Leeds Community Healthcare NHS Trust

LCH: Palliative and End of Life Care (PEoLC) MCN Update

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Summary

- LCH background / Health Needs Assessment
- Neighbourhood Team (NT) improvement plan
- How we are doing
  - Performance indicators / quality measures
  - PEoLC service review / feedback
- Priorities 2018-19

Adult Business Unit

- Neighbourhood Teams / Night Service
  - Neighbourhood Pall care Leads (NPCLs)
  - Pall Care Discharge Facilitators
- End of Life Care Home Team
- Health Case Managers
- Community beds, continence, tissue viability, falls

Specialist Business Unit

- Cardiac / Respiratory / Diabetes / others

LEEDS MODEL FOR DELIVERY OF HIGH QUALITY PALLIATIVE & END OF LIFE CARE (FUTURE)

ASSESSMENT

Patient is assessed by a health care professional (HCP) as likely to be in the last year of life

HCP offers the patient opportunities to have a conversation to form a shared understanding of their condition and its likely progression, and how they want to live

Carers' assessments are completed, implemented and reviewed as required

Patients are offered holistic assessments particularly at times of change in their condition

CARE PLANNING & CARE CO-ORDINATION

All patients are placed on practice palliative care list and the EoLC template is completed and shared (EPaCCS)

Pro-active care planning is put in place and reviewed regularly
? Link to Risk Stratification

Care Co-ordination will be provided by the patient's GP (as per GP Contract)

Patient has a single point of access 24/7 for advice and signposting

CARE DELIVERY

All patients referred to District Nurse (D/N) and the D/N Service Delivery Framework for Palliative and End of Life care is followed

D/N works with patient / family/ carers within integrated neighbourhood teams to ensure current and future care needs are met

For patients who have and extra level of need (see Leeds eligibility criteria for specialist palliative care), the GP, DN, CNS, care home or (if in hospital) ward team refer to specialist palliative care services

Patients who develop urgent problems are seen, assessed and their problems managed rapidly where ever they are.

Medicines for symptom management are available 24/7 wherever the patient is, with staff able to prescribe, administer them where needed

NURSE-LED BEDS FOR PALLIATIVE CARE – For patients who do not require specialist level of palliative care but choose/need an inpatient setting

The D/N service will provide an enhanced service eg: increased number of prescribers and verification of expected death

All staff and volunteers who come into contact with the patient are appropriately trained and treat the patient and family with dignity and respect (linked to Education and Strategy)

PREFERRED PLACE OF CARE/DEATH

Patients are able to choose their preferred place of care/death
HOME (Including Care Home where this is normal place of residence
HOSPICE
HOSPITAL
CARE HOME

- For patients who choose to move between care settings to die in their place of choice, appropriate transport is provided the same day
- Transfer is facilitated for more complex patients by Discharge Facilitators (7 days/wk)
- Equipment is provided according to need, to get or keep patients in their preferred place of care

CARE AFTER DEATH

When the patient dies, the death is verified within agreed timescales

Information on bereavement and support is available to those close to the patient

SPECIALIST EoLC Discharge Facilitators will be working a 7 day week to enhance the current service

