Isle of Wight NHS
NHS Trust

# END OF LIFE CARE POLICY

| Document Author | Authorised |
|---|---|
| **Written By:** End of Life Care Lead Nurse<br><br>**Date:** 16 February 2015 | **Authorised By:** Chief Executive<br><br>**Date:** 8 June 2015 |
| **Lead Director:** Executive Medical Director | |
| **Effective Date:** 8 June 2015 | **Review Date:** 7 June 2018 |
| **Approval at:** Trust Executive Committee | **Date Approved:** 8 June 2015 |

**DOCUMENT HISTORY**

(Procedural document version numbering convention will follow the following format. Whole numbers for approved versions, e.g. 1.0, 2.0, 3.0 etc. With decimals being used to represent the current working draft version, e.g. 1.1, 1.2, 1.3, 1.4 etc. For example, when writing a procedural document for the first time – the initial draft will be version 0.1)

| Date of Issue | Version No. | Date Approved | Director Responsible for Change | Nature of Change | Ratification / Approval |
|---|---|---|---|---|---|
| 15 Mar 15 | 0.1 | | Executive Medical Director J. Hazeldine | Template | |
| 28 Mar 15 | 0.2 | | Executive Medical Director J. Hazeldine | Change of Wording | |
| 28 Mar 15 | 0.2 | | Executive Medical Director J. Hazeldine | | Sent to EOL IMP Group |
| 28 Mar 15 | 0.2 | | Executive Medical Director J. Hazeldine | | Ward Sisters and Matrons for Consultation |
| 02 Apr 15 | 0.2 | | Executive Medical Director J.Hazeldine | | Strategy Group for Consultation |
| 18 Apr 15 | 0.2 | | Executive Medical Director | | Appropriate Clinicians for Consultation. |
| 06 Apr 15 + 19 Apr 15 | 0.2 | | Executive Medical Director | | EMH |
| 20 Apr 15 | 0.2 | | Executive Medical Director | | Draft Policy site and E-Bulletin for consultation purposes |
| 01 May 15 | 0.2 | | Executive Medical Director | | Ratified at Clinical Standards Group |
| 19 May 15 | 0.3 | | Executive Medical Director | Executive Summary | Ratified at Policy Management Group |
| 08 Jun 15 | 1.0 | 08 Jun 15 | Executive Medical Director | Requested amendments from PMG | Approved at Trust Executive Committee |

NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust.

**Contents** **Page**

## 1. EXECUTIVE SUMMARY

The Isle of Wight NHS Trust End of Life Care Policy has been developed to provide a framework for high quality care for all patients. The End of Life Strategy for England, published in 2008, encouraged early recognition of people entering the last phase of their life with open, sensitive discussion of their preferences for the care they received and the place in which they received their care.

The policy is aimed at all professionals who work in the Isle of Wight NHS Trust and who have the responsibility for providing end of life care. End of life care is everyone's responsibility; therefore this policy covers a broad range of services in the Trust, and applies to all staff who provide care for patients who considered to be end of life. Senior staff at Earl Mountbatten Hospice has been consulted in the development of this policy as the Hospice adopts the NHS Trust's policies.

High quality end of life care involves:-

- Identifying those who may die in the next twelve months.
- Promoting a proactive approach to identifying patient's plans for their future in the form of an Advance Care Plan or Preferred Priority of Care.
- Reduce inappropriate hospital admissions.
- Supporting those who wish to be discharged rapidly in order to die at home.
- Supporting and work with families and carers who are care for a dying person in their own home.
- Co-ordinating care across all services.
- Providing care and support after death for the bereaved in a way that meets the needs of those individuals.

The services represented in this policy portray their specific role in caring for the dying person and those close to them. The services included are:-

- Ambulance Service
- Children Services
- Mental Health Services

Please note that Maternity services have not been included in this policy but links to their guidance is available via the intranet.

## 2. INTRODUCTION

2.1 How we care for the dying is an indicator of how we care for all sick, vulnerable people. It is a measure of society as a whole and it is a litmus test for health and social care services. In July 2008 the Department of Health published the End of Life Strategy – Promoting High Quality End of Life Care for All Adults (DOH 2008).

