Welcome to the sixth issue of Gloucestershire’s newsletter *End of Life Care*.

The purpose of this newsletter is to raise the profile of end of life care by informing you about local and national end of life care issues and developments, promoting the message that end of life care is *everyone’s business*.

Through the sharing of best practice, together we can achieve high quality care for patients and their carers.

In this issue:

- National and Regional Updates
- Updates on activity in Gloucestershire
  - County-wide use of Liverpool Care Pathway
  - Advanced Care Planning pilot in care homes
  - Exploring local involvement for improving end of life care
  - Communication by professionals about Continuing Health Care funding – carers perspectives
  - Progress in bereavement support
- Sharing excellence
  - Delivering palliative care on a rehabilitation ward
  - Launch of new Hospice at Home Service, Forest of Dean
- Courses, conferences and study days

To improve the quality of care at the end of life for all patients and enable more patients to live and die in the place of their choice.
Liverpool Care Pathway in the National Press

The LCP Central Team at the Marie Curie Palliative Care Institute (MCPCIL) has released a statement in response to the ongoing media coverage regarding care of the dying.

The Institute welcomes the recent engagement of the media regarding the care of the dying. It has highlighted the need for clarity and understanding in this complex area, and also the need to raise societal awareness of issues relating to care in the last hours/days of life.

To read the full statement go to the website www.mcpcil.org.uk.

NHS Gloucestershire is committed together with provider, voluntary and independent organisations, to improving end of life care for the patients and carers across Gloucestershire. This includes commitment to implement county-wide the Liverpool Care Pathway, which promotes high quality and equity of care for the dying and their relatives/carers.


End of Life Care Steering Group welcomes carer involvement

The EOLC Steering Group welcomed Barbara Marshall as carer representative. Barbara is Chair of Gloucestershire Local Involvement Network (LINk).

Future plans include raising public awareness and consulting the public on end of life care issues for Gloucestershire at LINk engagement events.

Local Involvement Networks (LINks) are networks of local people and organisations who support and promote the involvement of patients, service users, the public, and voluntary and community groups in the commissioning, provision and scrutiny of their local health and social care services. Links are independent of all statutory services and will help people to say what they think about local health and social care provision. There is one LINk for Gloucestershire.

Go to www.gloslink.org.uk for more information.

Contact gloslink@grcc.org.uk
Tel: 01452 528491

The EOLC Steering Group operates on a quarterly basis and is commissioning led. Membership aims to be representative of a wide variety of key stakeholders to provide the following:

- Equal engagement and collaborative partnership working
- Continued commitment to develop and deliver an EOL strategy for Gloucestershire
- Leadership and sponsorship
- Robust systems for evaluation and reporting
- Coordination and direction for effective cross-boundary working
- Establish and support sub-groups to ensure all associated work streams are fully implemented and sustainable

Membership includes leading representatives from a wide range of sectors at both commissioning and provider level: primary care, secondary care, social services, specialist palliative care, hospices and other charitable organisations, mental health and learning disabilities, clinical networks, ambulance, Out of Hours, service users, Higher Education Institutions, private and independent partners.

The importance of involvement from organisations and departments with specific disease areas is recognised and representatives will be invited to attend for specific agenda items. Circulation of minutes will be widespread.

The next Steering Group Meeting will be held on 7th December 2009.
End of Life Care in Gloucestershire

New Post: GP Lead for End of Life Care
Dr Simon Smith has been appointed as GP Lead for End of Life Care at NHS Gloucestershire.

I have recently been appointed as Clinical Champion for End of Life Care, Gloucestershire. I am thrilled to be joining such a dynamic team at such an exciting time. The EOLC Strategy provides a solid basis on which to develop local services and with it is bringing all important funding.

I trained at the Royal London and did my GP training in Southampton where I also worked at Countess Mountbatten Hospice. I spent 2 years as a Senior Lecturer in Medical Education and for the past 11 years have been a GP in Stoke. In addition I was a Clinical Specialist in Palliative Medicine for 10 years at Douglas McMillan Hospice. I did the Diploma in Palliative Medicine at Cardiff and taught Medical Students in this field at Keele University. I have recently started as a Full time GP in Gloucester and am looking forward to enabling the team to take the local EOLC strategy forward.

