Milton Keynes
End of Life Care
Strategy
2016 -2020

In conjunction with
Ambitions for Palliative and End of Life Care:
A national framework for local action 2015 – 2020
www.endoflifecareambitions.org.uk
www.miltonkeynesccg.nhs.uk
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Foreword

Throughout my clinical career I have witnessed high quality, compassionate end of life care in a variety of settings including hospitals, care homes and people’s own homes. There has consistently been a desire from those involved to deliver the best quality care for the person who is coming towards the end of their life. There have been occasions when everything has not gone as hoped but through learning and expert advice we are now better able to plan for the right care for our patients. Milton Keynes End of Life Care Strategy documents our intention to build on existing good practice and deliver the best possible palliative care for local people.

Significant progress has been made in our understanding of caring for people who are coming towards the end of their lives and this new strategy describes the standards of care to which we aspire. I first learnt about the care of the dying patient during work experience in a hospice as a medical student more than 25 years ago. In those days the speciality focussed on people with cancer but we now have a much greater understanding of expected deaths from other chronic conditions including extreme frailty and old age, where the course of the condition is often much less predictable. We have also seen transformation in the specialist care of children and young people with life limiting conditions.

End of life care is the most important aspect of healthcare to get right. Benjamin Franklin famously said “In this world nothing can be said to be certain, except death and taxes”. Death will come to us all and for most of us our death will be expected, allowing for planning and preparation. This gives us the opportunity to make our own wishes known and make the most of the rest of the time that remains. A good experience of care at the end of life benefits the patient, their close family and friends. It also represents a positive fulfilling experience for carers and clinicians involved. Using this strategy we will build on existing good practice and work together to achieve our ambitions.

Dr Nicola Smith MBChB
NHS Milton Keynes Clinical Commissioning Group Chair
1. Executive Summary

The focus of this strategy is on adults but it does encompass children.

End of Life Care is everybody’s business.

- Every year approximately half a million people die in England. This is expected to rise by 17% by 2030.
- For at least three quarters of deaths it is not sudden but expected, providing opportunity to plan.
- In the last 12 months of life, people have on average 3 or more unplanned admissions to hospital (TVN commissioning guidance 2015).

“We need to make sure not only that people can be cared for and die in the place they want to be, but also wherever they are, they receive high-quality well-coordinated care that meets their needs and preferences.” (the National Council for Palliative Care 2013).

A definition for end of life care was developed by the National Council for Palliative Care (2006) and used in the National Department of Health End of Life Strategy (2008) which states:

“End of life care is care that helps all those with advanced, incurable conditions to live as well as possible in the last year of life. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes physical care, management of pain and other symptoms and provision of psychological, social, spiritual and practical support”

End of life care generally describes the period 12 months before death, this being marked by a progressive deterioration of a person’s condition which can vary depending on the particular disease trajectory.

This strategy was co-produced through the Care Pathway and Primary Care Programme Board, The End of Life Strategy Implementation Group and the Joint Palliative Care Group. Membership of these groups includes (and this list is not exhaustive) – service users, family and unpaid carers, commissioners, social care managers, community and hospital clinicians (nursing and medical), local hospice staff and other local stakeholders from statutory, voluntary, and community based organisations.

For Children and Young People

- ‘Life limiting conditions’ is used to describe complexities where there is no reasonable hope of cure and from which children and young people will die.
- Life threatening conditions are those for which curative treatment may be feasible but can fail, such as cancer.
- Complex health needs is used to describe children who may have a range of disabilities and associated health needs of which prognosis is hard to determine, therefore these children may die.
2. Introduction

The updating of the local strategy will allow the continued improvement of end of life care in Milton Keynes, building on the work completed such as the Advance Care Plan and the Willen Telephone Line. It will be used to develop an implementation plan and form a base on which to measure progress. The purpose of this strategy is to deliver the standards within the ‘One Chance to get it Right’ document (Leadership Alliance for the Care of Dying People 2014), Quality standards for end of life care for adults (National Institute for Health and Care Excellence), End of Life Care Guidance (General Medical Council) and the Five Priorities for Care of the Dying Person (NHS England) by commissioning and developing services for patients with end of life care needs, regardless of diagnosis or place of residence.

The focus of this strategy is on adults but it does encompass children. The independent review of children’s palliative care services ‘Better Care, Better Lives’ was published in February 2008 which is the first ever national best practice guidance for children’s palliative care. This sets out a clear framework for all partners to work together to improve health, wellbeing and experiences of services for disabled children and their families.

