Leeds Palliative Care Network

Annual Report 2024-2025

Prepared for

West Yorkshire Integrated Care Board in Leeds

June 2025

Foreword

The last year has seen Leeds Palliative Care Network (LPCN) continue to drive forward collaborative work and solutions to improve palliative and end of life services for the Leeds population in the context of a very challenging financial picture. All of our partners have had to review clinical services to meet system demands and this has placed the work of the Network in a position of even greater importance given that many of the improvements, solutions and efficiencies which we seek can only be realised by cross-organisational collaboration. 2024/25 also saw the LPCN playing a central role in the response to temporary hospice bed closures in Leeds over the Summer and Autumn of 2024 in order to minimise the impact on patients and their families and to ensure smooth transfer of care to support the wider health and care system.

There have been many examples of LPCN achievements over the last year and every LPCN project and workstream is covered in the report below, but I would like to draw your attention to just some of those achievements:

Our work to embed Equality, Diversity and Inclusion in everything the Network does has gathered momentum. Our EDI group oversees a number of pieces of work and we have developed and seen the publication on the LPCN website of a number of 'easy-read' leaflets to make information about palliative and end of life care accessible to people with a learning disability and others who face barriers to information. Further work has started this year around the outcomes and experiences of people with a learning disability at end of life. The Network also took the decision to focus on the experiences of people from diverse communities who we know are not currently achieving the best outcomes towards and at end of life (for example preferred place of death, advanced care planning in place) and this work will develop in 2025/26.

We worked with academic partners at the University of Leeds to pilot and review the 'Timely' early identification tool at a number of GP practices in Leeds to ascertain whether this tool would be beneficial to Leeds. The piloting concluded that this tool did not add value in identifying people who were approaching End of Life and the LPCN is building on the learning gained and is currently exploring other options with the support of the University.

Work was carried out by the LPCN to improve the prescribing of Anticipatory medicines which has resulted in improvements within the community.

The LPCN's Dying well in the Community Project in Seacroft Primary Care Network area concluded and Seacroft partners in the Primary care Network and local third sector have developed a number of community initiatives including death cafes and local information about End of Life, death and dying. Seacroft has become one of the areas for the Advanced Respiratory Disease & Proactive Planning Project and the Network continues to work closely on this with the Leeds Integrated Care Board who lead on the work.

The success of the Leeds Palliative care ambulance service created challenges over the last year in terms of a high demand for the service limiting it's ability to respond to more pressing same-day requests. LPCN partnership work involving the Yorkshire Ambulance Service, Leeds NHS trusts and the hospices has allowed changes to be made that now successfully provide for more pressing transfers to hospices and home. The LPCN will continue to monitor this during 2025/26.

We continue to build on our highly successful planning ahead approaches in Leeds and our city-wide commitment to a single ReSPECT for the city. The LPCN will support the progression of this in the coming year. Leeds continues to stand out as a place where a higher proportion of those at End of Life have a form of advanced digital care planning in place, putting us in a much stronger position to meet the population's needs and wishes.

Looking forwarding to 2026, the Leeds Palliative and End of Life care Strategy will expire, meaning that the LPCN is starting the process, together with the End of Life Board, to identify the key priorities for the next 5 years. Amongst other things, this will need to take account of significant future change to the landscape in the United Kingdom in respect of death and dying.

The commitment of our partners' time and enthusiasm to the LPCN is greater than ever, allowing us to advance a large number of projects and workstreams to benefit people in Leeds. My thanks go out to all those clinicians and practitioners involved, to the public for their contribution to our work and to the Integrated Care Board for it's ongoing support for the Network.

Dr Adam Hurlow, LPCN Chair

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Introduction

As a collaborative provider partnership group, Leeds Palliative Care Network (LPCN) is committed to the highest quality, consistent, equitable and sustainable care in the final phase of life. It brings together health, social care and academic professionals across Leeds, provides strong partnerships and transcends traditional boundaries to bring about systems wide change. LPCN is constituted as a Managed Clinical Network.

The purpose of this report is to provide the West Yorkshire Integrated Care Board (WY ICB) in Leeds with ongoing assurance:

- of the effectiveness of Leeds Palliative Care Network as a delivery model for the improvement of services for the people of Leeds.
- that the plans for the coming year align with system priorities

The Leeds End of Life Population Board will also receive the report.

The report will be useful for LPCN partners to be able to evidence the benefit and impact that we have made collectively. It provides a report of activities and achievements during 2024 / 2025 and highlights plans for the future.

2024/25 saw the continuation of a number of challenges for all partners in the Leeds health and care system including increased demand on PEoL services, increased complexity of those accessing services, recruitment and retention of a skilled workforce and a difficult financial environment including rapidly rising costs.

Capacity to deliver frontline services and maintain a programme of service improvement has therefore required commitment, dedication and acceptance of some delay to planned activity. The engagement and efforts of clinicians working within the network remains as great as ever and demonstrates the faith in the network to deliver real benefits to patients, their families and to staff.

Throughout, the LPCN continued to provide facilitation and direct support through the administration of system wide meetings, securing additional people to support the project work and the continued development of additional guidance and learning materials hosted on our website, which is accessible to all.

LPCN Governance

The organisations who are party to the LPCN Memorandum of Understanding are:

Leeds Teaching Hospital NHS Trust

Leeds Community Healthcare NHS Trust

St Gemma's Hospice

Sue Ryder Wheatfields Hospice

Leeds City Council Adult Social Care

Leeds & York Partnership NHS Foundation Trust

Primary Care

During 2024/25, the LPCN along with all its partners, the West Yorkshire ICB in Leeds and the End of Life Population Board (the Board) continued to work collaboratively and to deliver the jointly agreed LPCN programme priorities and deliver change.

The Chair of LPCN is a key member of the Board enabling LPCN to provide insight, inform and influence strategic planning and decision making for the future. LPCN functions as a clinical reference group for the Board.

LPCN continued to be an active member of the West Yorkshire ICB level Palliative, End of Life Care (PEOLC) group to maintain input, influence and strong wider partnership links. Previous work on the Leeds Health Needs Assessment in 2023/24 to support the development of the WY ICB Health Needs Assessment saw its publication in February 2025. LPCN is a key point for onward information sharing from ICB leads across partners.

