

# End of Life Care Strategy

## Equality Impact Assessment

### Action plan template: report on progress since 2010

Category	Actions	Target date	Person responsible and their Directorate
<p><b>Para 5.1, Age, Issue:</b> "...older people in particular will need information and support to help them make choices and be fully involved in planning their care...this needs to be provided at an early enough stage to ensure that the individual has the best chance of being able to participate in planning their care before their condition deteriorates"</p> <p><b>Para 5.2, Age, Action:</b> "Advance care planning is a useful way of ensuring that individuals can be involved in planning their care before their condition worsens to the extent that they are no longer able to communicate their wishes"</p>	<p>The work on QIPP (where EOLC is one of the 12 workstreams) continues. This aims to accelerate work on the first two stages of the EOLC pathway, one of which is effective care planning, putting people at the centre of decision making of their own care and care planning.</p> <p>The National EOLC Programme has published an updated guide for health and social care staff on advance care planning. The Programme's May 2011 newsletter focused on advance care planning issues. A patient guide, <i>Planning for your future care: a guide</i>, produced in 2009 by the National EOLC Programme, National Council for Palliative Care and University of Nottingham, has been evaluated by the Institute of Healthcare Management, taking account of the views of service users and carers. The report was published in July 2010.</p> <p>The National EOLC Programme has produced posters for</p>	<p>Ongoing</p> <p>May 2011</p> <p>July 2010</p>	<p>Tessa Ing, Head of Implementation, End of Life Care Strategy</p>

	<p>display in surgeries on encouraging people to ask to discuss their preferred priorities for care</p> <p>The EOLC e-learning package for staff across health and social care (e-ELCA), which was commissioned by DH and developed by e-Learning for Healthcare and the Association for Palliative Medicine together with the National EOLC Programme, includes core modules on advance care planning, assessment and communication skills.</p> <p>The work of the national Dying Matters coalition – set up under the Strategy and funded by DH – to increase public and professional awareness of EOLC issues, including encouraging planning for EOLC, continues. At June 2011, the coalition had over 15,000 members, including community groups, healthcare bodies, a range of faith groups and private individuals.</p>	<p>2011</p> <p>January 2010 and following</p> <p>Ongoing</p>	
<p><b>Para 5.3, Age, Issue:</b> “There is a need for increased awareness of dementia. Carers can play a crucial role in the care of people with dementia and medical professionals will benefit from their expertise in identifying when the person is in pain, distress or discomfort.”</p> <p><b>Para 5.4, Dementia, Action:</b> “The strong messages about the role of carers and the value they have in supporting patients to live in a place of their choice must not be ignored. The EoLC Strategy incorporates the needs of carers and devotes a chapter to this.”</p>	<p>The EOLC Strategy includes a chapter on support for carers and families.</p> <p>The National EOLC Programme has developed strong networks with organisations that support people who are approaching the end of life who have dementia. It has also worked with the DH dementia team to develop a good practice guide for the NHS, <i>Care towards the End of Life for People with Dementia – a Resource Guide</i> (August 2010). Its April 2011 newsletter focussed on dementia.</p> <p>The National EOLC Programme collaborated with NICE to produce <i>EOLC for people with dementia – commissioning guide</i> in July 2010 and DH produced a Dementia Commissioning Guide in July 2011.</p>	<p>July 2008</p> <p>August 2010</p> <p>April 2011</p> <p>July 2010</p> <p>July 2011</p>	<p>Tessa Ing, Head of Implementation, End of Life Care Strategy</p>