Dr Simon Smith
Contact: Simon.Smith@gp-l84606.nhs.uk

NHS South West
The Strategic Framework for the South West can be viewed on www.nhssouthwest.nhs.uk in ‘Publications’.

Gloucestershire will be represented at quarterly South West meetings to ensure progress is reported and updated appropriately, and that best practice is shared across the region to the benefit of patients and carers.

### EOLC Steering Group Membership

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
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<tr>
<td>Mary Morgan (Chair)</td>
<td>Commissioning Lead</td>
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<td>Karen English</td>
<td>EOLC Facilitator</td>
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<td>Gina King</td>
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<td>Helen Hodgson</td>
<td>Head of Community Service/CHC</td>
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<td>Tim Coupland</td>
<td>Mental Health &amp; Learning Disabilities</td>
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<td>Dr Simon Smith</td>
<td>GP Lead for EOLC</td>
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<td>Debra Clark / Jon Burford</td>
<td>Lead Nurse for Cancer GRHT</td>
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<tr>
<td>Janet Povey / Debra Clark</td>
<td>Clinical Nurse Manager Community SPC</td>
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<td>Dr Colette Reid</td>
<td>Palliative Medicine Consultant</td>
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<td>Dr Paul Perkins</td>
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<td>Dr Cath Blinman</td>
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<td>Dr Ian Donald</td>
<td>Consultant Physician (Medicine)</td>
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<td>Sian Cole</td>
<td>Head of Care Services, Cotswold Care Hospice</td>
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<td>Jane Hamilton</td>
<td>Clinical Nurse Manager Great Oaks Hospice</td>
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<td>Lorraine Dixon</td>
<td>Palliative Care Services Manager: Sue Ryder Care</td>
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<td>Jon Burford</td>
<td>Nurse Director 3 Counties Cancer Network</td>
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<td>Vicki O’Leary</td>
<td>Great Western Ambulance Service</td>
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<td>Barbara Marshall</td>
<td>Gloucestershire LINk</td>
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<td>Sue Dale</td>
<td>General Manager</td>
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Liverpool Care Pathway for the Dying (LCP) county-wide

HOSPITAL

The Liverpool Care Pathway (LCP) will replace the current Integrated Care Pathway (ICP) for the end of life, in the acute hospitals, to ensure one document is used county-wide. The community and community hospitals in Gloucestershire are already up and running with this document and it makes sense to have transferability between sectors with a streamlined approach that enhances good communication. This document also supports the requirements for the delivery of the End of Life Care Strategy in Gloucestershire.

There has been 4 training sessions at Sandford Education Centre and Redwood House where designated link nurses for wards at Cheltenham General and Gloucester Royal have been able to look at the paperwork, clarify and ask any questions. The aim is that the link nurses disseminate the information to their colleagues in their work area. The palliative care teams on both sites will provide ongoing support with the LCP and any end of life issues.

The LCP is due to be launched in November 2009 when the new documentation can be ordered and the current ICP paperwork destroyed, except for the syringe driver observation chart which has not changed.

If you have further questions please contact Helen Roberts, Clinical Nurse Specialist Palliative Care 08454 223447

Care Homes Pilot

Following a baseline review of documentation at 10 care homes across the county, the following care homes are now participating in a pilot to implement the LCP in their care homes:

- Brunswick House, Gloucester
- Cleeve Hill, Cheltenham
- Hazlehurst, Forest of Dean
- Moreton Hill, Stroud
- The Grange, Stroud
- Hyperion House, Cotswolds
- Mill House, Cotswolds

This is being supported by Maggie Martin, Care Home Education Project Nurse, the Care Home Support Team and EOLC Facilitators.

Contact Maggie Martin on 07824 837201 Maggie.martin@glos.nhs.uk

Community Steps

In collaboration with the Gloucestershire County Council Education Department, all Home Support Officers from the Community Steps Team will be trained to train their Home Support Workers in how to use the LCP within their role.

The aim is to improve multidisciplinary working between health and social care at the bedside and improve the skills and confidence of care workers in caring for dying patients and their families.

Training will take place during November and December.