There have been some significant changes to the LPCN Executive membership, project leadership and the LPCN Team this last year:

- Diane Boyne retired and left the role of LPCN Manager in October 2024 and was replaced by James Woodhead
- Andrew Dean provided representation from Wheatfields Hospice from October 2024
- Adam Hurlow has reached the end of his extended tenure as the Chair of LPCN. New arrangements will be put in place in 2025/26 to allow a smooth transition to a new chair with Adam providing continuity whilst this is finalised

The LPCN maintains a risk register to note all risks for the LPCN and a systems issues log that enables partners to highlight issues of concern that require collaborative action to resolve. These are discussed at every LPCN Executive meeting and have, for example, resulted in supporting system resilience, sharing information about anticipatory medicines and medicine shortages, working to improve data and interoperability, supporting colleagues from at risk services due to financial challenge. Partners are also able to share incidents that require cross-organisation responses to resolve.

The LPCN Executive team reviews its projects to agree priorities and monitors actions against the strategic outcomes throughout the year and meets on a monthly basis. The LPCN budget is reviewed at each LPCN Executive meeting based on quarterly budget reports. New spend of LPCN non-recurrent funding is considered by the LPCN executive through the submission of Business Cases which are assessed against agreed criteria.

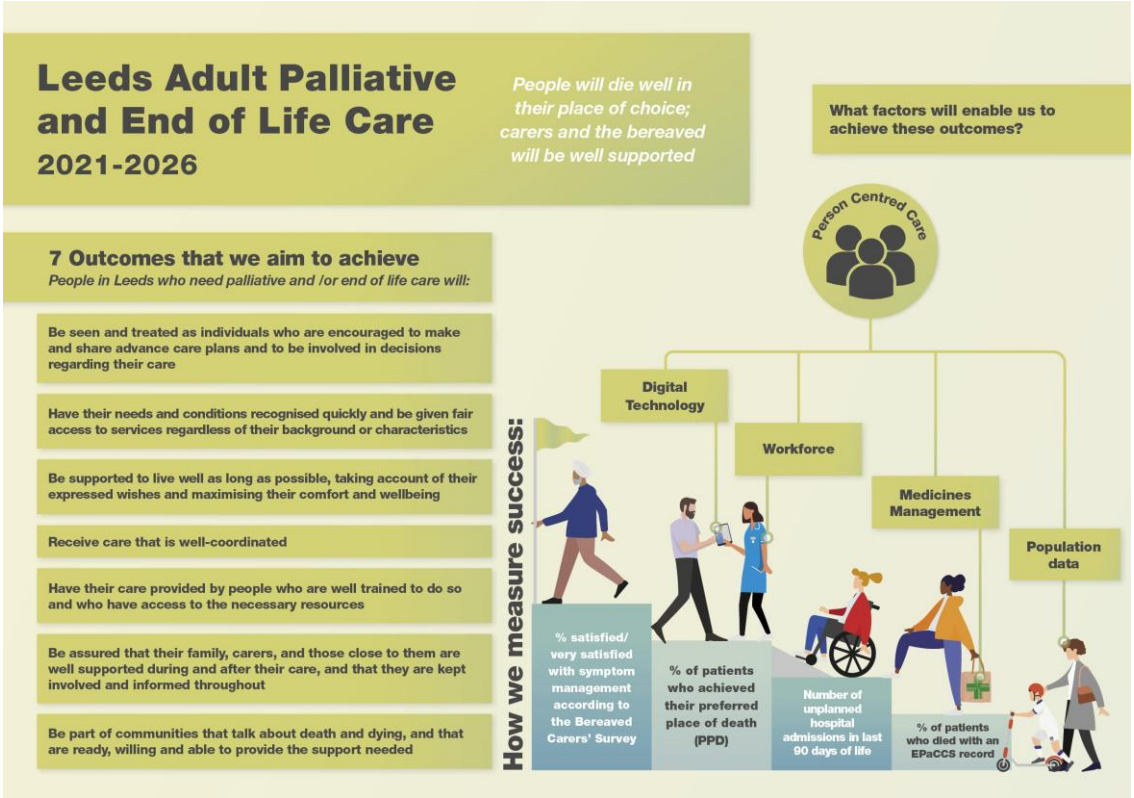
The LPCN ‘Group’ meetings provide an opportunity for the wider involvement of organisations in LPCN business and workstreams.

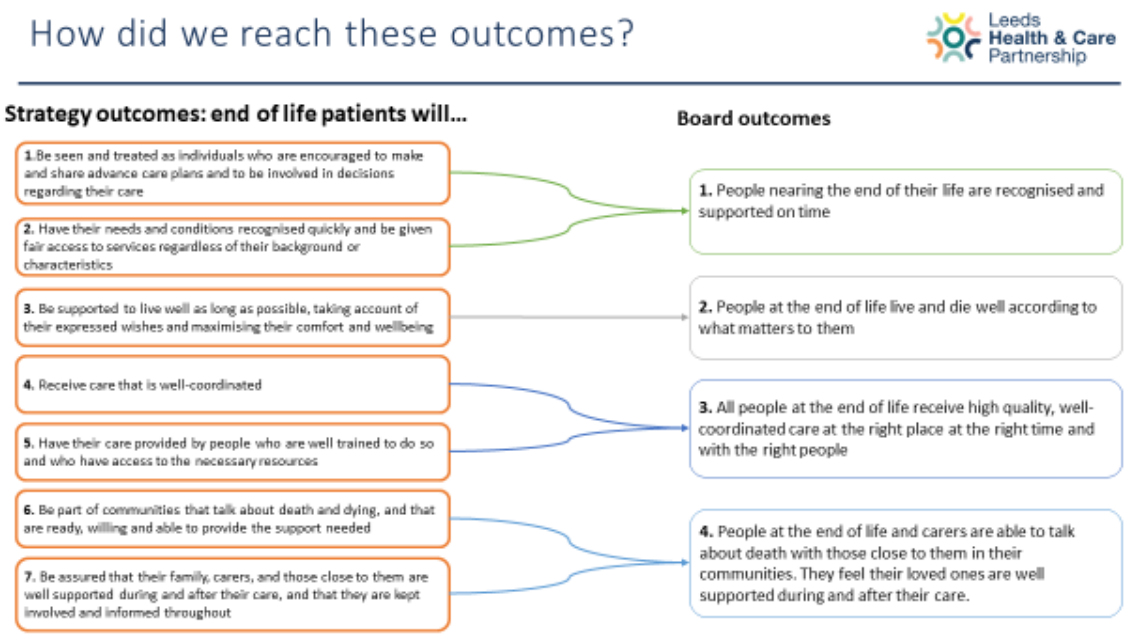
In 2024/25 all partners signed off revised Terms of Reference and a Memorandum of Understanding for the LPCN.