	<p>The National EOLC Intelligence Network, set up under the Strategy, has published a range of statistical reports on inequalities in EOLC provision. These cover such as deaths from respiratory disease, dementia, renal disease, neurodegenerative disease and variations in place of death. The reports analyse differences by gender, age and diagnosis.</p> <p>Also, see response to paras 5.32 and 5.34.</p>	<p>June 2010 and following</p>	
<p><b>Para 5.5, Disability and long-term conditions, Issue:</b> "...there is potential for inequality to occur in respect of people with a learning disability or severe mental illness. These people will require skilled professional care from people who understand the complexities of LD and MI...should also recognise the importance of the role of the family or carer..."</p> <p><b>Para 5.6, Disability and LTC, Action:</b> "More training is needed for those who work with people with a learning disability"</p>	<p>The annual reports on the EOLC Strategy highlight progress on work achieved and being implemented for workforce and our intentions for future years. During 2010/11, we worked with the National EOLC Programme, Skills for Care and Skills for Health to test how well the materials developed to date support the workforce delivering EOLC in learning disabilities, mental health and people with sensory impairment. The report of this work is currently being reviewed.</p> <p>The National EOLC Programme has developed strong networks with organisations that support people who are approaching the end of life who have communications difficulties or who have learning difficulties. Working with people with learning disabilities and health and social care staff, it has developed a guide to help professionals support people with learning disabilities at the end of life. <i>The route to success in end of life care – achieving quality for people with learning disabilities</i> was published in February 2011 and <i>The route to success in end of life care – achieving quality in domiciliary care</i> was published in March 2011. A DVD is available and the Programme's March 2011 newsletter focused on domiciliary care and learning disabilities.</p>	<p>Ongoing</p> <p>February 2011</p> <p>March 2011</p>	<p>Tessa Ing, Head of Implementation, End of Life Care Strategy</p>

	<p>The Dying Matters coalition (funded by DH) worked jointly with the National EOLC Programme and CHANGE to produce a DVD jointly with people with learning disabilities. The film – <i>We're Living Well but Dying Matters</i> - highlights the importance of including people with learning difficulties in discussions around death, dying and bereavement.</p>	<p>May 2011</p>	
<p><b>Para 5.7, Disability and LTC, Issue:</b> “To have any chance of closing the inequalities gap between the EOLC that cancer patients receive and that which those living with other LTC receive, it will be necessary to raise the profile of other LTC. The workforce will need to be equipped with the right skills...”</p> <p><b>Para 5.8, Disability and LTC, Action:</b> “EOLC Strategy will address workforce issues.”</p>	<p>The EOLC Strategy includes a chapter on workforce, covering all clinical areas across health and social care. Competence frameworks and e-learning developed in response to the Strategy cover LTC and other care areas to contribute to reducing inequality gaps through workforce training.</p> <p>We have established, with the Association for Palliative Medicine and e-Learning for Healthcare, an Editorial and Review Board for the EOLC e-learning package we have developed for health and social care staff (e-ELCA), which will periodically review content and commission additional modules or sessions. This review is due during 2012/13 and the evaluation of uptake etc is planned for early 2012.</p> <p>We continue to prioritise work related to e-learning access issues for all health and social care staff and employers and have made significant progress in social care and care homes.</p> <p>We continue to raise awareness with Medical Royal Colleges of our work on e-learning and competences and influence other professional bodies and standards to include EOLC. We continue to work closely with SHAs and associated networks to roll out the e-learning and competences developed to date.</p>	<p>July 2008</p> <p>June 2009, January 2010 and following</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>	<p>Tessa Ing, Head of Implementation, End of Life Care Strategy</p>