Contact: pat.williams@glos.gov.uk or Karen/english@glos.nhs.uk

Further training

Sessions continue to be offered to a wider audience, including GPs, Social Care and Nursing Home staff in collaboration with the Palliative Care Consultants, Sue Ryder Care, Cotswold Care Hospice and Great Oaks.
If you would like to contribute to the newsletter in any way then please email either georgina.king@glos.nhs.uk or Karen.english@glos.nhs.uk.

Advanced Care Planning Pilot in Care Homes

As a further development alongside the GP Service Level Agreement pilot commissioned by the Stroud Practice Based Commissioning Cluster, for enhanced care for residents within Care Homes, an Advance Care Planning document is to be piloted in the following 5 Care Homes within the Stroud Locality:

1. Church Court, Stroud
   Lead Rita Poole
2. Horsfall House, Minchinhampton
   Lead Margaret Greaves
3. Moreton Hill, Stonehouse
   Lead Trish Pyne
4. Resthaven, Pitchcombe
   Lead Jane Roberts
5. The Hollies, Dursley
   Lead Jenny Martin

The documentation has been adapted from the National Preferred Priorities for Care and the Weston Hospice Advance Care documents. The Pilot Phase will commence on 19th October 2009 and run until 18th January 2010.

Each Care Home lead has received training on how to use the ACP and they will train their relevant teams in the pilot phase. This will also be supported by Maggie Martin, Care Home Education Project Nurse and the Care Home Support Team. They have been supplied with a resource pack in support of this.

Dr Sarah Atherton is GP Lead for the pilot who will feed back to the PBC.

Contact: Maggie.martin@glos.nhs.uk for further information.

Exploring local involvement for improving End of Life Care in Gloucestershire

A focus group to explore local involvement in End of Life Care was held on 15th July at Gloucestershire Young Carers Centre in Twigworth, Gloucester.

A range of services available to carers across Gloucestershire were invited to attend. Services were also at liberty to invite carers involved with these services. The group was well attended by 22 representatives of carers’ services. Whilst carers-in-person were in the minority, several of the professionals were also carers.

Service represented were:

- Alzheimer's Society
- Breathe Easy Group
- Careshare
- Cotswold Care
- Crossroads Caring for Carers
- CRUSE Bereavement
- Gloucestershire Care Services
- Respiratory Service
- Glos Children’s Community Nursing Team
- Glos Heart Failure Service
- Glos Hospitals NHS Foundation Trust
- Gloucestershire Local Involvement Network (LINK)
- Gloucestershire Young Carers
- Multiple Sclerosis (MS) Society
- NHS Gloucestershire
- Winston's Wish
Updates for Gloucestershire

Discussions identified 5 key areas for future planning and involvement:

(1) Information on End of Life Care
- **Access.** Improving accessibility to information will help carers and professionals to identify their needs and be clear about what to do next.
- **Timing.** Information needs to be given at the right time, the right place and in the right way. Make the most of opportunities.
- **Services.** Services need to be clear about what they can offer to carers, how and when to refer.
- **Clear, honest, practical.** Keep it simple.
- **Signposting.** Organisations need to work together to be able to help carers receive the most appropriate support and information. A Directory of Services may support this.

(2) Co-ordination of services
"You’re all doing the same thing, but it’s not joined up”

(3) Public awareness
- **Difficult conversations.** Talking about death and dying is still a social and cultural taboo. Carers and professionals need support to have those conversations so plans can be put in place for individuals and so the fear of death in our society is diminished.
- **Opportunities.** Schools, making wills, use of media stories and taking a family approach to EOLC were examples of how public awareness can be raised. Taking a family approach.

(4) Burden of caring
- **Realistic expectations.** “Carers should not have to care if they don’t want to”. Services need to include carers’ needs and expectations in plans and should not expect or assume a relative or neighbour to manage the care of the person at end of life.
- **Respite.** Carers need respite to go to support groups as well as to help them look after themselves and their families.
- **Choices.** Carers’ choices at end of life may differ from patients’.

(5) Involvement in End of Life Care work at NHS Gloucestershire
- **Feedback.** Carers are happy to be involved in consultations and relevant projects with the proviso that feedback is given in acknowledgement of involvement.
- **Informed choice.** Details of plans, services and projects need to be shared with carers at the earliest opportunity to ensure full involvement. Children should also be involved.
- **Opportunity.** Given the opportunity, carers can make a valuable contribution to local plans and services.