Across and within all of the age spectrums the diseases (conditions), their trajectories, conditions, contexts, demographic and care needs can be very different as can the depth and breadth of expertise required to care and support patients and families. The numbers of patients and families affected will also vary as will the scale at which services will need to operate.
The End of Life Strategy Implementation Group will be tasked with the driving of the implementation plan. The plan will be monitored through Milton Keynes Care Pathway and Primary Care Programme Board, feeding in to the Commissioning Decision Group as necessary. (Appendix 2)

This strategy will complement and support other local strategies. These include:

- Milton Keynes Dementia Strategy (2014-17).
- Milton Keynes Mental Health Strategy (2014-17).
- The Mental Capacity Act including deprivation of liberties framework.

This strategy will compliment Milton Keynes Council Policies for staff working with service users.

- Dignity in Dying Policy.
- Resuscitation Policy.

Where appropriate the relevant end of life groups will link into the work of the Better Care Fund and the Prime Ministers Challenge Fund. They will also link into:

- The System Resilience Board.
- The Mental Health Board.
- Children’s and Maternity Board.

This strategy uses the recent national publication of the Ambition for Palliative and End of Life Care (2015) document as a foundation for its layout using Milton Keynes local knowledge to guide the implementation plan.
3. Implementation

Health and social care services for people with end of life care needs have improved considerably over recent years. The work of the hospice movement has provided an important impetus for this, as has the development of creative partnerships between public, independent, community and voluntary sector organisations, working together to design, develop and deliver services. As people live longer, and with the increasing prevalence of chronic conditions, it is essential that health and social care services collaborate, invest and develop further to meet the challenge of planning and delivering high quality palliative and end of life care for increasing numbers of people in Milton Keynes.

Care in any setting includes building such as hospices and hospitals but also includes anywhere the patient calls ‘home’. An example of this would be a residential home where the patient has been registered as living there.

The strategy builds upon the work of existing services within Milton Keynes such as the Hospital Palliative Care Team, Community Nursing Services, General Practice and Hospice Services. It recognises the need to implement recommendations made within the National End of Life Strategy (2008), the One Chance to get it Right document (2014), Better Care, Better Lives (2008) and the Ambition document. The strategy and the following implementation plans will incorporate best practice from the Mental Capacity Act and Deprivation of Liberties legislation.

Detailed records will be kept throughout the implementation process charting successes, variances and mitigations. All reports and similar information will be sent and discussed at the boards outlined in Appendix 2.
The strategy will follow a similar layout to the National Ambition in Palliative and End of Life Care document as it will use the same terminology. This document ‘provides a national framework for local action’ and puts existing resources to more creative and effective use, aligning with wider changes following on from the NHS Five Year Forward View (Ambitions 2015).

The Ambitions documents list, which are statement, which the authors believe are achievable priorities for the patient and carers; the document then summarises what is known about each ambition.

For each ambition there are then Building Blocks listed which are seen as actions that may be required to achieve each ambition. These are suggestions to achieve change.

The Foundation Levels it could be argued need to be put into place first. These areas may not be related solely to end of life care, they may not be specialist areas. They are usually part of a much wider health and social care economy.

This strategy outlines the six priorities for end of life care in Milton Keynes. The priorities take into consideration the needs of the local population and national/local best practice. The strategy will lead to an implementation plan which will deliver improvements in the six key priorities. The terminology in brackets is taken from the Ambitions documentation:

- To increase the training and education in end of life care for all stakeholders (foundation)
- To ensure people can access good quality end of life care 24/7 (foundation)
- To develop an advice line for support to all patients, families and social and healthcare professionals (ambition)
- To increase the numbers of patients achieving their preferred place of death (ambition)
- To reduce the inequalities in end of life care service provision (ambition)
- To improve the coordination of end of life care between providers (ambition)
4. National Government Drivers for End of Life Care

NHS England (2013) Everyone Counts, sets out ‘the need for bold and ambitious five year strategic plans from NHS commissioners. It describes an approach to deliver transformational change with the first critical steps over the next two years, to achieve the continued ambition to secure sustain-able high quality care for all, now and for future generations’

The ‘One Chance to get it Right’ document (2014) provides an auditable framework to benchmark and improve people’s experience of care in the last few days and hours of life.

