2020 Strategy for
End of Life and Bereavement Care
“When a patient is at the end of their life, we have one chance to get it right.”
I am very proud to launch our vision and strategy for end of life and bereavement care.

Providing outstanding end of life and bereavement care is everybody’s business and every staff member carries a personal responsibility to support patients and those close to them as they approach the final months, weeks and days of their life.

This strategy demonstrates our commitment to improving patient experience across the trust and sets out how we will achieve the specific components required in order to deliver high quality, individualised, patient-centred end of life care.

We strive to ensure patients and those close to them receive the practical, emotional and spiritual support they require, and to provide high quality facilities, information and resources to support them at the end of their life. End of life care is a key priority in our hospital, and we have one opportunity to get it right.

We will ensure relevant staff receive appropriate training in order to provide outstanding end of life care in the hospital setting, or can access the necessary resources to facilitate a safe discharge for end of life care in accordance with patients’ wishes.

We will seek out patient and carer feedback on their experiences and use this essential information to highlight examples of good practice to share, and areas for further development to ensure equitable provision of exemplary care across the Trust.

This strategy was developed in response to a wide-ranging consultation with staff, patients and their carers, and I would like to thank them for sharing their experiences, both good and bad, which has helped to identify our key priorities for the next two years. As we develop our end of life services into the future in the planned merger of the acute trusts within Liverpool, we will ensure our key objectives continue to be prioritised to meet the needs of our locality. The delivery of this strategy will be a tribute to all the patients we have had the highest privilege of caring for at Aintree in the final days and hours of their lives.

Dianne Brown, Chief Nurse
Statements from our Directors

“If we are going to deliver truly outstanding end of life care we need to make it everyone’s business. This strategy sets out how we intend to achieve this and how we offer people choice and control over things that are important to them at this point of vulnerability”

Steve Warburton – CEO

“Talking about dying is hard, but understanding how a person thinks helps us tailor our care in the most supportive way. Having practiced as a nurse and from my background in patient experience, I want every member of staff to think ‘it’s my business’ and feel supported and empowered to provide personal and individualised care at a time of great need.”

Mandy Wearne – Non-Executive Director for End of Life Care

“Supporting and caring for people at the end of their lives is a core aspect of the clinical care that we provide at Aintree Hospital, and we have a duty to support our patients and their families to talk openly and plan their care to ensure we meet their needs and wishes wherever possible.”

Tristan Cope – Medical Director
The Frangipani Model for end of life care

A compassionate, collaborative approach to providing individualised, patient-centred care at the end of life.

A person-centred, individualised approach to delivering responsive End of Life services across all clinical settings, by a work force who are:

C A R E

Compassionate
Able
Responsive
Engaged

End of Life Discharges
End of Life Projects
Workforce Training
DNACPR
Outcomes

The Frangipani Model for end of life care

Julie Raj, Clinical Director for Palliative and End of Life Care Services
Paula Parr, Team Leader, Palliative and End of Life Care Services
Tina Willis, Palliative and End of Life project Lead
Patient Experience

Commitment Statement

WE WILL: Ensure patients and those important to them are engaged and involved in the development and delivery of the highest quality, individualised end of life and bereavement services across the Trust.
To achieve this we will:

- Proactively involve patients and those important to them in service development and seek regular feedback about our existing end of life and bereavement care services.
- Actively seek to learn from end of life incidents and complaints, sharing best practice and lessons learned both internally and externally with the wider healthcare economy.
- Provide high quality resources and facilities for patients and those important to them throughout their end of life care and into bereavement.
- Provide timely and relevant written and online end of life information to support patients and those important to them throughout their end of life care and into bereavement.
- Ensure staff have ready access to information and resources to support the delivery of the highest quality end of life care to patients and those important to them.
- Extend the End of Life Volunteer Companionship Service to increase support to ward staff in the delivery of care for patients and those important to them.
- Ensure the end of life and bereavement care provided by the Trust meets the cultural, spiritual and religious needs of patients and those important to them.
- Ensure end of life and bereavement services are developed in line with best national, regional and local guidance.
- Improve the identification and documentation of the individual needs of carers and those important to the dying patient.