The Leeds Adult Palliative and End of Life Care Strategy and the Leeds Palliative and End of Life Care Population Board Outcomes

The Leeds Adult Palliative and End of Life Care Strategy underpins the work of the palliative and End of Life Board. The Strategy identifies 7 outcomes which Leeds aims to achieve. From these 7 outcomes, the Leeds Palliative and End of Life Care Population Board , distilled these down to 4 outcomes. The 4 outcomes underpin the delivery work of the LPCN:

1. People nearing the end of life are recognised and supported on time
2. People at the ned of life live and die well according to what matters to them
3. All people at the end of life receive high quality, well-coordinated care at the right place at the right time and with the right people
4. People at the end of life and carers are able to talk about death with those close to them in their communities. They feel their loved ones are well supported during and after their care.





The population outcomes developed for the strategy and by the Board have continued to direct the work plan for the LPCN.

LPCN quality improvement projects and workstreams continue to support delivery of these outcomes.

With the current Leeds PEoLC strategy expiring in 2026, the LPCN will work with the PEoL Board in 2025/26 to plan and delivery the next iteration of the strategy for the city. This will include the appropriate consultations with all stakeholders.

LPCN Priority Projects and Workstreams

In July 2024 the Leeds Palliative and End of Life Care Population Board (PEoLPB) and the LPCN agreed the project and workstream priorities for the LPCN. This ensures that the focussed work of the LPCN delivers the strategic ambitions of the PEoLPB and, in turn, aligns with the wider health and care plans for the city.

The agreed priority projects/workstreams for the LPCN were:

1. Community/city-wide respect audit
2. Timely Recognition Tool / early identification
3. Improving Planning Ahead (ReSPECT/EPACCs)
4. The respiratory and breathlessness pathway
5. Anticipatory Medicines Review

The table below sets out:

- the objectives for each priority project/work stream
- progress against these objectives in 2024/25 and
- plans for 2025/26

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Priority Workstream and objectives	2024/25 progress	Plans for 2025/26
<u>Improving Planning Ahead</u> Improve personalised approach to planning ahead through use of What Matters to Me, ReSPECT and EPaCCS Objectives 1. Establish feasibility of shared palliative care view within Leeds/ WY&H Care Record 2. Complete evaluation of Planning Ahead (ReSPECT/EPaCCS) to inform further quality improvements required 3. Audit the number and quality of ReSPECT forms across care settings 4. Identify training needs to support Planning Ahead implementation 5. Develop and review the Planning Ahead (ReSPECT/EPaCCS) template 6. Seek patient and public involvement and feedback 7. Make available patient information about the ReSPECT process within Planning Ahead 8. Review 2021 national changes to EPaCCS 9. Raise awareness about Planning Ahead and ACP.	The promotion and adoption of ReSPECT was further built into into the Home First city-wide work plan and Leeds continues to have a high proportion of the EOL population with a Planning Ahead approach in place. Links with national ReSPECT developments have been maintained with representation on the Resus Council UK ReSPECT Leads Group and national ReSPECT Subcommittee	In collaboration with the Home First accessible Programme we will continue to work on a PPM-based city-wide solution to multiple ReSPECT per person in Leeds. We aim to ensure to there is a one citywide ReSPECT per person read/write 24/7 across all electronic health records Working with LYPFT to support their roll out of ReSPECT within their Trust, including support around staff training.

Priority Workstream and objectives	2024/25 progress	Plans for 2025/26
Project Lead: Sarah McDermott Exec Lead: Gill Pottinger Strategy Outomes 1,4; EoL Board Outcome 1		
<u>Community/city-wide respect audit</u> Objectives 1. Commission UoL / AUPC to undertake Audit 2.Audit to include Quantitative and Qualitative Analysis of community ReSPECT data 3.Audit to include patient experience from any citywide providers Project Leads: Sarah McDermott & Matthew Allsop Exec Lead: Gill Pottinger Strategy Outomes 1,4; EoL Board Outcome 1	Research approvals sought incl. University of Leeds governance and NHS Ethics	• Preliminary analysis of ReSPECT data • Launch survey • Analyse survey data • Conduct in-person interviews/focus groups • January /February 2026 - write and submit the final report
<u>Timely Recognition Tool / early identification</u> To develop an early identification tool for patients approaching the end of life to use in primary care in Leeds • Secure funding to support the project • Establish working group • Agree resources required – Exec Lead, GP clinical leads, academic evaluation, data quality • Gain agreement to undertake project from National EARLY Team • Clarify scope, agree methodology and project plans • Appoint GP's to undertake project • Agree PCN and practices that will be within initial project phase • Review / Audit existing tool performance within Practices • Modify Tool as required • Test Modified Tool in same practices. • Review and adjust as required • Academic review of process, findings and report produced • Agree next phase and roll out into Primary Care if tool effective and validated Project Lead: Gill Pottinger Exec Lead: Gill Pottinger	The project aimed to develop a digital search tool embedded in primary care electronic patient records that would enhance recognition of people approaching the end of their life in the community in Leeds. The Yorkshire Strategic Clinical Network and the Leeds Ageing Well Fund supported it. A senior Clinical Lead and three other clinicians worked with the Central Local Care Partnership to test the tool. Pilot search tools for use in EMIS and SystmOne were developed and trialled. Data agreements were put in place so data could be analysed by AUPC to help validate the tools effectiveness. All project objectives (up to the point of completing the testing of the tool) were completed. Testing of the tool concluded that it was ineffective in its aim of identifying patients that primary care was not already aware of. Although this was not the outcome that partners had hoped to see, the approach was an objective one which sort to establish the efficacy of the tool and ensured that effort and resources were not wasted in rolling out a tool that did not add benefit	Sharing of the Timely end of project report once produced by the University of Leeds. To scope and begin a project to explore further early identification options that could be tested in Leeds. This includes working with AI colleagues at the University of Leeds Learning from the testing of the Timely Tool will be used to inform a new project. The existing project infrastructure and partner working relationships used to test the Timely tool would provide the structure for a new project in 2025/26.