Work is already underway at NHS Gloucestershire and other NHS, voluntary and independent organisations to address these issues and this includes making sure services are effective (patients and carers get what they need) and provide value for money. However there were some innovative and practical suggestions offered at this Focus Group which can now be taken further to help make the changes carers need.

Representatives agreed to share the information with their own support groups, teams and organisations, make contact with others and finding more information on EOLC. At least half of those attending would like to

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continue to be involved in helping NHS Gloucestershire develop EOLC. Carers and professionals found the session informative.

This report was presented at the Gloucestershire End of Life Care Steering Group on 14th September 2009 and is now being used to help local organisations take future action.

Contact Karen.english@glos.nhs.uk

Consultation of Carers at Sue Ryder Care - Leckhampton Court Hospice: Communication by professionals about Continuing Health Care funding

In May 2009, the Carers Support Group discussed and fed back their views of the Continuing Health Care Funding (CHC) Process Map, which had been drawn up by the Hospice Multi disciplinary team (MDT). One of the seven carers had recent experience of a CHC assessment while the rest of the group had never heard of CHC funding.

We explained to the carers that the MDT staff had drafted this pathway in response to the challenge to balance the need to inform patients when they may be eligible for CHC funding with the need for sensitivity because of the implications for peoples awareness of their terminal prognosis. The carers had an animated and enthusiastic discussion about communication by staff, during which the following points were made:

- They would appreciate honesty. They thought they might be able to take things in better if information about short prognosis is not left too late.
- They very much felt that carers as well as patients need to be kept up to date, ‘if they can take it’. Information should be given on a ‘need to know’ basis and carers need to know!
- They felt that by having the information earlier, the carer (as well as the patient) can be more prepared, and have more peace of mind before the terminal stage.
- If the patient is in the last few days of life, the carers agreed with the pathway that the family need this information even more if the patient is too ill to take it in himself.
- Carers did not want senior doctors (particularly thinking about in hospital) to ‘leave’ sensitive conversations to juniors who might be less well informed.
- Carers would like doctors in hospital to be more available to carers if they have questions.
- They would like staff to treat each patient / carer individually and be sensitive in how they give information about short prognosis, as they were very concerned that it might come as a shock.

The carers are now planning to draft a short user-friendly leaflet to inform other carers and encourage them to be involved in end of life care discussions.

Felicity Hearn
Head of Family Support. Sue Ryder Care, Leckhampton Court Hospice
Tel: 01242 230199

To improve the quality of care at the end of life for all patients and enable more patients to live and die in the place of their choice.
Great Oaks launched a new Hospice at Home Service on Saturday 10th October, World Palliative Care and Hospice Day. This coincided with the official opening of the Day Hospice’s new Labyrinth and an open afternoon. It was well attended.

Julie Wood, Nurse Co-coordinator for Hospice at Home said “The balloon launch of 150 or so balloons with names written on in memory of loved ones was a wonderful sight!

A small boy next to me stood in wonder and said ‘oh look – they’re all leaving us’

The Great Oaks Hospice at Home service in partnership with Gloucestershire Care Services will develop a quality holistic palliative nursing care service. It will aim to enable patients to stay at home, either in the final terminal phase of their illness or at times of specific need/crisis. We hope to be complimented early next year with the introduction of our Outreach Team which will provide additional support such as complementary and diversional therapies. Bereavement & Family support is already available from the hospice.

The most logical starting point for this project was to develop a vision statement. Once it was decided what the service was going to offer, where and to whom, a framework was made around which to shape the service.

Time was spent by the Nurse Coordinator visiting other Hospice @ Home, voluntary and social services around and beyond the county, keen not to either ‘re-invent the wheel’ or fall down familiar potholes. It soon became apparent that there is no ‘one size fits all’ model for Hospice at Home services. It is something that very much is influenced by local need and current support services.

The service consists of a small team of palliative care nurses (both Healthcare assistants and Registered Nurses), employed by Glos Care Services. The Nurse Coordinator acts as a ‘one stop shop’ for healthcare professionals requesting night or day care, working closely with District Nurses, Marie Curie, Social Services and Purchasing to provide as seamless a service as possible.

Hospice at Home is not intended as a replacement to the many other services available within The Forest, both statutory and Voluntary, but as a compliment to them, filling gaps and proving unmet current need.