We will monitor and measure our achievements through:

- Patient and carer service evaluations and feedback
- Bereaved relatives surveys
- Benchmarking services against national and regional end of life and bereavement specifications
- Thematic analysis of complaints, incidents and feedback
- Annual report of the Volunteer Companionship service
- Annual staff survey on end of life and bereavement care
- Ward compliance with standard 7 (end of life) of the Aintree Assessment and Accreditation Framework
- Participation in the national and local audits of care at the end of life
- Development of Trust online resources for end of life and bereavement services
WE WILL: Ensure all end of life tools and resources are embedded fully across all wards and departments within the Trust, to support staff to deliver the highest quality end of life care.
To achieve this we will:

• Embed the Frangipani model of individualised care that supports patients and those important to them for the last year of life and into bereavement, incorporating the Trust End of Life tools: Advance Care Planning, the AMBER Care Bundle, SAFE TRANSFER; unified DNACPR and the End of Life Care Plan.

• Embed the Frangipani blossom across all wards and departments as the Trust symbol for palliative, end of life and bereavement care.

• Deliver comprehensive training to ward staff to support them to recognise when and how to appropriately utilise the Trust end of life tools, and where to access them.

• Ensure adequate supplies of the Trust end of life tools are readily available on each ward and department.

• Support the delivery of targeted ward education and action plans in response to any identified concerns related to end of life care.

• Ensure all end of life decisions and treatment plans are communicated effectively and safely between teams and departments and with external partners where necessary.

• Ensure Trust end of life tools continue to meet national specifications, and work collaboratively with local and regional partners to ensure they are transferable across care settings.

• Develop electronic end of life tools which will operate effectively within the new electronic patient record.

• Provide patients and those important to them with appropriate information on the use of end of life tools to support aspects of their care.

• Ensure all Trust end of life tools and resources align with key Trust guidelines and policies including the Adult Safeguarding, Mental Capacity and Deprivation of Liberty Policies.

We will monitor and measure our achievements through:

• Audits of uptake and compliance with end of life tools

• Participation in national and local audits of care at the end of life

• Oversight of the Trust end of life dashboard

• Thematic analysis of complaints, incidents and feedback

• Annual staff survey on end of life and bereavement care

• Bereaved relatives surveys

• Incorporation of electronic end of life resources and tools in the electronic patient record

• Annual education report
Workforce Training

Commitment Statement

WE WILL: Develop a competent and confident work force to deliver safe, individualised palliative and end of life care.
Complete a training needs analysis of staff across the Trust to identify the staff groups that require specific education relating to palliative and end of life care.

Develop an education strategy that meets the needs of staff groups across the Trust and promotes equitable provision of education.

Ensure palliative and end of life care training is of the highest quality and meets the identified needs of staff.

Embed processes to provide clinical supervision and support to staff involved in caring for end of life patients and those important to them.

Work in partnership with the Learning and Development Department to develop a workforce training dashboard for palliative and end of life care education that links to the electronic staff record.

Implement the Frangipani accreditation scheme relating to educational achievements in palliative and end of life care, specific to individual roles/staff groups; ensuring all staff achieve a minimum level specific to their role.

Deliver a comprehensive integrated palliative and end of life care education programme in collaboration with external partners from Woodlands Hospice, the Walton Centre, Community Specialist Palliative Care Services, St Joseph’s Hospice and local care homes and secure settings.

Ensure all ward/clinical areas in the Trust have a nominated Palliative Care Champion who has completed appropriate training for the role and is supported to deliver cascade training in their own clinical area.

Establish online training modules for palliative and end of life care.

Ensure all relevant staff receive training on the safe use of syringe drivers and incorporate competency records into the workforce training dashboard.

Ensure staff have appropriate educational resources available to them in their ward/clinical areas, including well maintained, up to date noticeboards and resource files.

Support the delivery of targeted training and education action plans in response to areas of concern identified by complaints, incidents, inspections and feedback.

