Reaching the whole community?
End of life care for all who need it

Thursday 18th April
London Marriott Hotel Regents Park

#EOLCforall
Are you Tweeting today?
If so, please use #EOLCforall

Follow us for live tweets...

• @DyingMatters
• @SimonSimply - Director of Public & Parliamentary Engagement, NCPC
hard to reach
seldom heard
What do you think of when you hear these terms?
hard to reach
seldom heard
Tight knit ethnic minority groups
People that do not like or trust other people helping them
We don't know where they are and it would take too much effort to find them.
Easy to ignore
People who have slipped through the net
Not engaged
Difficult
Not like us
hard to reach

seldom heard
Always sounds patronising to me
Person holding unwelcome views
People who are overlooked

-the loop

me
Drug users may be ‘hard to reach’ but if you go to a drop in centre and ask them I am sure they would comment
We don't know who they are, they never get involved anyway, so move on
Isolated
They don't speak up
We've done all we can to manage the stuff they keep telling us about
Having an opinion but nowhere to voice it
Less powerful
Ignored, dismissed
Using words we don't know
We don’t have any of them here
We can’t cover all of them but let’s make it look as if we tried so that we can tick the boxes
There are all kinds of people
and there is always a way to reach them.
With thanks to members of
NCPC’s people bank
CQC’s Speakout network

for sharing their thoughts
Reaching the whole community?
End of life care for all who need it

Thursday 18th April
London Marriott Hotel Regents Park

#EOLCforall
THE NHS CONSTITUTION
the NHS belongs to us all
The NHS belongs to the people

It is there to improve our health and well-being, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most.
High quality care for all, now and for future generations
Our vision

Everyone has greater control of their health and their wellbeing, supported to live longer, healthier lives by high quality health and care services that are compassionate, inclusive and constantly improving.
Our Purpose

We create the culture and conditions for health and care services and staff to deliver the highest standard of care and ensure that valuable public resources are used effectively to get the best outcomes for individuals, communities and society for now and for future generations.
Behaviours

We prioritise patients in every decision we take.
We listen and learn.
We are evidence-based.
We are open and transparent.
We are inclusive.
We strive for improvement.
The values enshrined in the NHS Constitution underpin all that we do:
NHS Values

• Respect and dignity
• Improving lives
• Commitment to quality of care
• Compassion
• Working together for patients
• Everyone counts.
Reaching the whole community?
End of life care for all who need it
Thursday 18th April
London Marriott Hotel Regents Park

#EOLCforall
Eddy & Myrle

EDDY
• 89 years old
• Lived in ?? community setting for 5 years. Wants to stay there
• In pain; breathless; in bed much of the time; not eating much; depressed
• Doesn’t want CPR or antibiotics for a chest infection

MYRLE
• Eddy’s daughter, lives nearby; visits daily
• Helps Eddy on personal budgets (health & social care)
• Aged 65; cannot lift; restricted mobility

www.ncpc.org.uk
Governments, ministers & organisations change; people’s needs don’t

• More older people
• Living longer; longer ill-health
• More with multiple conditions
• 800,000 with dementia; 1 million by 2021
• Someone dies every minute
• More will die each year
• Most die in hospital, where they don’t want to be
• 21.8% die at home
• 1 in 3 over 65 die with dementia
We know...

- Cause(s) of death
- Age
- Gender
- Place of death (and care beforehand?)
- Preferences
Their place of death is changing...

- Decline in home deaths reversed; 21.8% died at home in 2011 (18%, 2004)
- Hospital deaths down from 58% (2004) to 51% (2011)
- 500,000 people die each year; each 1% change = 5,000 people living & dying in a different setting
There is a slow trend towards more deaths in the community but much further to go.

Proportion of home deaths in England & Wales 1974-2010

Footnote: Actual place of death provided by the Office for National Statistics; 1999-2003 based projections by Gomes & Higginson 2008. Percentages shown within the graph refer to 2003 (actual data for all deaths, cancer and non-cancer deaths) and to 2010 (including both actual and projected data).
Their age & gender

• 2/3 of people die 75+
• 74% of women & 58% of men die aged 75+
• 1 in 6 deaths are people aged 90+
• 2008:
  • 4 million people are aged 75+
  • 0.4 mill aged 90+
• Projections to 2033
  • 7.2 million 75+;
  • 1.2 million 90+

NEoLCIN 2010

www.ncpc.org.uk
We know that...

