Transforming Community Services: Ambition, Action, Achievement

Transforming End of Life Care

Transforming End of Life Care
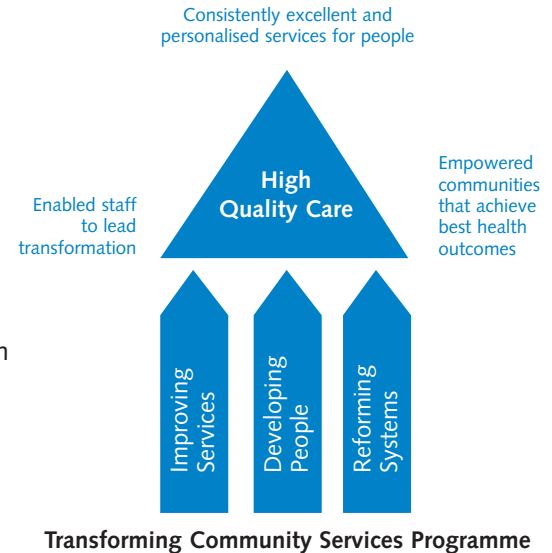
Contents

Introduction

Effective and efficient community services are the foundation of healthcare in the NHS. They help people stay healthy and care for them through debilitating illness and at the end of their lives. They are a lifeline for some of the most vulnerable, and at their best are innovative, flexible and personal. However, we face some major challenges:

- there is great variation in service quality and health outcomes
- much activity and achievement goes unmeasured
- we lack usable data, tariffs and currencies
- there is disparity in quality, productivity and costs
- infrastructure is frequently outdated
- access can be uncertain and confusing.

We recognise that the environment is changing for community services which – like all health services – face the challenge to drive up quality and drive down costs. The Transforming Community Services Programme is therefore about delivering improved quality *and* productivity, as well as building on preventive approaches to reduce costs associated with lifestyle related disease and preventable complications.

The Transforming Community Services Programme has set out a far-reaching plan to resolve some long-standing issues by harnessing the energy and enthusiasm of everyone to provide consistently high quality care. This will mean that the best, currently available for some, is there for all.

The programme takes a three-pronged approach: improving services, developing the people who provide them, and aligning systems to underpin the transformation.

Consistently excellent and personalised services for people

High Quality Care

Enabled staff to lead transformation

Empowered communities that achieve best health outcomes

Improving Services

Developing People

Reforming Systems

Transforming Community Services Programme

About the guides

There are six transforming community services guides for frontline staff and their leaders. Many practitioners will be interested in one particular guide and some will be interested in elements of more than one. The guides therefore have a common format and the first sections apply to all service areas and are the same. Subsequent sections cover specific changes and will differ between guides. Four of the guides deal with services for adults and older people. One guide relates directly to services for children, young people and families. The health and wellbeing guide contains information to enable all practitioners and teams to maximise their contribution to good health outcomes and reducing inequalities and is therefore relevant to all.

These best practice guides demonstrate what is considered to be best practice across community services and have been developed in conjunction with experienced and committed health professionals. They highlight a number of actions that people have said make a real difference to patients. They are based on a framework of *'ambition, action and achievement'*. By this we mean:

- Clearly setting out your **ambition**
- Taking **action** to deliver the ambition, using the best available evidence
- Demonstrating and measuring **achievement**

The Six Transforming Community Services Reference Guides

- Transforming Health, Wellbeing and Reducing Inequalities
- Transforming Services for Children, Young People and their Families
- Transforming Services for Acute Care Closer to Home
- Transforming Rehabilitation Services
- Transforming Services for People with Long Term Conditions
- **Transforming End of Life Care**

Quality for community services

The Next Stage Review states that high quality care requires a high quality workforce. In keeping with this, the guides describe **six transformational attributes**, which individuals and teams will need to demonstrate in order to meet the requirements of their high-performing 'practitioner, partner, leader' roles. These are in the later sections of the guide and are specific to each service area.

These guides will be successful if they help deliver the aspirations of *The Next Stage Review* and enable:

Practitioners closest to patients to lead change themselves and realise their own high ambitions for the care that they provide.

Provider organisations to align high quality care to organisational vision and strategy.

