

Annual Quality Account: St Nicholas Hospice Care 2009/2010

Being Safe Maximising Effectiveness Engaging with Service Users

Executive Summary

The year of our 25th birthday; the anticipation for celebration was palpable. Our objectives for the year were set. However, the rapid onset of the recession shook the foundations of our plans and forced us to reconsider priorities, redeploy staff and redefine service provision across all sectors of the organisation. At the end of the year, we reflect on many points of celebration with, naturally, memories of difficult decisions which impacted on staff, volunteers and their families. The reconfiguration of clinical services in order to thrive and survive left no-one unscathed, and yet, it brought out the best in everyone.

While no growth has been possible in absolute terms, there has been innovation and participation in research. It is my pleasure to present this report to you. It clearly illustrates the huge effort undertaken by a smaller workforce; achievements are plentiful. Patient and family care, professional support and high standards of governance remained paramount. We are decidedly stronger having faced the challenge of recession. This report will illustrate how our activity increased despite the constraints and restrictions and how exemplary practice has been recognised by national awards.

Our commitment to national end of life strategies and the development of Suffolk-wide plans was sustained. Our ability to influence local strategy grew with Barbara Gale (Chief Executive Officer) accepting the Chair of the Suffolk Palliative and End of Life Network Group, Madeline Bass, (Head of Education) working with the National Gold Standard Framework working group and Jackie Saunders (Clinical Services Director) working with the East of England Cross Cutting Palliative Care Group.

We realise that after 2011 the services commissioned by the NHS will need to maintain and improve without the growth funding experienced over the last decade. Our thorough review of funding and practice this year has enabled us to meet this challenge from a position of strength. Our clinical managers ensure a critical eye is upon making a difference for patients and families whilst developing our staff's expertise. We continue to set ourselves ambitious and innovative goals; targets which are determined in consultation with service users in order to ensure relevance.

Behind every clinician are support staff and fundraisers. Together their experience and determination continues to uphold the quality that our local community has come to expect from St Nicholas Hospice Care. I am truly grateful to all the staff, volunteers, service users and other supporters who have contributed to make such a difficult year such a success.

Thank you

Jackie Saunders

Clinical Services Director

Statement from Board

Our achievements in 2009 – 2010 are described below

We said we would manage the organisation's resources in light of the recession to endure the sustainability of the Charity.

During the year, with the Board of Trustees' approval the management team developed a planned response to the recession which included:

- Freezing vacancies and a restriction on training
- A request to staff for a reduction in hours
- No renewal of short term contracts
- A pay freeze
- Very tight cost control

An extensive marketing campaign raised public awareness about the effect of the recession on the Charity. In addition to this 3 staff were made redundant as their roles had been identified as non essential. The impact on services meant 4 beds on the inpatient unit were closed, day services ran on 2 days rather than 3 days a week and a creative art project was halted.

Staff, volunteers and the local community were kept fully informed during this process. Staff briefings and staff forum meetings were held more frequently. With the closure of 4 beds 2 Nursing Assistants (following consultation) were transferred to the Community Hospice Team.

In January 2010 the management and the Board of Trustees agreed to increase the beds available back up to 10 during 2010; this was the result of a steady increase in income together with the receipt of a large legacy and a grant from the Big Lottery.

We said we would further develop community services enabling more people to die at home.

The recruitment of 2 Nursing Assistants in the previous year, together with the 2 Nursing Assistants transferred from the Ward meant an increase in the amount of support the Hospice could give to people at home. Home deaths supported by the Hospice rose slightly from 215 in 2008/9 to 216 in 2009/10. The Community Hospice Team (CHT) managed to respond to a 44% increase in referrals and increasing activity at weekends and bank holidays.

This year saw a shift of workload with the nurse specialists reducing their numbers of visits and delegating visits to the nursing assistants; the nurse specialists increased their emphasis on supporting other professionals via Gold Standards Framework (end of life care) meetings and providing telephone advice. It is estimated that by working in this way the team prevented 194 potential admissions to hospital.

The nursing assistants provision of hands on care was focused on the last weeks of life, the majority of the nursing assistants' work was outside of office hours.

Liaising with other service providers at weekends and bank holidays continues to be a crucial component in enabling patients to die at home. The work with the Primary Healthcare Team at GSF meetings ensures that the Hospice is influencing the care of patients and families not known to the Hospice and ensuring when required, they can be referred early.

Our Head of Education has also led work on Do Not Attempt Resuscitation Community Policy, and is developing an e-learning tool for use when it spreads to the whole of the county, hopefully end of 2010. This work will also influence the East of England DNAR development.

We said we would develop new ways of meeting demand for the service.

A triage service was put in place to respond rapidly to all new referrals, this was run by a Nurse Specialist from the Community Hospice Team. This service saw an improvement in average response time from just under 3 days to less than 24 hours.

The Hospice was granted the Foundation of Nursing Studies 'Patient First' Award to develop preferred priorities of care practice specifically focussing on the patient experience.

We said we would work with the local community in raising awareness about end of life choices.