2.2 The Isle of Wight NHS Trust is committed to delivering high quality end of life care for all regardless of diagnosis and to assist patients to be cared for and die in their preferred place.

2.3 End of Life is considered to be the last twelve months of life (GMC 2012), including the dying phase. End of life care supports all those with advanced progressive incurable illnesses to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of the life and into bereavement.

2.4 The Mental Capacity Act (2005) provides a legal framework to empower patients to make their own decisions and to make clear their wishes regarding the care they receive in the form of an Advance Care Plan, and the treatment they don't wish to receive in the form of an Advance Decision to Refuse Treatment. The patient may also identify a person who has Legal Power of Attorney and those who can contribute to a decision made in a person's best interest.

2.5 Appropriate tools and frameworks such as the Amber Care Bundle and the Gold Standards Framework are used to support the identification of patients who are near the end of their life. Early recognition of those in the last year of life is essential to provide patients their family and/or carers with information so that patients are able to take part in choosing the care they receive.

2.6 A multidisciplinary approach to providing care is central to meeting the individual needs of the patients and those close to them. In order to provide well co-ordinated care Anticipatory Care Plans are held on the Adastra system in the Ambulance Hub.

## 3. SCOPE

This policy applies to all healthcare professionals who care for patients who are deemed to be in the last twelve months of life. End of Life Care is everyone's responsibility and applies to all healthcare settings within the organisation and Earl Mountbatten Hospice, (excluding Maternity who have their own guidance document).

## 4. PURPOSE

4.1 The purpose of this document is to ensure the appropriate clinical care and support is offered to those patients who are end of life, in all areas of the organisation. This policy is intended to standardise responses, processes and documentation of palliative and end of life care and raise the standard of end of life care to those of 'the best', as stated in the End of Life Strategy (2008).

4.2 This policy will ensure that all staff delivering patient care, understand what constitutes a good death. This will be achieved through proactive holistic assessment of the person nearing the end of life, their physical, social and psychological needs and the needs of their family and carers.

4.3 Supporting choice to enable to the person's preferred place of care and death. National statistics suggest that a significant proportion of people wish to be cared for in their usual place of residence.

## 5. ROLES AND RESPONSIBILITIES

### 5.1 Executive Medical Director and Executive Director of Nursing:

- Will ensure the Trust has an evidence based policy in place to support early recognition and responses to all end of life patients.

### 5.2 Clinical Directors and Heads of Clinical Services:

- Will ensure the policy is fully implemented within the Directorate and will receive the annual compliance report at the Directorate quality and risk meeting and received at the Directorate board.

### 5.3 Associate Directors:

- Will support the implementation of this policy.
- Will support the development of resources to provide safe end of life care for all patients.

### 5.4 Lead Clinicians: (medical and non-medical):

- Will ensure all their clinical teams and members have read this policy and understand their role, actions and responsibility they have for all end of life patients.
- Will champion this policy in practice.
- Undertake or delegate an audit the appropriate section of the policy and feed this into the overall data analysis of care of the dying.

### 5.5 Allied Health Professionals:.

- Will contribute to multidisciplinary decisions and care plans.
- Will provide assessment of needs and advice and care within their sphere of expertise.
- Will support patients in achieving their goals at end of life.

### 5.6 Matrons:

- Ensure the Ward Sister/Charge Nurse has set up a system to disseminate this policy with all ward and department team registered nurses.
- Ensure the Ward Sister/Charge Nurse is clear about what actions they need to take in the scope of this policy.
- Ensure your areas are complaint with the actions within this policy that relates to your services.

**5.7 Ward and Departmental Managers:**

- Ensure all registered and non-registered staff have read this policy and understand their role, actions and responsibility when caring for end of life patients, their families and carers.
- Ensure your staff follow the actions required of them within this policy.

**5.8 Doctors:**

- Must be aware of this policy and ensure that the process is followed correctly in the practice setting for all end of life patients, their families and carers.
- Complete all relevant documentation to evidence care delivery and decisions made about a patients care.
- All doctors are responsible for ensuring they are competent to deliver end of life care.

