Introduction

Palliative care is an approach that improves the quality of life of patients, and their families, facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, social and spiritual (WHO definition).

Specialist palliative care is provided by a multi-professional team who have undergone recognised specialist palliative care training. We also see palliative care as an important generalist skill. It is simply best practice and an obligation for all health professionals in the NHS. We can only succeed when the care on the wards and in the community is the best for the patient and family that it can possibly be.

We, in the specialist palliative care team, see two key dimensions to the scope of palliative care; palliative care meaning the last year of a patient’s life and end of life care meaning the last few days and hours. Predicting the accuracy of the last year of life is complex. The emphasis on the patients last year is about living as well as possible for as long as is possible. The emphasis of the last days is about the achievement of a good death for the patient, family and friends and the clinical staff who deliver the care.

This palliative care bulletin aims to inform the trust of both the current work of the team and future developments. We hope to foster greater collaborative working for all health professionals so that they have the skills and knowledge to provide a level of general palliative care.

Get to know the team

Acute hospital specialist palliative care team

The acute specialist palliative care team (SPCT) for the trust are based in Farndale House at the University Hospital of North Tees. They provide specialist advice, support and review of patients who have complex specialist palliative needs that the host teams in clinical areas are finding difficult to manage. In addition to a vast clinical caseload, they also provide specialist education and teaching to all disciplines and grades of staff, on subjects as diverse as complex symptom management, advance care planning, ethical dilemma and end of life care. The team also give specialist input to some specific MDT meetings.
The acute hospital team consists of:

Consultant in palliative medicine          Dr Laura McElhinney
Specialty doctor                           Dr Julie Barnsley
Nurse consultant in palliative care        Mel McEvoy
Macmillan clinical nurse specialist         Susan Whalley
Macmillan clinical nurse specialist         John Sheridan
Macmillan end of life co-ordinator         Liz Goddard

There is currently a specialist registrar based with the team, Dr Lucy Lowery.

Community specialist palliative care team

The community specialist palliative care team are currently based across to sites, one in Farndale House at the University Hospital of North Tees, and the other at University Hospital of Hartlepool. They provide on-going specialist advice, support and review of patients who have complex specialist palliative needs to people in their own homes and in care homes. They liaise closely with patients’ GPs and district nursing teams, and provide specialist input in regards to effective symptom management, advance care planning, holistic support and specialist therapy input.

The community team consists of:

Consultant in palliative medicine          Dr Jane Bentley
Consultant in palliative medicine          Dr Alice Jordan (Hartlepool Hospice)
Macmillan clinical nurse specialist         Hilary Sadler
Macmillan clinical nurse specialist         Jason Black
Macmillan clinical nurse specialist         Susan Burke
Macmillan clinical nurse specialist         Vanessa Cox
Macmillan clinical nurse specialist         Susan Smith
Macmillan clinical nurse specialist         Mags Lundberg
Macmillan clinical nurse specialist         Jude Spink
Macmillan occupational therapist           Helen Caudren
Macmillan occupational therapist           Carole Wright
Macmillan occupational therapist           Emma Watson
Macmillan physiotherapist                  Debs Alton
Macmillan therapy technician               Jean Abbey
Admin support                              Lynette Winter and Sam Robinson
Admin support                              Sheila Jenkinson
Dr Bentley's secretary                     Caroline Armstrong

Both teams are managed by the lead of the service, senior clinical matron Caroline Fitzsimons.

There are extended members of the specialist palliative care team MDT from both chaplaincy and psychology.

New members of the team

In the last 12 months, there have been a few new members join the acute specialist palliative care team at the University Hospital of North Tees:

Senior clinical matron Caroline Fitzsimons

Caroline joined the team in 2014 into a newly developed post, as the lead for the service. Her background is in community nursing here at the trust, where she was the clinical lead for out of hours service and more recently safe care lead and clinical care co-ordinator for adult nursing. Caroline leads both the hospital and community specialist palliative care teams, and is a key strategic role in relation to service development of palliative and end of life care within the organisation.
**Macmillan clinical nurse specialist John Sheridan**

John joined the team in September of last year, from York Teaching Hospital where he was lead clinical educator in palliative and end of life care for the trust. John has an extensive background, having worked at South Tees Hospitals NHS Foundation Trust in roles as diverse as cardiothoracic HDU, specialist palliative care and acute oncology. John joins the team as a CNS in the acute setting, reviewing patients referred to the service, providing specialist advice, support and review of patients who have complex specialist palliative needs that the host teams in clinical areas are finding difficult to manage.