It states that care given to people should -

- Be compassionate
- Be based on and tailored to the needs, wishes and preferences of the dying person and, as appropriate, their family and those identified as important to them and those holding power of health and welfare attorney
- Include regular and effective communication between health and social care staff themselves
- Involve assessment of the person’s condition whenever that condition changes and appropriate timely responses to those changes
- Be led by a senior responsible doctor and a lead responsible nurse, who can access support from specialist palliative care services when needed
- Be delivered by doctors, nurses, carers and others who have high professional standards, and the skills, knowledge and experience needed to care for dying people and their families properly

Every Moment Counts: new vision for coordinated care for people near the end of life (2015) calls for brave conversations. The people approaching the end of life receive consistent care that is co-ordinated effectively across all relevant settings and services at any time of day or night.

Dying Without Dignity (2015) has six key themes for poor care at end of life -

- Not recognising that people are dying, and responding to their need.
- Poor symptom control
- Inadequate out of hours services
- Poor communication
- Poor care planning
- Delays in diagnosis and referrals for treatment
For Children and Young People -

Children’s palliative care differs greatly from adult’s palliative care. Whereas the majority of adults only need palliative care at the end of their lives, children with life-limiting and life-threatening conditions require palliative care over a much longer period, often from birth. It is common for their conditions to fluctuate and, as such, it is often much more difficult to identify when a child is moving into their end of life phase. Children with life-threatening and life-limiting conditions often have complex disabilities, while the range of health conditions which results in children requiring palliative care is more diverse. (Commissioning Children’s Palliative Care 2014)

- Families and children should be given choices about place of care based on clear information and range of options, with 24/7 availability of support at home
- There should be a clear advanced care plan to ensure continuity of high quality care that meets the needs and preferences of children and their families
- Link to children’s palliative care expertise should be readily available

Transition to Adult Services –

‘Transitions’ is the phase between children’s service to adults services, typically 16 to 25 year olds.

With an increasing number of young people surviving with life-limiting or life-threatening conditions into adulthood, understanding their palliative care needs during transition and into adult services is paramount (Bridging the Gap Project 2014).

“While the entire course of some diseases occurs within childhood, others may persist into adulthood, and the need for palliative care may range from days to years or even decades” (Watterson and Hain 2003).

A review by Doug et al, 2011 showed that -

- The ‘keyworker’ was considered to be a core component of successful transition
- There was an important gap as transition guidance and care pathways did not address ‘palliative care’ as an overall concept
5. Local Need and Local Vision

Local Need

Linking into the national drivers of end of life care, there is a drive to increase patient choice about the care they receive and where they receive it. One of the biggest factors within this choice is the ability to die in a place of the patient’s choosing.

The scope of the strategy is the population currently registered with a Milton Keynes General Practitioner (GP), although it should be recognised that some care providers, such as the hospital or hospice, which are linked to this strategy, will care for patients from ‘out of area’ or that are not registered with a Milton Keynes GP.

The population currently registered with a Milton Keynes GP may also use care providers out of area such as Children’s and Young Person’s Hospice providers, such as Helen and Douglas House or Keech Hospice that support patients and families.

In June 2015, the number of patients registered with a Milton Keynes General Practitioner was 281,758. The population is slightly higher when the number of individuals living in the area that are not registered with a GP, e.g. travelling families, migrant workers and their families, the homeless etc. This total population must be considered in the implementation of this strategy.

When a patient is registered to a GP practice it is often the GP and other practice staff who act initially as the patients care coordinator.

Of a known population of 281,758 in Milton Keynes, approximately 1,700 people die each year; this equates to 4-5 people a day. More than half of these people die in Milton Keynes Hospital. Of the 1,700 that die approximately 1,250 have palliative care needs (Public Health England 2014).

From the data it would indicate that approximately five people a week die in Milton Keynes Hospital, who had no medical need to be an inpatient at the time of death and could have died in their home or hospice if that was their wish.
It is estimated that in England around 40,500 people are in the hostel system at any one time and that 464 people will sleep rough on any one night (Department of Health 2010). Over two thirds of these individuals have multiple disease processes including cardiac disease, liver failure, cancer and respiratory diseases. For many homeless people the last weeks of life are frequently distressing and often accompanied by a reluctance to be admitted to hospital and an inability to feel comfortable once there (St Mungo’s and Marie Curie Cancer Care 2010).

