Making End of Life Care Everybody’s Responsibility

Strategy for
Hillingdon Primary Care Trust
Hillingdon Community Health
The Hillingdon Hospitals Trust
London Borough of Hillingdon

September 2009
**Background and national context**

Over the past few years increasing attention has been focused on improving end of life care in the UK. A number of key publications have given strategic direction and guidance on how services should be developed and delivered in order to improve access and choice for patients. Much has been achieved both nationally and locally with the introduction of a number of tools such as ‘The Gold Standards Framework’, ‘The Care of the Dying Pathway’, and ‘The Preferred Place of Care’.

Approximately 500,000 people die each year in England. Most deaths follow a period of chronic illness. The common causes of chronic disease and death are those resulting from: circulatory disease, cancer, respiratory disease, neurological disease and dementia. Most deaths occur in hospital (58%), the remainder occurring at home (18%), in care homes (17%) and in hospices (4%). There is some evidence that indicates that most people would prefer to die in their own homes.

**What is End of Life Care?**

‘End of life care’ aims to help all those with advanced, progressive, incurable illness 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 life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support.’

A “good death” is described as one that would involve:

- Being treated as an individual with dignity and respect
- Being without pain and other symptoms
- Being in familiar surroundings
- Being in the company of close family/friends

**The National End of Life Care Strategy 2008**

The National End of Life Care Strategy aims to deliver high quality care for all people approaching the end of life irrespective of age, gender, ethnicity, religious belief, disability, sexual orientation, diagnosis or socio-economic deprivation. It should be available in any care setting. Key to delivering this service is the employment of a whole systems approach. It recommends that a ‘care pathway’ is used as a mechanism for commissioning services and for delivering care to each individual, as well as their carers. It includes the following six steps:
Six Step Care Pathway

1. Identification of people approaching the end of life and initiating discussions about preferences for end of life care; enhancing the skills of health and social care staff to equip them to identify patients approaching the end of life and initiate discussions around preferences for care

2. Care planning: assessing needs and preferences, agreeing a care plan to reflect these, reviewing these regularly and documenting them in a care plan accessible to relevant health and social care staff

3. Co-ordination of care; with particular emphasis on co-ordination across sectors and out of hours providers; a central co-ordinating facility and single point of access may be the most efficient way to deliver this

4. Delivery of appropriate high quality services in all locations including community, hospitals, hospices, care homes, extra care housing, ambulance service etc.

5. Management of the last days of life adopting a care of the dying pathway which can be used in all care settings

6. Care after death and access to bereavement services

A number of themes underlie the six steps and continue throughout the pathway and include:

- support for carers and families including the right to have their own needs assessed and reviewed
- information available to patients and their carers appropriate to the stage of their journey
- access to appropriate spiritual services
- education, training and continuing professional development of health and social care staff at all levels
- measurement of end of life care provision using the quality markers recommended by the Department of Health
- commissioning services to deliver end of life care

End of Life Care in Hillingdon

Vision Statement for End of Life Care:

Our vision is that all patients in the London Borough of Hillingdon who are approaching the end of life should have fast and equitable access to appropriate care, regardless of their age, ethnicity, religious belief, social status or diagnosis. The service should be flexible and responsive and delivered in the patients’ preferred place of care, as far as is practical.

In particular we need to ensure a co-ordinated approach to delivering that service. Patients need to receive continuity of care across the primary, secondary and tertiary boundaries that exist within the health service and between the NHS and voluntary sector. The quality of the service is to a considerable extent dependent on the skill of
health and other professionals and the infrastructure for access and delivery. We need to make end of life care everybody’s responsibility in Hillingdon.

Health needs for Hillingdon

The population of the Borough of Hillingdon is approximately 250,000. Social deprivation is average for the UK, but not equally distributed across the borough. There are around 2000 deaths a year; approximately 35% deaths are due to circulatory diseases (strokes, heart attacks etc), 25% to cancer, 17% to respiratory diseases, 3% to neurological disease and the remaining 20% to a variety of other diagnoses. The causes, as well as the place of death, are comparable to those in London and reflect national trends.

Current palliative care services and service development in Hillingdon

End of life care services in Hillingdon have been developed over many years. Primary care services (District Nurses, Community Matrons and General Practitioners) are responsible for most of the care delivered in patients’ own homes. Specialist Palliative Care Services have contributed significantly, particularly in the field of cancer and in complex cases.

