



End of Life Care Policy

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1 Introduction and Policy Statement

- 1.1. South East Coast Ambulance (SECAmb) Service NHS Foundation Trust's (the Trust) has recognised that its staff are increasingly involved in caring for, treating or transferring patients who are naturally approaching the End of Life as the result of terminal disease, long term conditions or multi-morbidity.
- 1.2. The Trust is committed to providing the best care to this complex group of patients by working within the wider health care system, to aim for a one system approach and by supporting its clinicians to manage these patients to achieve their goals of care, which may differ to the acute treatment pathways.
- 1.3. 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.
- 1.4. Patients may be experiencing a wide variety of conditions within their End of Life phase. Historically, end of life care services have catered mainly for cancer sufferers but now it is recognised that EoLC services are needed for patients who experience a range of long term conditions, such as dementia, frailty or organ failure. It also includes children and young people with a terminal or life limiting illness.
- 1.5. The Ambitions for Palliative and End of Life Care 2021-2025 (National Palliative and End of Life Care Partnership, 2015), set out a national framework for local action around improving EOLC services. This is through identifying key ambitions and the building blocks needed to complete this:
 - Ambition 1 – Each person is seen as an individual
 - Ambition 2 – Each person gets fair access to care
 - Ambition 3 – Maximising comfort and wellbeing
 - Ambition 4 – Care is co-ordinated
 - Ambition 5 – All staff are prepared to care
 - Ambition 6 – Each community is prepared to help

2 Policy Statement

- 2.1. The intention of this policy is to evidence the Trust's commitment to ensuring that it delivers high quality patient care to a complex group of patients' who we are increasingly called on to care for and who often require care different to the traditional ambulance model.
- 2.2. The Trust will treat all patients with dignity and respect. The importance of this is shown within the 'six C's' and also within The Trust values.

- 2.3. The Trust aims to support patients, their families and care providers in experiencing a 'good' death, that meets the diverse needs of the population. Allowing people to die with dignity. This includes children and young people with a terminal or life limiting illness
- 2.4. All patients have a right to decide on their preferred place of death (PPOD) and preferred place of care (PPOC). This may be recorded in an advance care plan.
- 2.5. All patients (and their families) who access the ambulance service who are at the end of their life will receive treatment and support in line with their wishes to ensure the alleviation of pain and suffering to the best of our ability.
- 2.6. This policy has been introduced in order to provide a framework of procedures which will support clinicians working for the Trust in their decision-making so that they can work in the best interests of patients. The policy will apply to all within the Trust and sets out the way in which we strive to achieve good quality care for those approaching the end of life.
- 2.7. The management of risk and evidencing of a governance-led approach to how the Trust plans and delivers care is vital. The Trust is committed to ensuring that this is always paramount.
- 2.8. The Trust believes in fairness and equality, and values diversity in its role as both a provider of services and as an employer. The Trust aims to provide accessible services, that respect the needs of each individual and exclude no-one. It is committed to comply with the Human Rights Act and to meeting the Equality Act 2010, which identifies the following nine protected characteristics: age, disability, race, religion and belief, gender reassignment, sexual orientation, sex, marriage and civil partnership and pregnancy and maternity.
- 2.9. Best practice within palliative and end of life care, is to seek a collaborative decision-making process when deciding a patient should receive palliative or end of life care. SECamb clinicians must ensure they follow the same process through all channels available (e.g. clinical call back, GP, local hospice, frailty service).
- 2.10. The Trust will support staff to make collaborative clinical decisions. Making shared care records available, where possible, working in partnership with wider NHS and charity system partners.
- 2.11. This policy does not, and will not, support negligent practice.
- 2.12. Staff are responsible for familiarising themselves with the documents which inform safe practice, professional standards and capability.

3 Statement of Aims and Objectives

3.1. Aims

- 3.2. To provide a framework in which clinicians can effectively manage patients approaching the end of life.
- 3.3. To be an overarching policy for staff to be directed to more detailed policies/procedures.
- 3.4. To promote the Trust as a provider, capable of managing emergency and urgent care.
- 3.5. To empower staff to make the correct decision about ongoing care for the patient.

3.6. Objectives

- 3.7. To recognise that those approaching the end of life may have preferences for their treatment and care goals, which differ from the standard approach for acute treatment. This may mean supporting patients to remain in their preferred residence of care and facilitating discharge back to specialist community teams where appropriate.
- 3.8. To ensure that the Trust meets its legal obligations.
- 3.9. To ensure staff follow the appropriate scope of practice and maintain high standards of clinical care.
- 3.10. To ensure that the Trust achieves its strategic objectives, specifically:
 - 3.10.1. to deliver high-quality and appropriate care based on transparent and fair rules with decisions devolved closer to patients;
 - 3.10.2. to provide care in the right setting;
 - 3.10.3. to improve clinical outcomes, quality of care, safety and governance;
 - 3.10.4. to demonstrate that appropriate intervention supports an individual's well-being;
 - 3.10.5. to reduce health inequalities across the dependent population;
 - 3.10.6. to ensure that services are delivered in the most efficient way possible;
 - 3.10.7. to deliver a timely, convenient and responsive access to care including preventative interventions and diagnostics.