Commissioners to understand the constituents of high quality care and enable world class commissioning decisions to be made that are clinically led and focus on achievements.

Our guidance on the **Quality Framework** for Community Services is part of the overarching quality improvement programme outlined in *High Quality Care for All*. The programme focuses on **bringing clarity to quality and measuring quality**, as the foundation for broader quality improvement. It is aimed at all those with a role in providing or commissioning community services.

Useful links and further information on these six transformational guides, national policy can be found on the Transforming Community Services website www.dh.gov.uk/tcs

Quality

A common misconception is that quality is expensive. On the contrary, quality can and should be a powerful way of cutting costs, doing things right first time without the need for repetition, and is the most effective way to reduce unnecessary cost. It's when things go wrong they become expensive and inefficient.

Quality Indicators

*More than 70 potential indicators of high quality care have been identified. They cover effective practice, safety and people's experience to help us to **measure what we value**, to benchmark and improve the quality of care we deliver. These are a starting point and more work is needed to refine, develop and pilot them to ensure that they enable practitioners to measure the ambitions set out in the transformational guides. They are not comprehensive and we know there are gaps, which is why we are asking for your views on what are good effective indicators of quality.*

Ambition

1

Getting the basics right – every time

People have urged us to stress how important it is to ensure that the basics are in place – not doing so compromises service users' experience and practitioners' ability to deliver high quality productive services as efficiently and effectively as possible. Provider management and clinical teams need to work together to get these right. What follows are recommended actions and how they can be measured through achievements. They are based on evidence and professional consensus and are for local organisations to consider when planning quality, innovation and productivity improvements.

Actions to deliver the basics for all community services

1. Know about local health needs and plan services accordingly

- Work with your public health observatory (public health team in the commissioning PCT) to access information on the health needs of your population: identifying those who may be disadvantaged or marginalised in society: target need.

- Work with your commissioners to agree the outcome data that needs to be collected for a specific service area to demonstrate effective intervention. Ensure that you have robust systems in place to collect this data. Link this to the quality framework and, if appropriate, contracts including the payment framework for commissioning, quality and innovation (CQUIN).

- Develop systems and processes, which encourage constant patient, service user and carer feedback. Audit changes, which have been made as a result of feedback on user experience

2. Create effective health and care partnerships

- Strengthen partnership working across health and social care. Work in partnership with organisations such as ambulance trust, acute trust, social services, GP practices (and practice-based commissioners), the voluntary and independent sectors so that care and treatment can be aligned along a care pathway and co-ordinated around the needs of the service users.

- Start discharge planning at the earliest possible moment. Make sure all practitioners are involved in this process, care is co-ordinated and discharge summaries provided for all key services involved in the patient's care.

3. Implement new services/approaches

- Addressing variability, working efficiently, demonstrating high levels of productivity and achievement of ambitions for quality are always important and particularly so in an economic downturn. Ensure that your teams use the most up-to-date and appropriate evidence and tools to ensure effective productive working. This may include the NHS Institute productive series or lean management techniques.

- Support teams to develop creative approaches to service provision, which will improve choice, personalisation, efficiency and effectiveness, for example, reducing avoidable admissions to the acute hospitals through making the best use of social care resources.

- Support and empower practitioners to develop innovative multidisciplinary teams using approaches such as the transformational attributes.

4. Access and availability

- Provide local health information about your services: the access, availability and choices, for patients, the public and professionals. Check against the experience of those using your services to ensure understanding.

- Provide clear information about out-of-hours service provision to patients, the public and practitioners. This should include the service and current contact details. Use self-referral as the optimum route and use new technology, for example, text and email where possible. Audit these services regularly to ensure that they meet the quality standards.

- Provide the right resource, in the right place, at the appropriate time in accordance with need. This may mean extending or changing the hours of service provision to 24 hours a day, overnight or weekend care. This may also mean working with other partners to ensure systems are in place to access care. This may include capacity management systems, access points and telephone triage. It may also include partners such as out-of-hours and ambulance trust.

- Provide the right equipment to the right patient in a fast and efficient manner and have systems in place to retrieve equipment no longer needed. You may need to undertake an equipment audit to ensure that the demand for equipment matches the resource available. Transforming Community Equipment Service (TCES) was launched in 2008. Its aim is to create a new service delivery model that puts users and carers at its heart giving more choice and control.