A model will be available where SPC CNS provide 7 day care

Key:
is proposed new service models

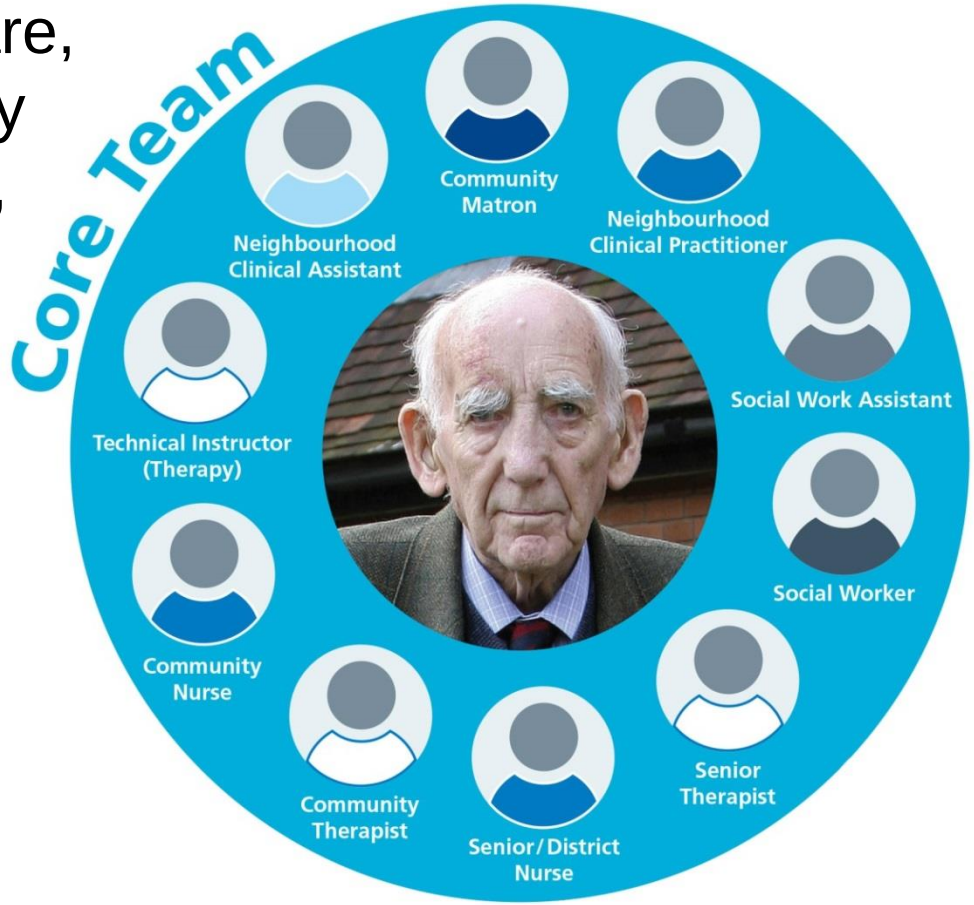
LCH objectives

- Improve access to medications
  - Guidance / prescribers / availability
- Increase capacity / Service Delivery Framework
  - Service integration / skills development
- Increase verification of expected death
- 7 day discharge / care home support

BCF funding 2015 – NPCL role / review 2018-19

What is a Neighbourhood Team?

- Previously Intermediate Care, District Nursing, Community Matrons, Adult Social Care,
- Local model x13
- 24/7 (night support)
- GP aligned



Neighbourhood Pall Care Lead

- Practice based 7 days
- Expertise / generalist
- Education and training
- Care home support at weekends

Discharge Facilitators

- Support Care Planning Meetings

NT improvement plan 2016-18

- Embed Service Delivery Framework
- Increase / develop training
- Embed EPaCCS
- Increase staff competent to verify death
- Electronic assessment tools / care plans
- Robust reporting / review of incidents

Improvements, continued

Symptom management

- More nurse prescribing
- Introduce subcut cannula for as required medication
- Remote prescribing guidance

Timely Fast Track funding reviews

Support new Mortality Review Process

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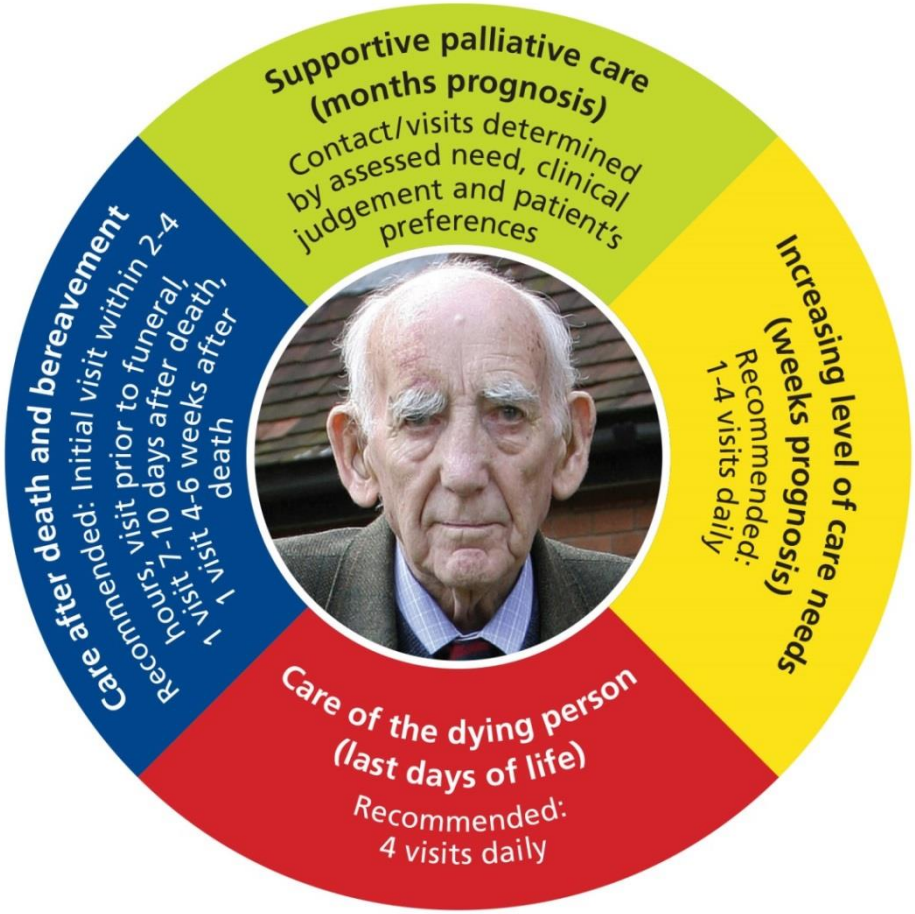
Service Delivery Framework