	<p>The National EOLC Programme has developed a pathway for neurological conditions working in collaboration with clinical champions, an expert clinical reference group and the Neurological Alliance. This was published in November 2010. The National EOLC Programme and NHS Improvement have published <i>End of Life Care in Heart Failure: A Framework for Implementation</i>. This aims to help commissioners understand the complex care environment in which people with heart failure live and ensure the delivery of sufficiently flexible and responsive services that meet their needs at each stage of the care pathway.</p> <p>DH's LTC QIPP workstream will adopt the 'surprise question' into its plans to be sure that people with conditions such as heart failure and COPD are identified as in need of EOLC at the right point.</p> <p>DH has consulted on a COPD strategy, which includes a chapter on EOLC, including specific recommendations aimed at improving access to EOLC services and ensuring appropriate information to carers and those who are bereaved. It also recommended that further work should be undertaken to pilot markers of a prognostic indicator to identify the EOLC phase for people with COPD, to develop an EOLC pathway and evaluate different models of support for carers. This work is supported by the National EOLC Programme.</p> <p>Early results suggest that staff awareness and recognition of death and dying of COPD as a major issue. They have therefore undertaken to train staff at all levels in their organisations to improve awareness and advanced</p>	<p>November 2010</p> <p>July 2010</p> <p>Ongoing</p> <p>February 2010</p> <p>July 2011</p> <p>Ongoing</p>	<p>Kevin Holton, Team Leader, National Strategy for COPD</p>
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	<p>communications skills. In all the projects, COPD patients identified by specific prognostic indicators have been offered advance care planning. There is substantial under-representation of COPD patients on primary care EOLC registers, and two of the LIP projects are aiming to increase the number of patients on the register, specifically through education of GPs.</p>		
<p><b>Para 5.9, Race, Issue:</b> "... staff education in multi-cultural health could play a large role in helping EOLC to embrace society's diversity and changing needs. Language has the potential to be a barrier to good quality EOLC"</p> <p><b>Para 5.10, Race, Action:</b> "The use of formal interpreters could be encouraged to prevent a large burden being placed on children and younger generations who often have to act as interpreters. This will help to create a more standard quality of service for people across the country and across difference ethnicities."</p>	<p>Our work on developing competences and e-learning (e-ELCA) for workers across health and social care takes into account the need to understand holistic, cultural, spiritual and lifestyle aspirations, goals and priorities, including after death.</p> <p>The final report of the National EOLC Programme's communication skills pilot project (<i>Talking about end of life care: right conversations, right people, right time</i>), recognises the competence needs of interpreters.</p> <p>The National EOLC Programme website highlights a case study of the work of the Marie Curie Delivering Choice Programme in Leeds to improve palliative care access to patients from BME groups, which includes improving access to, and providing extra support to interpreters.</p> <p>Whilst implementation of the EOLC Strategy, which is a strategy for the long-term, will raise awareness of these issues, it is not within the scope of the Strategy to introduce a central policy on an issue that is far wider than EOLC. The provision of interpretation services by NHS bodies remains a matter for local determination. When planning such services, NHS bodies should take due account of their legal duties, the composition of the communities they serve, and the needs</p>	<p>June 2009, January 2010 and following</p> <p>January 2011</p> <p>Ongoing</p>	<p>Tessa Ing, Head of Implementation, End of Life Care Strategy</p>

	<p>and circumstances of their patients, service users and local populations.</p> <p>NHS organisations are subject to the public sector equality duty (s149 of the Equality Act 2010) in their own right which means that they should pay due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between different groups in discharging all of their functions. In practice, this means that they need to ensure that people have real and equal access to the information and services that they provide. It is therefore individual NHS organisations' responsibility to ensure that any language support provision that they commission is delivered adequately and effectively.</p>		
<p><b>Para 5.11, Race, Issue:</b> “Communication skills are important and it will be essential that all professionals providing EOLC are trained in effective communication.”</p> <p><b>Para 5.12, Race, Action:</b> “Communication skills need to be part of all under and post graduate training.”</p>	<p>The Communication Skills Pilot Project, led by the National EOLC Programme, reported in January 2011. Twelve pilot sites across England explored the need and range of communication skills training provision for the health &amp; social care staff delivering EOLC and identified the delivery components and requirements for training. The learning and good practice from the project are now accessible on the Programme’s website.</p> <p>The Dying Matters coalition (funded by DH) worked with the Barnsley Black and Ethnic Minority Initiative, the LGBT Consortium and Social Action for Health to create joint messages and images targeting different communities. This has resulted in a four new posters and a number of talking heads, available to view on the Dying Matters website. (This work was originally planned to have been done with PRIAE).</p>	<p>January 2011</p> <p>Ongoing</p>	<p>Tessa Ing, Head of Implementation, End of Life Care Strategy</p>
<p><b>Para 5.13, Race, Issue:</b> “It should be recognised that some patients, particularly those of recent</p>	<p>The core competences for EOLC training for health &amp; social care staff for assessment and care planning includes to</p>	<p>June 2009,</p>	<p>Tessa Ing, Head of</p>