5. Care planning and case management

- Ensure that there are robust systems in place to safeguard children and young people and for adult protection.

- For people with long term or complex healthcare needs:
  – Provide a personalised care plan and, where appropriate, use joint care planning or integrated

assessments such as the single assessment process or common assessment process (CAF).

– Provide patients and carers with a named key worker or case manager to ensure high quality, safe and effective continuity of care.

– Ensure that you are familiar with your PCT's local carers strategy, providing all carers with a holistic assessment in their own right and giving the appropriate information, support and advise for them to remain healthy and within their own home.

6. Information and technology

• Provide clinicians with appropriate IT and ensure that where safe and practical to do so clinical pathways are interlinked using shared records and joint care plans. This could include investment in IT web design solutions and or portable IT solutions for remote access working such as tablets, laptops and palm tops.

7. Education and training

• Commissioners and provider management teams must be responsible for developing a competent workforce that will deliver sufficient current and future services safely, effectively and which have a positive impact on service user experience. Practitioners and clinical teams need to review best practice and prioritise development plans for service delivery.

– Equip practitioners with a wide range of skills, knowledge and competence to meet the future demands on community services, including the impact of new service models and shifts in care settings, for example, from hospital to community and patients' homes.

– Provide access to robust training and education, clinical supervision and improved clinical, leadership, managerial and business skills to improve health outcomes.

– Use and develop evidence based practice and validated research to improve clinical practice.

Achievement

✳ Clinical and multi-agency teamwork is supported by a robust infrastructure that enables all practitioners to deliver high quality care, achieve agreed outcomes, maximise productivity, promote and measure service user experience.

✳ Variability in productivity is reduced by efficient, effective systems, clearly described and measured.

✳ Community services contribute to the efficiency and effectiveness of partner services, for example working with acute trusts, primary care and social care providing a seamless care model.

✳ Practitioners have the confidence that these systems will support them when working in the community and allow them to spend the maximum amount of time with individuals and families.

Benefits realisation

With the increasing focus on **quality and innovation with productivity**, it is important to be able to demonstrate that the benefits envisaged (i.e. our ambitions) are actually derived (i.e. our achievements): this is known as **benefits realisation**. Actions to create the change and the delivery of outcomes should be monitored through a plan to track the implementation and the service improvements. The improvement plan should be aligned with the PCTs strategic priorities, focused on delivering improvements in health outcomes for the local population and in line with the aspiration for world class commissioning.

Productivity defined

- Productivity is a measure relating a quantity or quality of output to the inputs required to produce it.

- It is the quality of being productive.

Ambition 2

Making everywhere as good as the best

Actions to achieve the best – 'high impact changes'

The actions below grouped under seven main headings have gained support from all those who took part in developing the guides as most likely to have the **greatest potential to improve care and achieve the highest quality services**. In all of these guides, we have used the best research evidence available; however, we know that there are significant gaps in community service evidence. We have also drawn on expert professional opinion and service user experience to provide robustness to these **recommended actions and achievements** that practitioners should consider to deliver our ambition.

Summary of high impact changes

- Familiarise yourself with the Quality End of Life Care markers (DH), SHA and PCT strategic end of life care plans in accordance with the national end of life care strategy and Next Stage Review.

- Use an established systematic framework such as the Gold Standards Framework or Liverpool Care Pathway in order to optimise care delivery.

- Ensure that all patients are who are approaching the end of life are identified early and sensitive conversations are had about death and dying, choice and personalisation with patients, carers and families.

- Provide all patients with a key worker/case manager and care plan and, where appropriate, document advance wishes and preferences for care. Make sure that all practitioners (including other relevant organisations) are aware of these preferences, subject to the consent of the patient.

- Ensure that care for those approaching the end of life is accessible, responsive and available twenty-four hours a day.

1. Know about local health needs and plan services accordingly

- Familiarise yourself with your SHA and PCT end of life care strategic plans which encompass patients with all diagnoses, care provided in any setting by a collective of organisations and providers, and covers each step of the end of life care pathway.