A Needs Assessment for the Borough was undertaken in 2005. This informed the development of the 2005 Strategic Plan for Palliative Care Services (produced jointly by the Specialist Palliative Care Team (SPCT), the Primary Care Trust (PCT) and the Acute Trust). Much of what was proposed in the 2005 Strategy has been or is in the process of being implemented.

The 2009 End of Life Care Strategy for the London Borough of Hillingdon

A PCT Baseline Review of Services for End of Life Care was completed in October 2007. One of the goals of this review was the mapping of a care pathway for all patients, including those with end-stage non-cancer diagnoses. This Baseline review, together with the Baseline Assessment and the views of local stakeholders identified several areas of greatest need including: a single point of access, improved communication between service providers and access to information. This has determined a number of local priorities for action:-

Areas of greatest need

- Equity of access to services for all
- Increase in the number of people dying in their preferred place of care
- Co-ordination of care for patients and their carers
- Development of bereavement services
- Out of hours access to care
- Improve care at end of life in care homes
- Palliative care for people with dementia
Priorities for action

- Identification of patients approaching the end of life and assigning each patient a key worker (e.g. Cancer CNS, Community Matron or district nurse)
- Development of end of life tools (e.g. Gold Standard Framework, Liverpool care Pathway)
- Development of a care pathway for all patients at the end of life and adoption of a care planning approach in all settings to ensure co-ordination of care and the protection of patients’ interests and those of health care professionals
- Development of a single point of access, information and sign posting service
- Ensure provision of home care nursing services 24/7
- Enhanced end of life care for residents in care homes as part of the initiative to provide high quality care in different settings
- Review of bereavement services and care after death
- Enhanced carer support and assessment of the needs of carers

The local priorities for action will be implemented via the Six Step Care Pathway laid out in the National Strategy for End of Life Care 2008. This strategy relates specifically to adults. Separate provision for paediatric palliative care is provided within the borough.

The implementation of the strategy is outlined in the ‘Action Plan for Delivery of Hillingdon End of Life Strategy’ (Appendix I). This follows the national Six Step End of Life Care Pathway. The key steps are listed alongside the current service level and proposed developments. Quality markers and measurements are included for each of the steps. Each area of service development requires significant labour intensive projects involving several teams, currently without additional resources. In addition to the overall assumption that current teams can absorb this increased workload, each step has its own specific assumptions that need to be met for success to be achieved.

Furthermore, the overall success of the 2009 Strategy is also dependent on:

- An integrated approach to planning, contracting and monitoring service delivery across health and social care. The strategy is developed jointly by the NHS Hillingdon, the Specialist Palliative Care Team (SPCT) and acute trust with input from social services, relevant statutory and voluntary providers, as well as users

- Education and Training of health and social care staff at all levels, in primary and secondary care and also to specialist palliative care staff. The SPCT provides much of the training across the borough

- Death and dying have become ‘taboo’ subjects. Everybody however is, at some point in their lives, touched by the loss of a loved one. There is a need to raise awareness and open up the discussion around end of life care within the community we serve
Outcome measures

Primary outcome measures

1. To increase the number of patients who die in their own home by 1% per annum from a baseline position of 19% in 2006 to 24% in 2011.
2. To increase the number of patients who die in their care home by 1% per annum from a baseline position of 16% in 2007 to 20% in 2011.
3. Reduction in the number of patients transferred inappropriately from care homes to hospital in the last week of life.

Secondary outcome measures

Secondary outcome measures will monitor the effect of the each of the six steps in the 2009 Strategy. These outcome measures are quality markers suggested in the discussion paper.  

Review date: September 2012
References


2 Improving Supportive and Palliative Care for Adults with Cancer. National Institute for Clinical Excellence, 2004.

3 Our Health, Our Care, Our Say. DH, 2006.


8 Department of Health. Working definition End of Life Care; operating framework baseline review of end of life care services, 2007.