Priority Workstream and objectives	2024/25 progress	Plans for 2025/26
Strategy Outcome 2; Board Outcome 1		
<u>The respiratory and breathlessness pathway</u> Provide a collaborative partnership forum for reviewing patient experience and care pathways for patients at end of life living with respiratory conditions and / or breathlessness and support quality improvements Objectives: 1. Review existing Pathways and identify key issues 2. Agree actions that can be undertaken to improve service 3. Take actions as agreed 4. Share updated service offers and referral routes 5. Effectively share any amendments made, updated service specifications etc. Project Lead: Alison Boland Strategy Outcomes 3,6; Board Outcome 2	The LPCN respiratory and breathless workstream has continued to provide an active network for improving the pathway and co-ordinating efforts between the partner organisations. The group developed the Palliative Oxygen Therapy guidelines which were approved via the LPCN Evidence into Practice Group and then uploaded onto the LPCN website and Leeds Health Pathways. The group has also supported the Advanced Respiratory Disease & Proactive Planning Project. The LPCN has continued to stay connected with the Leeds Integrated Care Board-led Advanced Respiratory Disease & Proactive Planning Project which is testing new community approaches to pro-actively managing people from more deprived communities in the Seacroft and Crossgates Primary care Network patches, including people at end of life. This aims to offer more planned care within the community and avoid any inappropriate unplanned hospital admissions. The project links closely with the LPCN Dying Well in the Community Project (concluded in 2024) which focussed on the Seacroft LPCN area and which forged relationships between local Health care, the third sector and community hospice care. Guidance on the withdrawal of ventilatory support in awake patients updated	The Leeds respiratory and breathless pathway will continue to provide a partnership group to maintain knowledge, networks and to make inmprovements to the pathway for those at end of life. A Palliative care respiratory day on the 20th June promoting links and education within the wider team. Review of the opioid for breathlessness guidelines.
<u>Anticipatory Medicines Review</u> To provide consistent advice and access to Network member organisations on the prescribing and use of anticipatory medicines Objectives: 1. Audit of S/C medication administered in last days of life 2. Present Results to Anticipatory Meds Group 3. Review Anticipatory Syringe Driver Guidance Identify next Steps Project Leads: Moira Cookson, Karen Neoh Exec Lead: Chris Bonsell Strategy Outcomes 4,5; Board Outcome 3	Progress actions agreed from LPCN Exec Team meeting with regards to: • Revisit possibility of discharging patients with anticipatory meds prescribed in line with community guidance. • Revisit possibility of reducing quantities prescribed on discharge from LTHT.	Not feasible at present to reduce number of vials supplied. Initial project ended and will keep under review.

Further LPCN Projects and Workstreams

Workstream and objectives	2024/25 progress	Plans for 2025/26
<u>Evidence into Practice / Research</u> Overseeing the development, review, approval and dissemination of clinical guidelines relevant to palliative and end of life care Objectives: 1. To encourage adoption across Leeds of the guidelines produced and agreed 2. Share the learning from clinical audits undertaken locally 3. Consider research findings and incorporate into best practice where appropriate. 4. Maintain Guideline Tracker 5. Invite academic colleagues from UoL to discuss research 6. To provide a forum where different organisations and care settings can meet to discuss local, regional and national guidelines	The Evidence into Practice Group meets to ensure Leeds wide practice is utilising up-to date evidence, revising and updating existing guidance, identifying evidence and guidance gaps and providing a forum for clinical and academic partners to discuss and disseminate current research findings. The EiP group has updated and ratified primary (and secondary where needed) representation for all partner organisations and undertake quarterly meetings with good attendance from across the board. Linking into other medicine-related activities and audits across the city including updates and presentations from University of Leeds and other colleagues. Such as a sub-group was also formed between LCH and LTHT regarding a published Anticipatory medication audit with the aim of reducing medication waste while ensuring timely receipt of anticipatory medication for patients and professionals. The EiP group also keeps in touch with community pharmacy teams regarding any medication supply issues and communicates with partner organisations. Audits have been carried out using the new 'NHS Service Finder' across the city with several pharmacies in the centre, north, east, south and west of the city who offer the 'Pharmacy Palliative Care Stockholder' service to find out how well the service is used, any challenges/barriers and what goes well. This will inform staff needing to source anticipatory medication and improve awareness and uptake of the service. With a guideline tracker established and gaining agreement on governance processes, the group have reviewed and updated:- • using morphine and other opioid painkillers to treat moderate to severe pain in palliative care patients • Renal failure- prescribing at the end of life. There was	Review, sign off and publication of: • Guidance on prescribing and administering drugs for syringe drivers in the last days of life in the community • Opioids for Breathlessness • Yorkshire Symptom Management Guidelines in Primary Care • Parkinsons Disease EoL Symptom Management • Medicines Optimisation Guidance for Adult Patients with a Limited Prognosis • Guidance for Patient or Carer Administration of Subcutaneous Medication (Palliative Care) • Community Hydration Guidance The EiP group will continue to horizon scan and share other guidelines of relevance to partner organisations if they might be applicable and beneficial (or for awareness) for the LPCN and across the city.