- Ensure that a local practice register is kept and available for all health and social care practitioners involved in palliative and end of life care. This register should hold information regarding advance care plans and the do not attempt resuscitation (DNAR) status of the individual subject to their consent.

2. Create effective health and care partnerships

- Work in partnership with other practitioners to co-ordinate interventions at all stages of the patient pathway. Make sure GPs, ambulance trusts, out-of-hours providers, specialist palliative teams, district nursing teams, acute sector, hospices, care homes, social care and all other practitioners who have a contribution help devise care plans and agree roles, responsibilities and communication channels.

- Ensure that all end of life care teams make close linkage with continuing healthcare services so that, where appropriate, packages of care can be set up effectively and efficiently with no time delay for patients.

- Identify all local agencies and third sector organisations who provide end of life care provision and support, including those offering emotional and bereavement support for children and adults. Develop collaborative relationships to complement and co-ordinate care.

- Ensure that all providers who support end of life care within the home, and proactively work to prevent admissions into an acute trust, work together to understand their role in clinical care and prevention. This will include primary care teams, community pharmacists, ambulance trusts and out-of-hours providers and may include the development of joined-up technology (red-flag/green card fast track systems) to promote data capture.

3. Implement new services/approaches

- Use an established end of life framework to optimise care delivery for example the gold standards framework, preferred priorities for care and the Liverpool care pathway for the dying.

- Expand end of life care for all those approaching the end of their lives regardless of diagnosis and care setting. This should include developing end of life care services for patients with long term conditions and older people with co-morbidities. This should also include supporting the delivery of services in settings such as care homes, hostels and prisons.

- Offer all patients approaching the end of life the opportunity to express their preferences and wishes for care, death and dying.

4. Access and availability

- Care should be available twenty-four hours a day to enable people to live and die at the place of their choice. This may include providing telephone advice and support as well as fast track specialist referral and home visit. This may also include partnership working – joint system planning with those who already provide a twenty-four hour service, for example, ambulance services, out-of-hours providers.

- Patients should have access to twenty-four hour emergency medicines.

- Patients should have timely access to equipment (delivery and removal) in the home setting appropriate to their needs.
- Patients at the end of life can be transferred within locally agreed timescales to a setting that is most appropriate for their needs and, where appropriate, in line with their preferred place of care.

5. Care planning and case management

- Provide individual care coordination/case management for each patient, their family and carers using joint care planning principles.
- Offer advance care planning for example use of preferred priorities for care (PPC), allow natural death/DNAR policies, in accordance with the patient's wishes.
- Ensure that verification and certification of death is timely, family wishes are respected and bereavement support provided in a timely fashion.
- Recognise and respect individual's religious and cultural beliefs.

6. Information and technology

- Use technology to support shared care, joint care planning and identify documentation to draw attention to medications, specific conditions and the wishes of patients and families, such those outlined in advance care plans.
- Make sure such information is available for all out-of-hours teams and the ambulance service.

7. Education and training

- Provide practitioners with the skills needed to initiate sensitive conversations about end of life care, and to make appropriate judgements about how and when to offer information.
- Ensure practitioners are trained in assessment and care planning, symptom management and advance care planning relating to end of life care.
- Acknowledge the central role of families and carers. Support them and equip them with the skills they need.

Achievement

✳ People receive excellent care at the end of their lives – there is a reduction in the variation of quality in services that provide this care and more people die in the place of their choice.

✳ Patients, families and carers receive timely, sensitive communication, support advice and care 24/7 giving them the confidence for their loved one to stay at home, where this is their choice.

✳ Practitioners providing end of life care in all settings, including extra care, housing and care homes are supported by access to specialist palliative care advice to enable people to remain in their usual environment.

✳ Partnership working with all providers ensures the patient receives high quality continuity of care with respect to their preference of care.

✳ The percentage of people dying in hospital, who have expressed a wish to die at home, is reduced.

✳ Families and carers feel emotionally supported during end of life care and after the death of their loved one.

✳ Evidence, professional consensus on good practice, experience of service users and productivity tools are rapidly appraised and adopted to increase efficiency and effectiveness.