Working in partnership with the local community and all other providers is core to the way that the Hospice functions. To ensure close working relationships with NHS providers, the Hospice has representation on the Suffolk Palliative and End of Life Strategy Group (Barbara Gale is the Chair), the Anglia Cancer Network Supportive and Palliative Care Cross Cutting Group, the Strategic Health Authority End of Life Care Education Group and the Suffolk Workforce Development Group;

In November 2009 BBC Inside Out focused on the work of volunteers with the Hospice and highlighting the work of the Hospice in improving quality of life for patients.

During March 2010 the Charity took part in the National Campaign "Dying Awareness Week", the Charity designed and distributed a poster locally to engage the public in thinking about their wishes in preparation for their death. Details about this were also posted on the Hospice website and Facebook page to encourage discussion. The Hospice's Facebook page has 698 friends.

Introduction

This report will consider:

1. Strategy and objectives
2. Celebrations
3. Patient Safety: governance
4. Clinical Effectiveness - Research and Patient & Family Care

It will describe clinical activity from the four domains of:

1. The Community Hospice Team
2. Sylvan Ward
3. The Orchard Centre
4. Bereavement Services

It will present our progress against the objectives for the year and will highlight the work undertaken by the different disciplines and teams across the care settings

Strategy and objectives

Drivers and directions for clinical care took account of:

The East of England SHA's, Towards the Best Together: a clinical vision for our NHS now and for the next decade

The national Quality Markers for community and in-patient care

Health and Social Care Act 2008

The St Nicholas Hospice Care (STNH) 2009/10 Operational Plan (Appendix A)

Celebrations

We have:

- developed the out of hours community nursing assistant service which prevented unwanted admissions, supported family carers and increased home death numbers
- won the coveted International Journal of Palliative Care Volunteer of the Year award with the recognition of Pam Bailey's outstanding contributions
- reduced our response time to referrals from just less than 3 days to less than one working day following implementation of triage practice. Staff allocated promptly to urgent care needs.
- been chosen to be on prime-time BBC TV Inside Out programme: sensitively capturing the contribution of volunteers
- been granted the Foundation of Nursing Studies 'Patient First' Award: developing preferred priorities of care practice focussing on the patient experience
- participated in the national Bereavement Needs Assessment research
- received a The Big Lottery Fund grant to sustain Community Hospice Team activity for subsequent years
- published resuscitation and advance care planning articles: by Madeline Bass

Patient Safety: Governance

The Clinical Governance Committee, a sub-group of the Board of Trustees, monitored clinical activity and patient safety through reports from members of the Clinical Management Group (CMG).

Quarterly reporting to Suffolk and Norfolk PCTs highlighting progress against the national end of life initiatives occurs and both commissioners have expressed satisfaction with services provided and strategy.

Five clinical complaints were reported; all were resolved for the complainant.

The CMG oversees the production and review of Clinical Policies, the development of clinical practice and staff and volunteer development. The CMG takes quarterly reports from four subcommittees:

1. The Infection Prevention Committee

- assured compliance with the 'Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections'
- ensured training had high priority using a breadth of methods: from classroom to 'bed-side'
- recorded no notifiable infection outbreaks
- prioritised swine flu contingency planning, hand hygiene audit and practice, ward cleaning schedules and mattress care.
- closely monitored Hep B status of clinical staff
- the Uniform Audit resulted in clear mandate to enforce 'bare below the elbows' practice and no jewellery.

Our Care Quality Commission assessor commented informally upon his pleasure at seeing such a clean clinical environment with professional, friendly staff.

2. The Clinical Incident Analysis Committee

- reviewed all incident reports to identify trends, concerns and to ensure remedial actions were completed.
- promoted learning; changes in practice included informing families within 24 hours of any falls occurring on the ward, reviewing the Falls Risk Assessment procedures, changes in storage of medications, raising urgency of review of disposal of sharps procedures and protection from bodily fluids guidelines.
- noted that the Accountable Officer monitored 15 incidents linked to Controlled Drugs. Whilst none were of significant concern changes in practice were led by Senior Registered Nurse for Medicine Management. Quarterly reporting to Norfolk, Suffolk and Waveney LIN and attendance at the Suffolk Accountable Officer meetings and with West Suffolk Hospital pharmacists upholds exemplary practice.

3. The Audit Committee oversaw

Audits undertaken on

- Genogram
- Mouthcare
- Completion of Health Care Records
- Accountable Officer
- Pain – (Phase 2 in progress)
- Drug Administration
- Communication Skills
- Advance Care Planning
- CD Management
- Hand Hygiene
- Uniform

Surveys undertaken

- Disabled Access
- Patient and Family Satisfaction
- Syringe driver drug compatibilities

Each audit or survey resulted in changes in practice ranging from an instruction sheet how to dispose of unwanted controlled drug TTO's for families, heightened awareness of Healthcare Record documentation, development of a bedside 'hotel' guide and a need to support /coach staff when undertaking advanced care planning conversations.

4. The Therapeutics Committee

This Committee oversaw completion of the supplementary guidelines to the Medicines Management Policy and twenty six other guidelines. Five other guidelines are currently under review and two are being developed.