Oversight of the workforce training dashboard for the Frangipani accreditation scheme in palliative and end of life care

Evaluations of training delivered

Annual education report

Attendance at champions training

Annual review of syringe driver competencies

Compliance with mandatory training

Compliance with Section 7 of the AAA

Thematic analysis of complaints, incidents and feedback
End of Life Discharge

Commitment Statement

WE WILL: Develop a safe and effective discharge process for palliative and end of life patients that is responsive to the needs of the individual regardless of discharge destination.
To achieve this we will:

- Engage with appropriate staff groups who are involved in the discharge processes for palliative and end of life patients to establish current practice.
- Develop and implement a safe discharge process that is clear, timely and effective for palliative patients who are likely in the last months and weeks of life.
- Develop and implement a safe discharge process that is clear, timely and effective for dying patients who are likely in the last days of life.
- Develop a palliative and end of life discharge dashboard to monitor the effectiveness and responsiveness of the agreed discharge processes.
- Implement and embed in practice the SAFE TRANSFER palliative discharge tool within the hospital and work collaboratively with primary care partners to ensure a cohesive cross-boundary process.
- Adapt the SAFE TRANSFER palliative discharge tool to support the transfer of patients who are being discharged to a Hospice, to ensure the correct transfer of information and appropriate use of resources.
- Ensure staff are adequately educated on the discharge processes for palliative and end of life patients, and have the necessary resources available to be able to support such discharges for patients in their care.
- Support the delivery of targeted action plans in response to areas of concern relating to palliative and end of life discharges identified by complaints, incidents, inspections and feedback.

We will monitor and measure our achievements through:

- Oversight of the palliative and end of life discharge dashboard
- Annual audit of uptake and compliance with the SAFE TRANSFER discharge tool
- Annual audit of discharge outcomes
- Quarterly review of the utilisation and returns of McKinley T34 syringe drivers
- Annual audit of compliance with SAFE TRANSFER hospice discharge tool
- Annual education report
- Thematic analysis of complaints, incidents and feedback
Treatment Escalation Decisions

WE WILL: Develop a positive culture for timely treatment escalation decisions and end of life treatment recommendations that involves the patient and those important to them.
To achieve this we will:

- Develop an e-learning module to ensure all staff are fully informed of the process of DNACPR and treatment escalation decision making, appropriate to their role.
- Deliver face to face education to support staff to have complex conversations around treatment escalation decisions.
- Ensure that documentation regarding DNACPR and end of life treatment recommendations is completed correctly.
- Encourage discussions regarding DNACPR and treatment recommendations to be undertaken in a proactive and timely manner, by the clinical team with overall responsibility for the patient.
- Ensure staff on the ward are aware of those patients with a DNACPR or treatment escalation decision in place.
- Ensure treatment recommendations and DNACPR decisions are communicated effectively to primary care at the point of discharge.
- Update the Trust-wide policy regarding DNACPR and end of life treatment recommendations in line with national and local recommendations.

We will monitor and measure our achievements through:

- Quarterly divisional audits of DNACPR documentation and awareness
- Annual audit of appropriate DNACPR decision making and communication to primary care
- Uptake of e-learning and face to face training
- Analysis of complaints and incidents around DNACPR and end of life treatment recommendations
Outcomes

**Commitment Statement**

WE WILL: Ensure there are clear, measurable outcomes to demonstrate ongoing improvement in the end of life and bereavement care we provide.
To achieve this we will:

- Develop a Trust dashboard for end of life care which monitors activity, uptake and compliance of key end of life services, tools and resources.
- Ensure all current and proposed end of life tools and resources are developed and maintained in line with up to date national, regional and local guidance.
- Ensure all end of life and bereavement services meet the requirements of official regulatory bodies.
- Participate in data collection for identified national or local minimum or clinical data sets
- Work collaboratively with external partners to develop integrated electronic documentation, tools and resources to support palliative and end of life patients.
- Participate in local, regional and national audits to benchmark practice and produce appropriate action plans in response to areas of need identified.
- Participate in national, regional and local research studies to support the development of evidence based practice in palliative and end of life care.
- Incorporate an assessment of the quality of end of life care provision into the Trust mortality review process.
- Incorporate measurable end of life outcomes into the Aintree Assessment and Accreditation Framework
- Oversee the implementation of action plans to address any areas of concern identified through audit, complaints, incidents, feedback or inspections.