✳ Innovation and creativity are supported by the organisation and throughout the service. This will include the Transforming Community Services (TCS) innovation and leadership award scheme with emerging lessons on what constitutes a high quality service. Lessons learned are implemented rapidly and the scheme and emerging lessons disseminated nationally and adopted to improve services.

✳ Measuring quality, continually seeking improvement, and demonstrating high quality services to service users, public and commissioners is endemic: we need to move from **'valuing what we measure to measuring what we value'**.

Measuring what we value

Quality indicators for community services will be piloted with practitioners and community providers in Autumn 2009. Indicators for end of life care could include:

- Percentage of people who have an identified care plan.

- Proportion of people who have an identified case manager.

- Percentage of patients dying on the end of a care pathway.

- Percentage of patients dying in their preferred place of care.

Ambition 3

Delivering evidence based practice

Actions to improve the quality of commissioning and provision through implementing evidence

What does the evidence say?

More than 18,000 studies were analysed by Health Services Management Centre (HSMC) to examine the evidence for a range of community services.

Useful links and further information on all the studies can be found on the Transforming Community Services (TCS) website www.dh.gov.uk/tcs

What follows are **recommended actions and their achievements for end of life care,** based on evidence and professional consensus and are for local organisations to consider when planning quality innovation and productivity improvements.

Promote end of life care for all at the end of life

Some studies suggest that broadening palliative care from cancer diagnosis to all those nearing end of life has a significant potential for providing sustainable, high quality care. Joint working between specialist hospital care teams and community services can be particularly beneficial.

Supporting family members

Family members are vital carers for people at the end of their lives. There is evidence that their contribution can be enhanced by practitioners supporting them appropriately, offering training and

providing family members with prompt-type questions to enhance the dialogue they and the patient are able to have with doctors and health professionals.

What service delivery?

Some evidence suggests that while traditionally, practitioners have found it hard to move from curative to palliative interventions, this problem can be resolved by integrating both care models. This has been shown to enhance a patient's quality of life and improve psychological wellbeing during their last weeks. Evidence also suggests that whilst the spiritual aspects of care are under-researched, they may appear to have a significant impact on quality of life. Patients place significant importance to this dimension whilst practitioners often avoid assessment and discussion of the individual's spiritual needs.

Integrated pathways

Integrated pathways are a widely accepted model to improving standardisation, continuity and collaboration among multidisciplinary teams. Several studies suggest that these pathways demonstrate improvement in symptom assessment, documentation of care goals, and compliance with guidelines and pain control.

Deliver education in care homes to improve care

Several studies suggest that the availability of a skilled workforce in care homes can reduce unnecessary admissions near to the end of life. One study found that community based palliative care nurse specialists could offer advice on pain and symptom management to homes by telephone. This is a relatively cost effective use of time and can lead to substantial improvements in care. In other studies hospice and community staff offered educational sessions to staff resulting in measurable improvements.

Preferred priorities for care

Numerous studies suggest that people want to receive care at home or close to home in their final weeks and days. However, some studies indicate that high quality comprehensive information about people's preferences is not readily available or communicated to all members of the care team.

Multidisciplinary teams make a difference

Numerous descriptive studies outline the potential benefits of community and hospital teams working together. There is some evidence that multidisciplinary teams delivering care at home can increase patient satisfaction and reduce hospital admissions

Peer mentoring

Patients receiving mentorship and support from their peers may have a positive effect on some patients, though this approach may be more appropriate in some groups than others.

Achievement

* Community practitioners who have access to information on evidence based practice and audits have delivered successful outcomes.

* Commissioners and providers work together to ensure that where good evidence exists this is implemented within local services.

* The time taken from evidence collection to implementing the innovative change is improved.

* Historically the focus of palliative care services has been on cancer and malignant disease. Increasing supportive care should be available to everyone nearing the end of their life irrespective of diagnosis.

Achievement: What do transformed community services look like?

Supportive care pathway – Solihull NHS Care Trust

Solihull NHS Care Trust has developed a multiprofessional care pathway to support patients with end of life care needs in the community. The Community Supportive Care Pathway (SCP) was piloted in 60% of the community nursing teams, by February 2009 this will be extended to all integrated community teams in the trust.