Clinical Effectiveness: Research and Patient & Family Care

To put the size of the organisation's practice into perspective on any given day there are (on average):

- 300 patients care for by all departments, of which
- 200 by our Community Clinical Nurse Specialist (CCNS) team
- 90 by Family Support and Orchard Centre
- 8 on Sylvan Ward
- 90 bereaved clients supported by our Family Support Team bereavement service

In 2009-10

There were 739 referrals (2% lower than 2008/09), 208 discharges and 530 deaths

By March 2010 the clinical workforce was

- 57 practitioners (29 WTE) supported by
- 8 (5.6 WTE) administrators and
- 113 clinical volunteers.

Research

Beyond direct care the organisation is ambitiously aiming to increase its research portfolio:

A research proposal concerning lay perspectives on contemporary palliative care is being developed in association with a regional academic centre.

Joint work with Dr Linda Machin (Keele Univ) and Dr Marilyn Relf (Sobell Hospice) led by Family Support Team exploring tool for staff to use to identify bereavement needs before the death occurs.

Patient & Family Care

The **Triage** process led by a new CNS post was initiated to

- provide speedy response to all referrals
- provide consistency of understanding of our referral criteria
- maximise support to all referrers.
- stop the CCNSs being the default for first assessments for all community based patient care
- increase efficiency
- anticipate clinical problems prior to face to face assessment.

Triage reduced our time from receipt of referral to first response from over 2½ days to just over half a day.

Referral criteria were revised resulting in consistency across disciplines and uniform information to potential referrers. The newly developed referral form benefited from two key questions:

- What has triggered this referral?
- What do you hope St Nicholas Hospice Care can do?

It transpired that the adoption of criteria enhancing the end of life national incentives precluded referrals to our rehabilitation disciplines (OT, physiotherapy, psychology and social work); this anomaly will be addressed early next year with widening of referral criteria.

Admissions to the services have been reviewed and changes to practice include scheduling ward admissions to suit both staff and patients. Ward Registered Nurses now begin admission interviews without doctors present.

An **Early Assessment Clinic** commenced to enable ambulant patients to come to the hospice as an alternative to a home assessment to save CCNS and social work time whilst offering early introduction to the hospice building.

Feedback from the **Patient Survey** indicated that patients did not like the word 'assessment'; it felt intimidating to be invited to be 'assessed'. The Orchard Centre staff are working to develop the phrase, 'a getting to know you' meeting.

The majority of allied health professionals and nurses have attended either the National **Advanced Communication Skills** course or the St Nicholas Hospice adaptation resulting in staff confident and competent to thoroughly assess and undertake sensitive conversations.

Identification of patients' wishes has been a high priority with Orchard Day Therapy staff. They have observed patients having phenomenally in-depth conversations with each other; staff and volunteers creating the ambiance. Our audit of this practice highlighted our new, detailed, recording proforma designed to capture expressed wishes have not proved so successful and next year we will seek to determine why this should be. Madeline Bass, Head of Education lead the Suffolk-wide DNAR pilot in 2009: education will follow to spread understanding of practice across Suffolk in 2010.

Advice and 'sign-posting' A review of our established 'out of hours' advice line ensured cohesive practice between the CCNSs, ward nurses and doctors.

Multidisciplinary Team Meetings occur weekly within Orchard Day Therapy, the Community Hospice Team and Sylvan Ward. Next year we will establish systems whereby Orchard Centre clinics and group practice will report into MDTs. Decisions made are documented in the CHT MDT; the record will be forwarded to the GP in 2010 to increase sharing of information. On Sylvan Ward a review and planning meeting occurs on Monday to ensure plans from previous MDT are maintained in preparation for the next MDT.

Identification of the **family perspective** has been embedded in practice by our ward and Orchard managers. The ward staff have developed a 'flow chart' to highlight the key points during admission whereby the family will be offered the opportunity to ask questions/express

opinions. Orchard Centre staff consulted the Service User Forum to determine how best to ensure contact and support is made with family members; this practice will grow next year.

Anticipation of problems; **advanced care planning** The CCNSs work to an anticipatory model of care to minimise the need for a rapid response to emergency approach. Influencing decision making at **GSF meetings**, developing end of life drugs packs for home care are but two examples.

Flexible working – the principle of providing beds and home care to NHS Continuing Care through ‘spot purchased’ arrangements was established this year.

Community Hospice Team

This year the community team formally transformed from a nursing team to an interdisciplinary service. Case-management of complex end of life care was led by the Community Clinical Nurse Specialists (CCNSs). They concentrated on end of life interventions, influencing GSF meetings and supporting primary health care teams and care homes. Whilst the CCNS establishment reduced by 0.4 WTE we experienced:

- a 28% increase in SNHC patients discussed at GSF
- 71% of patients on CCNS caseload achieving their preferred place of death
- a 44% increase in CCNS referrals (from 491 to 708) which is idiosyncratic given the Triage post was established to ensure referrals were allocated across the services and disciplines, not just to CCNSs. The increase is likely to reflect the national impetus to facilitate more deaths at home.

