMC Teacher, Community Services. District nurses to support with their education e-training.
4. Assisting with the launch of the End of Life Forums where staff can network and listen to speakers on a variety of subjects, all related to end of life. More information regarding the launch of these forums can be found on page 6 of this newsletter

Both Gina King and I have also met and had some productive meetings with the local Care Quality Commission (CQC) manager and inspectors. The outcome has been a greater understanding of the CQCs role and how end of life education assists in providing evidence for the outcomes required by all organisations. This has to be good news!

Maggie can be contacted by email - maggie.martin@glos.nhs.uk or by phone **07775035437**

If you have any questions regarding End of life care education within Gloucestershire. Please contact Sue Goold preferably by email: sue.goold@glos.nhs.uk or if urgent Mobile: **07824445257**

Education and Training

Monthly free workshops have continued and some excellent feedback has been received. Don't forget you can book onto these workshops which are mainly at foundation level. Some of these workshops are becoming heavily subscribed so book your place now!

Workshops:

- Raising an awareness of EoLC / Communication with confidence
- Assessment and symptom Control (last hour of which is Syringe Drivers)
- Supporting bereaved adults

All information available on www.nhsglos.nhs.uk/your-services/help-for-those-with-a-long-term-condition/eolc-training/

Calendar of Events

Workbooks:

Don't forget if attending a workshop is difficult to do there are also Workbooks to download.

Gloucestershire goes global!

We can obtain information on who is viewing the EoLC education page – to date we have had 269! We can also see from which city they are viewing from. Amongst various cities in the UK such as London, Leeds, Edinburgh we have had viewers from Los Angeles, Nashville and Palm Beach!!

Training the trainers

28 staff attended 2 Train the trainer's sessions to enable them to use some of the free Education resources available on www.nhsglos.nhs.uk/content/services/eolc/eolc-education.html Additional Train the trainer's sessions will be planned for later in the year and will include optional presentation skills module.

End of Life Care Education strategy

for Gloucestershire has now been finalised and is on the End of Life Care webpage. The strategy also includes an Education Pathway for group B staff as

outlined in the EoLC Strategy 2008.

End of Life Key Workers

After wide consultation across the county it is recommended that organisations consider whether key workers with a keen interest in EoLC may be useful to them. Many have already shown a keen interest and plans are in place to assist in this development.

Calendar of events

This calendar is now up and running so do make sure you bookmark this page as a favourite! Find the Calendar through www.nhsglos.nhs.uk/your-services/help-for-those-with-a-long-term-condition/eolc-training/

Calendar of Events

Remember it's only as good as information that is sent in so please provide any EoLC education events you know about. Sue.goold@glos.nhs.uk

A – Z End of Life Resources

Gina has developed with Simon Shorrick from the 2gether Trust an A-Z of EoLC Information resources for EOLC and was launched the w/c 19th September.

The purpose of the A-Z of Resources is to support professionals who provide EoLC to maintain their knowledge and skills or gain information on a new aspect of care in order to deliver good quality care to achieve the aim of the EoLC strategy.

A-Z of Information resources

<https://guide.glosnhs.net/guide/resource/images/logos/A-Z%20Resources.pdf>

To Start Jan 2012

End of Life Care module, 8 week run 1 day per week, running at either St Peters Hospice Bristol or Dorothy House Hospice Bath, 20 credits at level 3 (BSc) or level M (Masters), cost 610 GBP. Info from clive.warn@uwe.ac.uk applications to <http://cpd.hsc.uwe.ac.uk/Default.aspx?pageid=50> module codes are **UZTR6Y-20-3 (BSc version)** **UZTSAE-20-M (masters version)**

The Mental Capacity/Act to support the Advance Care Planning Tool “Planning for Your Future Care”



The Mental Capacity Act (MCA) 2005 provides a statutory framework that empowers and protects some of the most vulnerable people in society. It sets out who can take decisions, in which situations and how they should do this on behalf of people who lack the capacity to make decisions for themselves. It also enables any member of the community to plan for the time when they may lack capacity.