Workstream and objectives	2024/25 progress	Plans for 2025/26
	also a further review of the community versions following clinician feedback (incl. liver failure – see below). • Impaired Liver Failure - Prescribing at the end of Life Palliative Oxygen Therapy Guidance • Commented on and supported Yorkshire Regional symptom management guidance. • Palliative Oxygen therapy All up to date documents are available on the LPCN Medicines Management page	
<u>Transfer of Care - Hospital to Hospice</u> To identify and work towards eliminating delays in the transfer of care, from hospital to hospice, of patients receiving palliative and end of life care. Objectives: 1. Monitoring TOC data to inform new work streams 2. Optimising transfer process in conjunction with ambulance group 3. Proactively identify cost / time saving opportunities and implement 4. Regular review of organisational identified themes / issues to identify new workstream / task and finish projects 5. Adapt to new / unpredicted challenges to patient flow – horizon scanning and acting on information from other LPCN groups 6. Trusted Assessor Model – (on hold)- scope and consider Leeds model to facilitate transfers to hospices OOH Project Lead: Lesley Charman Exec Lead: Lesley Charman Strategy Outcomes 3,4; Board Outcome 3	The group meets bi-monthly and remained proactive in managing the Transfer of Care arrangements between partners, including:. Wheatfield bed closures –supporting the system/partner response to the bed closures over Summer 2024 including the ICB-led bi-weekly meetings. Updating of the SOP for the daily referral meetings. Overseen improved engagement with the daily referral meetings Reviewed membership (see also Leeds Palliative care Ambulance below)	Establish a broader representation of Leeds Specialist Palliative Care Providers – Aim -Ensure Patients leaving LTHT with Specialist Palliative Care needs are supported in a timely manner Review daily referral meeting process and governance. Aim - to streamline and ensure equity across city Scope minimum service offer from both hospices – equipment; complexity of care provided. Aim - to minimise delays in referral process
<u>Leeds Palliative Care Ambulance</u> To provide support to the Operational Group and deliver service improvements identified Objectives: 1. Continue to deliver relevant training for the service	The Leeds Palliative Care Ambulance Group was merged into the transfer of Care group in 2024/25 in order to improve communication, avoid duplication of discussions and make the time commitment more efficient for the clinicians and managers involved.	The Task & Finish group is continuing into 2025/26 to ensure that the trial is successful and that non unintended down-time is created in the process. The ToC group will be the place for bringing any Palliative Ambulance matters once the Task & Finish Group has concluded.

Workstream and objectives	2024/25 progress	Plans for 2025/26
2. Monitor the Activity Reports each quarter 3. Add service information to YAS website 4. Develop and distribute service leaflet 5. Determine how best to gain user feedback 6. Ensure new ambulance is operational 7. Agree service improvement plan for 24/25 (Contracting and Commissioning is with WY ICB - Lisa Bentley) Strategy Outcome 3; Board Outcome 2	High demand for the ambulances (particularly through pre-booking) resulted in a lack of availability for those patients most in need of time-critical specialist transport (same day requests for transfer from hospital to hospice or back home). The ToC Group therefore established a Palliative Ambulance Task & Finish Group which agreed to trial the impact of the following measures: • Reducing the pre-booking timescale from 72 to 48 hours • Establishing two morning protected slots for hospice transfers that are held each day until 10:30am • LCH developed a tiered approach to transferring patients within their homes to reduce PC ambulance use. • Business case submitted to provide patient transfer boards etc... Initial monitoring shows that this has provided the required capacity for the priority hospice transfers.	LCH to implement bed transfer guidance and purchase PAT slides, funded by the LPCN, to aid transfers at home.
<u>Whole City Linked Data</u> Develop monitoring and insight of city wide P&EoLC through enhanced use of Leeds Data Model Objectives: 1. LTHT ReSPECT data incorporated into routine Planning Ahead reports 2. Initial inequalities analysis of combined GSF/EPaCCS/ReSPECT 3. Secured EOLC Board support Dec 23 for focus on ACP data and AUPC access to help analysis Project Lead: Adam Hurlow Exec Lead: Adam Hurlow Strategy Outcome: population needs	Progress has been made with regards to establishing an IG compliant basis for academic colleagues to access Leeds Data Model for QI/service development. Needed to address capacity issues within WYICB BI team to optimise analysis opportunities presented by a mature linked data set. Planning Ahead report has been enhanced to provide comparative analysis for all adult who die in Leeds- allowing greater insight into the impact of demographic characteristics on access to ACP in Leeds.	Aligning this workstream with post-TIMELY activity we aim to embed academic analytic capacity into LDM to gain further insights into access to P&EolC in Leeds and progress development of an AI -enabled tool to screen for unmet palliative care need.
<u>Information and website</u> To improve useful information available to the public Objectives: -Agree purpose and likely content for this work -Develop content -Build page and information leaflets -Promote website	The LPCN has simplified the LPCN website and carried out an edit of documents and pages that are no longer relevant or are out-dated. A joint workshop was held in March 2025 with LCC Leeds Directory colleagues to look at how the Leeds Directory and the LPCN website can work together to provide the best access to relevant information for both the public and professionals. This includes Leeds Directory providing a 'landing page' for death/dying/EoL/palliative crae with	Continue the development of the LPCN website alongside the Leeds Directory. Continue to add easy-read documents and merging approved clinical guidance. Improve the news and events pages of the website.

Workstream and objectives	2024/25 progress	Plans for 2025/26
	links to the LPCN website where appropriate. Successfully achieved Leeds Directory providing a regularly-updated list of bereavement support providers following the ending of Leeds Bereavement Forum. New 'easy read' leaflets page developed on the LPCN website.	

