Surrey Heartlands
HEALTH AND CARE PARTNERSHIP

SURREY COUNTY COUNCIL

NHS

Palliative & End of Life Care
Strategy 2021-2026

This strategy has been co-designed with input from a wide range of partners and voluntary organisations, taking into account the experiences and insight shared by individuals, relatives, carers and local people.

NHS Surrey Heartlands Clinical Commissioning Group

SURREY COUNTY COUNCIL

Princess Alice Hospice

THE BRIGITTE TRUST
SUPPORT FOR PEOPLE FACING LIFE THREATENING ILLNESS

Practice Plus Group

NHS Surrey and Sussex Healthcare NHS Trust

First Community Health and Care

NHS Surrey and Borders Partnership NHS Foundation Trust

Shooting Star Children's Hospices

NHS Epsom and St Helier University Hospitals NHS Trust

Phyllis Tuckwell Hospice Care
...because every day is precious

NHS Royal Surrey NHS Foundation Trust

Woking & Sam Beare Hospice and Wellbeing Care

Procare HEALTH

Children and Family Health Surrey

ST CATHERINE'S HOSPICE

South East Coast Ambulance Service NHS Foundation Trust

CSH Surrey

NHS Ashford and St. Peter's Hospitals NHS Foundation Trust

Primary Care Networks

Integrated Care Partnerships

Background

This strategy sets out the collective ambitions we want to achieve across Surrey Heartlands as an Integrated Care System to improve palliative and end of life care for our citizens.

In developing this strategy we have worked with organisations that provide palliative and end of life care, their staff, local voluntary organisations and other partners.

We have also considered previous research and sensitively carried out our own insight work with individuals who are receiving end of life care and their relatives - and their experiences have helped ensure individuals, their families and carers are at the centre of our plans to enhance end of life care.

It is now for Integrated Care Partnerships and local partners to work together to deliver these improvements for their local communities.

Ambition 1

Everyone is seen as an individual, with care tailored to meet their needs and wishes

"*We might go in and think their three main problems are nausea, pain and constipation but actually it's who's going to look after my cat when I die?" (Nurse consultant)*

What we are doing and our plans in this area

Advance care planning	We will continue to educate health and care staff on the role of advance care planning and in involving families and carers in these conversations. We will also continue roll out of the Surrey Care Record to share information.
Honest conversations	We will provide further training to ensure staff have the skills and confidence to have conversations about death with individuals and their families and carers.
Setting out clear expectations	We will do more to help individuals, families and carers understand what to expect, including launching a new website for carers with information and advice.
Equal access to bereavement support	We will review current access to bereavement services and address any barriers to ensure fair access for all.

Ambition 2

Everyone has equal access to palliative and end of life care

"…a lot of Black Asian and Minority Ethnic people want to care for their own at home or in a certain way and they think we can't accommodate that. I think that's certainly an area that needs to develop." (Nurse)

What we are doing and our plans in this area

Understanding where communities may not be accessing end of life care and any barriers that exist	We will address inequalities and any gaps in services and work with partners to overcome barriers.
Understanding place of death	We will monitor information to understand where people are dying and if people's preferences are being achieved.
Engaging with our communities and faith groups	We will continue to engage communities and faith groups, working with local Integrated Care Partnerships.
Using research and insight to enhance end of life care	We will continue to gain insight and work with colleagues to identify and spread best practice in end of life care.

Ambition 3 

People are made to feel comfortable and their wider wellbeing needs are met

“Focus on what we can do. We can give medication. We can support you. We can visit. We will spend more time.” (Consultant in Palliative Medicine)

What we are doing and our plans in this area

Measuring comfort and wellbeing	We will work with Integrated Care Partnerships to improve our quality monitoring and help us understand if comfort and wellbeing needs (including physical, psychological, emotional and social needs) are being met.
Symptom management	We will increase training and education in managing symptoms (particularly for non specialist staff) and also look at anticipatory prescribing to help manage symptoms.
Access to services and specialist support	We will work with Integrated Care Partnerships and providers to ensure people have access to advice and support 24/7 and that specialist palliative care assessments can be carried out when needed.

Ambition 4

Care is coordinated, with different services working together

“Part of the problem is that there are so many systems for information and communication and they don’t all marry up.” (Nurse for Supportive and Palliative Care)

What we are doing and our plans in this area

Introducing a shared record and other digital services	We will continue the roll out of the Surrey Care Record and explore other digital solutions to join up care.
Coordinating care through practices	We will work with Integrated Care Partnerships to understand how GP practices can best support end of life care.
Improving communication	We will work with providers to improve communication and make sure information is clear and informative.
Making sure care is coordinated for specific groups	We will improve coordination of care for children who transition into adult services, those living with dementia and people with learning disabilities.
Certification of death	We will streamline and improve this process for families, working with our council and digital colleagues.