The admission rate for end of life care in Willen Hospice is the second highest in England. The reasons for this are probably related to the lack of 24 hours cover by other out of hour’s services in the area, but it does offer 24/7 weekly support in the community. This support encompasses admission to the inpatient unit as required in time of crisis and a telephone advice and support line for patients, carers and health and social care professionals. Willen Hospice also offers an education programme for paid carers.

National and Local Government drivers are emphasising the need to achieve the patients preferred place of death and there has been a slight increase over the last few years of individuals dying at home, however it should be noted that the preferred place of death may not be in the individuals usual residence (home).

<table>
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<tr>
<th>The National End of Life Care Intelligence Network Data 2014</th>
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<tr>
<td>Patients usual place of residence at death registered in Milton Keynes</td>
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<td>Rolling 12 month basis</td>
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<tr>
<td>Oct 2012 – Sept 2013</td>
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<tr>
<td>All deaths</td>
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<tr>
<td>1,668</td>
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<td>All deaths</td>
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<td>1,575</td>
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Of course, patient’s choices may change throughout their disease progression and a useful element in supporting change and choice is the use of the Advance Care Plan.

Milton Keynes has a relatively young population so the proportion of individuals dying each year will increase as this young population ages. Milton Keynes is also an area which is growing in population with increased housing, which will encourage more movement of the population into the area.
Services and Priorities in Milton Keynes

Driving the service improvement expectation of this strategy requires ownership and leadership across all areas, including clinicians in all settings/sectors, commissioners and providers in partnership with the public, patients and carers. The roles of public, independent, community, and voluntary sector organisations, and the collaborative arrangements that exist between them are essential to end of life care. The strategy reinforces the need to continue to strengthen these creative partnerships, through local and regional infrastructure and strategic planning.

The local vision has been informed by patients, carers and all other stakeholders, and it is to commission an integrated end of life care pathway for all patients, including children, with advancing disease, irrespective of their diagnosis, who are thought to be approaching the end of their life.

The vision for end of life is that it is embraced by a society that has increased awareness and a more open attitude to discuss individual preferences for end of life care.

The End of Life Strategy Implementation Group have looked at the national legislation, local need, current provision and priorities for end of life patients in Milton Keynes and six areas have been identified as the most important for local development of support of patients and their families.

These are set out as the six strategic priorities for the next four years:-

- To develop an advice line for support to all patients, families and social and healthcare professionals
- To increase the training and education in end of life care for all involved in providing palliative care as professionals, patients and families, and the wider community
- To increase the numbers of patients achieving their preferred place of death
- To reduce the inequalities in end of life care service provision, including bereavement
- To ensure people can access good quality end of life care 24/7
- To improve the coordination of end of life care between providers
6. Strategic Priorities for the Next Four Years

- **Increase in training and education in end of life care for all stakeholders**

Every professional needs to be competent and up to date in the knowledge and practice that enables them to play their part in good end of life care. It is vital that every locality and every profession has a framework for their education, training and continuing professional development, to achieve and maintain this competence. That framework must allow expertise and professionalism to flourish in the culture of every organisation and every caring contact. It should offer practical examples of how care can be delivered in a way that is tailored to the person (Ambitions 2015). This is to ensure -

- That pain and suffering amongst people approaching the end of life is kept to an absolute minimum
- That people's needs, priorities and preferences for end of life care are identified, documented, reviewed, respected and acted upon wherever possible
- That high quality care is provided at the end of life, and after death for families

- **To ensure people can access good quality end of life care 24/7.**

Every person at their end of life should have access to a 24/7 service, as needed as a matter of course. The distress of uncontrolled pain and symptoms cannot wait for ‘opening hours’. This is a necessary system-wide expectation and good end of life care cannot be achieved without it. All commissioners and providers have to engage in defining how their services will operate to ensure expert responsiveness to needs are available at any time of day or night. (Ambitions 2015) Delivering 24/7 end of life care will ensure -

- That carers are appropriately supported both during a patient’s life and into bereavement. Care for those left behind must be catered for. Resource does not currently cover demand
- That all people are treated with dignity and respect at the end of their lives
- That services provide good value for money for the taxpayer

- **Develop advice line for support for all patients, families and social and healthcare professionals.**

The overarching ambition is ‘Care is Coordinated’ – I get the right help, at the right time, from the right people. I have a team around me who know my needs and plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of the day or night. (Ambitions 2015)

Milton Keynes local hospice, Willen Hospice, provide an advice line for palliative care patients known to the hospice and for out of hour’s health and social care professionals, for example paramedics or district nurses. The aim of this strategic priority is to expand and develop the existing advice line to all individuals seeking support and information, furthermore to include the provision of community visits when necessary.
The aim is for this telephone line to act as a single point of access, initially overnight, but to expand as the need dictates. There is a need to ensure that individuals who are deaf or hard of hearing have access to this advice line using any available assistive technology, to ensure equality.