CCNS work being enhanced by newly appointed nursing assistants giving ‘hands on care’

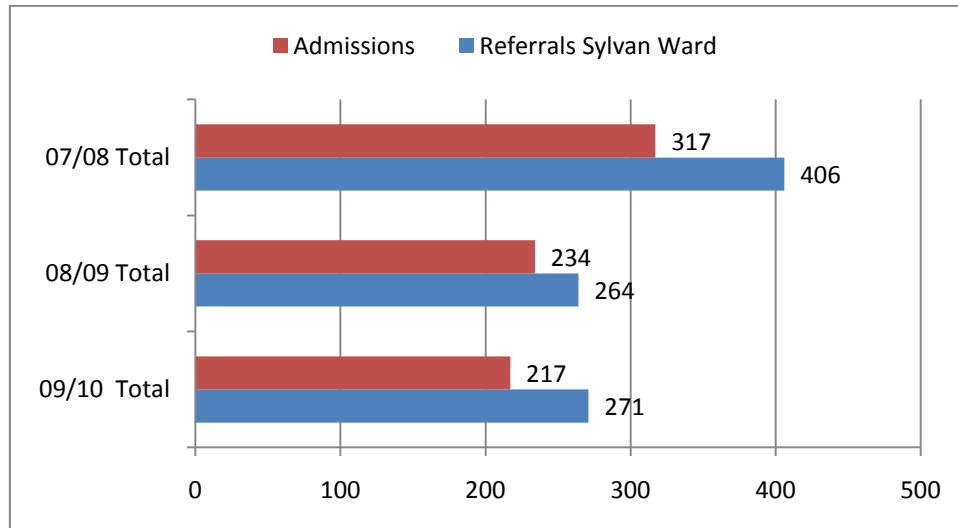
- a 14% increase in number of patients dying who were known to CCNS (307 increased to 350)
- 194 inappropriate admissions prevented by CHT nurses
- 23% less visits by CCNSs – change of practice to:
- influence via GSF
- increase telephone liaison¹
- delegate to nursing assistants

A CCNS commenced MSc level education and a NA started a Foundation Degree in end of life care. These learning opportunities are in line with the strategy of developing community practice

¹ The Family Support Team also recorded 48% of their contacts with patients/families were by telephone

Sylvan Ward

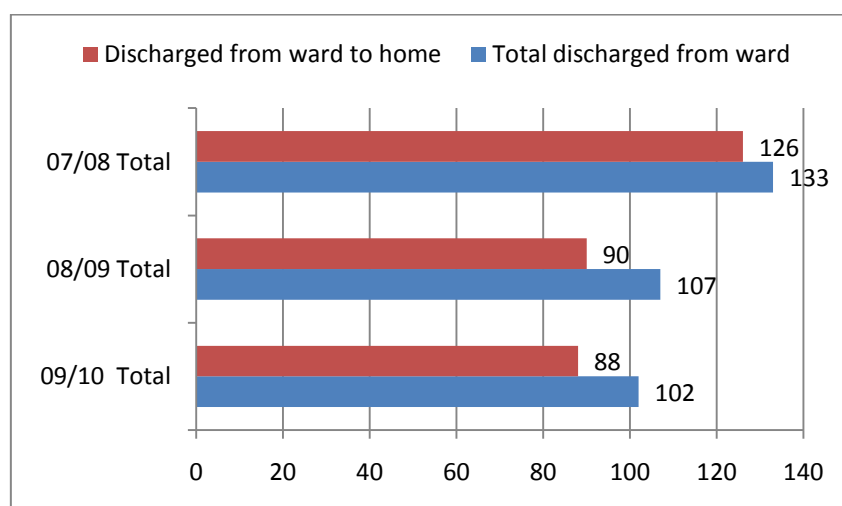
In May the bed capacity reduced from 12 to 8 with significant changes to nursing staff rostering. Both referrals to the ward and subsequent admissions have reduced over recent years as demonstrated in this chart below.



The hospice will monitor this reduction and explore if the reasons might be:

- the national agenda of enabling people to die at home being upheld in local practice
- the impact of the CHT strategy
- the reduction to 6 beds during refurbishment in 08/09 compounded with ward size of 8 beds during the recession influencing professionals concept of bed availability

Occupancy in 07/08 was 80%, this year it was 83% with average length of stay 9.5 days, in line with patients' choice to be at home most discharges were to home with only one to hospital in the year. The remainder were discharged to care homes.



114 (52.3%) patients died on the ward. With only 8 beds the clinicians admitted the most severely ill people. The principles of the Liverpool Care Pathway is integral to all end of life care.

Orchard Centre

The Orchard Centre hosts Day Therapy, out-patients for various disciplines and groupwork. Each service/individual reports to either the Head of Community Hospice Team, Head of Family Support or the Consultant in Palliative Medicine. These managers led meetings to provide integrated services using a matrix management model. The weekly business meetings were, fittingly, called the 'Crucible'; a space for creative problem solving and 'alchemy'!