We will monitor and measure our achievements through:

- Oversight of the Trust end of life dashboard
- Oversight and maintenance of the Palliative and End of life audit forward plan
- Monitoring and review of action plans from national, regional and local audit
- Monitoring and review of action plans from the thematic analysis of complaints, incidents and feedback
- Monitoring of results and action plans from AAA ward assessments
- Oversight of Annual staff survey on end of life and bereavement care
- Bereaved relatives surveys
- Incorporation of electronic end of life resources and tools in the electronic patient record
- Annual education report
- Quarterly audit of end of life mortality reviews
Implementation and monitoring

The implementation of the Strategy for End of Life and Bereavement Care will be led by a nominated work stream lead with support from the divisional teams and the wider End of Life and Bereavement Care Group. Achievement against the key objectives will be monitored by the Quality Committee who will provide bi-annual updates to the Board of Directors.

Target delivery dates against each commitment are laid out below:

<table>
<thead>
<tr>
<th>Commitment 1 – Patient Experience</th>
<th>Year 1</th>
<th>Year 1-2</th>
<th>Year 2</th>
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<tbody>
<tr>
<td>Proactively involve patients and those important to them in service development and seek regular feedback about our existing end of life and bereavement care services.</td>
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<td>Actively seek to learn from end of life incidents and complaints, sharing best practice and lessons learned both internally and externally with the wider healthcare economy.</td>
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<td>Provide high quality resources and facilities for patients and those important to them throughout their end of life care and into bereavement.</td>
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<td>Provide timely and relevant written and online end of life information to support patients and those important to them throughout their end of life care and into bereavement.</td>
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<tr>
<td>Ensure staff have ready access to information and resources to support the delivery of the highest quality end of life care to patients and those important to them.</td>
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<td>Extend the End of Life Volunteer Companionship Service to increase support to ward staff in the delivery of care for patients and those important to them.</td>
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<td>Ensure the end of life and bereavement care provided by the Trust meets the cultural, spiritual and religious needs of patients and those important to them.</td>
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<td>Ensure end of life and bereavement services are developed in line with best national, regional and local guidance.</td>
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<td>Improve the identification and documentation of the individual needs of carers and those important to the dying patient.</td>
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<tr>
<th>Commitment 2 – End of Life Tools</th>
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<tr>
<td>Embed the Frangipani model of individualised care that supports patients and those important to them for the last year of life and into bereavement, incorporating the Trust End of Life tools: Advance Care Planning, the AMBER Care Bundle, SAFE TRANSFER; unified DNACPR and the End of Life Care Plan.</td>
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<td>Embed the Frangipani blossom across all wards and departments as the Trust symbol for palliative, end of life and bereavement care.</td>
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<td>Deliver comprehensive training to ward staff to support them to recognise when and how to appropriately utilise the Trust end of life tools, and where to access them.</td>
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<td>Ensure adequate supplies of the Trust end of life tools are readily available on each ward and department.</td>
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<td>Support the delivery of targeted ward education and action plans in response to any identified concerns related to end of life care.</td>
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<td>Ensure all end of life decisions and treatment plans are communicated effectively and safely between teams and departments and with external partners where necessary.</td>
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<td>Ensure Trust end of life tools continue to meet national specifications, and work collaboratively with local and regional partners to ensure they are transferable across care settings.</td>
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<td>Develop electronic end of life tools which will operate effectively within the new electronic patient record.</td>
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<td>Provide patients and those important to them with appropriate information on the use of end of life tools to support aspects of their care.</td>
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<td>Ensure all Trust end of life tools and resources align with key Trust guidelines and policies including the Adult Safeguarding, Mental Capacity and Deprivation of Liberty Policies.</td>
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### Commitment 3 – Workforce Training