14 The Hillingdon Hospital and Hillingdon Primary Care Trust: Specialist Palliative Care Services. Annual Report 2008.

Appendices

Appendix I

Appendix II
Care Pathway. DH 2008

Appendix III
PEPSI COLA aid memoire
### NATIONAL END OF LIFE CARE STRATEGY 2008: ACTION PLAN FOR DELIVERY OF HILLINGDON END OF LIFE STRATEGY (PCT, ACUTE TRUST, HILLINGDON COMMUNITY HEALTH AND LONDON BOROUGH OF HILLINGDON)

<table>
<thead>
<tr>
<th>Key Step</th>
<th>Current Service Level</th>
<th>Planned Service Development</th>
<th>Assumptions</th>
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<tbody>
<tr>
<td>Pathway Step 1 Discussions as the end of life</td>
<td></td>
<td>Raise the level of awareness of end of life care in the community and also health care</td>
<td>Application of the Gold Standards framework (GSF), clinical experience and</td>
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<tr>
<td>approaches</td>
<td></td>
<td>professionals; information to inform choices available regarding care; use public information</td>
<td>Prognostic Indicators Guidance etc to identify patients approaching the end of</td>
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<tr>
<td></td>
<td>Identification of patients approaching end of life</td>
<td>identification of patients approaching the end of life (approximately 6 months):</td>
<td>life</td>
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<td></td>
<td>Via site specific multidisciplinary team meetings (MDTs) e.g. Lung Cancer MDT and</td>
<td>- <strong>In the community</strong> (GPs, Community Matrons, DNs) using the Gold Standards Framework in</td>
<td></td>
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<td></td>
<td>agreed pathways (End Stage Renal Failure, A&amp;E, Care of Elderly teams etc)</td>
<td>all GP practices</td>
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<td></td>
<td>Care home MDTs, primary health care MDTs</td>
<td>- <strong>In hospital</strong> with all clinical teams, but particularly Care of the Elderly, and at</td>
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<td></td>
<td>Initiating discussions with the patient, carer and wider health care team</td>
<td>MDTs</td>
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<td></td>
<td></td>
<td>- <strong>In care homes</strong> using the Gold Standards Framework</td>
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<td>Triggers for discussion: identifying patients</td>
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<td>approaching the end of life</td>
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<td>Open, honest communication</td>
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<td>Key Step</td>
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| Quality markers                             | Mechanisms to identify patients approaching the end of life                           | **Measure:** number of GP practices that have adopted GSF or similar  
Ensure entry onto a locality-wide end of life register  
**Measure:** proportion of deceased patients on register                                                                                                                  |                                                                                                                                                                                                                                       |
| Pathway Step 2                              | **Assessment, care planning and review**                                              | A multiprofessionally agreed document – the ‘Supportive care form’ will replace the Harmoni Form to document:  
- Recognition of end of life  
- A summary of the care plan  
- Patient’s preferences  
- Professionals/ key-worker involved  
- DNAR status (transferable across health care boundaries)                                                                                                                     | GP s, Community Teams,  
Hospital Teams and  
Specialist Palliative Care Team (SPCT) and other specialist teams including Community Matrons, Key workers etc. are familiar with documentation and procedures for implementation and communication with the wider healthcare team  
Transferability of care plans, including DNAR status, across health care boundaries                                                                                       |
| (i) Agreed care plan and regular review of needs and preferences. All patients/ carers approaching end of life to be offered: 1. Discussion of end of life issues 2. Needs assessed 3. Preferences recorded in a care | **Assessment** by health care professionals in 1st and/or 2nd care; for complex cases involve Specialist Palliative care Team (SPCT)  
**Documentation**  
Harmoni Form to document preferred place of care and care  
Holistic Care Plan for patient and their carer using the Gold Standards framework and the ‘PEPSI COLA’ framework (See Appendix)  
The supportive care form aims to protect all parties with an open and transparent record of preferences and care plan agreed jointly by |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                       |
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<tbody>
<tr>
<td>plan</td>
<td>plan for patients in the community and in care homes RIO community computerised record Care home notes Medical records</td>
<td>preferences and care plan agreed jointly by patient/carer and health care professional.</td>
<td></td>
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<tr>
<td>Quality markers</td>
<td>Ensure all patients offered a care plan documenting preferences Ensure entry onto a locality-wide end of life register</td>
<td></td>
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<tr>
<td><strong>Measure: proportion of deceased patients on register</strong></td>
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<tr>
<td>Measure: contents of register – names, care plans, DNAR status</td>
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<td>Ensure discussions regarding end of life issues are undertaken by appropriately trained staff</td>
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<tr>
<td>(ii) Assessing the needs of carers</td>
<td>Carers assessment is part of the Gold Standards Framework. Carers support available across the Borough from statutory and voluntary services</td>
<td>• Information for carers including list of services available • Use of the ‘PEPSI COLA’ framework to document carer’s needs • Development of quiet rooms in hospital to talk with carers</td>
<td>Transferability of care plans across health care boundaries Funding to enable improvement of facilities at Hillingdon Hospital</td>
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<tr>
<td>Carers require information about services, practical and emotional support during the person’s life and bereavement care afterwards. Carers have the right to have their own needs assessed and to have a carers care plan</td>
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| Quality markers | Ensure needs of carers are assessed and recorded and support offered  
*Measure: audit documentation of needs*  
*Measure: availability of quiet spaces in wards for relatives* | | |
| Pathway Step 3  
Co-ordination of care | | |
| (i) Strategic co-ordination | PCT End of Life Forum | • Register of people approaching end of life  