**5.9 Registered Nurses:**

- Must be aware of this policy and ensure that the process is followed correctly in the practice setting for all end of life patients, their families and carers.
- Complete all relevant documentation to evidence care delivery and decisions made about a patients care.
- All registered nurses are responsible for ensuring they are competent to deliver end of life care.

## 6. POLICY DETAIL / COURSE OF ACTION

6.01 This policy applies to all clinical staff within the Isle of Wight NHS Trust who provide care for the dying person and their family.

6.0.2 The procedural detail for Isle of Wight Integrated End of Life Care Policy is divided into sections focussing on specific areas of the organisation, namely:

- Ambulance service
- Paediatrics (Children's Ward and Children's Community Nursing Team)
- Adult ' inpatient' wards and Community Nursing Service
- Mental Health Services

## 6.1 AMBULANCE SERVICE

6.1.1 The ambulance service plays a significant role in co-ordinating end of life care using IT systems in the following way:

- The HUB receives Anticipatory Care Plans (ACP) completed by either the patient's GP in primary care, Consultant/CNS in secondary care or Doctor/CNS in Palliative Care following conversations with the patient and family.
- The information is entered onto Adastra, a shared IT system including Ambulance Beacon Centre, and the Crisis Response Team. Healthcare professionals from these services have 24 hour access to the information held in the Anticipatory Care Plan.

- A ‘flag’ indicating an ACP is added to PAS, the information from which will show in the ISIS IT system for Healthcare professionals in SMH to access via the HUB or Beacon.
- Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms completed in all clinical areas are ‘flagged’ with patient’s details on Adastra. A flag is also added to PAS and linked to ISIS indicating that a DNACPR is in place. A copy of the DNACPR form is held in the HUB.
- Updates and retractions of the above forms are recorded on Adastra and PAS.
- The 111 service in the HUB receives out of hours calls reporting expected deaths in the community.

## 6.2. PAEDIATRIC WARD AND CHILDREN’S COMMUNITY NURSING TEAM

6.2.1 The paediatric teams work together to provide seamless end of life care for children, and their families, in a place of their choice. Children for whom active curative treatment is no longer appropriate or those for whom life expectancy is likely to be limited are identified by the paediatric team.

- Early discussions regarding EOL care and completion of an Advanced Care Plan, help clarify future treatment options.
- The plan is discussed in a calm situation before the child deteriorates, to reduce the family’s anxiety.
- Regular updates and consultations are offered to ensure that the family feel well supported and involved in all aspects of their child’s care.
- Discussion always involves the child (if appropriate) and the family. Respect is given to any religious and cultural considerations that the family may have.
- Child-focused EOL care can be provided in 3 locations :

– Acute Children’s Ward – if chosen by family, or if symptom management is proving difficult. Supported by the CCN team.
– Earl Mountbatten Hospice – staffed and supported by the children’s community nursing team and paediatricians
– Home – supported by 24hr on-call service from children’s community nursing team and paediatricians.

- The specialist palliative care team from Southampton are utilised for advice regarding symptom management and they offer us an on-call service for children terminally ill with cancer.
- Liaison with the multidisciplinary team is vital in providing a seamless service. Discussions and communications with other key team members are recorded.

## 6.3. ADULT IN-PATIENT WARDS AND COMMUNITY NURSING SERVICES

6.3.1 This policy aims to enable staff to deliver sensitive, supported and well co-ordinated end of life care and achieve a ‘good death’ for patients, and an acceptable memory for family and those close to the patient. Cultural and religious beliefs and needs will be integral to all the patient’s care.

- A holistic assessment will be undertaken by a multidisciplinary team to identify individual patient needs, which will be recorded in the medical and nursing notes.