<p>migration, will either wish to return to their 'home' country to die or will wish to be buried in their country of origin after they have died. Where possible these wishes should be elicited by the professional responsible for the individual's care at the time of care planning and while the patient is still well enough to travel."</p> <p><b>Para 5.14, Race, Action:</b> "Assessment and care planning should include a prompt by the healthcare professional about the option of returning to another country to die. Having a discussion about EOLC and drawing up a care plan at early stage within a person's illness could also help family /friends living abroad to have sufficient time to make arrangements to travel to England to visit the individual or for the person to return to their country of origin."</p>	<p>ensure that all assessments are holistic, including cultural, spiritual and lifestyle aspirations, goals and priorities, including after death. This is also reflected in the e-learning developed for EOLC (e-ELCA).</p> <p>However, it is ultimately for the local NHS to choose whether or not to actually fund or commission the repatriation of a patient to another country. There is no central Government policy on this issue and there is no provision in EU regulations or in any bilateral agreements with non EEA countries, for repatriation or for covering the cost of repatriation.</p> <p>Whilst implementation of the EOLC Strategy, which is a strategy for the long-term, will raise awareness of these issues, it is not within the scope of the Strategy to introduce a central policy on an issue, which is far wider than EOLC.</p>	<p>January 2010 and following</p>	<p>Implementation, End of Life Care Strategy</p>
<p><b>Para 5.15, Race, Issue:</b> "Formal statistical collection by care homes, hospices, extra care housing etc about the ethnicities of residents would be a useful way of monitoring whether uptake to these services increases over time."</p> <p><b>Para 5.16, Race, Action:</b> "PCTs and LAs should make information widely available... care homes, hospices, extra care housing etc should consider collecting information about a resident's ethnicity, religion, language &amp; culture."</p>	<p>DH commissioned a pilot study to revise the VOICES (Views of Informal Carers – Evaluation of Services) tool, to align it to the EOLC Strategy, test its use, and provide recommendations on how it could best be utilised in a national survey. An important aspect of the study was to explore response rates from BME communities, and how these might be improved. A national survey is to be commissioned and is expected to be complete by March 2012.</p> <p>Other data sources include:</p> <ul style="list-style-type: none"> <li>National Council For Palliative Care: the Minimum Data Set includes data on ethnicity. This is a non-mandatory collection from statutory and voluntary sector specialist palliative care providers. This</li> </ul>	<p>Ongoing</p> <p>Ongoing</p>	<p>Tessa Ing, Head of Implementation, End of Life Care Strategy</p>

	<p>collection is currently being updated in liaison with DH and the National EOLC Programme.</p> <ul style="list-style-type: none"> <li>• The NHS Information Centre: collects information on Proforma P1, P4 and P7 (new from 2010-11) of the Referrals Assessments and Packages return, on clients in Residential Care and Nursing Care by age, primary client type, gender and ethnicity.</li> <li>• Care Quality Commission: <ul style="list-style-type: none"> <li>• Page 32 of the Essential Standards of Equality and Safety states: "Equality, diversity and human rights... Providers must consider equality, diversity and human rights in every aspect of their work. You should consider the needs of each person using a service against six key strands of diversity: Race, Age, Gender, Disability, Sexual orientation, Religion or belief. We sometimes refer to this as identifying a person's "diversity" or "diverse needs"."</li> <li>• The guidance document states, for Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: "Outcome 1: Respecting and involving people who use services... 17.— (1) The registered person must, so far as reasonably practicable, make suitable arrangements to ensure — (h) that care and treatment is provided to service users with due regard to their age, sex, religious persuasion, sexual orientation, racial origin, cultural and linguistic background and any disability they may have."</li> <li>• Question 1G of the Provider compliance self assessment tool; Outcome 1(Regulation 17):</li> </ul> </li> </ul>	Ongoing	
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	<p>Respecting and involving people who use services, asks providers to give evidence to demonstrate that people who use services receive care, treatment and support that is provided in a way that ensures their human rights and diversity are respected.</p> <p>Whilst implementation of the EOLC Strategy, which is a strategy for the long-term, will raise awareness of these issues, it is not within the scope of the Strategy to introduce a central policy on an issue, which is far wider than EOLC. We will, however, continue to draw this issue to the attention of the responsible bodies.</p>	Ongoing	
<p><b>Para 5.17 Religion &amp; Belief, Issue:</b> "...It will be important for healthcare professionals to have a basic knowledge of the differences between different religions &amp; be aware of the limits to their knowledge."</p> <p><b>Para 5.18, Religion and Belief, Action:</b> "Spiritual care should be coordinated across the care pathway and those caring for the dying and bereaved should have a reasonable knowledge of various faiths and practices."</p> <p><b>Para 5.19 Religion &amp; Belief, Issue:</b> "...Religious practice is an area where discrimination could occur, even if this is indirect."</p> <p><b>Para 5.20, Religion and Belief, Action:</b> "PCTs and LAs should ensure that there is space and time for religious practices to be carried out by both the individual and their visitors, family or carers"</p>	<p>Using information obtained through the literature review (see below), conferences and expert working groups, we prepared draft Quality Markers (QM) on spiritual care and bereavement. These have been made available to NICE to support and inform its work on a Quality Standard for EOLC. The draft QM have been published on the National EOLC Programme's website for information. An on-line self-assessment tool, EOLC Quality Assessment (ELCQuA), has been produced by the National EoLC Intelligence Network in conjunction with SHA EOLC leads and wider NHS colleagues. This will enable commissioners and providers to monitor progress against standards based on the DH QM. It will in due course incorporate the NICE EOLC Quality Standard. The tool was launched in June 2011.</p> <p>The core competences for EOLC training for health &amp; social care staff for assessment and care planning includes to ensure that all assessments are holistic, including cultural, spiritual and lifestyle aspirations, goals and priorities,</p>	<p>May 2011</p> <p>June 2011</p> <p>June 2009</p>	<p>Tessa Ing, Head of Implementation, End of Life Care Strategy</p>