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<tr>
<td>Complete a training needs analysis of staff across the Trust to identify the staff groups that require specific education relating to palliative and end of life care</td>
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<td>Develop an education strategy that meets the needs of staff groups across the Trust and promotes equitable provision of education</td>
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<tr>
<td>Ensure palliative and end of life care training is of the highest quality and meets the identified needs of staff</td>
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<td>Embed processes to provide clinical supervision and support to staff involved in caring for end of life patients and those important to them</td>
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<td>Work in partnership with the Learning and Development Department to develop a workforce training dashboard for palliative and end of life care education that links to the electronic staff record</td>
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<td>Implement the Frangipani accreditation scheme relating to educational achievements in palliative and end of life care, specific to individual roles/staff groups; ensuring all staff achieve a minimum level specific to their role</td>
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<td>Deliver a comprehensive integrated palliative and end of life care education programme in collaboration with external partners from Woodlands Hospice, the Walton Centre, Community Specialist Palliative Care Services, St Joseph’s Hospice and local care homes and secure settings</td>
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<td>Ensure all ward/clinical areas in the Trust have a nominated Palliative Care Champion who has completed appropriate training for the role and is supported to deliver cascade training in their own clinical area</td>
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<td>Establish on line training modules for palliative and end of life care</td>
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<td>Ensure all relevant staff receive training on the safe use of syringe drivers and incorporate competency records into the workforce training dashboard</td>
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<td>Ensure staff have appropriate educational resources available to them in their ward/clinical areas, including well maintained, up to date noticeboards and resource files</td>
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<td>Support the delivery of targeted training and education action plans in response to areas of concern identified by complaints, incidents, inspections and feedback</td>
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### Commitment 4 – End of Life Discharges

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<tr>
<td>Engage with appropriate staff groups who are involved in the discharge processes for palliative and end of life patients to establish current practice</td>
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<tr>
<td>Develop and implement a safe discharge process that is clear, timely and effective for palliative patients who are likely in the last months and weeks of life</td>
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<td>Develop a palliative and end of life discharge dashboard to monitor the effectiveness and responsiveness of the agreed discharge processes</td>
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<td>Implement and embed in practice the SAFE TRANSFER palliative discharge tool within the hospital and work collaboratively with primary care partners to ensure a cohesive cross-boundary process</td>
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<td>Adapt the SAFE TRANSFER palliative discharge tool to support the transfer of patients who are being discharged to a Hospice, to ensure the correct transfer of information and appropriate use of resources</td>
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<td>Ensure staff are adequately educated on the discharge processes for palliative and end of life patients, and have the necessary resources available to be able to support such discharges for patients in their care</td>
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<td>Support the delivery of targeted action plans in response to areas of concern relating to palliative and end of life discharges identified by complaints, incidents, inspections and feedback</td>
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### Commitment 5 – Treatment Escalation Decisions

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<td>Develop an e-learning module to ensure all staff are fully informed of the process of DNACPR and treatment escalation decision making, appropriate to their role</td>
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<td>Encourage discussions regarding DNACPR and treatment recommendations to be undertaken in a proactive and timely manner, by the clinical team with overall responsibility for the patient</td>
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<td>Ensure staff on the ward are aware of those patients with a DNACPR or treatment escalation decision in place</td>
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<td>Ensure treatment recommendations and DNACPR decisions are communicated effectively to primary care at the point of discharge</td>
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<td>Update the Trust-wide policy regarding DNACPR and end of life treatment recommendations in line with national and local recommendations</td>
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### Commitment 6 – End of Life Outcomes

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<td>Develop a Trust dashboard for end of life care which monitors activity, uptake and compliance of key end of life services, tools and resources</td>
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<td>Ensure all end of life and bereavement services meet the requirements of official regulatory bodies</td>
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<td>Participate in local, regional and national audits to benchmark practice and produce appropriate action plans in response to areas of need identified</td>
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<td>Participate in national, regional and local research studies to support the development of evidence based practice in palliative and end of life care</td>
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<td>Incorporate an assessment of the quality of end of life care provision into the Trust mortality review process</td>
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<td>Incorporate measurable end of life outcomes into the Aintree Assessment and Accreditation Framework</td>
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<td>Oversee the implementation of action plans to address any areas of concern identified through audit, complaints, incidents, feedback or inspect</td>
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Thank you to all our staff, patients, families and carers who contributed to the development of our 2020 Vision for End of Life and Bereavement care.

This brochure is available in large print, Braille, easy read, on audio tape and in other languages on request.

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