Kirklees Integrated End of Life Care Vision

1. Introduction

The aim of this document is to set out integrated strategic priorities for end of life care in Kirklees. Across Kirklees, much work is taking place to improve outcomes for people and their carers at end of life. This document is not a work programme to replace existing work across Kirklees Council, Hospices, Clinical Commissioning Groups (CCGs), Hospital Trusts and the Voluntary and Community Sector. It seeks to identify shared strategic integrated priority areas.

It has drawn on information from previous strategies, commissioning documents, existing knowledge, current work programmes and national guidance. Patients will be engaged in the implementation of the strategy making use of existing forums and reference groups.

This overarching set of strategic priorities is based on an underpinning Outcomes Based Accountability analysis. An action plan sets out the response to the shared Kirklees priorities.

It has been developed by lead representatives for commissioning bodies in Kirklees including Kirklees Council, Kirkwood Hospice, North Kirklees and Greater Huddersfield and in consultation with provider organisations such as Locala.

2. Vision and Principles

This strategy reinforces commitment to the following outcomes for people in Kirklees.

- People are informed as early as possible about the approach of end of life to enable informed decision making about their preferences.
- End of life care is timely, compassionate and reflects their needs and wishes as far as possible with respect to physical, social, psychological, cultural and spiritual aspects.
- People during end of life phase remain in a place of their preference where possible avoiding unnecessary hospital admissions.
- Pain and other symptoms are managed as effectively as possible.
- All children and adults in Kirklees die with dignity and in a place of their preference.
- People and their carers feel supported both during end of life care and after the person has died.
- People and their carers are engaged in the co-production of services and service developments linked to end of life care.

In order to do this, Kirklees will take a joint commissioning approach to ensure that knowledge, best practice and resources can be shared where possible, which will in turn facilitate:

- an integrated approach across service areas and professionals
- more consistent standards of care and support across Kirklees

The commissioning approach that the two CCGs wish to take is to identify a lead organisation, who will ensure delivery on their behalf to make the vision real.
In addition where grant agreements are in place to support local provision, the CCGs will ensure these are of a reasonable duration to support sustainability and interdependencies with other pathways.

3. Strategic Priorities

3.1 Discussions as end of life approaches

- People, carers and their families are encouraged to discuss their end of life needs as early as possible with relevant professionals. Professionals need to feel able to broach this subject and have the skills to do this sensitively. This will facilitate the development of a timely co-ordinated care plan that most effectively meets their needs and wishes.
- Further steps are taken locally to tackle the taboo for the public and professionals about discussing death and dying as a life event.

3.2 Assessment, care planning and review, co-ordination of care

- People nearing end of life are identified and recorded in GP Practices so that a co-ordinated care plan is in place that can be shared by those staff and professionals supporting patent/ carer/ family both in and out of hours.
  GHCCG and NKCCG will continue to implement Electronic Palliative Care Co-ordination Systems (EPaCCS) (locality registers) or equivalent systems in Kirklees as a means of supporting this.
- People at the end of life have a care coordinator identified.
- End of life care pathways are incorporated into the Care Close to Home model, paying specific attention to requirements as part of implementation of the Care Act.

3.3 Delivery of high quality care in different settings, care in the last days of life

- Improve where necessary, end of life care for those in residential and nursing homes by developing targeted information and training for staff within residential and nursing care homes.
- Improve were necessary, end of life care for those in acute hospitals by developing targeted information and training for staff.
- Ensure that people are not prevented from dying in a place of their preference by process/ systems barriers (e.g. lack of access to specialist equipment such as profiling beds).

3.4 Care after death

- Ensure that recently bereaved people have timely access to information about relevant services such as bereavement support.

3.5 The whole end of life pathway

- Ensure that individuals, carers and their families' experiences actively influence and shape local services.
- Ensure that non specialist staff receive appropriate and effective education and training on an ongoing basis through a more co-ordinated approach across partners in Kirklees.
- Ensure that families and carers are supported through the whole end of life pathway**.**
- Develop use of End of Life Champions across Kirklees.