• Single point of access /gateway | Funding available to implement development |
| Quality markers | Strategic plan for palliative care services  
*Measure: availability of a strategic plan for PCT & Locality and for the SPCT in the community and in the Acute Hospital* | | |
| (ii) Co-ordination of individual patient care: ensure that each person approaching end of life receives co-ordinated care in accordance with care plan, across sectors at all times of day and night | Key workers co-ordinate care:  
DNs & Community Matrons in community  
Hospital based site specific CNS  
Joint meetings 2º/1º care  
Use of GSF  
Patients known to SPCT have ‘Pall Care’ alert on Hill Hosp computer | • Enhance key worker role  
• Using GSF in all GP practices  
• Documentation that crosses health care boundaries (Supportive care form, DNAR)  
Further engagement with social services | GPs, Community Teams, Hospital Teams and Specialist Palliative Care Team (SPCT) and other specialist teams including Community Matrons, Key workers etc. are familiar with procedures for |
<table>
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<tbody>
<tr>
<td>Quality markers</td>
<td>Nominate a key worker for each person approaching the end of life</td>
<td></td>
<td>Communication of care plan to the wider healthcare team</td>
</tr>
<tr>
<td><strong>Measure:</strong> audit proportion of patients approaching end of life with a documented key worker</td>
<td><strong>Measure:</strong> audit proportion of patients approaching end of life with a supportive care form</td>
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<tr>
<td>(iii) Rapid response services: PCTs and Local Authorities to ensure medical, nursing and personal care and carers support services are available in the community 24/7. Patients and their carers know who to contact and how to contact health care professionals</td>
<td>Specialist palliative care advice available 24/7 (MSH advice line) District Nursing services available 8 a.m. to midnight Harmoni Out of Hours GP, Co-op, Rapid Access using Harmoni form, Marie Curie night sitters, Harlington Hospice at Home</td>
<td>Access to nursing care and home care throughout the night (e.g. Marie Curie ‘rapid response’ model) Services in existence do not meet current needs</td>
<td>Funding available to support service development Staff availability for service</td>
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<tr>
<td>Quality markers</td>
<td>Mechanisms to ensure care is co-ordinated across organisational boundaries 24/7</td>
<td></td>
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<tr>
<td><strong>Documentation processes for transfer of information</strong></td>
<td><strong>Audit:</strong> e.g. availability of care plan to OOHs &amp; emergency services Access to advice from SPCTs 24/7 irrespective of diagnosis or location Access to equipment within 24-48 hours</td>
<td>Measure: access to equipment</td>
<td></td>
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<tr>
<td>Key Step</td>
<td>Current Service Level</td>
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<tr>
<td>Pathway Step 4</td>
<td>Care pathway approach established for all approaching the end of life in different settings including: hospitals, community, care homes, hospices and ambulance services.</td>
<td>Continue development of end of life care pathway for patients with non-malignant conditions</td>
<td>Two-way engagement with specialist teams and services</td>
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<tr>
<td>Delivery of appropriate high quality services in different settings</td>
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<tr>
<td>Quality markers</td>
<td>Appropriate provision of Specialist Palliative Care Services in the community and in the hospital</td>
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<tr>
<td><strong>Measure: existence of multiprofessional SPCT in the community and in the acute hospital</strong></td>
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<tr>
<td>Measure: number of specialist palliative care beds per 100,000 population</td>
<td></td>
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<td></td>
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<tr>
<td>Measure: number of enhanced palliative care nursing home beds per 100,000 population</td>
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<td></td>
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<tr>
<td>Measure: audit of specialist palliative care provision to care homes</td>
<td></td>
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<tr>
<td>Pathway Step 5</td>
<td>Care of dying pathway established on medical wards in acute trust and for enhanced palliative care nursing home beds in the community</td>
<td>Use of the care of dying pathway in all appropriate settings</td>
<td>Attendance of Health care professionals at educational sessions</td>
</tr>
<tr>
<td>Care in the last days of life</td>
<td></td>
<td></td>
<td>Capacity of SPCT to provide teaching to health care professionals in the community and the hospital</td>
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<tr>
<td>Key Step</td>
<td>Current Service Level</td>
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<tr>
<td>Quality markers</td>
<td>All care providers to adopt a common approach to care for people in the last days of life</td>
<td><strong>Measure: number of providers adopting a ‘care of dying pathway approach’</strong>&lt;br&gt;Measure: number of dying with a ‘care of dying pathway’ in place</td>
<td></td>
</tr>
</tbody>
</table>
| **Pathway Step 6**<br>**Care after Death**  | Bereavement services mapping task completed. Limited written/internet information available about local services. Some individual bereavement support services in place, within health service and voluntary sector. Long waiting lists. Palliative care bereavement support group established. | Continue to develop the 3 component model of bereavement care as follows:  
- Information leaflet with directory of bereavement services  
- Development of a bereavement pathway for carers  
- Training for health and social care professionals  
- Annual bereavement study day for providers to encourage closer coordination/joint working between services | Funding available for additional staffing – estimated to be an additional 2 sessions per week psychology input  |
<table>
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<tr>
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<th>Current Service Level</th>
<th>Planned Service Development</th>
<th>Assumptions</th>
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<tbody>
<tr>
<td>Quality markers</td>
<td>Bereavement support information and services available to all. Measure: Number of carers supported by care after death section of care of the dying pathway</td>
<td>Measure: information about local services to be widely available on paper and over the internet</td>
<td>Measure: number of families of palliative care patients to be invited to drop in support group</td>
</tr>
<tr>
<td></td>
<td>Measure: number of families of palliative care patients to be invited to drop in support group</td>
<td>Measure: Carers report of their own experience of support and care after bereavement (VOICES)</td>
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## Appendix II