Equality and Diversity Workstreams

Workstream and objectives	2024/25 progress	Plans for 2025/26
Equality Diversity and Inclusion (EDI) Objectives 1. Establish oversight LPCN EDI Group 2. Provide oversight, co-ordination and support to EoL EDI agenda and projects Project Lead: Temba Ndirigu Exec Lead: Hannah Zacharias Strategy Outcome 2; Board Outcome 1	The EDI oversight group has established it's work programme (detailed below) and provides a forum for networking and sharing local developments. LPCN Funding identified to implement 'No Barriers Here' training.	West Yorkshire ICB colleagues to present the findings of the West Yorkshire Health Inequalities Report (published Jan 2025) to the EDI group. Group to continue to monitor and
Learning Disability Resources Objectives: 1. Review existing ACP documentation and agree what is required in Easy Read Format 2. Document identified resources 3. Prioritise for Easy Read and develop those where gaps agreed Project Lead: Sarah McDermott Exec Lead: Hannah Zacharias	A number of 'easy-read' documents developed and published on a new easy read page on the LPCN website. Leaflets published: When Someone Dies Care & Support in the Last Days of Life Mental Capacity Act Fast Track Funding for End of Life Care What does it cost- information about palliative care funding My Future Wishes booklet	Continue to develop and publish new Easy read leaflets Promote the publishing through the network.
EDI - Review and agree training related to EOL and EDI Objectives: 1. Establish T&F Group 2. Discuss and share known existing training for EDI 3. Agree actions required Project Lead: Leigh Taylor Exec Lead: Hannah Zacharias	Known and existing training for EDI shared. Cultural competency training offered and delivered to those interested in the LPCN. No Barriers here (NBH) business case submitted for funding. Bidding successful. Places booked for 9 people to become NBH trainers throughout Leeds.	Plan for sub group to – focus on integration/ maintenance of cultural competency into education Consider strategies to increase awareness throughout city wide organisations. Steering group to form post NBH training to plan city wide roll out of workshops.
Homelessness (Inclusion Service) Widening access to palliative and end of life care for homeless and vulnerably housed people in Leeds. Objectives: 1. Establish project steering group. 2. Develop project plan. 3. Develop Job descriptions. 4. Recruit project Lead and project worker 5. Set up regular GSM 6. Develop educational sessions/teachings. 7. Develop a hand held easy read information tool. 8. Review existing system to enable identification of homeless people with palliative care needs. Project Lead: Nicky Hibbert Exec Lead: Hannah Zacharias	All project objectives were met and project valuation demonstrated the benefits of the service. and the service has secured a level of funding from the ICB for continuation in 2025/26.	Service to pursue longer-term recurrent funding. No longer an active LPCN project/ working group.

Workstream and objectives	2024/25 progress	Plans for 2025/26
PEoLC - Experience of EDI communities To gain feedback on experience of EOLC by carers of recently deceased patients and their communities Objectives: 1. Work with partners on design, promotion and analysis Project Lead: TBC Exec Lead: Sarah McDermott Strategy Outcomes 3,6; Board Outcome 2	EDI Board agreed three communities to focus on: People with a learning disability People from BME communities People living in the most financially disadvantaged communities Existing information and data compiled on communities 1 and 2. The LPCN Board and EDI Group agreed that a focus on the experience of groups that we know are currently experiencing poorer outcomes would be more beneficial than the generic information provided by the Bereaved Carers Survey which also had a low return rate (see also below).	Deeper dive into the Learning Disability LeDeR data to ensure that learning regarding the experience/outcomes at EoL/death is adopted by all LPCN partner organisations and by the LPCN workstreams and projects Consider how to build knowledge of groups 1 and 2 into outcomes across the LPCN programme

LPCN Education and training workstreams

Workstream and objectives	2024/25 progress	Plans for 2025/26
<u>Communication Skills Project</u> To refresh the Leeds Communication Skills Strategy to provide a clear model and standards of communication skills training for all health and social care professionals in relation to PEOLC. Project Lead: Trish Stockton Exec Lead: Leigh Taylor (covering) Strategy Outcome 5; Board Outcome 3	Scoping of current provision of communication throughout the city. Review of previous strategy	Strategy Updated.
<u>Planning Ahead Training</u> To deliver training to all partners who will use the Planning Ahead Template across Leeds Objectives: 1. Plan ongoing delivery of training 2. Identify facilitators 3. Deliver training 4. Evaluate training Project Lead: Leigh Taylor Exec Lead: Leigh Taylor (covering) Strategy Outcome 5; Board Outcome 3	Unfortunately 2 sessions have been cancelled at the start of the year due to low numbers and unforeseen circumstances. 2 further sessions are available in September and December. ReSPECT training material has been reviewed and adapted accordingly Business case successful in gaining funding for PCN's and Primary care communication training linked with Planning Ahead. St Gemma's have been commissioned to deliver this.	Continue training offer 2025- 2026 Consider outcomes of the ReSPECT community audit and review training content if required.
<u>Tele-education (including ECHO)</u> To continue to deliver and develop the use of ECHO/ tele-education in Leeds Objectives:	Cohort 1 of Palliative and EOL ECHO programme for Allied health professionals including 7 online sessions have been delivered to OT'S and PT's city wide. Cohort 2 is now on its 5th session (running Feb 25- Sept 25).	Plan to complete 7 sessions of ECHO programme for Cohort 2. Waiting list formed through expressions of interest for future programmes.