**Macmillan end of life co-ordinator Liz Goddard**

Liz joined the service in April, from St. Cuthbert’s Hospice where she was patient services manager. Liz comes to us with nine years palliative care experience and has worked in both hospice and hospital settings including being ward manager at North Tyneside Palliative Care Unit. She joins the trust as its first Macmillan end of life co-ordinator, an innovative role looking at developing and improving the care that we deliver to those patients felt to be entering the end stage of their life, supporting the patient and their family and carers and supporting the clinical teams on the wards in decision making and best practice. Liz reviews patients who are on the virtual EOL ward and also supports the ward teams in the management of those patients whose preferred place of care is home or out of hospital.

**Allied health professionals in palliative care**

As part of the community based team across both sites we have a limited amount of allied health professional input consisting of physiotherapists, occupational therapists and a specialist therapy technician. We provide ongoing specialist assessment, advice, treatment and holistic support to assist patients to achieve and maintain their maximum physical, emotional, spiritual, vocational and social potential, however limited this may be as a result of the patients disease progression. We liaise closely with the patients’ GPs, district nursing team and social support providers and with the acute team.

**Palliative care and psychology**

Consultant clinical psychologist Elaine McWilliams is head of the palliative and end of life care psychology service which provides support for individuals who are in their last year of life. The psychologist can support people in living with a palliative diagnosis and the uncertainty this can bring, in adjustment around their diagnosis and treatment as well as psychological support for families and couples and others involved with the patient.

Psychological issues, if left unresolved, can have a significant impact on a person's health generally. Individuals may benefit from a referral to this psychology service. For example, they may suffer from anxiety, trauma, depression, adjustment or other issues as a consequence of their diagnosis or because a pre-existing issue has become more difficult to manage as a result of their diagnosis and treatment.

All of these issues and others may benefit from specific psychological interventions which are right for that individual's needs. The service also accepts referrals from staff to support them in their working with a particular case, but where a referral for direct work with the patient/other is not possible or simply not appropriate at that time.

The nurse consultant provides CBT for palliative care patients at level 2/3 and a number of specialist palliative care members provide level 2 CBT.
Chaplaincy working in palliative care

Chaplains work as part of the specialist palliative care team to offer spiritual care to all patients, families and staff. Experiences like receiving bad news, recognising that life is limited, or that deteriorating health is going to mean huge change, pose challenging questions about meaning and purpose to patients and families alike.

Sometimes these questions take a religious form for some but not for others. In both cases chaplains offer their time to be with people as they seek to process what is happening to them. They offer a confidential, listening ear to patients and their families both in hospital and the community from diagnosis, through to end of life care and the experience of bereavement.

Chaplains should automatically be informed, by phoning extension 22515 whenever a patient is placed on the care of the dying document. It is then their task to visit, make a spiritual assessment and offer on-going care and support to patient and family. Staff are also welcome to refer any patient when they become aware that they are expressing a spiritual need – all those things that either sustain or undermine our sense of wellbeing. Chaplains offer similar care to staff when their work or their personal circumstances become especially demanding, to contact them for this phone extension 83138.

A framework for end of life care: helping health and social care professionals support adults with progressive, life limiting illnesses

This framework embodies at a strategic level what we are working to achieve. It integrates the core ideas of the following six key documents: the Quality Standard for End of Life Care for Adults NICE QS13 (2011), the National End of Life Strategy (2008), National End of Life Programme: Routes to Success Guide (2012), Derbyshire End of Life Guidance (2010) and ‘More Care, Less Pathway’ A Review of the Liverpool Care Pathway (2013), as well as the document produced by the Leadership Alliance for the Care of Dying People (2013). This framework combines several different approaches on the subject of end of life care. Such as NICE standards; aspects of the national end of life strategy; practical support from National End of Life Programme; the key phases of end of life from Derbyshire, and the principles that have evolved from the findings of the Liverpool Care Pathway Review. Together they form this framework.