The reorganisation of services caused by recessionary pressures had huge impact on the Centre;

- Day Therapy reduced from three to two days over 44 rather than 52 weeks.
- Rosetta Life artistic programme, Carers Group, Time for You and Gentleman's Tonic days ceased. A complementary therapist and physiotherapist resigned and were not replaced
- Early Assessment Clinic (EAC) – developed as a creative way of extending choice for both patients and carers referred to the service. The EAC helps shift the perception that needs assessments can only take place in the community or ward setting.

	2007 - 2008	2008 – 2009	2009 - 2010
Referrals	101	99	111
Attendances	837	756	582
Complementary Therapy sessions	619	743	680
Group attendances	48	130	42

Achievements:

- Staff engaged with service redesign
- Leaflets for patients designed
- Volunteer role under review
- 7 volunteer complementary therapists recruited and trained
- Redefinition of 'up stream'/'preparatory' supportive activity
- Redefinition of artistic partnership with Suffolk Community Education
- Preparations for 'wellbeing' service commenced
- Nursing team granted Foundation of Nursing Studies award to support practice review of 'preferred priorities of care practice' following year

Bereavement Services

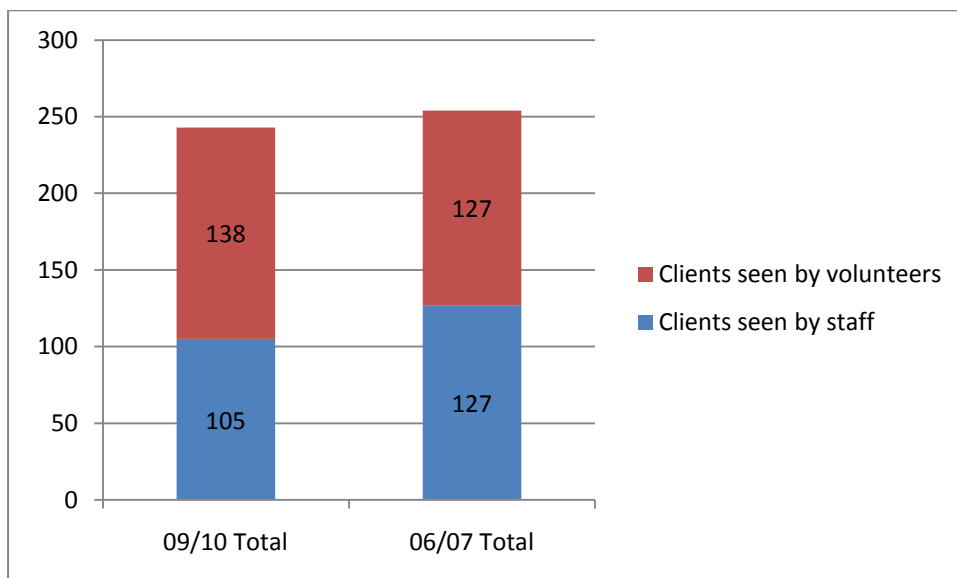
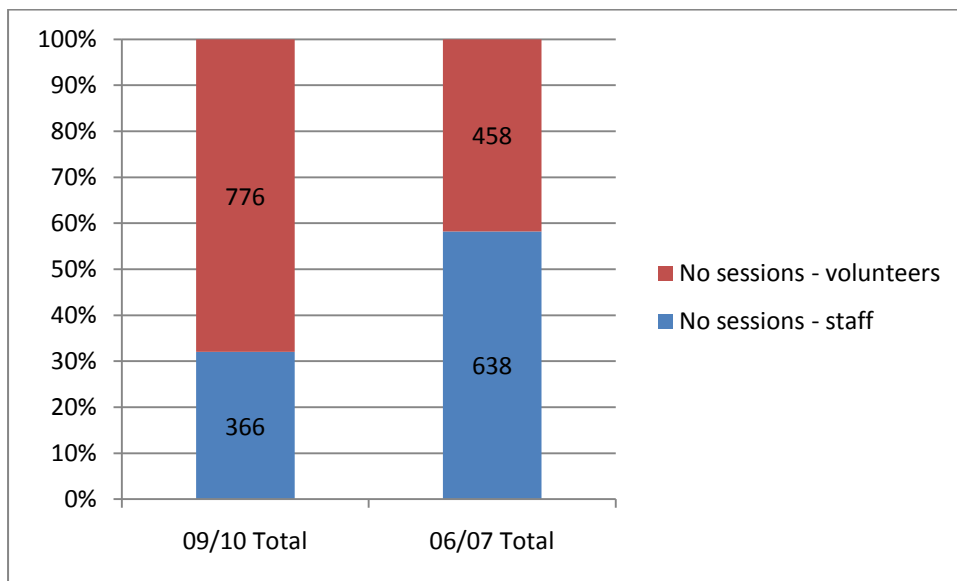
The Bereavement coordination by the Palliative Care Psychological Specialist was interrupted following the resignation of the post holder and the reappointment of a highly skilled therapist. Important work continued:

- Bereavement Needs Assessment (BNA): participation in national research programme – focus on new assessment tool, replacing outmoded 'risk' models with a