- 78% will be admitted to hospital at least once in the last year
- 89% of those who die in hospital do so following an emergency admission:
  - 32% of those die after a stay of 0-3 days
  - 18% after a stay of 4-7 days
  - 50% after a stay of 8 days or longer
- People have an average of 2 emergency hospital admissions in the last year of life
- 20% have 3 or more emergency admissions
You are more likely to die in hospital if you are...

• **A man** (55% men 52% women died in hospital in 2010) OR

• **Over 75** (57% of 75-79) **but not over 90** (48%) OR

• **Live in a deprived area** (61% from most deprived quintiles of LA areas v 54% from least deprived, 2007-9)
Gender differences

Figure 4.2: Proportion of deaths by place in males and females aged 75 and over, England, 2006–08 (proportion of deaths in males and females)

Source: South West Public Health Observatory from Office for National Statistics data
People with advanced dementia are more likely to die in care homes

- Dementia, Alzheimer’s or senility identified as cause or factor on 15% of death certificates (2001-9)
- Underlying cause:
  - 32% died in hospital; 59% in care homes; 8% in own home
- Contributory:
  - 42% in hospital; 47% care homes; 9% own homes

NEoLCIN (2010)
Where people would like to die

Figure 5 - Most preferred place of death by age group

- 16-24: 73% own home, 6% hospice, 14% hospital, 20% care home, 37% home of a relative or friend
- 25-34: 75% own home, 14% hospice, 14% hospital, 20% care home, 37% home of a relative or friend
- 35-44: 72% own home, 20% hospice, 14% hospital, 20% care home, 37% home of a relative or friend
- 45-54: 58% own home, 37% hospice, 14% hospital, 20% care home, 37% home of a relative or friend
- 55-64: 67% own home, 28% hospice, 14% hospital, 20% care home, 37% home of a relative or friend
- 65-74: 56% own home, 37% hospice, 14% hospital, 20% care home, 37% home of a relative or friend
- 75+: 45% own home, 41% hospice, 14% hospital, 20% care home, 37% home of a relative or friend

Age differences were statistically significant (Kruskal-Wallis test = 43.287; p-value < 0.001).
Where people don’t want to die

Figure 9 - Least preferred place by age group

Age differences were statistically significant (Kruskal-Wallis test = 24.036; p-value < 0.001).
Preferences & Realities

- 67% of deaths are people aged 75+
- 41% of people aged 75+ 1st preference would be to die in a hospice
- 3% people aged 75+ die in a hospice
We know that....

• EPaCCS pilots have enabled up to 80% to die in their place of choice
• You are more likely to die at home if you access....
  • community-based specialist palliative care (MDS)
  • Home-based nursing care (Nuffield)
• Lower use of hospital care is associated with higher use of social care (Nuffield)
They are most likely to access spc if they have cancer

Chart 32: Growth in diagnoses other than cancer
Understand the data

- What is it saying about where people are dying?
- What links do those settings have with necessary services?
- Are there differences between conditions and settings?
- Data needs intelligence to be applied!
Care homes

- Parkinson's disease: Men 49, Women 33
- Motor neurone disease: Men 19, Women 16
- Multiple sclerosis: Men 20, Women 17
- Huntington's disease: Men 46, Women 35
- Multiple system degeneration: Men 23, Women 17
- Progressive supranuclear palsy: Men 29, Women 40

www.ncpc.org.uk  www.dyingmatters.org
Snapshot: West Sussex

Key facts

- Population: 799,701
- %s of older people living and dying here are significantly above England averages
- 8,680 deaths each year
- Place – 47.6% in hospital, 18.2% at home, 24.8% care home, 7.4% in hospice
- Cause - 30.5% CVD, 26% cancer, 13.6% respiratory

Source: National End of Life Care Intelligence Network end of life profiles
It’s not just location, location, location...

Focus on Quality

www.ncpc.org.uk

www.dyingmatters.org
VOICES survey, 2012

• First national survey of bereaved people
• Views of Informal Carers for the Evaluation of Services
• Questionnaire sent to 48,766 people who registered deaths
• 1 in 6 of deaths between 1/11/10-30/6/11
• 4-11 months after death
• 45.7% response rate
VOICES key findings
dignity & respect

All of the time:
• Hospice doctors 87%
• Hospice nurses 80%
• District/community nurses 79%
• GPs 72%
• Care homes 61%
• Hospital doctors 57%
• Hospital nurses 48%
VOICES & NICE....

