

## End of Life Care Charter

**Each Director of Adult Social Services (DASS) will affirm that:**

*Everyone, regardless of their age or condition has the right to experience a good death; and that social care practitioners have a central role in ensuring that a sensitive, appropriate and holistic approach is provided at the right time taking account of the practical, emotional and spiritual needs of people approaching end of life and their carers.*

**What good looks like for us: Pan London EoL Alliance Lay representatives Board statement:-**

- I am actively engaged in holistic care-planning to maximise my quality of life
- I am supported and cared for by professionals with compassion, care, commitment, competence, courage, good communication and listening skills.
- My voice and that of my carer is heard, our individual needs and preferences respected and acted on sensitively, ensuring a high quality experience of care
- I receive seamless continuity of care and all organisations work together and in partnership.
- I only need to communicate information once and everyone has access to the most up to date and accurate information about me.

**What DASSs will do to ensure effective social care practice in their area:**

- Focus on the outcomes that people approaching end of life and their carers identify
- Promote dignity, choice and independence throughout their last year of life experience, managing risks to ensure they receive their care in the manner and setting of choice and that agreeing responsibility for care costs does not impede or delay delivery of care or support
- Develop an information and advice strategy that enables people, service users and carers to get comprehensive information regarding end of life issues including processes and services. This will be aligned with local CCG information and advice;
- Develop systems for sharing information across providers to ensure timely and appropriate support
- Ensure that core assessment formats have key questions to prompt the timely discussion about the needs of the service user and carer in the last year of life and provide the necessary social care intervention to meet their needs;
- Ensure there is a flowchart in place describing the local end of life care pathway including access to 7 day working, which identifies roles and responsibilities for health, social care and voluntary and community sector partners;
- Put in place a Learning and Development Plan for specialist and non-specialist workforce to ensure social care practitioners have the knowledge and skills to: understand their and other's roles; conduct difficult conversations about end of life wishes and assess the needs of individuals and their carers, in a holistic and timely way, taking account of spiritual and cultural needs;
- As part of promoting learning and utilising collaborative opportunities across London ensure that their locality actively participates in the London wide programme of work through appropriate representation on the LSCP End of Life Care Network

**What DASSs will do to promote good commissioning practice in their area:**

- Ensure the market shaping and oversight role of Adult Social Care reflects the findings of the local JSNA in relation to end of life care and takes account of the Public Health role in working with communities to improve end of life care and promote a flexible response to individual needs and preferences;
- Ensure that service specifications clearly state expectations in relation to quality, knowledge, skills and values and also reporting requirements in terms of delivering a holistic and outcome focussed approach to end of life care, in line with KPIs and QAFs across health and social care, irrespective of which agencies will pick up the cost;
- Ensure an integrated whole system approach across health and social care is used to review Key Performance Indicators (KPIs) and assess their impact on the effectiveness of the entire local end of life service provision;
- Identify demonstrable outcomes in partnership with service users and carers and using the commissioning process as a means to establish the required competencies and service delivery models for staff at all levels and in all settings in relation to end of life care;
- Explore opportunities to secure a timely, whole system approach to care and support for service users and their carers from early intervention through to post death signposting to emotional and practical support; and
- Include end of life care and user and carer experiences as part of wider user engagement strategies to inform service development and commissioning intentions

**We will have been successful when we know that we: \***

- listen to the person and their carers; create opportunities for them to express their views and concerns. Understand how their culture and lifestyle affects their choices and how they wish to be treated;
- develop care plans around the stated priorities of the person, keep them up to date and share them across the care and support team. Goals will be clear, roles understood and there is a named co-ordinator;
- share, as appropriate, information important to the person's care and support and keep it up to date. Everyone, including the person and their carers, know about and understand any changes and how they affect the care plan;
- value and understand everyone's role and contribution (the person, their family/carers and health and social care colleagues)
- support each other (the person, their family/carers and health and social care colleagues), listen, share expertise , be comfortable asking for support or information; and
- use ordinary language and speak in ways that are easily understood taking account of the situation and the person you are talking with.

Further details can be found at:

<http://www.londoncouncils.gov.uk/policylobbying/healthadultservices/jip/endoflife.htm>

\*extract from: Working together: improving end of life care through better integration –skills for care/health/NCPC.