Workstream and objectives	2024/25 progress	Plans for 2025/26
1. Continue to deliver established programmes in response to workforce development need 2. evaluate and amend accordingly to maintain high standard of education 3. develop feedback reports Project Lead: Leigh Taylor Exec Lead: Leigh Taylor (covering) Strategy Outcome 5; Board Outcome 3		Review citywide need for further ECHO programmes.
<u>Review Advance Care Planning training in Leeds</u> Objectives: 1. Map out city wide ACP education provision. 2. Scope current resources used 3. promote consistent and standardised training throughout the city Project Lead: Leigh Taylor Exec Lead: Leigh Taylor (covering) Strategy Outcome 5; Board Outcome 3	Report completed on current training on ACP throughout the city. Recommendations reviewed with LPCN Education group. 3 key recommendations focused on and developed. - Introduction standardised pre/ post confidence rating questionnaires to evaluate training. - Development of resource page for facilitators. - Development of easy guide for facilitators to base key elements from each level of training.	Revisit ACP report and scope further implementation of recommendations.
<u>Support Homelessness Citywide Training</u> Objectives: 1. Schedule 5 dates for the programme to deliver training to those organisations that work with homeless people. 2. Work on the actions of meeting in order to ensure training is delivered. Project Lead: Nicky Hibbert Exec Lead: Leigh Taylor (covering) Strategy Outcome 5; Board Outcome 3	5 Palliative and EOL training sessions delivered to non-clinical workers, supporting those who are homeless or vulnerably housed. Sessions Evaluated.	Report to be circulated. Further scoping to offer training to the probation service who support those who are homeless and vulnerably housed.
<u>Care Home Education Report</u> To provide information on current education provision in care homes, and make recommendations for future development of education Objectives: 1. Establish Care Home Education 'Core LPCN Projects' group 2. Agree TOR 3. Scope out current Education offer and agree training gaps 4. Agree Actions required to meet education need identified Project Lead: Trish Stockton Exec Lead: Leigh Taylor (covering)	Report complete – Care home education group agreement to focus on the following recommendations • Incorporate webpage of resources on LPCN website for care homes. • Developing / linking with reward/ recognition of skills and knowledge learnt. • Sub-group developed to review current education offer in care homes.	Sub-group to form once core capabilities published to adapt and integrate city wide into care homes. Plan to adapt e-learning from CSW project to be applicable to city wide learning need and support current education. Further scoping of developing/ linking with reward/ recognition of skills and knowledge learnt.

Workstream and objectives	2024/25 progress	Plans for 2025/26
Strategy Outcome 5; Board Outcome 3		
<u>LTHT CSW Clinical Educator project</u> To provide EOLC training to 2000 CSW in LTHT and plan for how future refresher training could be sustainably delivered. Objectives: 1. Appoint Clinical Educator 2. Design the training programme 3. Determine how best to deliver training to targeted staff group 4. Deliver training 5. Monitor and report uptake 6. Evaluate Effectiveness 7. Determine future package and delivery model 8. Liaise and share with system wide partners as appropriate Project Lead: Claire Iwaniszak Exec Lead: Leigh Taylor (covering) Strategy Outcome 5; Board Outcome 3	Project successfully completed and evaluation report completed and shared. Rolling programme for clinical Support Workers (CSW) Band 2 & 3 palliative and end of life care priority training continued with all LTHT clinical service units (CSUs). 1012 CSW's trained (62%).	Project closed and learning/evaluation shared

Planning Ahead Report

Combining community and LTHT data demonstrate that over 80% of adults who die in Leeds have digital ACP in place prior to death; ReSPECT and/or EPaCCS. This compares to just over 40% of adults who die being registered in community systems as approaching the end of life.

Inequalities in access to digital ACP persist with people who are younger, male, black and Asian and with non-cancer diagnoses overrepresented in groups without any form of ACP.

Of those with documented preferred place of death in community systems the majority are cared for in their preferred settings in the last days of life. This dipped slightly this year which may reflect the temporary closure of Sue Ryder Wheatfields Hospice and is phased reopening.

Approximately 70% of people with a Community Planning Ahead (EPaCCS) die outside of hospital compared to just over 50% of all those who die in Leeds (DHSC 2023). DHSC (2023) data to shows consistent reduction in the proportion of people who ide in hospital in Leeds in line with national trends Leeds remains a positive outlier in the proportion who people who die who have 3 or more unplanned admission in the 3 months of life; 4% compared to 6% nationally.

Bereaved Carers Survey

The EOL Board agreed in 2023 that due to the low return and concerns by the registrar's office that registration is not the right time to share the survey, the LPCN should explore other priorities for gaining feedback from carers/families. In 2024/25 the LPCN met with the Leeds Medical Examiners office, in light of its newly extended function of to speak to families of people who have died in the community. The purpose of the meeting was to explore whether information that they now gathered regarding deaths in the community

could be collated to The LPCN Board and EDI Group agreed that a focus on the experience of groups that we know are currently experiencing poorer outcomes would be more beneficial than the generic information provided by the Bereaved Carers Survey which also had a low return rate.

West Yorkshire Health Needs Assessment for P&EOLC
The LPCN Chair and Network Manager contributed significantly to the design, development and content review of both the West Yorkshire Healthwatch report into people's lived experience and production of the Health Needs Assessment. This document was published in February 2024/25 provides a useful reference point/benchmarking. The document will inform the forthcoming updated Joint Strategic Assessment for Leeds. The LPCN is working with the West Yorkshire Team to ensure report recommendations are built into our EDI work and, through this, the wider work of the LPCN.

Dying Matters Partnership

LPCN continued to work with this Public Health-led citywide programme of initiatives and activities to enable people in Leeds to:

• Feel more comfortable about death and dying

• Discuss their end of life wishes with family members and/or health and social care professionals

• Plan for their death including writing their will, registering as an organ donor and communicating their funeral wishes.

The work is coordinated by the Leeds Dying Matters Partnership of which the LPCN is an active member

E- Prescribing for Hospice Outpatients and Community Services
This project is was on hold in 2024/25 pending adequate capacity within the hospice pharmacy and community teams and effective SystmOne knowledge to undertake the project. It is being re-instated in 2025/26 as a project led by St Gemma's partly fundied through the remaining funding for in the LPCN budget.

The project will facilitate a transition from paper FP10 prescriptions (and/or tasks to GPs) in St Gemma's Community Service to the SystmOne Electronic Prescription Service (EPS), including building a drug formulary within SystmOne specific to the community team prescribing needs. Once successfully implemented this approach could be adopted by the rest of the city.