In order to help staff understand their responsibilities under the Act, the new Multi-Agency MCA Policy, Procedure & Guidance and its appendices are available on the Gloucestershire County Councils & partner agencies websites. It provides a guide for anyone involved in the assessment of capacity and related activities in health and social care practice, and identifies the Service Governance Framework used in Gloucestershire relating to adults who do not have capacity to make decisions. This policy should be read in conjunction with the Gloucestershire Safeguarding Adults Multi-Agency Policy & Procedure. It has been adopted by 11 partner organisations including all local Health Trusts. Each organisation has an Organisational MCA Lead who is responsible for ensuring the quality and efficacy of the services provided to adults who may lack capacity within their organisation.

The policy includes a common assessment framework for day to day and significant mental capacity assessment decisions and contains a number of specific tools – Mental Capacity Assessments and Advance Decision formats which will enable staff to more effectively implement the Act. The policy also contains sections on: consultation and advice, quality and accountability, IMCAs, finance and the

MCA young people, carers and the MCA, personalisation and mental capacity, research, consent and capacity, covert medication, restraint, Court of Protection, staff liability, the police and the ambulance service, training and the tricky interface with the Mental Health Act.

The Policy will help staff recognise when they need to carry out a mental capacity assessment, how they should record it and understand their responsibilities pending the outcome of the assessment i.e. best interests decision. The form ‘Significant Decisions (MCA2)’ should now be available in both paper & electronic formats for staff to use in order to evidence and record Mental Capacity assessments and Best Interests significant decisions. Use of MCA2 will be audited & the quantity and quality of MCA activity measured through regular reports to the Adult Safeguarding Board.

The policy has been developed in close collaboration with the development of Advance Care Planning (ACP) in Gloucestershire by Gina King & colleagues. Three appendices are relevant to ACP. MCA5 provides detailed guidance on Advance Decisions, MCA6 provides a checklist for Advance Decisions, to help professionals when assessing the validity & applicability of an Advance Decision & MCA8 provides a checklist for professionals wishing to confirm the validity of a Lasting Power of Attorney. MCA7 is the local ACP document.

Contact:

David Pugh, Mental Health Act & Mental Capacity Act Implementation Manager, david.pugh@gloucestershire.gov.uk Tel **01452 427088** or **07867 501128**

Raising Awareness

Dying Matters Awareness Week May 16th- 22nd 2011 'Why Dying Matters to me'

Dying Matters

Let's talk about it

Gina King and Sue Goold joined the PALS Team on the Guide/PALS bus on the 19th May in Bishops Cleeve, Cheltenham in the Tesco's Car Park. Gina and Sue attracted a lot of attention from passers-by on route to their weekly shop. Over 30 people stopped by to see our display. The majority were interested in the ACP Booklet and reported it would help them and their family hold discussions if the "what if" happened. Some felt the topic too imposing but after a friendly conversation soon changed their minds and recapped on past situations where end of life care wishes and plans had not been discussed leaving a sense "if only we had spoken"

To find out more visit:
www.dyingmatters.org



New resource: "Difficult Conversations"



This month's joint meeting of the All-Party Parliamentary Groups on Hospice and Palliative Care and Dementia saw the launch of the new Dying Matters publication, "Difficult Conversations for Dementia". The booklet is intended to help professionals and carers of people with dementia to open up conversations about end of life wishes, especially early on in the disease, and to provide support.

There was a great turnout at the meeting, and Barbara Pointin spoke movingly about her experience caring for her husband who had dementia. Alistair Burns, the National

Clinical Director for Dementia said: "End of life care for people with dementia is a key part of delivering good quality dementia care. Conversations with people with dementia early on in the disease, at the appropriate time, to establish their wishes about end of life care couldn't be more important."

You can read the full story on the Dying Matters website
<http://10.175.164.133:15871/cgi-bin/blockpage.cgi?ws-session=503441646>, and copies of Difficult Conversations for Dementia can be obtained
<http://10.175.164.133:15871/cgi-bin/blockpage.cgi?ws-session=3338791143>.

Dying Matters videos

We've had some great feedback from members about our new video, We are Living Well but Dying Matters. Produced by CHANGE for Dying Matters and the National End of Life Care Programme, the video is about including people with learning difficulties in discussions around death, dying and bereavement. Thank you to all our members who have used the video and sent us their thoughts. A DVD of the film is available to order here, and it can be viewed online here.