The pilot phase showed improvements in recording preferred place of care, proactive care planning, symptom assessment and symptom management, prescribing anticipatory medicines for the dying phase and co-ordination of care. The pathway templates, which are divided into two parts, include Supportive and palliative care and Comfort care in the dying phase. All patients on the practice gold standards framework/palliative registers are placed on the pathway.

Information on the Community SCP is on the trust palliative intranet site and included in the Palliative Training Programme.

Contact: helen.meehan@solihull-pct.nhs.uk

Case study

Lincolnshire Community Health Services

The 'Green Card' scheme provides a system where patients with palliative care needs can have fast track access to out-of-hours (OOH) services and have direct contact with an experienced clinician. The scheme was a joint initiative between OOH and Macmillan in 2006.

Frontline clinicians identify patients through the mechanism of the gold standards framework. Transfer of information is faxed through to OOH including details of the patients care plan and prescribed drugs, thereby promoting anticipatory care. These patients are given a small green coloured card with the direct contact details of the OOH service and an explanatory leaflet. This enables patients and their carers to have a direct telephone conversation with an experienced clinician, bypassing computer triage - they are assured that this can be at any time of the day or night.

The green card system has significantly reduced the need for patients and their carers to phone 999 thus avoiding inappropriate hospital admissions. It is an inexpensive, easy to use system which enables patients to receive a quick response and reassurance when they are at their most vulnerable. Relief at being able to contact someone 'anytime' is very comforting and stress-free according to patient and carers' feedback.

Contact: mark.thompson@lpct.nhs.uk

The TCS innovation award winners for services related to end of life care are listed below. The Department of Health will be working with the leads of these new and innovative services to support the successful development of these pilots. Useful links and further information, including regular updates can be found on the Transforming Community Services (TCS) website www.dh.gov.uk/tcs

The TCS innovation award winners: End of Life Care

- Calderdale PCT – Innovation council
- Derby County PCT – Care home support service
- Hampshire PCT – Training to enable nutrition screening to identify at risk patients
- Kirklees CHS – Productive teams and empowering change with service users
- NHS Bath and North East Somerset – New service delivery model
- NHS Devon – Development of health hubs
- NHS North Somerset – Development of generic assistant practitioner
- NHS Wakefield – Integration in action
- North of Tyne PCT – Innovation and leadership for end of life care patient pathway
- North Yorkshire and York PCT – A patient-centred approach to workforce planning in community services
- Portsmouth City PCT – Develop and support 'expert carers' targeting young carers with no access to local services
- Redbridge PCT – Reconnect using community resources
- South of Tyne and Wear PCT – Improving safety of care by supporting access into community services via single point of contact
- South West Essex Community Services – Growing an NHS workforce in partnership with Jobcentre Plus
- Telford and Wrekin PCT – Transforming patient care using the year of care approach
- Torbay Care Trust – End of life care in care homes
- Torbay Care Trust – End of life care lay carers' education
- West Kent PCT – Self-referral for supported discharge

Transforming End of Life Care   Ambition 4: Developing and supporting people to design, deliver and lead high quality community services

24

Ambition 4

Developing and supporting people to design, deliver and lead high quality community services

Actions to develop a 'social movement approach' to change owned and led by local services and practitioners

Transformational change happens when those delivering care are motivated and inspired to do things differently.

The Next Stage Review emphasised the need for a high quality workforce to deliver high quality care and introduced the healthcare professional for the 21st century being 'practitioner, partner, leader'. Contributors to the programme have built on the concept of practitioner, partner, leader to develop attributes for community practitioners that will generate radical improvement.

Many good initiatives flounder because insufficient attention is paid to the staff themselves and the actions needed to create the climate in which the desired attributes can ensure success. Organisations implementing change will want to consider how they promote such attributes in their own workforce, and the action needed on a number of fronts. How staff are educated and trained, managed and led; how services are commissioned and regulated, and how performance is monitored, can all contribute to the creation of a positive, enabling culture in which staff constantly strive to improve safety, effectiveness and experience of care. Conversely, the same factors can mitigate against empowerment, motivation and personal accountability, reducing the likelihood of success.