- The needs of the family or carers will be included and appropriate referrals for support will be made.
- The Amber Care Bundle will be considered for patients (in hospital) whose recovery is uncertain in order that the patient's wishes regarding treatment and care can be recorded.
- The involvement of the patients and those close to them is an integral part of care.
- The patient's understanding of their situation will be established and meaningful conversations held with the patient will be integral to their care.
- All conversations/communications will be accurately recorded in the patient's notes to reduce repetition and inform the multidisciplinary team members and other agencies.
- An ongoing multidisciplinary assessment of patients' needs and wishes, including preferred place of care and death, will be undertaken and recorded in the patient's medical and nursing notes.
- All staff are kept informed of the patient's current needs during handover to ensure that they provide appropriate care.
- Access to specialist palliative care is available for all patients who are identified as being in 'end of life'.
- All patients who are considered to be at the end of their life will be offered psychological and spiritual support.
- An individualised care plan for the last days and hours of life will be used to ensure that all the patient's physical, psychological and spiritual needs are assessed and cared for.
- The comfort of the patient is promoted at all times, including mouth-care, skin care and repositioning.
- The Privacy and Dignity of the dying person is observed at all times and a person-centred approach adopted in the care provided.
- All patients who are admitted to hospital and recognised as being end of life, will have any bed moves limited so that continuity of care is promoted. When appropriate, patients may be transferred to Earl Mountbatten Hospice for end of life care.

## 6.4. MENTAL HEALTH SERVICES

6.4.1 Patient with mental health needs will receive care in line with that detailed for adult care with adaptations to meet their mental health needs, these include.:-

- Ensuring that the environment for the last days of life is peaceful and reduces anxiety.
- Communication is undertaken in a way which supports understanding, repeating the information as required.
- Adapting the way in which pain and symptom relief is delivered if the use of a syringe driver is not appropriate.
- Provide close monitoring of pain and symptoms as the patient deteriorates.

## 7. CONSULTATION

7.1 This policy has been developed in co-operation with leads from key clinical areas in this policy, including Earl Mountbatten Hospice. The leads were asked to develop the appropriate part of the policy with their teams and to gain further contributions, comments and feedback.

7.2 The policy will then be distributed initially to the End of Life Implementation Group and the End of Life Strategic Group, before being sent out for general consultation.

7.3 The following staff has been included in the consultation for this document:-

- Ward sisters
- Modern Matrons.
- Heads of Clinical Services.
- Community Nursing Teams.
- Consultants
- Junior and Middle Grade Doctors.
- Hospital Palliative Care Team
- Clinical Leads at Earl Mountbatten Hospice

## 8. TRAINING

8.1 The Implementation of this policy will be supported through awareness sessions with all relevant Clinical Directorates and Corporate Teams.

8.2 This End of Life Care Policy does have a mandatory training requirement:-

- End of Life e-learning will be mandatory for groups of clinical staff.
- End of Life taught education will be mandatory for all 'End of Life Care Champions'.

8.3 This is detailed in the Trusts mandatory training matrix and is reviewed on a yearly basis.

8.4 The following non-mandatory training is also recommended:-

- Communication skills for all clinicians.
- 'Breaking Bad News' for Clinicians who have to have significant conversations with patients and those close to them.

## 9. DISSEMINATION

9.1 When approved this document will be available on the Intranet and will be subject to document control procedures. Approved documents will be placed on the Intranet within five working days of date of approval once received by the Risk Management Team.

9.2 When submitted to the Risk Management Team for inclusion on the Intranet this document will have fully completed document details including version control. Keywords and description for the Intranet search engine will be supplied by the author at the time of submission.

9.3 Notification of new and revised documentation will be issued on the Front page of the Intranet, through e-bulletin, and on staff notice boards where appropriate. Any controlled documents noted at the Trust Executive Committee will be notified through the e-bulletin.

9.4 Staff using the Trust's intranet can access all procedural documents. It is the responsibility of managers to ensure that all staff are aware of where, and how, documents can be accessed within their areas of work.

9.5 It is the responsibility of each individual who prints a hard copy of any document to ensure that the printed hardcopy is the current version. Current versions are maintained on the Intranet.

## 10 EQUALITY ANALYSIS

10.1 This policy identifies that the needs of each patient are individual and care will be given in line with their cultural and religious beliefs. It is inclusive of all patients in all care settings.

