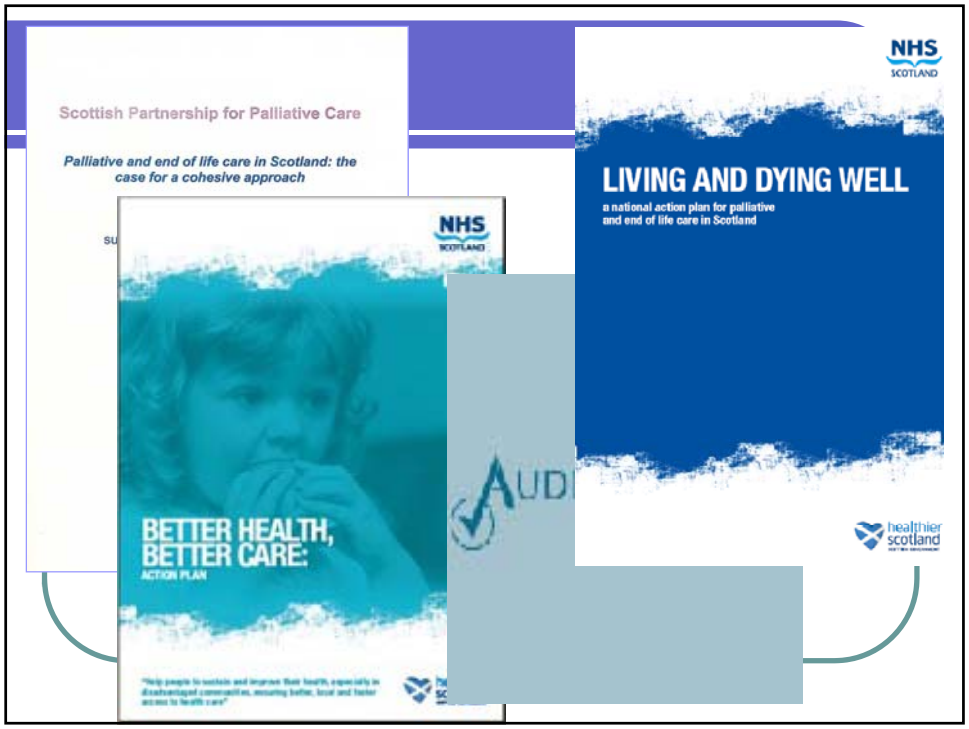
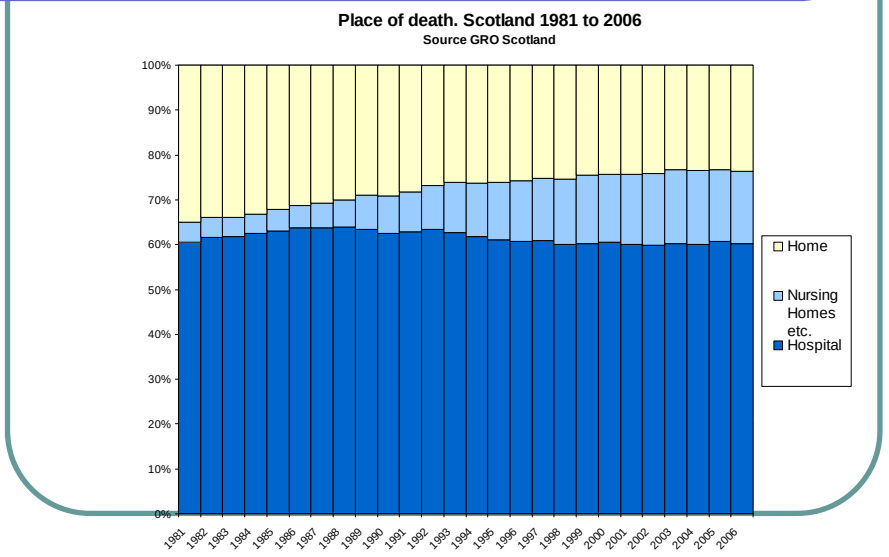
# LIVING and DYING WELL

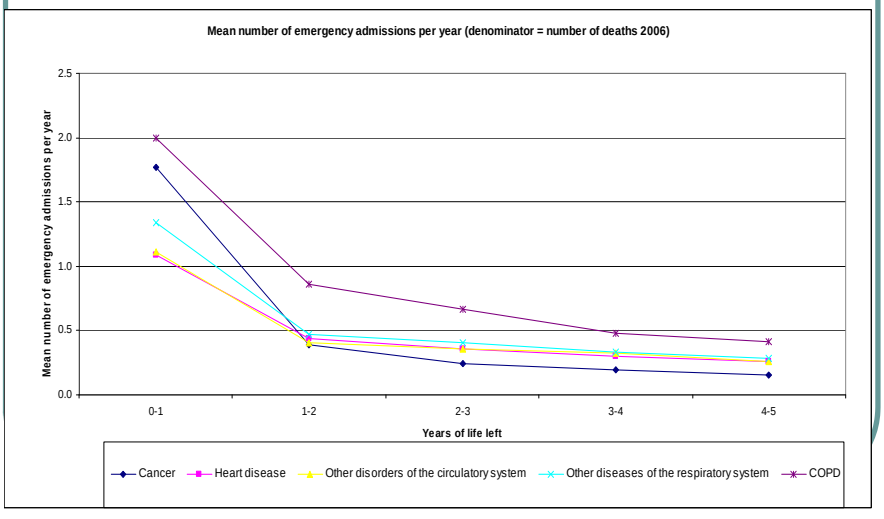
A national action plan
For
Palliative and End of Life Care
In Scotland