Care of the dying patient review group

As examples of the work of the group, the care of the dying patient document was created and implemented. It embodies the recommendations suggested in Independent Review of the Liverpool Care Pathway (LCP) ‘More Care, Less Pathway’. Two audits have been undertaken that show both negative and positive feedback. These audits have taken place during an extremely busy time in the trust when the number of deaths had increased and the trust had been under NEEP 3 and 4. A significant number of patients were not started on the document until a very late stage, sometimes only in the last 12 hours. It was acknowledged that many doctors are reluctant to use the document due to previous problems with the Liverpool Care Pathway and the way it was covered in the media.

A new document has been created by the regional care of the dying group that contains much of the work from the trust’s original document. We will switch to the new document on 1 September as well as the new palliative care kardex. This documentation is being developed by a sub-group of the regional end of Life network, which has a consultant in palliative medicine representation from the trust.

Educational strategy for palliative care

The specialist palliative care team have developed an educational strategy for palliative care. With the launch of the new regional document and the new medicine cardex staff will require education and awareness sessions.
Palliative care initiatives

Communication skills training

One of the most common complaints related to care is poor communication. With a palliative care focus Sage and Thyme communication skills training initiative is being introduced to the trust. It is a nationally recognised level one communication skill qualification. It is being offered to the whole trust. It is now a part of the preceptorship programme. It aims to provide all nurses with a level one communication skill. We have plans for creating more Sage and Thyme trainers so we can speed up the training. For booking on the course please contact lynette.winter2@nth.nhs.uk

Monitoring palliative care patients in the last year

We have a palliative care register and two virtual palliative care wards and an end of life virtual ward. In any hospital bed in England at any one time 20% of the patients are likely to be in their last year of life and we aim to differentiate this group of patients from others.

We have developed a process of monitoring those palliative patients we suspect are in the last year of life. We inform the GP by discharge letter and request that they place them on their palliative care register. The patient is then added to the trust’s own palliative care register, we don’t know whether the GPs actually act on this information. Auditing this aspect will occur. When these patients are subsequently admitted they populate two virtual wards. The first is called a palliative care ward. The second is called an amber ward. The amber ward is a particular group of palliative care patients who will become a high priority for monitoring because it is at least their second admission since the letter. The data assures us that they are more likely to die sooner. As these patients are admitted they will appear on the handover sheets of both nurses and doctors and they will be identified by the following phrase “assessed as palliative” and the date when this occurred.

We know who has sent them to hospital, why they were admitted, what day and time. We know if they came in through A&E or GP admission. We know their length of stay. We know how many times they were admitted before dying.

- 1,300 patients have been place on our palliative care register since July 13
- 857 have died
- 231 have died in the trust
- 92 on the end of life ward

Of those on the our register 73% have died outside of the hospital and 27% in the trust.

In addition, the analysis of historic admission information, the list of patients in their final year of life, and the patients known to be on the palliative care teams caseload, allows the specialist palliative care team to identify improvements to pathways and communication, such that the right care can be provided in the right setting in accordance with clinical need and patient preferences. For those patients who do die in the trust, they are added to our third virtual ward, called end of life care. This is in place to help ensure that the specialist palliative care team inclusive of the chaplaincy team are informed, and the Family’s Voice given to relatives.

We are starting to build up a valuable database so we can provide quality of care to this group and aim that their last year is about living due to reduced hospital admissions. It is probable that this work will impact on summary hospital-level mortality indicator (SHMI).

This project will need more statistical support and other expertise to make it into a robust model for the future.
The Family's Voice diary

The Family’s Voice continues to be given out within this trust and community.

March 2011 – February 2015 the combined results show

Hospital

762 family members were offered the diary
501 (66%) completed it
261 (34%) did not complete
1,263 individual ratings to the six questions were made
501 (60%) (302) made qualitative comments
Average score of satisfaction (21/24)
Top score of 24 given by 23.7% of the family
Scores between 19-23 given by 58.8%
Scores below 19 given by 16.5%
No score was given by 1% of users
The average length of use of the diary was 2.52 days.

Community

In total we have 45 diaries since November 2011.

2011 = 3
2012 = 11
2013 = 11
2014 = 20

Reviewing 2014 here is the list of practices

<table>
<thead>
<tr>
<th>Hartlepool</th>
<th>Diaries</th>
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<tbody>
<tr>
<td>Pheonix Centre</td>
<td>1</td>
</tr>
<tr>
<td>Masefield Road</td>
<td>1</td>
</tr>
<tr>
<td>One life Centre Bank Lane</td>
<td>3</td>
</tr>
<tr>
<td>Hartfields</td>
<td>1</td>
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<tr>
<td>McKenzie House Group</td>
<td>1</td>
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<td>Victoria</td>
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</tbody>
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Family’s Voice research project

The Family's Voice is undergoing a multi centre trial due to finish in September. It is being used in eight trusts nationally and a cluster of nursing homes and a Marie Curie Hospice.