QS 8: “People approaching the end of life receive consistent care that is coordinated effectively across all relevant settings and services at any time of day or night...”
VOICES
Pain Relief

THE NATIONAL COUNCIL FOR PALLIATIVE CARE

Percentages

- Completely, all of the time
- Completely, some of the time
- Partially
- Not at all

Home | Hospital | Care home | Hospice

www ncpc org uk www dying matters org uk
OUR GREATEST FEAR

How scared are you of the following happening to you?

- Dying in pain 83%
- Dying alone 67%
- Being told you are dying 62%
- Dying in hospital 59%

Compare with:

- Going bankrupt 41%
- Divorce/end of a long-term relationship 39%
- Losing your job 38%

Comres 2011
IMAGES & LANGUAGE

The National Council for Palliative Care

Dying Matters

"Let's talk about it"

Images:

- A picture of a person smiling.
- A person holding a leaflet with the text: "I wish we’d spoken earlier."
- A person holding a leaflet with the text: "Planning for dying gives you peace of mind for those left behind.

Text:

"We all deserve to die well. Together we can achieve this."

If you want to make sure everything is prepared for your own death or that of a loved one but don’t know where to start, we can help.

Pick up a leaflet, call freephone 08000 21 44 66 or visit: www.dyingmatters.org

It's important to have conversations with your loved ones before it's too late, but sometimes where to start. We can help.

Pick up a leaflet, call freephone 08000 21 44 66 or visit: www.dyingmatters.org

You have the right to make choices about your care but you only have one chance to get it right. We can help.

Pick up a leaflet, call freephone 08000 21 44 66 or visit: www.dyingmatters.org

Talking about dying doesn’t bring it closer; it’s about making the most of living. And helping your loved ones after you’ve gone. We can help.

Pick up a leaflet, call freephone 08000 21 44 66 or visit: www.dyingmatters.org

www.ncpc.org.uk
Who cares?

Support for carers of people approaching the end of life

“Aren’t you OK?”

“Yes, I’m fine”

“Are you sure you are OK?”

“I need help”
NEoLCIN website

- End of life care was data poor
- It is improving – we know much more about where & when people die, what conditions they have
- Social care profiles
End of life care quality assessment

- Web-based tool to support service improvement.
- Use to electronically self-assess and track progress against NICE Quality Standard for end of life care
- Includes 42 measures – mix of patient outcomes and process indicators
- Benchmark against other similar services throughout the country
- Use to plan priorities for end of life care
- Share good practice with other organisations
- ELCQuA is user-friendly, easy to update, personalised to each user and free to users
- To register - visit www.elcqua.nhs.uk
Reaching the whole community?
End of life care for all who need it

Thursday 18th April
London Marriott Hotel Regents Park
Putting it into practice: Who is approaching the end of life in my community?

Michael Kerin,
Chief Executive, St Joseph’s Hospice
Overview

• Commissioning and engagement for Hospices
• St Joseph’s journey towards community engagement ... and participation
• Implications for the Hospice
Information

Growth in available data

- National: eg NHS CB, Public Health England
  Marie Curie Map; Nuffield Trust reports on social care
- Local: JSNAs
  Hospice research: eg StJH Needs Assessments published 2008 and 2012
- Voices as well as “facts” (eg Survey of Bereaved People)
Approach to Need : I

• Traditional hospice approach
  – Individualised care;
  – Strong on local relationships - No central planning
  – Charities: ‘At the margin’ or ‘Good Samaritan’
  – Community engagement: for fundraising and volunteers

• Commissioning/public health approach
  – Comprehensive services
  – Population focus: needs and priority based
  – Outcome driven
Approach to Need : 2

• Hospices as co-commissioners
  Adopt the best of both approaches:
  – understanding and responding to the care needs of the population and
  – delivering individualised care
    sustaining strong local relationships
My community is not neat

• Ethnic and cultural diversity ... and ever changing

• Not homogenous across age structure
  – White British population majority of ‘oldest’ residents, and BME communities majority of young residents
  – Different communities ageing at different rates – eg depending on when they settled in area

• Differences within communities
  • Generational differences
  • Different origins or histories

• Multiple diversities

St Joseph's Hospice
Implications

• Don’t make assumptions: understand the individual
• One size does not fit all – either in service delivery or in community engagement
• Diverse workforce adds to complexities of communication and culture
2006: The starting point

- Hospice isolated: “behind walls”
- Much loved by some parts of population but unknown by many parts of the local population “A hidden jewel”
- Limited relationship with users (current or potential)
- Lack of skill and confidence about how to engage more
Why change?