This is to ensure -

- That all those approaching the end of life have access to physical, psychological, social and spiritual care that they require, whenever they require it
- That the many services people need are well coordinated, so that patients receive seamless care, regardless of address, ethnicity, age or diagnosed palliative disease

**To increase the numbers of patients achieving their preferred place of death.**

The overarching ambition is ‘Each Person is Seen as An Individual’ – I, and the people important to me, have opportunities to have honest, informed and timely conversations around the fact that I might die soon. I am asked what matters most to me; those who care for me know that and work with me to do what is possible (Ambitions 2015).

National and local data demonstrates that only a small proportion of patients choosing to die at home actually achieve this in Milton Keynes. However, the strategy will aim to provide choices for the individual about planning and achieving their preferred place of death. The combination and collaboration of the other five key priorities will positively impact on this important strategic goal. By formulating a robust implementation plan to drive the aims of the strategy it will ensure -

- That where possible, patients are facilitated to achieve their preferred place of care
- That all people are treated with dignity and respect at the end of their lives
- That all those approaching the end of life will have access to physical, psychological, social and spiritual care
- That service’s provide good value for money for the tax payer
To reduce the inequalities in end of life care service provision.

The overarching ambition is ‘Each Person Gets Fair Access to Care’- I live in a society where I get good end of life care regardless of who I am, where I live or the circumstances of my life (Ambitions 2015).

Taking data from national surveys such as VOICES and from engaging with local patient and carers groups, there appears to be inequalities with access to end of life care provision. There are also members of the ‘hidden’ population, those not registered with a GP that are unable to access some service provision. These groups include people for which English is not a first language, the homeless and others who may not be in receipt of care. Those with difficulty in accessing community or palliative services may present in Emergency Centres in a crisis situation. This strategy aims to direct the work that needs to be done to offer access to end of life service provision as required. This will ensure -

• That high quality care is provided for ALL who require it at the end of life, and after death for families
• That the many services people need are well coordinated, so that patients receive seamless personalised care
• That ALL those approaching the end of life have the right access to physical, psychological, social and spiritual care

To reduce the inequalities in end of life care service provision.

The building blocks for this ambition include – shared records, clear roles and responsibilities, a system-wide response, everyone matters and continuity in partnership (Ambitions 2015). This includes regular and effective communication between the dying person and their family, health and social care staff, and between health and care staff themselves. Within the aims of the strategy, this involves regular assessment of the person’s condition, whenever that condition changes and timely and appropriate responses to those changes, and is led by a responsible doctor and a responsible carer/nurse, who can access support from specialist palliative care services when needed. This will ensure -

• That pain and suffering amongst people approaching the end of life is kept to an absolute minimum
• That people’s needs, priorities and preferences for end of life care are identified, documented, reviewed, respected and acted upon whenever possible
• That the many services people need are well coordinated, so that patients receive seamless care
7. How will we know that the Strategy has made a difference?

**Governance: Overseeing the Implementation**

The Strategy Implementation Group will formulate the implementation plan leading to the formation of ‘task and finish’ groups. This Strategy Implementation Group will report progress and issues through to the Care Pathways and Primary Care Programme Board at the Clinical Commissioning Group (CCG). This brings together commissioners and managers of services across the NHS, public health, social care and children’s services, representatives of the voluntary and charitable sector and Healthwatch to build strong local partnerships, leadership and joint working across health and social care within Milton Keynes.

**National Data**

The National End of Life Care Intelligence Network (NEoLCIN) works to improve the collection and analysis of information related to the quality, volume and costs of care provided by the NHS, social services and the third sector, for example, local hospices, AgeUK etc. to adults approaching the end of life. This intelligence will form the baseline of any strategic service development and be used to show improvements in reaching delivery of the six priorities of this strategy.