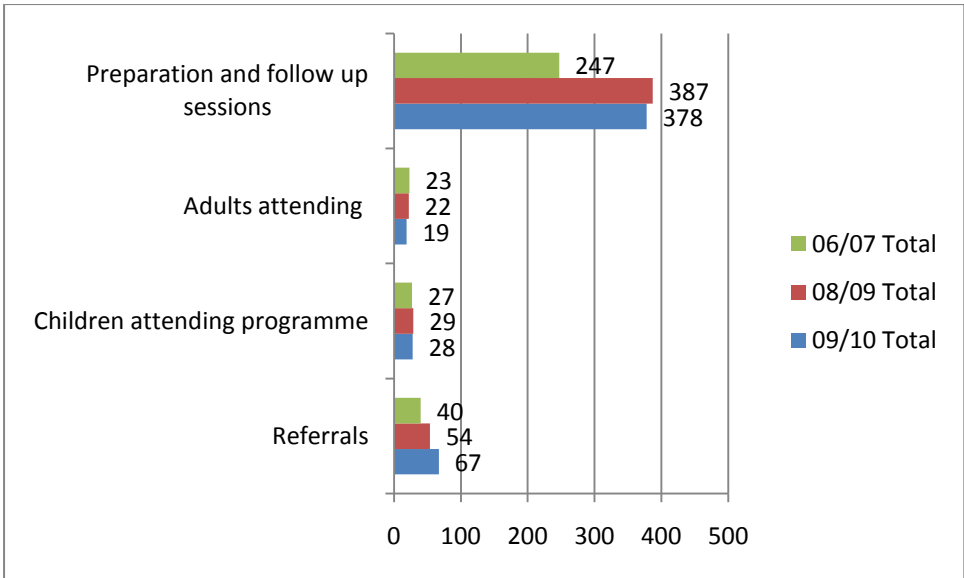
needs—orientated approach, based on a coherent psychological understanding of grief. Presented at the Help the Hospices conference; awaiting publication.

- Bereavement volunteers continue to hold higher caseload and undertake greater sessional activity for bereaved clients than staff as planned.

The figures below show the change since 2006/07

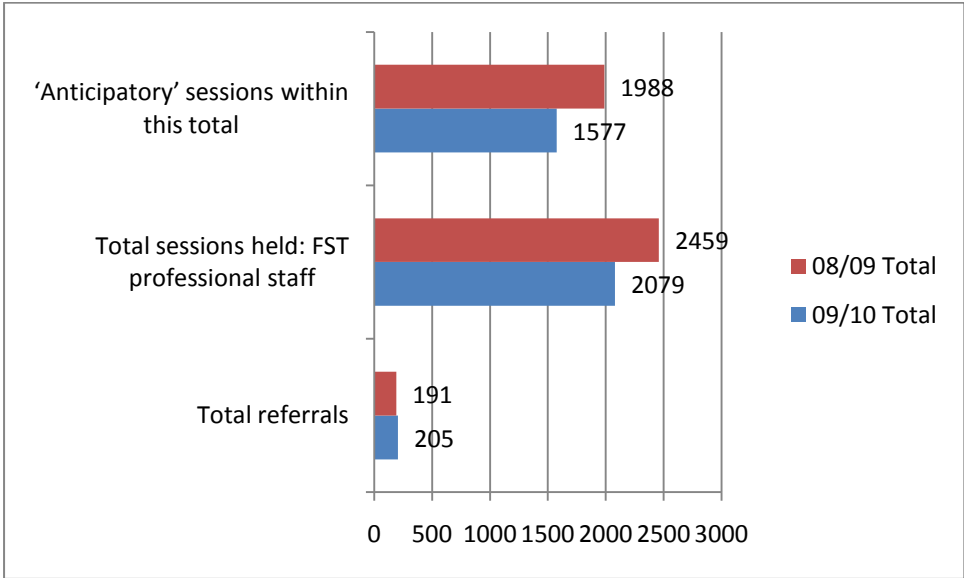


Nicky's Way Children's Bereavement Service has stable activity levels regarding the 6-week programmes for adults and children however the referrals and preparatory work is increasing (See details below). To meet this demand a sessional worker was appointed.



Family Support Team

The social workers and palliative care psychological specialist work across Sylvan, Orchard, CHT & Bereavement. The activity data below highlights their ‘anticipatory’ focus i.e. support before the death.



Professional development achievements include the Head of FST gaining his Cambridge (Clinical) Supervision Training Certificate enabling him to be the lead for supervision planning, evaluation and strategy. Our Psychological Palliative Care Specialist completed her PhD.

Medical Team

Two GPs have been appointed to the Hospice Physician (HP) role; Dr Kitchen, Consultant, has the challenge of coordinating 4 HPs, all of whom are part time or very part time. The first GP VTS doctor had long period of sick leave which impacted upon service provision. Dr Kitchen led in the revision of the Medicines Management Policy, associated guidelines and early development of Homely Remedies and Patient Group Directives. The latter will increase the scope of practice of the ward RNs

Occupational Therapy and Physiotherapy: the Rehabilitation Team

An OT student started as an OT volunteer

Review started regarding the teams contribution to CHT end of life care.

Headstart

Practitioners are exploring working in West Suffolk Hospital cancer unit on funded basis.