<p>regardless of the setting.”</p> <p><b>Para 5.21 Religion &amp; Belief, Issue:</b> “Respect and forethought needs to be given to whether certain medical practices are acceptable to certain religions.”</p> <p><b>Para 5.22 Religion &amp; Belief, Action:</b> “Assumptions should not be made about the treatment or care an individual may wish to receive. Health care professionals should seek individuals’ views about whether any aspect of their religion would make certain medical practices inappropriate.”</p>	<p>including after death.</p> <p>Our work on developing e-learning (e-ELCA) for workers across health and social care takes into account the need to understand holistic, cultural, spiritual and lifestyle aspirations, goals and priorities, including after death. A specific module on spiritual care was published in May 2011.</p> <p>The National EOLC Programme commissioned a literature review, gathering together all available evidence and information on spiritual care at the end of life. We published <i>Spiritual Care at the End of Life: a systematic review of the literature</i> in January 2011.</p> <p>The National EOLC Programme has developed strong networks with organisations that support people who are approaching the end of life who have a variety of different beliefs and cultural backgrounds.</p> <p>The National Council for Palliative Care has established a Meaning, Faith and Belief group.</p>	<p>January 2010</p> <p>May 2011</p> <p>January 2011</p> <p>Ongoing</p> <p>Ongoing</p>	
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## End of Life Care Strategy Equality Impact Assessment

### Action plan template: report on progress since 2010 report (continued)

Category	Actions	Target date	Person responsible and their Directorate
<p><b>Para 5.23 Sexual orientation and gender identity, Issue:</b> “health care professionals should be careful not to make assumptions that people are heterosexual and if an individual reveals they are lesbian or gay, stereotypical assumptions should not be made about what type of person they are. The language that health care professionals use should be selected carefully so as not to inadvertently make someone feel that they have to reveal their sexual orientation or transgender identity.”</p> <p><b>Para 5.24 Sexual orientation and gender identity, Action:</b> “Care homes, hospices and extra care housing should be encouraged to positively market themselves as being gay friendly places...Staff need to be trained to understand LGBT issues and policies should be developed to require staff to report any incidences of discrimination by staff or other residents.”</p> <p><b>5.25</b> ...it should be a requirement, as part of continuing professional development, that staff attend</p>	<p>In 2007, DH produced a series of documents under the title <i>Reducing health inequalities for lesbian, gay, bisexual and trans people - briefings for health and social care staff</i>. These are accompanied by two documents from the Practical Guides for the NHS series on Sexual Orientation and Trans. DH has also published guidance on bereavement relating to trans people, which includes practical advice to protect dignity in death relating to gender identity. Guidance for appropriate and sensitive accommodation of trans people in single-sex in-patient settings can be found in Annex E of this communication (this Annex remains current).</p> <p>The National EOLC Programme is looking to do further work on the LGBT agenda and is linking with the National Council for Palliative Care and the University of Nottingham on this. All the National EOLC Programme’s work on advance care planning enables clear equality for LGBT groups with regards to choice etc</p> <p>The Dying Matters coalition (funded by DH) has worked jointly with the LGBT Consortium to produce a report and associated film highlighting the inequalities faced by some</p>	<p>2007 and ongoing</p> <p>Ongoing</p>	<p>Tessa Ing, Head of Implementation, End of Life Care Strategy</p>