It is hoped that as Hospice at Home is used, it will continue to grow and develop into an excellent resource for our local community.

Julie Wood, Nurse Coordinator, Hospice at Home, Great Oaks, Coleford, Glos GL16 8QE
Tel 01594 811910

To improve the quality of care at the end of life for all patients and enable more patients to live and die in the place of their choice.
Progress in Bereavement Support

A working group has been set up to address level 1 bereavement support given by community nurses that would support the Liverpool Care Pathway Care After Death section and create a bereavement protocol or guidelines that would promote standardisation of care and information rather be dependent on individual practitioners’ practices.

A local bereavement leaflet, developed by BIGG in collaboration with CRUSE is in the final stages of development and will be published shortly.

For further information contact gina.king@glos.nhs.uk

Summary of Local Service Updates

Ogether Trust

A multi-agency meeting was held to discuss EOLC in Mental Health and Learning Disabilities. An action plan was generated to include:

- Training and Education (identifying a Lead and champions, links to generic EOLC training, identify roles and responsibilities, care pathway approaches)
- Critical Incidents (learning from live issues and problems)
- Service User Involvement (Focus Group)

Progress will be discussed in 6 months time.

Gloucester Royal Hospital Foundation Trust

The Acute Trust has an EOLC Steering Group led by Dr Janet Ropner (Assistant Medical Director). 5 working groups are currently operating focusing on specific areas:

- Advanced Care Planning in the acute setting
- Diagnosing dying
- Discharge home to die
- Bereavement Care
- Last Days of Life

Outcomes of these groups will be reported following internal piloting.

NHS Gloucestershire Care Services

The scoping of locality working for EOLC will be complete by Jan 2010.

Work continues relating to Continuing Health Care and streamlining an EOL pathway.

There is now a general manager Lead for Transport Services.

New documentation (FACE) for District Nurses is being implemented from September. This should improve consistent record-keeping and had been developed from the former common assessment framework. This will be the first documentation to include documentation of the patient’s preferred place of death.

Kate’s Home Nursing

Activity has doubled, the role of the service widening to include caring for patients over a longer trajectory. There have also been more recent appointments to the staff Bank.
Community Hospitals
The LCP is now in use in Community Hospitals. The Matrons were pleased to receive clinical support offered by Dr Paul Perkins.

Community Specialist Palliative Care
The Survivorship project which will be going live in September 2009. This project involves supporting Cancer survivors in life beyond discharge from clinical care. Village Agents are also available in some areas of Gloucestershire and have received extra training to support them in their role.

Cotswold Care Hospice
Education at Cotswold Hospice is busy. Hospice at home service is also increasing in activity and had now extended its service to Gloucester City areas.

Sue Ryder Care
Locality working groups are focusing on areas such as Continuing Health Care, Respite, Hospice at Home and other voluntary services. SRC is updating its documentation, including the uptake of the Liverpool Care Pathway in inpatient and Hospice at Home Services. A Carers Group is also ongoing.

Gloucestershire County Council
GCC have an action in the Carers’ Strategy to link to the End of Life Care Strategy work. A representative from the Carers Team at GCC will also attend the EOLC Steering Group. The national Carers Strategy link is http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_085345. Contact Louise West, Carers Planning, Policy and Projects Officer Tel: 01452 426502 Email: louise.west@gloucestershire.gov.uk

Useful Links
www.endoflifecareforadults.nhs.uk
www.goldstandardsframework.nhs.uk
www.lcp-mariecurie.org.uk
www.cancerlancashire.org.uk/ppc
www.ncpc.org.uk
www.doh.gov.uk
www.nice.org.uk/
www.carers.org/
www.the3ccancernet.org.uk
www.palliativedrugs.com/

Specialist Palliative Care Out of Hours Advice for Professionals
5pm-9pm Monday to Friday
24 hours cover at weekends and bank holidays
PAGER: 07659 119458

Share your ideas and initiatives for improving End of Life Care in Gloucestershire.

This newsletter is an ideal resource to share such developments and spread best practice.

If you would like to share your local progress then please contact either Karen or Gina on Karen.english@glos.nhs.uk or georgina.king@glos.nhs.uk
To improve the quality of care at the end of life for all patients and enable more patients to live and die in the place of their choice.