• A new strategic plan (2007) – explicitly based on population needs, consultation and co-commissioning principles

• A realisation that our user profile did not reflect the make up of our local population

• Living out St Joseph’s ethos:
  “Caritas” and “Service to the poor”: social justice
First steps

• Acknowledging the gaps in our knowledge and relationships
• Finding a partner to guide and support – Social Action For Health
• Shaping our approach: listening to communities
• Reaching out: involving many staff
• Relinquishing control and power

St Joseph's Hospice
Symbols of change
First rewards

• Good engagement with some communities
• Hearing stories via health guides – experiences, aspirations and disappointments
• Face to face meetings with community members
• Some early pointers about issues around hospice care
Engaging in more detailed dialogue

- How to make hospice care more acceptable and appropriate
- Working with specific myths about hospice care
- Listening to, and responding to issues of concern
  - Communicating bad news
  - Care in the last hours of life
  - Alternative models of home care
Embedding the results

• Changes to models of delivery
• New facilities. Finding Space – a physical space for engagement and to attract new kinds of volunteers and activities
• New structures to facilitate shared learning and improvement where necessary: PhD research student
• Nurturing relationships and new friendships
  – proactive and serendipitous
  – Working with others eg East London Strategic Alliance (policy development) and Marie Curie, East London Mosque and Richard House Children’s Hospice (engagement and service development)
Future Plans – Community participation

• Moving beyond widening access to hospice care to the development of new models of end of life care
• Building on expertise, resource and relationships within communities to improve the experience of end of life and bereavement
• Hospice involved and offering advice, training, space but not directing.
• Sustaining and nurturing community links.

St Joseph's Hospice
It isn’t only about fundraising and volunteering.

- Individuals
- Providing care
- Communities
- Funding and volunteering
Hospice - Providing elements of care which cannot be provided by lay carers, friends and families. Individual – guiding the hospice in how to do it well

Community members deliver social and spiritual care, practical support, education, navigation and advocacy. Individuals offer awareness re experience of dying

Community offers funding and volunteering. Strategic and service improvement guidance and help. Hospice helps build community capacity
Panel Discussion

Chair: Sanjay Chadha, Founder, Asian Multiple Sclerosis (MS) Support Group and Member, National Council for Palliative Care (NCPC) People in Partnership Group

Simon Chapman, Director of Public & Parliamentary Engagement, NCPC & Dying Matters Coalition

Professor Steve Field, Deputy National Medical Director (Health Inequalities), NHS Commissioning Board and GP, Birmingham

Michael Kerin, Chief Executive, St Joseph’s Hospice

#EOLCforall
Special Event Offer!

Come and visit the NCPC stand during the break for 50% off our publications
Reaching the whole community?
End of life care for all who need it

Thursday 18th April
London Marriott Hotel Regents Park

#EOLCforall
Learning Exchange: Inequalities 101

Please make yourself comfortable at your first table. You will spend approximately 10 minutes at each table, and you will have the opportunity to visit 5 out of the below 7 tables. The Chair will give you a 2 minute warning before you have to move tables. Please move around the room in a clockwise direction:

BAME (Black, Asian & Minority Ethnic)
Homelessness
Humanist
Learning Disabilities
LGBT (Lesbian, Gay, Bisexual & Transgender)
Transitions
Travellers

#EOLCforall
Special Event Offer!

Come and visit the NCPC stand during the break for 50% off our publications
Reaching the whole community?
End of life care for all who need it

Thursday 18th April
London Marriott Hotel Regents Park

#EOLCforall
Workshop A: Stronger together - Working in partnership

Chair: Simon Chapman, Director of Public & Parliamentary Engagement, NCPC & Dying Matters Coalition

Bev Barclay, Director of Nursing, The J's Hospice

Sarah Roderick, End of Life Care Facilitator / Educator, ABC End of Life Education Project for Cambridgeshire

Sarah Russell, Director of Education and Research, Hospice of St Francis, Hertfordshire ABC End of Life Education Project Lead for Bedfordshire, Hertfordshire and Luton Doctoral Research Student (Advance Care Planning) University of Hertfordshire

#EOLCforall
ABC Education Project:

Collaborating for Impact

Homelessness and End of Life Care Education

sarah.roderick@nhs.net  : Anglia ABC Project
sarah.russell@stfrancis.org.uk  : Bedfordshire, Hertfordshire & Luton ABC Project

On behalf of the ABC Project:
Anglia, Essex, Bedfordshire, Hertfordshire and Luton

April 2013: NCPC Reaching Out Conference

Further information from: Vanessa.Convey@eoe.nhs.uk
Why are we here?