<p>relevant courses on LGBT issues, equality and diversity and keep themselves up-to-date on current equality legislation.”</p> <p>“<b>5.26</b> Healthcare providers also need to have in place a clear policy on confidentiality...”</p> <p><i>[NB: We recognise that, since the publication of the EqIA and the EOLC Strategy, the Equality Act 2010 has been enacted, which lists sexual orientation and gender assignment as separate protected characteristics, and that terminology has also changed.]</i></p>	<p>LGBT people in discussing and accessing appropriate EOLC services as well as good practice. [Both expected to be available from July 2011.]</p> <p>Arrangements for training and development of staff are for decision by individual Trusts or providers. There are no requirements to provide LGBT-specific training, although most providers would usually offer some level of generic equality &amp; diversity training, and would be expected to be compliant with the Equality Act and the new Public Sector Equality Duties.</p> <p>Whilst implementation of the EOLC Strategy, which is a strategy for the long-term, will raise awareness of these issues, it is not within the scope of the Strategy to introduce a central policy on an issue, which is far wider than EOLC. We will, however, continue to draw this issue to the attention of the responsible bodies.</p>	<p>[July 2011]</p>	
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<p><b>Para 5.27 Homeless people, Issue:</b> "... for many, it will be important to have advocates to help in the care planning process...health care professionals [should] ask the individual if there is anyone else they would like to be involved in their care and to refrain from making assumptions about the individual's relationship with family members."</p> <p><b>5.28</b> "... it will be important for hospital discharge teams to understand the history of the homeless person... and to work with organisations supporting homeless people to plan the discharge and produce an appropriate care plan."</p> <p><b>Para 5.29 Homeless people, Action:</b> "The care planning process should help to ensure that hospital discharge teams identify when a homeless person might be at the end of their life and work with other organisations to put in place an appropriate package of care."</p> <p><b>Para 5.30</b> "...Further work may be needed in the UK to ascertain whether the same benefits (both for the residents and in respect of cost savings) [from studies in Canada] could be realised here."</p>	<p>The EOLC e-learning package developed for workers across health and social care (e-ELCA) includes an integrated learning module around specific EOLC scenarios, including one for homeless people.</p> <p>The Dying Matters coalition, which is funded by DH, has worked jointly with St Mungos and Marie Curie to produce leaflets aimed at homeless people and those who care for them, available on the Dying Matters website (<i>My life, my choices</i>, and, for professionals, <i>Talking about end of life choices with people who are homeless</i>). They have worked with Homeless Link to ensure distribution to all homeless shelters.</p> <p>The National EOLC Programme has developed strong networks with organisations that support people who are approaching the end of life who are homeless. It has produced <i>Route to success in hostels and for homeless people</i>, a resource aimed to help hostel staff to support homeless people at the end of life and its December 2010 newsletter focussed on homelessness.</p> <p>A pilot scheme supported by the National EoLC Programme and Marie Curie Cancer Care is underway on the blue wallet scheme, which aims to ensure information about a person is available if that person is unable to communicate, for example, which hostel is their current home, medications and wishes and preferences.</p>	<p>January 2010 and following</p> <p>2011</p> <p>Ongoing</p> <p>December 2010</p> <p>Ongoing</p>	<p>Tessa Ing, Head of Implementation, End of Life Care Strategy</p>
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<p><b>Para 5.31 Carers, Issue:</b> "...regular support should be provided...breaks from care should also be considered as a means to support people to continue living at home and to support carers to enable this to happen"</p> <p><b>Para 5.32 Carers, Action:</b> "The service should recognise the vital role carers play in enabling someone to die in the place of their choice and acknowledge that they are central to the caring team. Carers have a right to an assessment of their own needs and systems should be in place to ensure that in addition to supporting carers in a planned way, they are also able to provide support to carers who, because of a crisis or emergency, are temporarily unable to care."</p> <p><b>Para 5.33 Carers, Issue:</b> "...visiting hours (in hospitals, care homes and hospices) could be more flexible."</p> <p><b>Para 5.34 Carers, Action:</b> "Visiting times for patients at the end of their lives should be flexible where possible and dedicated family rooms for relatives and friends to sleep the night when a loved one is very close to death should be made available."</p>	<p>The EOLC Strategy includes a chapter specifically on carers and families, which is reported on each year in the annual report on the Strategy.