Become a Bereavement Volunteer – your county needs you!

Most people cope perfectly well with the death of a friend or relative with the support of family, friends and neighbours, but others really need the chance to talk through their grief with someone who can offer empathy and a good listening ear.

Bereavement volunteers can’t make the problem go away but they can, for a critical period, stay alongside the bereaved person, offering support. Most of us have experienced our own losses and we know something of the journey ahead.

Have you ever thought of using your own life experience to enable you to give help to others?

Cruse Bereavement Care has an office in Cheltenham as the focus for its work in Gloucestershire. We are part on a national organisation whose mission is to: “...promote the well-being of bereaved people and to enable anyone suffering from bereavement ... to understand their grief and cope with their loss.”

We are keen to increase our number of volunteers so that we can more thoroughly cover all parts of the county and all sectors of the community. All are welcome, but helpers from rural areas or minority communities would be particularly welcome.

You don’t need previous qualifications, full training is provided and, when you start to practise, there is professional supervision.

If this seems like something you feel you’d like to do then please phone: 01242 252 518; or drop in or write to: Cruse Bereavement Care, Lower Ground Floor, 31 St. George’s Road Cheltenham GL50 3DU, open 10.00am to 12.30pm, Monday to Friday.
Isn’t the emphasis on getting people better, moving around and even sometimes a bit like boot camp? You know - up out of bed in the mornings, out the bathrooms to wash, nurses prompting but not “doing” the care? Surely the palliative patient cannot do that, so will they get the support and time they need, whether it’s for symptom control or last days of life?

No one can fully understand the feelings and needs of the relatives of the dying patient; we can only ensure we are ready to face any challenge that is put to us. The patient may be frightened, in pain, losing control of their situation, and is brought into a hospital setting which however hard we try is not their home.

The patients with their family are brought through the ward which can appear busy, with the normal hustle and bustle of any clinical environment, and settled into their room. This is where the busy, frantic ward disappears. The patient and family are in their “new” home area. It’s theirs to use for the journey ahead. Whether for a quick symptom adjustment or to end their days the staff stands back and it’s now their control.

We discuss with them that we are guests in a situation; we will assist as needed but will not take control. Who worries and who are we to judge if the family and patient sit with chips, a tot of whiskey or in absolute silence. Only by giving them the opportunity to use the room, us and the time as they need will they be able to feel in control of the situation.

We have seen it all, champagne on the mouth care sticks, Chinese meals, children lying next to mum on the bed, who cares if it’s not the ‘done’ thing?

But how can we change from rehab to palliative care? The skill of the nurse is paramount to be able to judge how to approach the situation and to be able to change his or her approach. They may need to take a potentially lengthy time to teach a new stroke patient how to put on his cardigan but the hazard is thinking that this is more important than sitting with the relative as they need to just hold your hand.

We don’t ever seem to have that issue, using the multidisciplinary team we find it relatively easy to ensure we utilise people for the different needs of all our patients. The benefit of being on the rehab ward ensures we have the people readily available for assistance, such as assisting coughing, positioning, and all the aspects to promote comfort. The team are there if the patient wishes to
Sharing excellence in EOLC in Gloucestershire
delivering palliative care on a rehab ward, can it be done?

To improve the quality of care at the end of life for all patients and enable more patients to live and die in the place of their choice.

go home for the last hours of life, - it is amazing how quickly a situation can be turned around with no “no transport is available” or “the bed will be delivered tomorrow” barriers actually being easily surmountable. The patient and relatives know that we can do whatever they need. How? Because we ensure they lead us in the plan. As teams we can advise, support and assist but the plan of dying is for the patients and relatives.

One aspect which has had a major impact is the implementation of the Liverpool Care Pathway (LCP). It has helped the staff give a clear explanation of what is going to happen. How many times do we hear, “he is deteriorating” or “he isn’t responding to treatment” but not very often is it said so clearly “he is dying”.

Of course the LCP isn’t just handed to the relatives or patient like a book. The majority of the communication with the patient and family has been going on even before they are admitted to hospital. But this tool has had an effect of ensuring everyone understands the stage of their condition the patient is now in. Who understands what? Where do you want to be? Do you understand that medical management is going to a supportive stage? Using the tool gives a clear explanation of the plan. It ensures we have discussed those difficult questions.