## 11. REVIEW AND REVISION ARRANGEMENTS

11.1 This policy will be reviewed every three years.
This policy will be revised in line with national guidance and best practice.

## 12. MONITORING COMPLIANCE AND EFFECTIVENESS

12.1 The compliance for this policy will conducted annually by the clinical leads for each section that this policy covers which includes: All reports and findings from audits will be presented to the SEE committee, QCPC and TEC.

- Twice yearly audit of deceased patient's notes against the guidance within this policy.
- GMC Audit of the Dying Person.
- DNACPR audit three monthly.
- Care Plan twice yearly.
- Data collected via Clinical Coding with each deceased patient.
- Mortality and Morbidity Audit.
- Data collected in relation to bed moves.

## 13. LINKS TO OTHER ORGANISATION POLICIES/DOCUMENTS

Resuscitation Policy
Do Not Attempt Cardiopulmonary Resuscitation Policy

## 14 REFERENCES


1. Delivering Better Care at End of Life (2010) Kings Fund.
2. End of Life Strategy, Department of Health. (2008) Department of Health.
3. Definition of End of Life.(2012) General Medical Council.
4. More Care, Less Pathway (2013) Neuberger J. Department of Health
5. Priorities of Care for the Dying Person**,** in One Chance to Get it Right (2014) LACDP
6. Transforming End of Life Care in Acute Hospitals: The Route to success, How to Guide.

   NEoLCP. (2012) National End of Life Programme.


## 15. DISCLAIMER

15.1 It is the responsibility of all staff to check the Trust intranet to ensure that the most recent version/issue of this document is being referenced.

**Appendix A**

## KEY DEFINITIONS FOR DOCUMENTATION

### Definition of 'End of Life'

People are approaching the end of life when they are likely to do die in the next twelve months. This includes people whose death is imminent (expected within a few hours or days) and those with:-

- Advanced, progressive, incurable conditions.
- General frailty and coexisting conditions that mean they expected to die within twelve months.
- Existing condition if they are at risk of dying from a sudden acute crisis in their condition.

GMC 2012

### AMBER Care Bundle

The AMBER care bundle improves the quality of care of people in hospital whose recovery is uncertain. It is for people who are at risk of dying in the next one to two months, but who may still be appropriate to receive active treatment.

The AMBER care bundle helps identify patients who may have end of life care needs. It supports staff to be clear about the plan of care, to start conversations about uncertainty and gives patients, carers and others close to them time to prepare.

AMBER stands for:

**A**ssessment
**M**anagement
**B**est Practice
**E**ngagement of patients and carers
For patients whose **R**ecovery is uncertain

Guy's and St Thomas' Hospital

### Five Priorities of Care

1. The possibility that a person may die within the next few days or hours is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.
2. Sensitive communication takes place between staff and the person who is dying, and those identified as important to them.
3. The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.
4. The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.

An individual plan of care, which includes food and drink, symptom control, psychological, social and spiritual support, is agreed, coordinated and delivered with compassion

Leadership Alliance for the Care of the Dying Person 2014

**Appendix B**

## CHECKLIST FOR THE DEVELOPMENT AND APPROVAL OF CONTROLLED DOCUMENTATION

To be completed and attached to any document when submitted to the appropriate committee for consideration and approval.