1. End of Life Care Strategy (2008)

2. Identified a lack of knowledge & Confidence in Health and Social workforce

3. Recognised the need to fund training to improve confidence & knowledge

Further information from: Vanessa.Convey@eoe.nhs.uk
Who will we educate?

A
Specialist Palliative

B
Staff who frequently deal with EoL care as part of role

C
Staff who infrequently have to deal with EoL care

Further information from: Vanessa.Convey@eoe.nhs.uk
What Is Our Goal?

1. ↑ knowledge & confidence
2. ↓ hospital admissions
3. ↔ Ensure patient dies in preferred place of care
4. ↑ dignity

Further information from: Vanessa.Convey@oeo.nhs.uk
Group B Staff

Either: E-learning – End of Life Care for All (E-ELCA)


✓ nationally recognised with facilitation
✓ 10 mandatory modules plus 8 others
✓ Portfolio
✓ Reflection

Or: Workshops based on E-ELCA

✓ Generic sessions or specific workshops for professional groups

Further information from: Vanessa.Convey@eoe.nhs.uk
Why?
To Make A Difference

‘Collaboration, it turns out, is not a gift from the gods but a skill that requires effort and practice.’
Douglas B. Reeves, Founder,
The Leadership & Learning Center

Further information from: Vanessa.Convey@eoe.nhs.uk
The average age of death is 47 years compared to 77 years for the general population.

Further information from: Vanessa.Convey@oeo.nhs.uk

Health Education East of England
“evidence that people who are sleeping, or have slept, rough and/ or are living in hostels and night shelters have significantly higher levels of premature mortality and mental and physical ill health than the general population.”

(Healthcare for single homeless people, Department of Health, 2010)

Further information from: Vanessa.Convey@eeo.nhs.uk
In England around 40,500 people are in the hostel system at any one time.

Further information from: Vanessa.Convey@eoe.nhs.uk
• **End of Life Care Strategy (2008)**

• “high quality end of life care should be available wherever the person may be”

• The homeless a hidden population

Further information from: Vanessa.Convey@eoe.nhs.uk
This hidden population often miss out on end of life care because:

- do not regularly access services
- are difficult to diagnose and follow up
- may also have other health issues

Further information from: Vanessa.Convey@eoe.nhs.uk
Homelessness in the East of England

- 47 local authorities
- 7% of all the day centres in England.
- 7% of all hostels in England

Further information from: Vanessa.Convey@oe.nhs.uk
NHS East of England ABC Education Project

Aim:
To improve quality of end of life care through blended learning in Anglia, Essex, Bedfordshire, Hertfordshire and Luton
- Hospital and community staff
- Care home and domiciliary care agencies

Homeless Population:
Blended learning using E Learning for Health End of Life Care Programme – adapted for this population and staff

Further information from: Vanessa.Convey@eoe.nhs.uk
Why the homeless?

A hidden and hard to reach

Local case studies showed a need for training

Anglia developed an education programme using established resources

Inspired by work done at St Mungos and Peter Kennedy

Further information from: Vanessa.Convey@eo.e.nhs.uk
Challenges to design and deliver end of life education

- Difficult to find appropriate person to speak to – takes time

- Initially, people working with the homeless felt all clients deaths were sudden.

- After further discussions, client base was seen differently.

Further information from: Vanessa.Convey@eoe.nhs.uk
Solutions 1: Reaching Out

- End of life education sessions delivered by multiple providers
- Understand how all services work and how to collaborate for the future.
- Inter service dialogue

Further information from: Vanessa.Convey@eoe.nhs.uk
Solutions 2: Adapting Resources

- Adapting end of life care pathway and resources
- Further education and shadowing sessions
- Learn from the national leaders
- Monitor and report activity and outcomes

Further information from: Vanessa.Convey@eoe.nhs.uk
Collaborating for Impact takes effort

‘Collaborations can be extremely time-consuming. But there are much bigger costs if it doesn’t happen.’

But it is worth it.....

Because the staff at the coal face are the ones who make the difference

Further information from: Vanessa.Convey@eoe.nhs.uk
and this is what they said........

“Sounds crazy I know but it’s such a refreshing topic to concentrate on – usually a taboo subject”

Further information from: Vanessa.Convey@eoe.nhs.uk
“I did not think it would be of interest but it was, and discussing end of life we can now associate with our client group”

“Realising clients benefit from talking and planning death”.