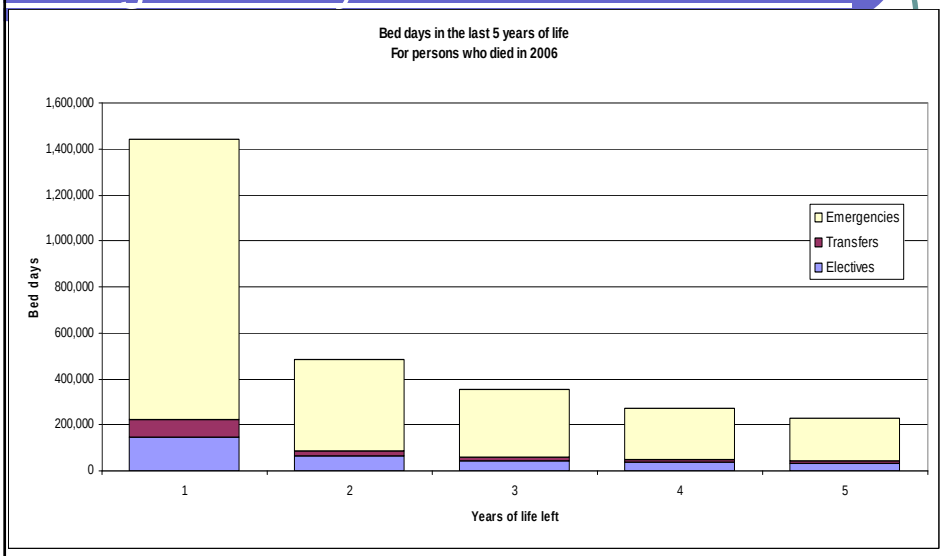
# From ISD




# Patient Journey
# Emergency admissions



# Patient Journey
# Length of Stay




# *LIVING and DYING WELL*

- Assessment and Review of palliative and end of life care needs
- Planning and delivery of care for patients with palliative and end of life care needs
- Communication and Coordination
- Education, training and workforce development
- Implementation and future developments

The Scottish Government

## Implementation and Governance

- Executive Leads in all NHS Boards
- CEL 40 (2008) to Chief Executives
- Advisory Group
- Delivery Plans
  - Living and Dying Well
  - Audit Scotland
- Performance and Accountability Arrangements
- Integration with other National Programmes e.g.
  - Long Term Conditions
  - Shifting the Balance of Care

The Scottish Government

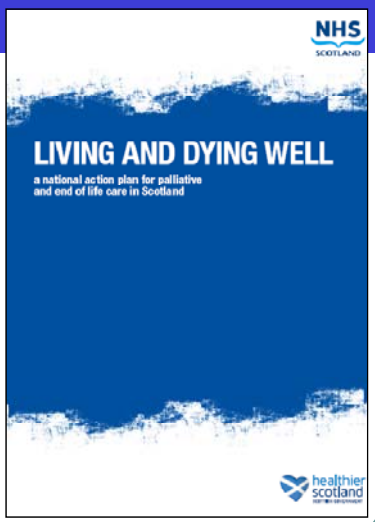
## *LIVING and DYING WELL*

- **Developments**
  - **National Advisory Group**
  - **Education**
  - **Direct Enhanced Service**
  - **Short Life Working Groups**
  - **QIS- Palliative Care Standards**
  - **eHealth**
  - **Resources**
  - **National events- June 08- 09- 10**

The Scottish Government

# Cross Party Group in the Scottish Parliament on Palliative Care

## 7 January 2009




## 3.1 Assessment and review of palliative and end of life care needs

**Aim**

To ensure that all patients and carers with palliative and end of life care needs are identified and their physical, social, emotional and spiritual needs are appropriately assessed and reviewed.

## 3.2 Planning and delivery of care for patients with palliative and end of life care needs

**Aim**

To ensure that care plans are developed and implemented for all patients and carers with palliative and end of life care needs as the outcome of a patient centred planning process which takes account of their needs, wishes and preferences at every stage of the patient journey.

## 3.3 Communication and co-ordination

**Aim**

To ensure that all patients and carers with palliative and end of life care needs are supported to participate fully in developing care plans and making decisions about their care.

## 3.3 Communication and co-ordination (cont.)

**Aim**

To ensure that patient and carers needs are communicated clearly across care settings and systems to all professionals involved.

To ensure that the care of all patients and carers with palliative and end of life care needs is co-ordinated effectively between specialities and across care settings and sectors.

## 3.4 Education, training and workforce development

**Aim**

To ensure that all health care professionals are equipped with the knowledge, skills, competence and confidence to care for the diversity of patients and families living with and dying from any advanced, progressive incurable condition

## 3.5 Implementation and future developments

**Aim**

To ensure that the aims of this Action Plan are met in a manner that is sustainable, compatible with quality improvement and patient experience programmes, and based on recognised good practice

## Conclusion

- Logical plan
- Comprehensive
- Well received
- Achievable