| Title of document being reviewed: | | Y/N/ Unsure | Comments |
|---|---|---|---|
| **1.** | **Title/Cover** | | |
| | Is the title clear and unambiguous? | y | |
| | Does the title make it clear whether the controlled document is a guideline, policy, protocol or standard? | y | |
| **2.** | **Document Details and History** | | |
| | Have all sections of the document detail/history been completed? | y | |
| **3.** | **Development Process** | | |
| | Is the development method described in brief? | y | |
| | Are people involved in the development identified? | N | But alterations have been made in line with their feedback |
| | Do you feel a reasonable attempt has been made to ensure relevant expertise has been used? | y | |
| **4.** | **Review and Revision Arrangements Including Version Control** | | |
| | Is the review date identified? | y | |
| | Is the frequency of review identified? If so, is it acceptable? | y | |
| | Are details of how the review will take place identified? | y | |
| | Does the document identify where it will be held and how version control will be addressed? | y | |
| **5.** | **Approval** | | |
| | Does the document identify which committee/group will approve it? | y | |
| | If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document? | y | |
| **6.** | **Consultation** | | |
| | Do you have evidence of who has been consulted? | y | Through emails |
| **7.** | **Table of Contents** | | |
| | Has the table of contents been completed and checked? | y | |
| **8.** | **Summary Points** | | |
| | Have the summary points of the document been included? | y | Executive summary |
| **9.** | **Definition** | | |
| | Is it clear whether the controlled document is a guideline, policy, protocol or standard? | y | |
| **10.** | **Relevance** | | |
| | Has the audience been identified and clearly stated? | y | |
| **11.** | **Purpose** | | |
| | Are the reasons for the development of the document stated? | y | |
| **12.** | **Roles and Responsibilities** | | |

| Title of document being reviewed: | | Y/N/ Unsure | Comments |
|---|---|---|---|
| | Are the roles and responsibilities clearly identified? | y | |
| **13.** | **Content** | | |
| | Is the objective of the document clear? | y | |
| | Is the target population clear and unambiguous? | y | |
| | Are the intended outcomes described? | y | |
| | Are the statements clear and unambiguous? | y | |
| **14.** | **Training** | | |
| | Have training needs been identified and documented? | y | |
| **15.** | **Dissemination and Implementation** | | |
| | Is there an outline/plan to identify how this will be done? | y | |
| | Does the plan include the necessary training/support to ensure compliance? | y | |
| **16.** | **Process to Monitor Compliance and Effectiveness** | | |
| | Are there measurable standards or Key Performance Indicators (KPIs) to support the monitoring of compliance with and effectiveness of the document? | n | |
| | Is there a plan to review or audit compliance within the document? | y | |
| | Is it clear who will see the results of the audit and where the action plan will be monitored? | y | |
| **17.** | **Associated Documents** | | |
| | Have all associated documents to the document been listed? | y | |
| **18.** | **References** | | |
| | Have all references that support the document been listed in full? | y | |
| **19.** | **Glossary** | | |
| | Has the need for a glossary been identified and included within the document? | y | |
| **20.** | **Equality Analysis** | | |
| | Has an Equality Analysis been completed and included with the document? | y | |
| **21.** | **Archiving** | | |
| | Have archiving arrangements for superseded documents been addressed? | n | No previous policy |
| | Has the process for retrieving archived versions of the document been identified and included within? | n | |
| **22.** | **Format and Style** | | |
| | Does the document follow the correct style and format of the Document Control Procedure? | y | |
| **23.** | **Overall Responsibility for the Document** | | |
| | Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the documentation? | y | |
| **Committee Approval** | | | |
| If the committee is happy to approve this document, please sign and date it and forward copies for inclusion on the Intranet. | | | |

| Title of document being reviewed: | | | | Y/N/ Unsure | Comments |
|---|---|---|---|---|---|
| Name of Committee | | Date | | | |
| Print Name | | Signature of Chair | | | |

**Appendix C**

## IMPACT ASSESSMENT ON DOCUMENT IMPLEMENTATION

**Summary of Impact Assessment (see next page for details)**

| **Document title** | **End of Life Care Policy** |
|---|---|

| **Totals** | **WTE** | **Recurring £** | **Non Recurring £** |
|---|---|---|---|
| **Manpower Costs** | | | |
| **Training Staff**<br>E learning for appropriate clinical groups<br>Mandatory | | | Equates to 40mins of time per person trained |
| End of Life Champion's study days<br>Mandatory | | | 1.5 days |
| **Equipment & Provision of resources** | | | |

**Summary of Impact:**

**Risk Management Issues:**

**Benefits / Savings to the organisation:**

Less complaints
Improved Care
Improved Patient and Family satisfaction

**Equality Impact Assessment**

- Has this been appropriately carried out? **YES**
- Are there any reported equality issues? **NO**

If "YES" please specify:

**Use additional sheets if necessary.**

## IMPACT ASSESSMENT ON POLICY IMPLEMENTATION

Please include all associated costs where an impact on implementing this policy has been considered. A checklist is included for guidance but is not comprehensive so please ensure you have thought through the impact on staffing, training and equipment carefully and that ALL aspects are covered.

| **Manpower** | **WTE** | **Recurring £** | **Non-Recurring £** |
|---|---|---|---|
| ***Operational running costs*** | | | |
| Additional staffing required - by affected areas / departments: | N/A | | |
| | | | |
| | | | |
| | | | |
| **Totals:** | | | |

| **Staff Training Impact** | **Recurring £** | **Non-Recurring £** |
|---|---|---|
| E learning for some clinical staff groups | 30 mins per year | |
| Taught study days for End of Life Champions | Half study day per year | 1.5 days per staff member |
| | | |
| | | |
| **Totals:** | | |

| **Equipment and Provision of Resources** | **Recurring £ *** | **Non-Recurring £ *** |
|---|---|---|
| Accommodation / facilities needed | N/A | |
| Building alterations (extensions/new) | N/A | |
| IT Hardware / software / licences | N/A | |
| Medical equipment | N/A | |
| Stationery / publicity | N/A | |
| Travel costs | N/A | |
| Utilities e.g. telephones | N/A | |
| Process change | N/A | |
| Rolling replacement of equipment | N/A | |
| Equipment maintenance | N/A | |
| Marketing – | N/A | |
| | | |
| **Totals:** | | |

- Capital implications £5,000 with life expectancy of more than one year.

| | |
|---|---|
| Funding /costs checked & agreed by finance: | |
| Signature & date of financial accountant: | |
| Funding / costs have been agreed and are in place: | |
| Signature of appropriate Executive or Associate Director: | |

***IMPACT ASSESSMENT ON DOCUMENT IMPLEMENTATION - CHECKLIST***

**Points to consider**

## Have you considered the following areas / departments?

- Have you spoken to finance / accountant for costing?
- Where will the funding come from to implement the policy?
- Are all service areas included?
  - Ambulance
  - Acute
  - Mental Health
  - Community Services, e.g. allied health professionals
  - Public Health, Commissioning, Primary Care (general practice, dentistry, optometry), other partner services, e.g. Council, PBC Forum, etc.

**Departments / Facilities / Staffing**

- Transport
- Estates
  - Building costs, Water, Telephones, Gas, Electricity, Lighting, Heating, Drainage, Building alterations e.g. disabled access, toilets etc
- Portering
- Health Records (clinical records)
- Caretakers
- Ward areas
- Pathology
- Pharmacy
- Infection Control
- Domestic Services
- Radiology
- A&E
- Risk Management Team / Information Officer – responsible to ensure the policy meets the organisation approved format
- Human Resources
- IT Support
- Finance
- Rolling programme of equipment
- Health & safety/fire
- Training materials costs
- Impact upon capacity/activity/performance

**Appendix D**

## Equality Analysis and Action Plan

*This template should be used when assessing services, functions, policies, procedures, practices, projects and strategic documents*

### Step 1. Identify who is responsible for the equality analysis.

| |
|---|
| **Name: Jacqueline Hazeldine** |
| **Role: End of Life Care Lead Nurse** |
| |
| Other people or agencies who will be involved in undertaking the equality analysis: |
| |

### Step 2. Establishing relevance to equality

| | Relevance | | |
|---|---|---|---|
| **Protected Groups** | **Staff** | **Service Users** | **Wider Community** |
| Age | N/A | N/A | N/A |
| Gender Reassignment | N/A | N/A | N/A |
| Race | N/A | N/A | N/A |
| Sex and Sexual Orientation | N/A | N/A | N/A |
| Religion or belief | N/A | N/A | N/A |
| Disability | N/A | N/A | N/A |
| Marriage and Civil Partnerships | N/A | N/A | N/A |
| Human Rights | N/A | N/A | N/A |
| Pregnancy and Maternity | N/A | N/A | N/A |

Show how this document or service change meets the aims of the Equality Act 2010?