Programme risks and issues

LPCN risks logged in 2024/25

- Limited capacity for staff to deliver work of LPCN. Risk to stability and sustainability.
- The health system is under significant financial strain with efficiencies being sought across all providers and the ICB

LPCN issues logged in 2024/25

- Interoperability of Patient info Systems
- Financial Pressures on PEoL and wider services
- Securing of long term future funding for the Homeless (Inclusion) Service
- Funding of the Mental Health Therapy Post
- Impacts of changes to certification of death process (MCCD) which started in September 2024
- Timely availability of the Palliative Care Ambulance (see workstreams above)

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Finance Report 2024/25

Table 1 – Recurrent Funding 2024/25

LEEDS PALLIATIVE CARE NETWORK FINANCE REPORT April 24-March 25							
WORKFORCE							
Roles	**Budget 24/25**	**Q1 actual**	**Q2 actual**	**Q3 actual**	**Q4 actual**	**Actual**	**Remaining**
LPCN Management Clinical & Admin	£85,460	£21,132	£21,729	£14,610	£26,914	£84,384	£1,075
Clinical Practice Educator & Admin	£71,562	£17,512	£18,682	£18,203	£18,563	£72,959	-£1,397
ELM/Comms	£6,000	£600	£900	£450	£1,800	£3,750	£2,250
Sundries / expenses	£1,000	£88	£30	£8	£26	£152	£849
Website	£1,000		£108	£886		£994	£6
Overheads	£13,200	£3,300	£3,300	£3,300	£3,300	£13,200	£0
Final amount for recharge purposes 24/25	**£178,222**	**£42,631**	**£44,749**	**£37,457**	**£50,602**	**£175,439**	**£2,783**
Pipeline bids							

The LPCN received £178,222 recurrent funding from the Integrated Care Board-Leeds in 2024/25. Actual expenditure was £175,439 leaving £2,783 in the budget. For comparison, the remainder carried over at the end of 2023/24 was £7,761.

St Gemma's Hospice continued to provide the 'hosting' of the LPCN, meaning the Financial management (including contracting with the ICB) function and employment/estate/IT function on behalf of the LPCN partners. The consideration for this (£13,200) is seen in the 'overheads' line above.

Staffing costs (£127,811) accounted for 73% of recurrent expenditure costs; back-fill for Executive members LPCN hours (£29,172) 17% and 10% for other running costs.

£43,279 recurrent underspend from previous years was carried forward into 2024/25. With the £2,783 underspend in 2024/25 a total of £46,062 of recurrent underspend is carried over into 2025/26.

Recurrent budget forecast 2025/26

The ICB has provided an uplift of 2.15% to the LPCN budget for 2025/26 which will mean an income of £182,054. As with all services, significant increases in staffing and back fill costs continue to grow including additional NI costs for hospice-employed staff in the coming year. This means that, for the first time, we are likely to see expenditure exceeding income in 2025/26. The LPCN would need to use some of the recurrent roll over from previous years (see above) to make up any difference at the year end. In the meantime, we will continue to work as efficiently as possible and identify any opportunities to reduce expenditure.

Table 2 – Non-recurrent funding

PROJECTS		Income 2024 – 25	Expenditure				
Title/Workstream Lead	Actual B/F		Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	Actual C/F
Citywide Bereaved Carers Survey	£3,938						£3,938
Implementation of E prescribing – Moira Cookson	£4,029		£166				£3,863
EPaCCS Planning Ahead training and development	£35,135		£266	£697	£411	£4,452	£29,308
Education Projects	£14,584	£0				£64	£14,521
Heart Failure MDT cover	£721	£4,509	£1,001	£1,001	£1,001	£1,001	£1,228
LPCN new project fund	£33,666		£4,500			£4,948	£24,219
Timely Recognition Project	£28,133			£865	£525		£26,743
Equality Diversity and Inclusion	£21,000						£21,000
LTHT CSW's Training	£10,128	£16,012	£26,140				£0
Contingency Fund	£15,000						£15,000
Total	**£166,334**	**£20,521**	**£32,074**	**£2,562**	**£1,936**	**£10,464**	**£139,819**

Non-recurrent position 2024/25

LPCN non-recurrent funding is derived from previous successful funding bids and other non-recurrent sources. It also includes the 'Contingency Fund' (£15,000) to cover LPCN staff redundancy costs if the network was to be discontinued at any point. Everything apart from the Contingency Funding is referred to here as Project Funding.

In 2024/25 a total of £47,038 was spent on funding projects. £151,334 in total was carried forward from 2023/24 and there remains £139,819 at year end of 2024/25.

Non-recurrent funding 2025/26

Note on table 2 that from Q1 2025/26 onwards the following lines will be removed from the budget:

- City-wide Bereaved Carers Survey (when this was conducted in previous years it was funded through additional ICB funding)
- Heart Failure MDT cover. This is being mainstreamed and will move across to St Gemma's budgets permanently
- LTHT CSW's Training. The project has completed and the funding is spent.

This means that the non-recurrent Project Funding (excluding contingency fund) for 2025/26 will be:

Project	2025/26 carried forward
Implementation of E prescribing	£3,863
EPaCCS Planning Ahead training and development	£29,308
Education Projects	£14,521
LPCN new Project Fund	£24,219
Timely Recognition Project	£26,743
Equality, Diversity & Inclusion	£21,000
Total c/f	**119,654**

Business cases for funding approved in 2024/25

- Advanced Communications Skills training
- No Barriers Here training
- Promoting excellent in End of Life Care through visual reminders

LPCN Website usage

We manage the LPCN Website, a resource for professionals, and the public and a Twitter account.

According to our website provider, Seegreen, the LPCN website had 92,858 visits in 2024/25. In an average month there were 4,042 unique visitors to the website.

Most visited LPCN website pages in 2024/25 were:

Rank	Website page
1	Contact
2	Medicines Management
3	A guide to Patient and Carer Administration of Subcutaneous Medication in Palliative Care Leaflet (PDF)
4	Leeds Opioid Conversion Guide for Adult Palliative Care Patients (PDF)
5	End of Life Care and Support Leaflet
6	EOLC Learning Outcomes/ Education & Training
7	Services
8	Advanced Care Planning/ Planning ahead / ReSPECT training resources
9	Recruitment
10	Resources
11	News & Events
12	A Guide to Symptom Management in Palliative Care - Yorkshire and Humber End of Life Care Group (PDF)
13	Professionals
14	Symptom Management Guidance in the last days of Life LCH April 2022 (PDF)
15	Bereavement Support
16	Impaired Liver Function - Prescribing at the End of Life (PDF)
17	Local Government Association - End of Life Care Guide for Councils (PDF)
18	Leeds Dying Well in the Community Project Resources