Placements with specialist palliative care team in the community

Over the last couple of years the clinical nurse specialists within the specialist palliative care team on both sites have been offering a weeks placement with the team for new starters to the community. The scheme has been well supported by community service managers who release the nurses from normal duties for a week at a time.
The scheme has proved popular with the community nurses and they receive an introduction to palliative care working in the community and how the service links into other services across the Trust such as chaplaincy, chemotherapy and psychological services.

The nurses on placement have an opportunity to see how the team work and ensure an holistic, multidisciplinary approach to each individuals care. They experience the role the team can have in coordinating care across multiple disciplines.

The nurses have an opportunity to shadow the various members of the team and are asked to write a reflective piece at the end of the placement demonstrating their learning outcomes.

The feedback has been positive and in the future the team would like to offer hospital staff similar opportunities.

The team are in the process of evaluating the work and hope to publish this soon.

**Walk and talk group**

The team are in the first stages of developing a *walk and talk support group*.

The team recognise the strong evidence demonstrating the benefits of gentle exercise. It is acknowledged that specialist nurses in palliative care are well placed to identify the need for support post bereavement. The role of the support group would be to minimise the risks to health specifically associated with bereavement by offering support proactively to those who may be at risk of developing complicated grief.

The team envisage offering bereaved relatives and friends the opportunity to meet on a monthly basis in a local park and *walk and talk*.

The initiative is in its infancy but a basic needs assessment has been completed and management are looking into costing this project and possibly working collaboratively with Macmillan Cancer Support.

Team members will ensure that there are two members of staff managing the group and providing the professional support that may be needed but hope that the main benefit for those attending will be the support provided by group members to each other.

**RPIW 8 - end of life care for dementia patients**

This project is now completed with the dementia collaborative and as a result there is now a rapid discharge pathway completed with the north tees discharge liaison. Education has been completed for care home staff to improve their awareness of palliative care for dementia patients. MDT meetings have been set up in four pilot homes and have reduced unwanted and unnecessary hospital admission at end of life by 20%. Many other new and innovative ideas to improved end of life care for patients with dementia will result from this work.

**Discharge check list**

We have a rapid discharge home to die checklist. This checklist is for both the dying patient and the palliative care patient - meaning any patient known to be in the last year of life. It will incorporate the regional forms for NEAS (ambulance services) and OOH (out of hours) doctors to inform them about palliative patients.
An Oasis for families and patients in end of life care

There are two types of suite at the University Hospital of North Tees. One provides a haven for families of patients who are at the end of their lives. This suite, on the west wing outside of ward 42, was furnished entirely from charitable donations and provides a peaceful space away from the ward environment. The room has all of the comforts, including a sofa, bathroom, sitting area and a kitchen.

A second type of suite is based within three ward areas - wards 24, 26 and 28. These rooms are integrated into the ward for end of life that supports patients and family together in one conducive environment.

Link workers

The specialist palliative care team are looking for staff to become link workers in their clinical areas. Nurses, AHPs, pharmacists, HCAs, therapy assistants, ward clerks who care for patients requiring palliative care across the trust have been encouraged to apply. We are looking for a minimum of two per clinical area, one of whom should be a registered professional.

Role objective

- Raise awareness of essential palliative care in your clinical area
- Enable teams to take a leading role in palliative care development and empower them to excel
- Support colleagues in delivery of palliative care in clinical areas
- Provide a network of link workers who are able to support each other and improve patient experience

Please email lynette.winter2@nth.nhs.uk with names of interested parties.

Feedback from relatives about end of life care

We would like you to watch the videos from relatives of patients who died recently. It is educational, insightful and there is much to learn from their experience. The introduction of the Family Voice to relatives is an emotional challenge to many staff. These videos highlight the importance of giving out the diaries both in hospital and in the community.

How to access?