| Equality Act – General Duty | Relevance to Equality Act General Duties |
|---|---|
| Eliminates unlawful discrimination, harassment, victimization and any other conduct prohibited by the Act. | Promote recognition of individual patient and family needs when the patient is 'End of Life' and ensure they are met. |
| Advance equality of opportunity between people who share a protected characteristic and people who do not share it | As Above |
| Foster good relations between people who share a protected characteristic and people who do not share it. | As Above |

### Step 3. Scope your equality analysis

| | Scope |
|---|---|
| What is the purpose of this document or service change? | To provide provide clear statements and standards of care to be provided.<br>It applies to adults at home, in hospital, in care homes or intermediate care.<br>It provides clear and current evidence-based information and policy guidelines for use by health and social care staff and any other agency responsible for the care of patients who are considered to be end of life |
| Who will benefits? | 1. the patient<br>2. Those close to the patient<br>3. The organisation |
| What are the expected outcomes? | To support good practice in line with NICE guidelines.<br>Consistent high quality care.<br>To provide care in line with all National guidelines and developments |
| Why do we need this document or do we need to change the service? | It ensures that practice in clinical areas represents high quality care in line with national guidance. |

It is important that appropriate and relevant information is used about the different protected groups that will be affected by this document or service change. Information from your service users is in the majority of cases, the most valuable.

Information sources are likely to vary depending on the nature of the document or service change. Listed below are some suggested sources of information that could be helpful:

- Results from the most recent service user or staff surveys.
- Regional or national surveys
- Analysis of complaints or enquiries
- Recommendations from an audit or inspection
- Local census data
- Information from protected groups or agencies.
- Information from engagement events.

**Step 4. Analyse your information.**

As yourself two simple questions:

- What will happen, or not happen, if we do things this way?
- What would happen in relation to equality and good relations?

In identifying whether a proposed document or service changes discriminates unlawfully, consider the scope of discrimination set out in the Equality Act 2010, as well as direct and indirect discrimination, harassment, victimization and failure to make a reasonable adjustment.

**Findings of your analysis**

| | Description | Justification of your analysis |
|---|---|---|
| **No major change** | Your analysis demonstrates that the proposal is robust and the evidence shows no potential for discrimination. | |
| Adjust your document or service change proposals | This involves taking steps to remove barriers or to better advance equality outcomes. This might include introducing measures to mitigate the potential effect. | |
| Continue to implement the document or service change | Despite any adverse effect or missed opportunity to advance equality, provided you can satisfy yourself it does not unlawfully discriminate. | |
| Stop and review | Adverse effects that cannot be justified or mitigated against, you should consider stopping the proposal. You must stop and review if unlawful discrimination is identified | |

## 5. Next steps.

5.1 Monitoring and Review.
Equality analysis is an ongoing process that does not end once the document has been published or the service change has been implemented.

This does not mean repeating the equality analysis, but using the experience gained through implementation to check the findings and to make any necessary adjustments.

Consider:

| | |
|---|---|
| How will you measure the effectiveness of this change | |
| When will the document or service change be reviewed? | |
| Who will be responsible for monitoring and review? | |
| What information will you need for monitoring? | |
| How will you engage with stakeholders, staff and service users | |

5.2 Approval and publication
The Trust Executive Committee / Policy Management Group will be responsible for ensuring that all documents submitted for approval will have completed an equality analysis.

Under the specific duties of the Act, equality information published by the organisation should include evidence that equality analyses are being undertaken. These will be published on the organisations "Equality, Diversity and Inclusion" website.

**Useful links:**

**Equality and Human Rights Commission**
http://www.equalityhumanrights.com/advice-and-guidance/new-equality-act-guidance/equality-act-guidance-downloads/

Sources of further help and guidance:

- Local guidance document - see intranet under Quality Team
- Member of the Quality team
- Liz Nials – Equality and Diversity Lead
- Paul Dubery - Head of Information Management
- NHS Employers website; www.nhsemployers.com & follow the Equality and Diversity link.
- Equality and Human Rights Commission website: www.equalityhumanrights.com

A summary of equality impact assessments will be made available to the public via the organisation's intranet annually.