Social movement

A group of people with a common ideology who try together to achieve certain general goals; features include:

- Energy
- Mass
- Pace
- Momentum
- Passion
- Commitment
- Spread
- Sustainability

Demonstrating the six attributes in end of life care
Practitioners and teams are:

Health promoting practitioners

- Working within a philosophy of 'living well until the end of life'.
- Normalising death and dying.
- Supporting families and carers with their own health and supporting the emotional health of carers during and after the death of a loved one.

Clinical innovators

- Introducing new ways of working, organising care around the needs of patients, families and carers.
- Developing communication skills, competencies in end of life care enabling effective rapport and relationships to be developed facilitating open and honest discussion with patients and families.
- Developing competencies in advance care planning to support patients and family discussion in preferred priorities for care.
- Developing skills and extending roles to enable patients' symptoms and pain to be effectively managed in the community.

Professional partners

- Taking action to eliminate barriers between primary, secondary, acute and tertiary care other professionals such as the out-of-hours provider or ambulance service.

The six transformational attributes for community practitioners

Health promoting practitioners focusing on health, wellbeing and addressing health inequalities

Clinical innovators and expert practitioners enabling increasingly complex care to be provided at home

Professional partners in an expert to expert relationship with patients and in building teams across organisations

Entrepreneurial practitioners exploring business opportunities including expanding social enterprise and other innovative approaches

Leaders of service transformation individual, organisational and across systems

Champions of clinical quality using new techniques and methodologies to embrace continuous improvement

---

- Forging purposeful links with other agencies including voluntary sector organisations and charities who support patients living with a life limiting illness.
- Including patients, families and carers as essential and knowledgeable members of the care team.
- Being able to feel comfortable when discussing death and dying with patients/carers.

Entrepreneurial practitioners

- Developing new care delivery models, based on multidisciplinary, self-directed teams.
- Exploring concepts such as social enterprise, integrated care organisations and personalised budget setting.
- Having skills, taking responsibility and being accountable for resources and for the delivery of agreed outcomes.

Leaders of service transformation

- Proactive service planning in alignment with policy documents such as the national end of life care strategy and SHA end of life care plans.
- Working with commissioners, managers and others to redesign care pathways and services which address all elements of the care closer to home initiative.
- Understanding the business process and how to put together a business case for service need.
- Developing the ability to process map and re-design services along care pathways.
- Displaying influencing skills and ability to implement change.
- Modelling leadership behaviours, courage, integrity and excellent communication.
- Displaying expert leadership skills ensuring that the attributes become embedded within work practice and used as part of the annual appraisal cycle in conjunction with the leadership quality framework (LQF).

- Ability to lead the team to deliver high quality end of life care. This may involve enabling discussions about death and dying and providing emotional support for team members.

Champions of clinical quality

- Using new techniques and methodologies to embrace continuous improvement – measuring quality in terms of patient safety, evidence and effectiveness and through people's experiences of the services that you offer.
- Working with all partners, including the residential and nursing home sector, to ensure high standards for quality – safety, evidence, communication and symptom control are in place across the local community.
- Implementing quality improvement processes such as Plan, Do, Study, Act (PDSA) cycle.
- Focusing on essential quality indicators, measuring and monitoring achievements.
- Displaying expert clinical skills, values and authority to champion quality in end of life care locally.
- Valuing diversity and ensuring end of life care meets people's cultural and religious values.
- Seeking and using patient and family feedback to improve services.

Achievement

✴ People are developed to be high quality community 'practitioners, partners, leaders' who can clinically own and lead local change.

✴ Local practitioners (individually and as teams) use the transformational attributes applied to their services together with evidence based practice to become part of the 'social movement' for transformation of community services.

Next Steps: Taking forward the best practice guides

Taking forward the guides: **Providers**

- Share the guides widely with relevant staff and stakeholders including PCT provider committees, local partners and frontline clinical teams.

- Consider undertaking a stock-take of where you are against 'the basics' and 'the high impact changes' to identify priorities for improvement.

- Discuss the priorities and agree an action plan for 'Getting the basics right – every time' with relevant staff and stakeholders.

- Discuss and agree with commissioners the priority high impact changes and agree the action plan for taking forward.

- Where an evidence base exists ensure this is accessible to staff and services – audit performance on evidence based service delivery.

