

## **Joint End of Life Care Strategy - Implementation Update April 2013**

### **The Palliative Care Support Service**

The team have now cared for 81 patients to the end of February. During January and February 16 patients being supported by the service died of which 15 died at home and 1 died in hospital but all were in their preferred place.

### **Contributes to objectives 3, 4, 5, 6 and 8**

**DNAR Policy Implementation:** Further work is needed linking the policy with advanced care planning and GSF. A workshop is being held on 4<sup>th</sup> April lead by Dr. L Schofield Consultant in Specialist Palliative Care; the workshop will provide a comprehensive introduction to advanced care planning and an overview of GSF.

### **Contributes to objectives 2, 3, 4 and 6**

**Multi Disciplinary team** working with 10 care homes ensures advance care plan in place where appropriate-

The team have completed 110 advanced care plans and 116 Do Not Attempt Resuscitation forms. This has led to 96% of patients dying in their preferred place.

### **Contributes to objectives 2, 3, 4, 6, 7, 8 and 9**

There is a pan London EoLC register '**Coordinate My Care**' that LAS have access to that the GP / palliative care leads in put patient information in to which eventually will replace our palliative care handover forms and the system we currently use. The soft launch of 111 took place on 20<sup>th</sup> February 2013 and the public launch was on 12<sup>th</sup> March 2013. Full uptake of co-ordinate my care may be delayed however, as our main hospice provider does not currently have an N3 connection; this will be vital to manage co-ordination of care.

### **Contributes to objectives 2, 3, 4 and 9**