Chaplaincy

Strategy drafted - to develop community activity (only 10 domiciliary patient visits this year).

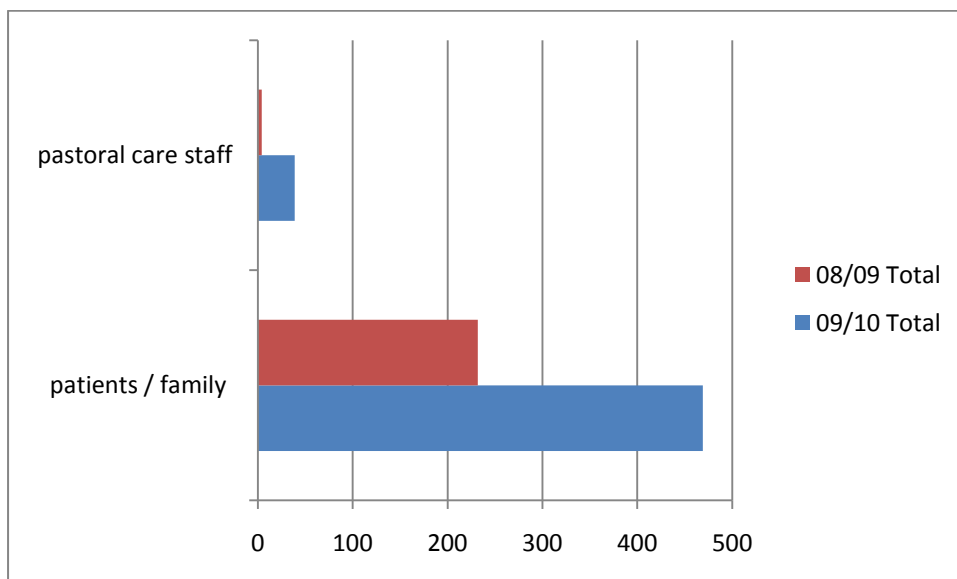
Revd. Charles Amoah recognising the importance of partnership work with community churches and faith organisations as well as direct patient care

Successful LUAL, raising more money than before and forging firm links with community church groups to support LUAL next year

Early plans completed to establish international link with Ghanaian palliative care service.

Training programmes for local clergy have resulted in offers of support for our hospice pastoral care activity.

The figure below highlights how the new chaplain is increasing support to both staff and patients and families

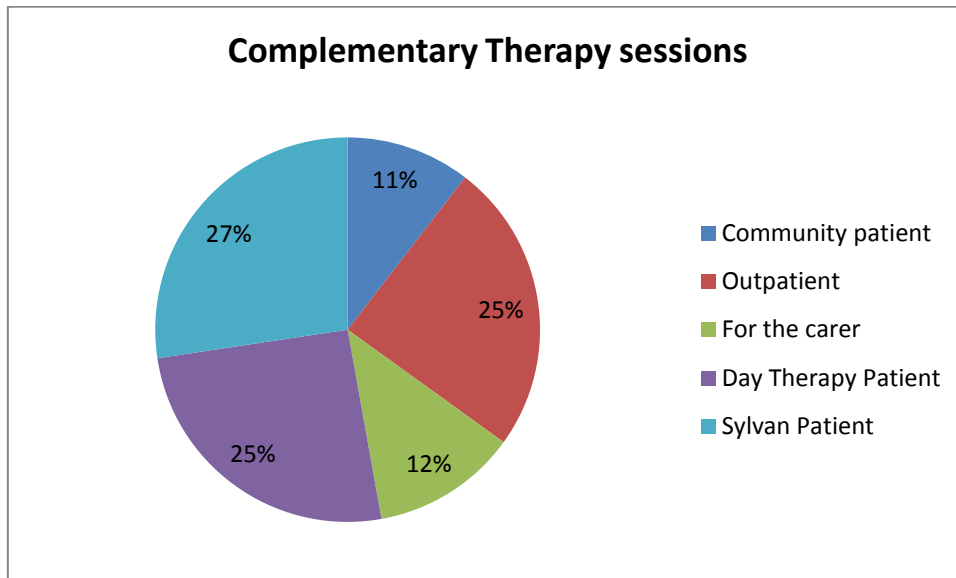


Complementary Therapy

The work reduced due to the resignation of the CHT therapist. The imbalance between community and within the Hospice building is evident in the pie chart below. Nevertheless 621 therapy sessions have been received

To sustain the practice 7 volunteer therapists have been recruited.

To support their practice guidelines have been updated and a thorough training programme started.



The Service User Forum

With sadness we acknowledge with gratitude the two key contributors to the Service User Forum who had to withdraw from active membership following marked deterioration in their health and subsequent death; our thoughts are with their families.

The Forum had a lead role in the review of service description leaflets, many of which are now completed.