Further information from: Vanessa.Convey@eoe.nhs.uk
“Realising we had many residents pass through the hostel who were heading towards end of life”

“We need to keep talking to each other – come and visit our services = CAN partnership = adult drug and alcohol”

Further information from: Vanessa.Convey@eoe.nhs.uk
“Do not be afraid to have “the conversation”

“its ok to talk end of life”

“Fantastic training, was good to reflect on practice of how to deal with end of life care”

Further information from: Vanessa.Convey@eoe.nhs.uk
“Making me realise that it’s okay to have discussions with service users about what they want at the end of their life”

Further information from: Vanessa.Convey@eoe.nhs.uk
Increased their confidence and ambition for end of life care

“Bloody Excellent Training – Thank You”

Further information from: Vanessa.Convey@oeo.nhs.uk
“It is our belief that societies should be judged by the compassion they show to all their members, whatever their circumstances”.

Marie Curie Cancer Care

Further information from: Vanessa.Convey@eoe.nhs.uk
"WE CAN
COLLABORATE FOR IMPACT
TO MAKE A DIFFERENCE"

Thank you
Sarah Roderick and Sarah Russell on behalf of the ABC Project and Health Education East of England
Reaching the whole community?
End of life care for all who need it

Thursday 18th April
London Marriott Hotel Regents Park

#EOLCforall
Screening of ‘Can You See Me?’

A short film from NCPC & the Dying Matters Coalition
Reaching the whole community?
End of life care for all who need it

Thursday 18th April
London Marriott Hotel Regents Park
Why this matters: a real story

Lynn Cawley
Joshua.
Joshua

- Spastic quadraplegia
- Learning difficulties
- Partially sighted
- Tube fed
- Scoliosis
- Bronchiectasis
- Multiple surgeries

- Superman!
Family life
Palliative care - professional definition

- A *World Health Organization* statement describes palliative care as "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 and spiritual."
Palliative care – our definition

- Our lovely son aged just 22 is dying and there’s nothing we can do about it!
Ideal of dying at home

- Gold Standard Framework
- Liverpool Care Pathway
Quick decisions
24/7 care
The need for a good death
The need for a good death
The need for a good death
The need for a good death
What could be done better?

- More support and training for those dealing with people with learning difficulties
- Support for the family – don’t assume they are emotionally able to continue the care they have always given
- Some people don’t fit into the pathways so easily; little thought was given to Joshua’s emotional and spiritual needs
What could be done better?

- People with complex needs deserve the same rights to die at home and not in a hospital side-ward simply because it’s easier.

- Support for the family after death – we had no support once they took Joshua’s body away.
Conclusion – we are often defined as:

- A Gay family
We are often defined as:

- A family with complex needs
We are often defined as:

- A family with adopted children
We are often defined as:

- A family who are carers
But ultimately we are just:

- A family with a bed in the living room trying to give our boy the very best death we can!
Reaching the whole community?
End of life care for all who need it

Thursday 18th April
London Marriott Hotel Regents Park
Action planning to understand difference: “We treat everyone just the same don’t we?”

In your groups, please discuss the points on the A3 sheets which you will find on your tables.

Fill in your Personal Action Plans (found in your delegate pack) and take these back to your workplace with you. What will your one small action be?
Evaluation

We would be very grateful if you would visit the below link and give us your feedback on the event:

http://ncpc.nativeye.com/reaching-the-whole-community

You will find a slip of paper in your pack with the same link on for ease & we will also email you with a copy of the link tomorrow after the event.
Final Tweets: reflecting on the end of life

If you could send one Final Tweet, what would it say? Something witty, something inspiring, something poignant or prophetic?

Some good real life examples:

“Oh wow. Oh wow. Oh wow.” Steve Jobs

“My wallpaper and I are fighting a duel to the death. One or the other of us has to go.” Oscar Wilde

Share your Final Tweet - here's how:

On Twitter, add the hashtag #FinalTweets to your tweets so that we can easily identify them.

Check the website (www.dyingmatters.org) for more details...
Become a member of the Dying Matters Coalition

Joining costs nothing! We have nearly 17,000 members so far, and are actively enlisting those that are committed to supporting changing knowledge, attitudes and behaviours around death and dying.

Visit the following link for more information:

www.dyingmatters.org
Reaching the whole community?
End of life care for all who need it

Thursday 18th April
London Marriott Hotel Regents Park

#EOLCforall