</p> <p>A number of the projects funded through the DH's £40m capital fund for hospices (2010/11) have enhanced facilities for carers and families in hospices [see third annual report].</p> <p>We are providing funding to Age UK to develop potential models to support carers in later life, to enable a loved one to die with dignity in the place of their choice</p> <p>The Standing Commission on Carers recognised the need to encourage closer links between the implementation plans for the Carers Strategy and other strategies relevant to carers, including the EOLC Strategy.</p> <p>A number of activities were launched under the auspices of the Carers Strategy, including Carers Direct, a website and helpline to provide accessible information and advice to all carers.</p> <p>DH set up 25 Carers Demonstrator sites to gather evidence of different ways of providing breaks, health checks and better NHS support for carers. A number of the sites have a particular focus on EOLC. The Demonstrator Site project ended on 31 March 2011. The evaluation of the work of the Demonstrator Sites, which is being carried out by CIRCLE at Leeds University, is expected to be published in September/October 2011.</p> <p>On 25<sup>th</sup> November 2010, the Government published an</p>	<p>July 2008</p> <p>March 2011</p> <p>August 2010 and ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>	<p>Tessa Ing, Head of Implementation, End of Life Care Strategy</p> <p>Elaine Edgar, Head of Policy, Carers Team</p>
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	<p>update to the Carers Strategy – <i>Recognised, valued and supported: Next steps for the Carers Strategy</i> - setting out the priorities for action over the next four years focusing on what will have the biggest impact on carer’s lives. These are:</p> <ul style="list-style-type: none"> <li>• Supporting those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset both in designing local care provision and in planning individual care packages.</li> <li>• Enabling those with caring responsibilities to fulfil their educational and employment potential.</li> <li>• Personalised support for carers and those they support, enabling them to have a family and community life.</li> <li>• Supporting carers to remain mentally and physically well.</li> </ul> <p>DH is providing additional funding of £400m to the NHS over the next four years to enable more carers to take breaks from their caring responsibilities. This is in addition to existing DH revenue grants to councils for adult social care which has continued and will rise in line with inflation over the next four years. This includes the funding that was previously known as the Carers Grant.</p> <p>It remains for local hospitals to decide on visiting hours. They should, however, bear in mind the needs of visitors regarding such as shift working, child care and transport issues and be flexible about visiting hours wherever possible.</p> <p>Whilst implementation of the EOLC Strategy, which is a</p>	<p>November 2010</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>	
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	<p>strategy for the long-term, will raise awareness of these issues, it is not within the scope of the Strategy to introduce a central policy on an issue, which is far wider than EOLC. We will, however, continue to draw this issue to the attention of the responsible bodies when opportunity arises.</p> <p>The planned national survey of the bereaved (VOICES, see above), will feedback from the bereaved not just on their views on the care experience of the deceased, but also on their own experience.</p>	Ongoing	
<p><b>Para 6.1 Monitoring:</b> “NHS &amp; social care bodies will wish to ensure that, when implementing this strategy they bear in mind their responsibilities towards ensuring that EOLC is available equitably, and with due regard to the differing needs and wishes of different members of society. To this end they will wish to put in place suitable ways of monitoring EOLC to provide assurance.”</p>	<p>One of the top ten Quality Markers is, for PCTs, to monitor the quality and outputs of EOLC and submit relevant information for local and national audits.</p> <p>The new on-line self-assessment tool, ELCQuA (see above), will enable commissioners and providers to monitor progress against standards based on the DH EOLC Quality Markers and will in due course incorporate the NICE EOLC Quality Standard.</p> <p>The work on the locality register pilots, the VOICES survey of bereaved relatives and the National EOLC Intelligence Network described above will contribute to monitoring how effective implementation of the EOLC Strategy is and how services are improved.</p>	Ongoing  Ongoing	Tessa Ing, Head of Implementation, End of Life Care Strategy

<b>Name of person who carried out the EqIA Progress Report:</b>	Robert Freeman, End of Life Care Team, Clinical Policy and Strategy
<b>Date EqIA completed:</b>	<b>August 2011</b>
<b>Name of Director/Director General who signed the EqIA Progress Report:</b>	Gerard Hetherington, Director of Clinical Programmes, Clinical Policy and Strategy
	
<b>Date EqIA Progress Report was signed:</b>	31 <b>August 2011</b>