Milton Keynes will be able to compare its strategic delivery and performance against other areas of the country using NEoLCIN and other national pieces of research and audit.

**Local Monitoring**

Local monitoring will include the collection of data by individual services and the CCG, which will demonstrate progress in many of the areas outlined in this strategy. This information will provide activity data, for example, how many patients are using a service, the type of support they are receiving and how many health or social care professionals are benefitting from training courses.

Patients and carer/family experience of using the end of life care services will be utilised to inform the effectiveness and the quality of the strategic changes to service provisions. These experiences will be collect by questionnaire, face to face contact or via other methods including social media.

The Strategy Implementation Group will be monitoring the outcomes of the implementation plans ensuring the six priorities are achieved and monitoring any variations. That means analysing and mitigating any reasons for not achieving a priority.
8. References

Ambitions for Palliative and End of Life Care: A national framework for local action (2015 – 2020) National Palliative and End of Life Care Partnership


Dying Without Dignity: Investigations by the Parliamentary and Health Service Ombudsman into complaints about end of life care (2015) Parliamentary and Health Service Ombudsman

End of Life Care Guidance (2010) General Medical Council

Everyone Counts: Planning for Patients (2013/14) NHS Commissioning Board


Five Priorities for Care of the Dying Person (2014) NHS England


http://endoflifecareambitions.org.uk/

http://www.endoflifecareforadults.nhs.uk/publication/eolc-strategy

All located at www.miltonkeynes.gov.uk
Milton Keynes Health and Wellbeing Strategy (2012 -15)


One Chance to get it Right (2014) Leadership Alliance for the Care of Dying People

Quality Standards for End of Life Care in Adults (2011) National Institute for Health and Care Excellence

St Mungo’s and Marie Curie Cancer Care 2010 – www.mungos.org/endoflifecare


The National Council for Palliative Care (2013)

The National Council for Palliative Care and Marie Curie Cancer Care (2013) 10 Questions to Ensure Good End of Life Care in Your Area


9. Glossary

Hospice Care
A hospice is not just a building; it is a way of caring for people. Hospice care aims to improve the lives of people who have life-limiting or terminal illness, helping them to live well before they die. Hospice care not only takes care of peoples’ physical needs, but looks after their emotional, spiritual and social needs as well. It also supports carers, family members and close friends, both during a person’s illness and during bereavement. (http://www.helpthehospices.org/about-hospice-care/what-is-hospice-care/)

Palliative Care
Palliative Care - is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual (source: World Health Organisation 2003)

Palliative Care aims to -
• Affirm life and regard dying as a normal process
• Provide relief from pain and other distressing symptoms
• Integrate the psychological and spiritual aspects of patient care
• Offer a support system to help patients live as actively as possible until death.

Transitions
Transitions – The phase of care between for patient, 16 – 25 years of age usually, from Children’s service to Adults services.
## Appendix 1  Membership of the Steering Group

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<thead>
<tr>
<th>Name</th>
<th>Organisation Address and contact number</th>
<th>Title</th>
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Telephone: 01908 691691  
Minicom: 01908 252727  
Our out of hours emergency telephone: 01908 226699 | Interim Senior Joint Commissioner          |
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5510 John Smith Drive  
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OX 4 2LH | Thames Valley Clinical Network End of Life Generalist                                                   |
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Milton Keynes  
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| Tracey Doherty    | Milton Keynes Clinical Commissioning Group Sherwood House  
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01908 278660 | End of Life Care Commissioner                                                                      |
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<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Sara Godward</td>
<td>Consultant In Public Health</td>
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<td>Milton Keynes University Hospital Foundation Trust&lt;br&gt;Standing Way&lt;br&gt;Milton Keynes&lt;br&gt;01908 660033</td>
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Appendix 2

Table 1 – Governance Accountability of the Steering Group within the Clinical Commissioning Group (CCG)

Commissioning Decision Group

Care Pathways and Primary Care Board

Strategy Steering Implementation Group

Joint Palliative Care Group
Education Group
Task and Finish Groups

Table 2 – Formal Alignment with other CCG Boards

Commissioning Decision Group

Care Pathway and Primary Care Board
System Resilience formally known as Urgent Care Board
Maternity, Children’s and Young Person’s Board
Mental Health Learning Disabilities Board

Attended by

SIG Chair Dr Carson Tracey Doherty
Tracey Doherty Eol Rep
Eol Rep