The medical team have embraced the tool, the nurses feel empowered to discuss all care with the patient and relatives, gone are the problems of different people having different goals and expectations. We can discuss with the patient and relatives the care which will be delivered.

It is measureable, relevant and incorporates the spiritual needs of the patient and relatives. It prompts the staff to check are we still doing the right thing? Do we need to change our approach? Do the patient and relatives still understand that death will occur soon?

Even on our hectic busy rehab ward this tool is used very effectively, it is discussed an early stage in the MD team meetings and activated it as soon as needed.

The relatives have given positive feedback as they had ownership of the dying process; we were guests in their private situation. We can be invited into their grief and by using the tool we ensure we continue a high standard of care. We are there whenever they need us but will not be doing invasive unnecessary nursing tasks (if I am dying please don’t turn me 2 hourly!) but will be checking their loved one regularly.

We will be remembered when we get it right but never forgotten of we get it wrong.

Karen Fawcett
Ward Sister, Coln Ward, Cirencester Hospital
Karen.fawcett@glos.nhs.uk
Conferences, courses and study days

End of Life Care Conference

“One chance to get it right” - Working together towards excellence for everyone in End of Life Care

Thursday 4th February 2010
The Cheltenham Chase Hotel, Gloucestershire

A conference for everyone involved in end of life care in Gloucestershire, including health and social care acute and community services, voluntary and independent services, service users and carers.

An opportunity to work together to share best practice and contribute to the progress being made across Gloucestershire in improving End of Life Care.

National Speakers
Claire Henry
National Programme Director
National End of Life Care Programme
Debra Murphy
National Lead Nurse LCP
Associate Director
Marie Curie Palliative Care Institute, Liverpool
Dr Colin Murray Parkes
Consultant Psychiatrist Emeritus
St Christopher’s Hospice, Sydenham

Prof Allan Kellehear
Professor of Sociology,
University of Bath
Barbara Pointen
Carer

For more information and to book contact:
Sam Green on
samantha.green2@glos.nhs.uk
Tel: 08454221732
Cost: Free (*conditions apply)
Book now! Places are limited!
Spiritual Care and the Older Person
24th October 2008
Redwood Education Centre
Gloucestershire Royal Hospital
Mark.Read@glos.nhs.uk
Tel: 08454 226200 Cost £15

National Council of Palliative Care’s forthcoming conferences:
http://www.ncpc.org.uk/events/asktheexperts.html

“A breath of fresh air”
Implementing the EOLC Strategy for Respiratory Diseases
18th November 2008
The Hellenic Centre, London
Email: m.rana@ncpc.org.uk
events@kingsfund.org.uk

6th National Liverpool Care Pathway Conference
“Care of the Dying: Time to make a Difference”
25th November 2009
The Royal Society of Medicine, London
www.rsm.ac.uk/palliative

RCN End of Life Care Roadshow
RCN HQ, 20 Cavendish Square, London
19 Nov 2009 10:00 to 16:00
Contact: Suzanne Sinclair
suzanne.sinclair@rcn.org.uk
020 7647 3581

World COPD Day
19th November 2008
University of Gloucestershire
Oxtalls Campus
FREE! Booking required
Kathy.cambell@glos.nhs.uk

Living with Grief
Learning 2 Cope is a seven week programme aimed at those who have experienced the death of a loved one.
We are currently setting up support groups in Gloucestershire and would like to hear from anyone who feels that they or someone they know would benefit from attending.
To find out more or book a place, please contact
Barbara Piranty or Vicki Hewlett at GRCC on 01452 528491

Learning 2 Cope is a seven week programme aimed at those who have experienced the death of a loved one.
We are looking into running a group tailored especially for men, using a specially-trained male facilitator.
If you think you or someone you know may benefit from attending please contact
Barbara Piranty or Vicki Hewlett at GRCC on 01452 528491
“Call for contributions – Case Studies, Letters, Question and Answers, New Posts”? If you would like to submit an entry for the next issue of the newsletter, please contact Gina King mobile: 07990 803221 or georgina.king@glos.nhs.uk and Karen English mobile: 07990 802047 or Karen.english@glos.nhs.uk