There's also our taboo-busting film Dying for a Laugh, in which top comedians reflect on the place of humour in death and dying. You can watch the film, as well as special extra footage, here. The film was made by PictureWise Productions, supported and funded by Bolton Dying Matters Group, part of Bolton PCT.

Co-ordination of care



The Village and Community Agent Service in Gloucestershire: supporting people affected by cancer

The 3CCN is supporting an innovative project in Gloucestershire that is helping people affected by cancer, patients and carers aged 18 and over, access information, support, and practical help. Recognising the project's potential, Macmillan Cancer Support has recently agreed to give further funding support until March 2013.

What is the Village and Community Agents Service?

The Village and Community Agents is a service that was set up in 2006 in Gloucestershire to help people aged over 50 access the information and services they need. The service started as a pilot scheme, went on to achieve national commendation and, in 2008, the service was mainstreamed with funding from Gloucestershire Primary Care Trust and Gloucestershire County Council. All agents receive comprehensive training and ongoing support and are employed by the Gloucestershire Rural Community Council.

What do the Agents do?

The Village Agents provide high quality information, promote access to a wide range of services, carry out a series of practical checks and identify unmet need within their community. They offer a facilitated signposting service putting people in direct contact with the agency or agencies, whether statutory or voluntary, that are able to provide the service needed. Community Agents work in a similar way to the Village Agents but with the BME and migrant communities across the whole county.

How is the service supporting people affected by cancer?

Building on the service's success, it was recognised that the Village and Community Agents Service could be beneficial to people affected by cancer (patients and carers, aged 18 and over). So, with funding from Macmillan Cancer Support, all agents received training in cancer awareness and a pilot scheme was started as part of the National Cancer Survivorship Initiative. A group of agents also received further training to become Specialist Agents supporting people affected by cancer. The pilot was then taken forward as part of the National

Long Term Conditions QIPP (Quality, Innovation, Productivity and Prevention) work stream. Funding to support the ongoing development of the service has been secured until the end of March 2013 and it is a priority to identify how to make the service sustainable. Patients and carers can self-refer or a referral can be made by their Clinical Nurse Specialist in the urology, breast care and community palliative care teams – the teams currently taking part in the pilot.

Service Specification

A full service specification is in place confirming:

- the key areas where the Specialist Village and Community Agents can make a contribution to people affected by cancer – patients and carers.
- the main providers and services that the Specialist Agents are likely to use and refer onto for people affected by cancer. Where cancer-specific resources or services are available these are included.

The topics covered in the service specification are:

Employment	Transport
Finance eg. Pensions/benefits/grants	Childcare
Social care	Daily Living Support
Health & Wellbeing	Travel Insurance
Complementary therapies	Information and Support

What can people affected by cancer expect?

- To be put in touch with the right people to help in a wide range of areas including health, finance and social care
- To help ensuring people are receiving the financial support they are entitled to
- Access to services to help people stay as independent as possible

To find out more contact
Kate Darch, Village and Community Agents Manager
01452 528491
kated@grcc.org.uk/www.villageagents.org.uk

Co-ordination of Care

Hospice at Home – NEW 24HR CARE

Phone: 01453 733704 Fax: 01453 885282 (Mon – Fri 08.30- 16.00 excluding Bank Holidays)

Hospice at Home is delighted to announce an exciting service development.

We are now able to provide CARE PACKAGES. This will enable our trained Carers and Nurses to give support at regular intervals throughout the day and overnight in order to:

- Enable patients to have choice about their place of care
- Assist discharge from a hospital setting
- Provide physical care and symptom control
- Give respite for carers
- Prevent unplanned hospital admissions
- Support patients and carers through periods of crisis
- Facilitate palliative nursing provision including terminal care

As with our current service we aim to be responsive to need and provide help within 24hrs regardless of additional assessment or finance. If an ongoing Care Package is required a Fast Track request (via Continuing Healthcare) should be completed.

The Hospice at Home support team are always happy to help to clarify expectations. We would therefore encourage this information to be passed on to any Health and Social Care Professionals who may wish to refer their clients.

THE MESSAGE IS: IF IN DOUBT – REFER.