Five easy steps click on the following:

1. Internet Explorer
2. Visitors
3. Under strategy operations and performance click palliative care
4. Left hand side bottom of menu videos for teaching
5. Click video one

Or by clicking on the following link http://commsport/Departments/Palliative_Care/Pages/Multimedia-Videos.aspx

Any thoughts or views please contact nurse consultant Mel McEvoy mel.mcevoy@nth.nhs.uk
**Future initiatives**

**Bereavement support worker**

The specialist palliative care team are hoping to introduce a new bereavement support worker to the team. The team have identified the significant support that carers and families need while their loved one is living with cancer and the ongoing support that can be valuable after the patient has died.

An initial business plan has been drafted and the team hope for support from the trust and Macmillan Cancer Support in piloting this role in the near future.

They hope the role will help streamline the bereavement pathway across the team in acute and community and ensure bereavement support is offered in line with evidence based practice in a timely manner.

The support worker will be responsible for identifying risk factors for the bereaved and offering an appropriate level of support for families and friends who are bereaved. The team would in time hope this would help to reduce depression, isolation and anxiety for those who are struggling with bereavement issues.

**Palliative and end of life study days**

The specialist palliative care team, in partnership with Macmillan, are running a series of four study days aimed at raising awareness and educating around key elements of palliative and end of life care. The days are suitable for any discipline of registered healthcare professional, looking to improve their knowledge of care planning, symptom management and their ability to cope with ethical issues. The study day is open to trust and non trust staff who will be involved in care of patients with a palliative diagnosis, or who care for patients at the end of their life. The first day on June 30 is fully booked, with 75 candidates enrolled. The day is a mixture of presentations, workshops and delivered learning, with an anticipation that attendees will take learning back to their clinical areas. The dates of the further three days are yet to be confirmed, but we anticipate they will be popular so apply early:

- 9am-5pm
- Baltic Suite, Hartlepool Maritime Museum
- Lunch and refreshments will be provided
- The study day is free; however, please note a fee of £75 will be charged for non-attendance
- To book a place on a study day or express an interest, please contact Lynette Winter for an electronic booking form lynette.winter2@nth.nhs.uk

**Palliative care resources in clinical areas**

In an effort to support clinical areas with the delivery of palliative care, the team are providing each clinical area that may care for patients who have a palliative diagnosis with a dedicated palliative care resource filing cabinet. Clinical areas will start to see blue metal filing cabinets appearing, with an emphasis on documents and guidance that support palliative care for those patients potentially in the last 12 months of their life. The drawers will be mirrored across the organisation, allowing for all clinical areas to have the main key documents available to enable teams to promote advance care planning and support patients in the end of their life. These drawers will be rolled out to the community TAPS in addition to the clinical areas in the acute hospital, and the key documents and information will be mirrored on the palliative care section of the trusts main website, enabling external stakeholders to
access key documents and guidance. This can be accessed through the specialist palliative care section of the trust site www.nth.nhs.uk/services/specialist-palliative-care/

1. Information folder palliative and end of life care
2. Deciding Right Approach
3. Preferred priorities for care / place of death
4. Emergency health care plans
5. Advance decision to refuse treatment
6. Continuing health care funding – fastrack
7. Rapid discharge of dying patient check list
8. Caring for the dying patient documentation (CFDP) inclusive of the Family Voice Diary
9. Palliative and symptom management drug chart
10. When someone is dying booklet
11. Guidance for staff responsible for care after death
12. Referrals to community specialist palliative care team
13. Hospices – Hartlepool, Butterwick, Alice House Care Agency
14. Palliative and end of life care guidelines
15. DNACPR forms, information leaflets

Preferred priorities of care/emergency healthcare plans

The preferred priorities for care (PPC) document is designed to help people prepare for the future. It gives them an opportunity to think about, talk about and write down their preferences and priorities for care at the end of life. As far as possible, patients should include anything that’s important to them. If they are worried about a particular aspect of their care, they can make a plan for what they would like and record this in their preferred priority for care statements.

Examples include:

- Where they would like to be cared for if they can no longer look after themselves - for example at home, in a hospital, nursing home or hospice
- What kind of care they would like - however, they can’t demand particular treatments
- Where they would like to be cared for when they are dying - for example at home, in a hospital, nursing home or hospice
- Information about specific spiritual or religious practices that they would like to be carried out or reflected in your care
- Which people - family or close friends - they would like to be involved in their care
- Who they would like to act on their behalf if decisions need to be made about their care
- Who they would like to look after any pets
- Whether they would like someone to tell them how serious their condition is and the likely prognosis
They should also talk through your plans with one or two of the healthcare professionals looking after them, such as your GP or nurse specialist. They may want to discuss whether their choices and wishes are realistic and if not, thinking of some alternatives. For example, if they would prefer to die at home but have no close friend or family member who would be able to support them at home, it may be more realistic for them to be cared for in a nursing home or hospice.