Education

- Mandatory and statutory education have been redesigned
- Learning opportunities created beyond the 'classroom'
- Advance care planning in dementia care for local EMI unit project commenced
- Development of Assistant Practitioner role and Foundation Degree in Palliative Care (Help the Hospices and Foundation Degree Forward funded).
- First national conference, supported by Help the Hospices and the National Council for Palliative Care confirmed for June 2010.
- Income targets met in spite of recession.
- Teaching of student nurses and medical students; university based and ward placements
- Medical Student on elective
- Consultant and CNSs contributed to Cambridge Medical School education
- Joint work with University College Suffolk.

Staff presented at

- RCN international Education Conference: topic, Foundation Degree, Speaker Madeline Bass
- Help the Hospices Conference: topic, Bereavement Needs Analysis, Speaker Dave Rushton
- Help the Hospices Conference: Managing in a Recession, Speaker Barbara Gale
- NAPCE conference: DNAR pilot in Suffolk, Poster by Madeline Bass

Priorities for next year

Title	Details
New projects	Dept of Health funded Capital work Care Home initiatives Hospice Neighbours Scheme New IT systems
Increase volunteer support to clinical teams	Nursing support Administration support Data collection
Develop patient services	Open Sylvan to 10 beds Explore the potential for <ul style="list-style-type: none"> • Respite across departments • Using beds to meet different needs
Review clinical systems and practices	Triage, admissions and discharges Orchard services Early assessment clinic OOHs services & Telephone Advice Drug administration Patient documentation Advance care planning Integrated holistic assessments Family focused practices Agree referral pathway to Mental Health services for level 4 psychological/psychiatric work Work with schools to ensure bereavement work for children starts before the death
Staff developments	Develop career pathways, including the advanced practitioner role Appoint Lead Nurses to Sylvan Ward (currently staff on placement) Revisit nurse prescribing and advanced practice To explore staff rotation through Sylvan/Orchard/CHT Ensure maintenance of specialist competencies
Develop multidisciplinary practices	Ensure multidisciplinary input across all services Ensure all staff training is conducted across all services

Appendix A Progress against Clinical Operational Plan 2009 – 10

Aims	Objective	Status 1/4/2010
Giving specialist care	<p>Embed triage and first assessments</p> <p>Explore ways of generating income.</p> <p>Develop out of hours services</p> <p>Review and develop practice guidelines</p> <p>Ensure adequate 24/7 specialist practitioner cover</p> <p>Collate evidence for Peer Review, EOLC quality markers and agreed KPIs</p> <p>Increase use of volunteers in all departments</p>	<p>√ further work needed on ward</p> <p>√ Nicky Way, Big Lottery</p> <p>√ Review of advice line commenced</p> <p>√ see Annual Report Therapeutics Committee</p> <p>√ as 3 above</p> <p>√ Pal care data collection reviewed, Sylvan bed usage needs further work</p> <p>√ Complementary therapy, BV, Ward achieved</p>
Community Hospice Team	<p>Develop and evaluate a community interdisciplinary service delivery model (subject to funding)</p> <p>Demonstrate effectiveness - true impact on improving preferred place for care. Specifically provide fixed episodes of care, predominantly out of hours, by nursing assistants to patients who have an anticipated prognosis of less than 2 weeks</p> <p>Refocus FST work of assessment through community team.</p> <p>Embed medical input into community practice</p>	<p>√ Integrated service achieved and reports created for funders</p> <p>√ data presented in this document</p> <p>√ target achieved and then superceded with doubling of NA staffing following redeployment of ward NAs</p> <p>√ work commenced and ongoing</p> <p>√ work needed next year: focus has been ward medicine</p>
Orchard	<p>Improve attendance on patient and carer programmes</p>	<p>= managers recognise patient health status worse on referral hence our outcome targets need to change. Inappropriate to expect sick people to attend full series of sessions</p>
Sylvan	<p>Improving staff skills in line management and leadership on the ward</p> <p>Changing ways of working within the skill mix.</p>	<p>√ Ward sister appointed, two deputies on placement trialled, junior RNs given practice development roles</p> <p>√ all nurses and admin staff tasked to adopt new</p>

	Integrated admission to Sylvan ward	practices √ after slow start most RNs now confident – this needs to develop further
Enabling patients and families to live with illness and bereavement	Develop family assessment and befriender assessment. Develop partnerships with Adult services and Cruse. Develop community pastoral relationship with hospice. Review information for families	√ BNA and family focused established – need to evaluate impact √ defer one year following appointment of new lead √ achieved √75% achieved
Teaching and influencing other professionals	Increase education to Nursing Homes Attend train the trainers course to deliver more advanced communications skills courses Develop clinical pastoral care course. Increase income from courses Deliver foundation degree module in October for Untrained staff (with University of Northampton) Develop a foundation degree in palliative care for September 2010 for untrained staff with UCS	√ work started but no extra resources hence await GSF funding next year √ most nurses and AHPs attended √achieved with scope for further development √ hindered by recession √achieved √ contract established with UEA
Empowering communities to care for those affected	Marketing of hospice care, end of life care and raising awareness about advance planning	√ website improvements, Dying Matters and BBC documentary began this work

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http://www.opsi.gov.uk/acts/acts2008/pdf/ukpga_20080014_en.pdf

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Towards the Best Together: a clinical vision for our NHS now and for the next decade. NHS East of England. 2009.