### The End of Life Care Pathway

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Step 2</th>
<th>Step 3</th>
<th>Step 4</th>
<th>Step 5</th>
<th>Step 6</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Discussions as end of life approaches</strong></td>
<td><strong>Assessment, care planning and review</strong></td>
<td><strong>Coordination of care</strong></td>
<td><strong>Delivery of high quality services</strong></td>
<td><strong>Care in the last days of life</strong></td>
<td><strong>Care after death</strong></td>
</tr>
<tr>
<td>- Open, honest communication</td>
<td>- Agreed care plan and regular review of needs and preferences</td>
<td>- Strategic coordination</td>
<td>- High quality care provision in all settings</td>
<td>- Identification of the dying phase</td>
<td>- Recognition that end of life care does not stop at the point of death.</td>
</tr>
<tr>
<td>- Identifying triggers for discussion</td>
<td>- Assesses needs of care</td>
<td>- Coordination of individual patient care</td>
<td>- Hospitals, community, care homes, hospices, community hospitals, prisons, secure hospitals and hostels</td>
<td>- Review of needs and preferences for place of death</td>
<td>- Timely verification and certification of death or referral to coroner</td>
</tr>
<tr>
<td></td>
<td>- Assessing needs of carers</td>
<td>- Rapid response services</td>
<td>- Support for both patient and carer</td>
<td>- Support for both patient and carer</td>
<td>- Care and support of carer and family, including emotional and practical bereavement support</td>
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**Support for carers and families**