Ambition 5

Staff have the skills and knowledge to provide the best care

“Some of those softer skills about actually dealing with families [who are bereaved]. I think that could be really improved.” (Pharmacy representative)

What we are doing and our plans in this area

Supporting our staff and carers	We will build on the education and training we provide to our staff and we will ensure staff and carers get the support they need.
Upskilling our general workforce	We will make sure our general workforce has the right training and feels equipped to provide high quality end of life care, linking in with specialist staff when they need to.
Developing specialist skills	We are looking at where more specialist roles may be needed. These need to be developed with local providers but could include specialist roles in end of life care for people with learning disabilities.

Ambition 6

Communities come together to provide help and support

“Talking about death and dying remains the biggest taboo in our society.” (Palliative Nurse Specialist)

What we are doing and our plans in this area

Building compassionate communities	Integrated Care Partnerships will work with partners, the voluntary sector and local communities to talk about end of life care and how we build compassionate communities.
Helping people to talk about death and dying	Together, we will take part in national awareness campaigns such as Dying Matters Week to get people thinking and talking about death earlier.
Starting conversations in schools	We will work with Surrey County Council to explore if there is more we can do to support teachers to start conversations with school age children.
Empowering local communities to provide support	We will work closely with our voluntary, community and faith sector partners to build on the volunteer networks that already exist, helping to provide practical support to people who need it.

Delivering this strategy

This strategy sets out our ambitious plans to improve palliative and end of life care across Surrey Heartlands.

Delivery of this strategy will need the commitment of all partners.

We will be working with our ICP colleagues to provide support and monitor progress to ensure these ambitions are realised for the benefit of our citizens.

We will monitor progress against specific outcomes through a range of methods including monitoring quality of care, data collection, surveys and feedback from individuals, families, carers and staff.

Monitoring our progress

Desired outcome	Individual and family outcome	System outcome	Metrics and evaluation
People die with dignity and their wishes are respected	Individuals can choose where they are cared for and die, and they die with dignity. Their wishes, and those of their loved ones, are met, wherever possible. Symptom control is effectively managed for the dying patient in all settings.	Increase in achievement of preferred place of care and death.	Upward trend in positive response to the question: 'Overall do you feel the person close to you died in the right place?' Feedback from individuals, families and carers (including surveys, complaints and compliments)
Care is provided in the community, wherever possible, and palliative and end of life care is available when people, families and carers need it	Trips to, and stays in, hospital are minimized for people at end of life, only happening when clinically necessary. Individuals, their families and carers have access to rapid advice and support, including out of hours or in a crisis situation, in the community.	More individuals are being supported in the community. The general workforce have access to specialist telephone advice and support when needed.	Downward trend in unplanned admissions to hospital in the last three months of life. Feedback from individuals, families and carers (including surveys, complaints and compliments)
Palliative care needs across all health conditions are identified early and support is provided	Palliative care needs are identified early on and a care offer is made from the start. Individuals are given the opportunity to plan ahead, and be involved in decisions about their care.	Timely identification of palliative care needs for all disease types, with appropriate support.	Evidence from general practice palliative care registers that all disease types are represented. Feedback from individuals, families and carers

Monitoring our progress (continued)

Desired outcome	Individual and family outcome	System outcome	Metrics and evaluation
Palliative and end of life care is coordinated	Individuals, their families and carers experience coordinated care, with clear and consistent information and different organisations coming together to seamlessly wrap care around the individual.	Partners are working together effectively to provide co-ordinated care. Continued expansion of advance care planning (ReSPECT, PACe etc) with effective solutions to share clinical records and care plans to enable the system to work efficiently.	Increase in the number of personalised care plans created Increase in the number of personalised care plans being reviewed and updated Evidence that digital solutions are in place to share clinical records and personalised care plans. Feedback from individuals, families and carers (including system-wide survey, complaints and compliments)
After someone has died families and carers are supported and the certification process is quick and easy so they can make arrangements swiftly if they wish to do so	The next of kin is offered bereavement support. They also experience a faster and easier death certification process so they can make the necessary arrangements.	The Medical Certificate of Cause of Death (MCCD) process is streamlined, leading to death certificates being issued more quickly.	Increase in achievement of death certificates being issued within 5 days of death (Surrey currently at 58%) Reduction in the number of certificates referred to the Coroner due to missing information Feedback from individuals, families and carers

Next steps

It is now for local Integrated Care Partnerships (ICPs) to work with other partners and the voluntary sector to make this vision a reality, putting local plans in place to deliver improvements, taking into account local needs.

It is for ICPs to determine the changes that are needed locally to deliver this strategy and agree realistic timescales for delivering these improvements for people living in Surrey Heartlands.

You can read our full
Palliative and End of Life Care Strategy
online at www.surreyheartlands.uk