End of Life Care in Gloucestershire – ensuring its everyone's business.

The End of Life Care Strategy was released in July 2008 to promote that everyone nearing the end of their life had equal access to services, care and choice regardless of their diagnosis or setting. Nhs Gloucestershire employed two part-time facilitators to support the implementation of the strategy and to work with all organisations in the county to achieve this goal.

Gloucestershire has so far developed a county-wide approach to end of life care which has helped to provide a more consistent and standardised level of care. This has been achieved by having key “tools” and resources that are recognised by all professionals involved in a person's care as well as the patient and family themselves and to reduce the need for the repeating of information when at times it can be emotive and stressful for those involved.

Our key achievements so far include:

- Planning for Your Future Care – Advance Care Planning Booklet
- The Liverpool Care Pathway
- Implementation of a Locality Register
- Bereavement Leaflet
- Internet Page
- Education and Training for all staff
- Raising awareness
- Information Resources e.g. leaflets
- Supporting carers

However, we acknowledge there is still work to do to ensure that everyone is informed about available services, information and how to access them.

Gina King Clinical Facilitator for EoLC
Georgina.king@glos.nhs.uk /07790 803221



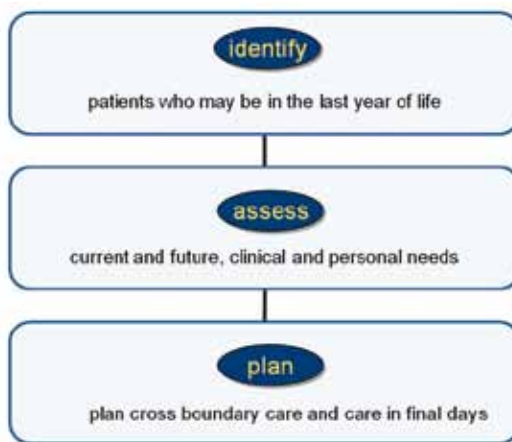
A re-audit of the Gold Standards Framework

The Gold Standards Framework (GSF) is a system focused approach formalising best practice for individuals in their last year of life. It provides tools and resources to identify, assess and plan care in a more coordinated and communicated way so that all professionals feel empowered to give the best possible care. It originated initially in G.P Practices in 2001 and is now being adopted in Care Homes and Acute Hospitals across the United Kingdom. The key aspect of the GSF is that it enables the Multi-Disciplinary Team, at regular meetings, to proactively plan ahead, anticipate possible crises, carer's needs and bereavement concerns of the family/relatives. It involves the holistic assessment of the individual and their family advance care planning and care of the dying. The Gold Standards Framework (GSF) in the community setting has been paramount in changing how professionals plan care and involve other members of the MDT (Specialist Palliative Care, Allied Health Professional, Social Care, Receptionist) who are involved in the patient's pathway.

The Gold Frameworks Framework is comprised of one aim, 3 steps, 5 goals and 7 c's as explained as below:

One aim: To deliver a "gold" standard of care for all patients nearing the end of life

3 Steps:



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5 Goals	7C's
1. Consistent high quality care	Communication
2. Alignment with patients' preferences	Co-ordination
3. Pre-planning and anticipation of needs	Control of Symptoms
4. Improved staff confidence and teamwork	Continuity of Care
5. More home based, less hospital based care	Continued Learning
	Care support
	Care of the Dying

The key of the Gold Standards is to identify early when a person is entering the end of life stage and when their condition progresses into different stages of decline. Their disease trajectory is predicted by using the Needs Based Coding (below) to estimate their stage to plan their care needs



It was felt that although in Gloucestershire, GSF had been up and running for several years a re-evaluation of its progress was required to establish how Primary Care was engaging in GSF as it is the cornerstone of End of Life Care.


The key objectives of the audit:

How many G.P Practices are:

- Are "signed up" to GSF?
- Advance Care Planning
- Proactive Planning versus reactive
- Identifying dying
- Achieving the actual preferred place of death
- Receiving Education and Training

The findings will enable the PCT to provide focussed training and support and help Practices identify how they can improve end of life care locally. The review should also support the move to see more people die in their preferred place of care and outside of the hospital setting.

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