- Gain widespread clinical, managerial and commissioning support to take forward agreed service redesign strategies.

- Build agreed priority areas for action into 2010/11 service improvement plans and, as appropriate, through service contracts which may include the CQUIN payment framework.

- Consider how to involve patients and carers in any proposals to change pathways.

- Consider reviewing the ability of local systems to support data collection and real measurement to support local improvement.

Taking forward the guides: **Practitioners and clinical leaders**

- Share the guides widely with all members of your team including local delivery partners.

- Consider undertaking a stock-take of where you are against 'the basics' and 'the high impact changes' to identify priorities for improvement.

- Agree where the team can take action to improve quality based on evidence and good practice. Plan and implement local action.

- Where change requires wider action discuss and agree with senior managers the priority areas for taking forward.

- Consider how to actively involve local people, service users and carers in all proposals to change care pathways.

- Consider how change will be actioned and benefits measured – for example through clinical audit, user satisfaction, improved performance on outcomes.

- Consider the workforce implications and the impact on roles within the team.

- Identify any training and development requirements and agree a plan for addressing.

- Identify relevant indicators from the initial community services indicator set to monitor progress (assured set available Autumn 2009).

Taking forward the guides: **Commissioners**

- Share the guides with relevant commissioning leads, including PBC colleagues and joint commissioning partners.

- Consider, in line with world class commissioning, incorporating changes into local commissioning strategies and, where appropriate, care pathways.

- Discuss and agree with community providers the priority high impact changes.

- Build agreed priority areas for action into 2010/11 service specifications and contracts and, if appropriate, consider possible goals to link with, through CQUIN payments.

- Identify relevant indicators from the initial community services indicator set to monitor progress (assured set available Autumn 2009).

Definitions

Gold Standards Framework – GSF

Designed to care for people with advanced progressive incurable illness in the community setting the GSF enables GPs and multidisciplinary teams to identify patients in need of supportive/palliative care and provide assessment, co-ordination and planned care to ensure that the patient a peaceful death in the place of their choosing. www.goldstandardsframework.nhs.uk

Liverpool care pathway of the dying – LCP

The Liverpool care pathway (LCP) provides an evidence based framework for the delivery of care for the dying patients and their relatives in a variety of care settings. It encourages a multiprofessional approach to the delivery of care, providing guidance on the different aspects of care required in the last 76-48 hours of life, including comfort measures, anticipatory prescribing, and discontinuation of inappropriate interventions. It also explores bereavement and support. www.liv.ac.uk/mcpcil/liverpool-care-pathway/index.htm

Preferred priorities for care – PPC

PPC is an example of an advanced care plan, used to identify an individual's preferences and wishes at the end of life. It is a document that individuals hold themselves and take with them if they receive care in different places. It has space for the individual's thoughts about their care and the choices they would like to make, including saying where, if possible, they would want to be when they die. www.endoflifecareforadults.nhs.uk/eolc/ppc.htm

Policy documents: End of Life Care

Building on the Best (DH, 2003)

Supportive and Palliative Care for Adults with Cancer (NICE, 2004)

The End of Life Care Strategy (DH, 2008)

High Quality Care for all: NHS next stage review (DH, 2008)

Quality Markers for End of Life Care (DH will be finalised this year) including primary care. community hospitals, care homes, district and community nursing services and out-of-hours services.

NHS Operating Framework 2007/2008

NHS Operating Framework 2008/2009

NHS Operating Framework 2009/2010

The National Dementia Strategy (DH, 2009)

The Renal NSF, part two (DH, 2005)

The National Stroke Strategy (DH, 2007)

The Cancer Reform Strategy (DH, 2007)

Framing the Contribution of Allied Health Professionals: delivering high-quality healthcare (DH, 2008)

Modernising Allied Health Professionals (AHP) Careers: a competence-based career framework (Skills for Health/DH, 2008)

National Institute for Health and Clinical Excellence (NICE) Improving Outcomes Guidance (IOG) for Cancer Services.

Common Assessment Framework (DH, 2009)

Useful links and further information on these six transformational guides, national policy, evidence based research, case studies and innovation in practice can be found on the Transforming Community Services (TCS) website: www.dh.gov.uk/tcs