**Information for patients and carers**

**Spiritual care services**
# Holistic Patient Assessment - Pepsi Cola Aide Memoire

<table>
<thead>
<tr>
<th>Physical (P)</th>
<th>Emotional (E)</th>
<th>Personal (P)</th>
<th>Social Support (S)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Consider</strong></td>
<td><strong>Emotional needs, including:</strong></td>
<td><strong>Personal needs, including:</strong></td>
<td><strong>Social care needs, including:</strong></td>
</tr>
</tbody>
</table>
| - Physical needs, including:  
  - Symptom assessment and use of validated tools  
  - Medication assessment, Regular/PRN  
  - Review stopping non-essential treatments  
  - Treatment/medication side effects | - Psychological assessment including:  
  - Understanding expectations of patient; Patient wishes for depth of information; Low mood, fears, anxieties, strengths; Coping mechanisms and interests; Altered body image; Relationships with others; Disturbed sleep; Attempts to avoid uncomfortable thoughts / feelings. | - Cultural background/ethnic group language/sexuality/religious/spiritual needs | - Social care assessment  
  - Welfare rights screening assessment  
  - Carer assessment for carers |
| **Cue Questions** | **What worries you most?**  
  - During the last month have you lost interest in things you usually enjoyed?  
  - How do you normally cope in stressful situations?  
  - Have you had difficulty coping in the past?  
  - How do you achieve support (i.e. family/professional, reading/talking)?  
  - Have psychological/quality of life assessment tools been completed? | **How do you make sense of what is happening to you?**  
  - What can we do to help respect any of your identified personal concerns?  
  - Would you find it helpful to talk to someone who could help you explore the issues?  
  - How does your condition affect your ability to achieve these needs? | **How are things in relation to:**  
  - Social at home  
  - Work and finance  
  - Family and close relationships  
  - Social and recreation  
  - Is anyone dependent on you?  
  - Do you have any legal or immigration issues or concerns |
| **Resources** | **Validated symptom assessment tools**  
  - Specialist clinician/palliative care  
  - Symptom guidelines  
  - Accredited professionals e.g., Physiotherapist, Occupational Therapist, Dietician, Speech and Language, Complementary Therapists, Pharmacist  
  - Day centres  
  - Oxygen Provider Companies | **Local hospital/hospice switchboard**  
  - Cancer patient Information centre  
  - Macmillan Cancer Support website  
  - Cancer Black Care  
  - Gay and Lesbian switchboard  
  - Network/PCT directory of resources/website | **Social services or Continuation Care referral**  
  - Local assessment  
  - Work and finance  
  - Family and close relationships  
  - Social and recreation  
  - Is anyone dependent on you?  
  - Do you have any legal or immigration issues or concerns |
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<tr>
<th><strong>CONSIDER</strong></th>
<th><strong>CUE QUESTIONS</strong></th>
<th><strong>RESOURCES</strong></th>
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</thead>
</table>
| Information Communication | - Information and communication needs  
- Identify the key worker  
- Liaison with MDT/Primary Health or receiving health care worker  
- Patient held records if appropriate  
- Is MDT outcome documented, communicated, and is patient aware of plan/understands  
- Is mode of communication/language appropriate? | - Are you aware of your key worker?  
- Have you been asked if you would like to be copied into correspondence?  
- Have you been informed of relevant information that is appropriate at this stage?  
- Do you know how to access further information should you require it?  
- Have you been informed of the user/carer support groups and the location of their nearest cancer information centre? | - Network Key worker guidance document  
- Cancer patient information and support centres  
- Macmillan/cancer backup website and literature  
- Patient information  
- Refer to appropriate services, e.g.: Speech and language therapy, optometrists, audiologists, translation services |
| Control and Autonomy | - Level of autonomy needs:  
- Assess mental capacity to make decisions around patient choice: Treatment options/plans: Preferred place of care: Advanced care planning | - Do you have a patient held record?  
- Have you discussed and documented your future care with anyone?  
- Do you have any documentation setting out your wishes? If yes, who has access to it?  
- If your health deteriorated where would you like to be cared for? | - Key worker  
- Personal Management Plan/ Patient Held Record  
- Gold Standards Framework register if appropriate  
- Local national guidance relating to mental capacity |
| Out of Hours | - Advanced care planning needs:  
- Identification of appropriate services according to treatment intentions  
- Preferred Priorities for Care (PPC)  
- Transfer of information to Out of Hours Services and London Ambulance Service | - Are you aware of who to call for out of hour’s advice and assistance?  
- Do you and your family know how to contact service(s) out of hours? | - Out of hours referral form  
- Patient Held Record information  
- Allow A Natural Death/ Do Not Artificially Resuscitate documentation  
- Symptom guidelines |
| Living with your illness | - On-going care needs, including:  
- Rehabilitation support  
- Referral to other agencies  
- End of life care planning (if appropriate) | - How are you managing with daily living tasks?  
- How is your appetite, mobility, swallowing, communication and diet?  
- Have you been informed of support services available?  
- Have you been given an opportunity to discuss your future/expectations/goals? | - Specialist allied health professionals  
- Intermediate care services  
- Local cancer information and support services  
- Self support programmes  
- Specialist palliative care referral |
| Bereavement needs, including:  
- Funeral arrangement  
- Bereavement risk assessment  
- Future support - family  
- Bereavement follow up | - Are there funeral arrangements?  
- Do you have relevant contact numbers?  
- Do you have bereavement services information? | - Contact numbers for timely removal of equipment  
- Patient Information Centres  
- Bereavement services directory |