It may not always be possible for their wishes and preferences to be met at the time when you become less well. For example, they may want to be cared for at home by a family member but if they become ill or over-tired they may be unable to care for the patient. In this case, healthcare professionals may be able to arrange care for patients to enable them to stay at home. However, if this isn’t possible they will plan for them to receive the best possible care somewhere else, for example in a nursing home or hospice.

**Tackling an emergency health care plan**

An emergency health care plan (EHCP) makes communication easier in the event of a healthcare emergency. The principles of writing and using an EHCP are fully described on page four of the Deciding Right EHCP document (see www.theclinicalnetwork.org for a printable version). These notes are intended as a practical guide to discussing and documenting an EHCP, and include an EHCP document with advisory notes in each of the domains.

- If the individual has capacity for these decisions: the discussion is one of shared decision making. If the individual wishes, this may include the parents (for children), partner or relatives.

- If the individual lacks capacity for these decisions: any decisions must be made following the nine point checklist of the Mental Capacity Act: see form MCA 1 & 2 on http://www.cnne.org.uk/end-of-life-care-the-clinical-network/Decidingright/plusresources

The plan should:

- include a brief summary of the individual's diagnosis/es and their understanding of
- include a list of regular and prn* medications, and indications for any rescue
- indicate any ceilings of care that have been requested by the patient and any that have been recommended by healthcare professionals
- describe actions for emergencies arising at home

Further resources to aid completion of emergency healthcare plans, including useful phrases to use, can be found on the above website, or on their app which can be downloaded to smartphones and tablets.

**WEBICE system of referrals**

Since October of 2014, Referrals to the hospital specialist palliative care team have been on the ICE request system. This has enabled requests to be undertaken in a much more efficient and ‘real time’ manner, replacing the system of faxing a written referral. It allows the team to not only allocate referrals accordingly, but to also triage referrals, and respond to urgent cases timely. It also enables nurses, medics and AHPs to refer patients from their clinical areas in a timely manner without looking for referral forms and fax machines. This system is now supplemented by the specialist palliative care duty bleep, 3199. This dedicated bleep is held by a member of the team on a daily basis, enabling one person as a point of access for advice calls, urgent advice and to alert of new referrals, as the ICE request system prompts. In addition, the North East Palliative Care Guidelines – the purple bible to those common with its use – is also now available in the resources section of ICE requester, and also on the Ice home logon page by a weblink (ICE FRONT & ICE RESOURCES)
Palliative and end of life care assistance and advice

In hours

Refer on ICE/Trakcare referral system

Specialist palliative care duty bleep – 3199

End of life co-ordinator – bleep 3198

Out of hours

Nurses can obtain advice from the Hartlepool Hospice helpline on 01429 855558

Medics can obtain advice from the on-call palliative medicine consultant by switchboard

Top tips for clinical practice

If in doubt ask for advice Monday to Friday 9am - 5pm specialist palliative care team at UHNT bleep 3199

1. Out of hours Hartlepool helpline 01429 855558 or medical team can contact palliative care consultant on call through switch.

2. If eGFR is below 30 patient should not be given morphine or oxycodone they should have alfentanil or fentanyl.

3. Ondansetron is only licensed for use post surgery, and pre and post chemotherapy and radiotherapy. Major side effect is constipation!!

Future bulletins

To all doctors, GPs, allied health professionals, senior clinical matrons, ward matrons, nurses, link workers and, community matrons.

This bulletin provides an overview of some of the initiatives the specialist palliative care team are involved with in supporting you to give the best care for palliative and dying patients and relatives.

We work together by establishing a two way dialogue between the team and all clinical staff. Read the bulletin and reflect upon your own clinical practice and identify the areas where you feel you want to improve and where you need more support.

Tell us:

• about the difficult palliative care challenges you face on a daily basis in the clinical area

• about the topics, subjects and skills in palliative and end of life care you wish to learn more about

• how we can best help you deliver better care in clinical practice

Please send your views and feedback to the nurse consultant in palliative care by email to mel.mcevoy@nth.nhs.uk or lynette.winter2@nth.nhs.uk. Your views and feedback will be in the next edition of this bulletin. Thank you.