Bolton Clinical Commissioning Group

Bolton Palliative and End of Life Care Strategy Action Plan

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Acknowledgement

The strategy and this associated Action Plan have been developed with our partners and users, we would like to thank everyone for the continued partnership working in developing the strategy:

Bolton Hospice
Royal Bolton Foundation trust
Bolton Council
Bolton Public Health
Macmillan Cancer Support
Bolton Dementia Carers Support Group

Introduction

The Bolton Palliative and End of Life Care Strategy sets out clear objectives to help direct better palliative and end of life care in Bolton. Each of the objectives has been discussed at the Bolton Palliative and EoL Care Strategy Group. Out of these discussions we have developed some key actions around the 5 objections. These actions bring together current work which supports the objectives and suggestions of key actions which will help us deliver the objective outcomes. This table supplies a brief summary of these actions. Each of the actions will be allocated a sponsor and lead who will help facilitate delivery of the work stream. This is then feedback to the Bolton Palliative and EoL Care Strategy Group.

Action planning Bolton CCG EoL Care Strategy: Primary Care

Objectives	Key specifications of objective	Actions	Timescales
Objective 1: Awareness, recognition and communication	a) Encourage a culture of empathy and professionalism in all people working with patients nearing and at end of life. b) Facilitate wider early recognition of patients reaching end of life particularly around non cancer conditions such as COPD, heart failure, dementia and frailty. c) Have effective systems to ensure all people identified as being in their last 12 months of life are identified on a register which is linked across the social and health care sector. d) Health and social care staff working across primary and secondary care have the skills need to enable a well-informed, sensitive and honest conversation about dying with people who are nearing end of life. e) Ensure patients know what they are entitled to and what to expect as they reach the end of their lives. f) Engage the public and local communities to help improve awareness of the challenges around the dying person and how we can work together.	1. Implement and monitor the Bolton EOL Care Standard of the Bolton Quality Contract ensuring early recognition of patients and effective monitoring of EOL care patients. 2. Integrate early recognition of EOL patients in secondary care, focusing on non-cancer patients. 3. Work with services to ensure discharge summaries clearly identify patients on EOL pathway	2018 2018 2018
Objective 2 : Education and training	a) Health and social care professionals who are caring for people reaching their end of life will have the necessary communication skills and training to have sensitive conversation with the people involved and provide high quality care and support. b) Health and social care professionals who are caring for people reaching their end of life will have the necessary skills and training to assess and manage symptoms in an effective, holistic patient centered way.	1. Develop the existing Alliance between Bolton University, Bolton Hospice and Bolton FT. 2. Evaluate current Palliative and EoL care education provided within Bolton and formulate a new unified education programme, which is tailored to the educational needs of professionals and carers who look after patients nearing end of life. 3. Create a central repository for EOL care training materials for all providers and stakeholders.	2017 2020 2020

Objective 3 : **Integrated, coordinated and patient centered equitable care**	a) Develop a 24/7 responsive patient centered model of integrated health and social care service for people nearing end of life. b) Develop and implement an Electronic Palliative Care Coordination System (EPaCCS) shared care records, which will help coordinate care for patients across the health and social care sector. c) Work in partnership with health, social care, hospice, voluntary sector and the public to co-design a sustainable and well-resourced service for patients nearing end of life. d) Work with people nearing end of life to enable them to be at the heart of their care, ensuring effective assessments, care coordination, care planning which will recognise their wishes, goals and aspiration. e) Ensure services and staff assess and treat patients holistically addressing their social, psychological, physical and spiritual needs. f) Ensure services are equitable and easily accessible by all members of the public regardless of their background. g) Ensure patient have access to rapid specialist palliative care when needed.	1. Work closely with Integrated Bolton Digital Care Record project to ensure the solution meets the requirements of a successful EPaCCS. Develop and implement a Bolton Electronic Palliative Care Coordination System (EPaCCS) shared care record. Ensure End of Life care information is being recorded across all clinical systems in an agreed and uniform manner to enable information sharing. 2. Work with Primary Care to align EOL nurse practitioners with neighborhoods ensuring a good community model is in place. 3. Carry out a process mapping exercise to establish current pathways for EOL care patients, utilizing the results to redesign and develop an integrated 24/7 responsive pathway.	2017 2020 2020
Objective 4: **Supporting families and carers**	a) Develop and link in services to support family, friends, carers, other loved ones and their community preparing them for loss, grief and bereavement. b) Ensure an adequate and well-resourced bereavement service. c) Identifying carers through primary and social care, enabling a carers register to be formulated with offer of structure carer review and support.	1. Establish a project to develop respite models of care, working with nursing home, care home and sitting services. 2. Develop and simplify access to bereavement support ensuring voluntary sector organisations are utilized effectively. (linked in with objective 3 process mapping)	2017/18 2020

Objective 5: **Data and monitoring good quality care**	a) Use existing local and national data sets to identify needs and gaps to ensure service development is targeted to address these issues. b) Develop a robust set of quality outcome measures, including patient related outcomes around palliative and EoL care to help monitor good quality, safe, patient centered care.	1. Develop Standard Data Set for EOL Care, ensure appropriate relevant monitoring can take place over the next 5 years to benchmark the services and ensure quality is being improved. 2. Implement new GSF register and templates to ensure data can be captured effectively for analysis. (part of the EPPaCCS work stream) 3. Develop “soft data” set ensuring patient and carers experiences are captured.	2017 2017 2017