4 Support to Trust Clinical Staff

- 4.1. To promote a culture within the Trust of supporting staff to make holistic and collaborative decisions with patients and their families. Ensuring that staff feel confident and supported.
- 4.2. For operational staff when seeking to share a decision, this can be undertaken through the Paramedic Practitioner (PP) led urgent care hub by requesting a clinical call back through your local dispatcher. Alternative agencies such as that of the patient's own GP, local hospice, frailty service or hospital based care team may also be an appropriate consideration. In addition, a local 'single point of contact' service may also be the most appropriate.

5 Principles

- 5.1. This policy will seek to meet the aims set out, through providing a framework within clinical procedures, in which clinicians are guided to provide high quality care for patients approaching the end of life.

5.2. Procedures

- 5.2.1. Advance Care Planning Documentation Procedure
- 5.2.2. Symptom Control of Patients at the End of Life Procedure
- 5.2.3. Adult Death Procedure
- 5.2.4. Child Death Procedure

6 Definitions

- 6.1. End of life – This term is used to describe patients in the last year of life.
- 6.2. Palliative care – Care given where the aim is not curative. It is a multi-disciplinary approach to specialised medical & nursing care for people with life-limiting illness.
- 6.3. Care of the dying adult/child – Care within the last days, hours or minutes of life.
- 6.4. DNACPR – Do Not Attempt Cardio-Pulmonary Resuscitation
- 6.5. ADRT – Advance Decision to Refuse Treatment
- 6.6. ACP – Advance Care Plan
- 6.7. ReSPECT – Recommended Summary Plan for Emergency Care and Treatment
- 6.8. TEP – Treatment Escalation Plan

- 6.9. PPOC – Preferred Place of Care
- 6.10. PPOD- Preferred Place of Death

7 Responsibilities

- 7.1. The **Chief Executive Officer** has ultimate responsibility for ensuring the effective management of patients approaching the end of life attended to by SECAMB.
- 7.2. The **Executive Medical Director** has executive responsibility for the care provided to those at the end of life.
- 7.3. The **Executive Director of Operations (DOO)**, through delegation by the CEO, has overall responsibility for the implementation, operation and local assurance of this procedure. The DOO also has overall responsibility for holding his/her staff to account for any deviation from this procedure.
- 7.4. The **Consultant Paramedic** is responsible for overseeing the policy on a day-to-day basis.
- 7.5. The **End of Life Care (EoLC) Lead** works within the clinical development team and has the responsibility for ensuring the policy is upheld by supporting leaders within their team, managers supporting staff and individual clinicians.
- 7.6. The **Executive Director of Operations** is responsible for ensuring that staff work in accordance with this policy.
- 7.7. Managers must make documentation available to staff using the systems available (such as team briefing folders) and review staff understanding of key document through the PADR process.

8 Competence

- 8.1. All staff in clinical roles has defined levels of training and education in order to practice at grades with a variety of abilities and rights to use alternative pathways.
- 8.2. Considering that End of Life Care Education has not been standardised even within professional roles clinicians are expected to work within the scope which they are professionally competent.

- 8.3. The Scope of Practice & Clinical Standards Policy defines the competency and referral rights for all staff employed by the Trust in clinical roles.

9 Monitoring

- 9.1. This policy will be monitored by the **Clinical Governance Working Group** or **appropriately delegated committee**. This will be achieved by quarterly reports from the **End of Life Care Lead**, supported by the **Consultant Paramedic/Head of Clinical Development** containing incidence of practice outside the definitions laid out in this document.
- 9.2. The **End of Life Care Lead** supported by the **Consultant Paramedic Team** will be responsible for ensuring adherence to the policy by reviewing internal reporting systems (i.e. risk registers).
- 9.3. Any non-compliance or deviation from this policy that results in an adverse outcome for a patient will be dealt with in accordance with the Incident Reporting Procedure. Staff will be guided and supported through a learning process.
- 9.4. All staff and managers are responsible for reporting incidences of practice operating outside the definitions laid out in this document.
- 9.5. Reporting will be done through the usual Trust systems of incident reporting, such as:
- 9.5.1. Patient Experience Team (PET)
 - 9.5.2. IWR1 report forms
 - 9.5.3. Serious Incident reviews.

10 Audit and Review

- 10.1. The **Consultant Paramedic** will review the implementation of this policy on a yearly basis and/or in response to incidents of non-compliance. A report will be sent to the Clinical Governance Working Group.
- 10.2. This document will be reviewed every three years or sooner if new legislation, codes of practice or national standards is introduced.

11 Equality Analysis

- 11.1. The Trust believes in fairness and equality, and values diversity in its role as both a provider of services and as an employer. The Trust aims to provide accessible services that respect the needs of each individual and exclude no-one. It is committed to comply with the Human Rights Act and to meeting the Equality Act 2010, which identifies the following nine protected characteristics: Age, Disability, Race, Religion and Belief,

Gender Reassignment, Sexual Orientation, Sex, Marriage and Civil Partnership and Pregnancy and Maternity.

- 11.2. Compliance with the Public Sector Equality Duty: If a contractor carries out functions of a public nature then for the duration of the contract, the contractor or supplier would itself be considered a public authority and have the duty to comply with the equalities duties when carrying out those functions.