Skills development

- Neighbourhood nursing staff – 300+
- Therapists – 40+
- Health care assistants – 100+
- DNACPR / FT signatories – 30+
- Locally coordinated
- Consolidated in practice

How are we doing? 2017-18

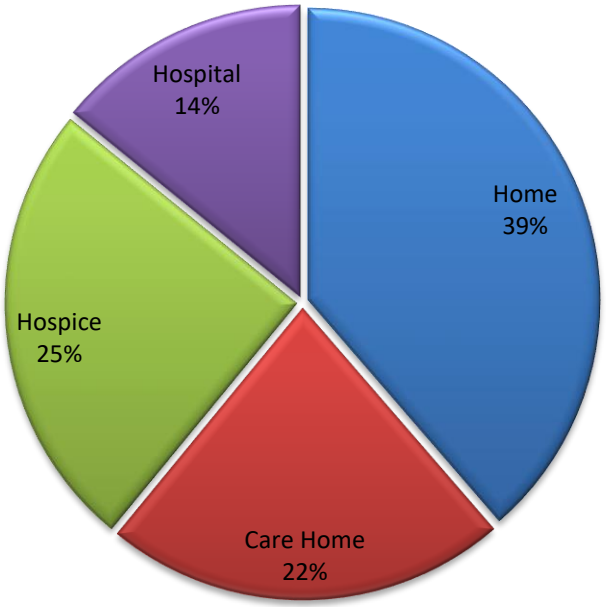
2169 patients

- PPD target 85%

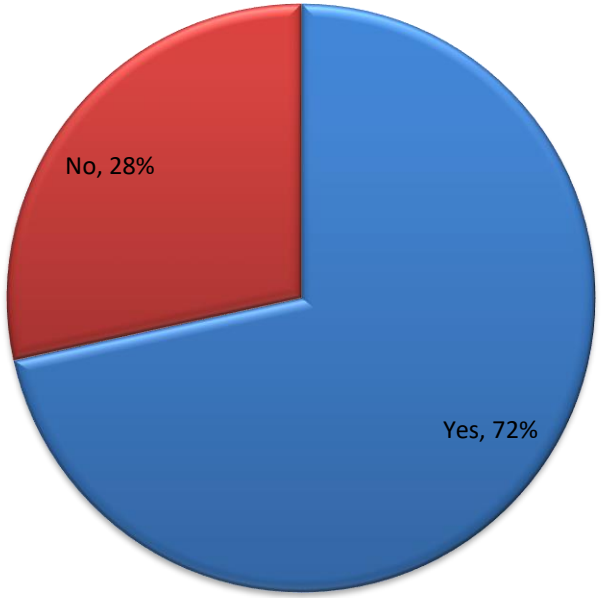
PPD Achieved(Ist Choice)	85%
PPD Achieved(Ist + 2nd Choice)	89%
% With Correct Recording	90%

- ?Earlier identification in 2017-18

Actual Place of Death 17/18



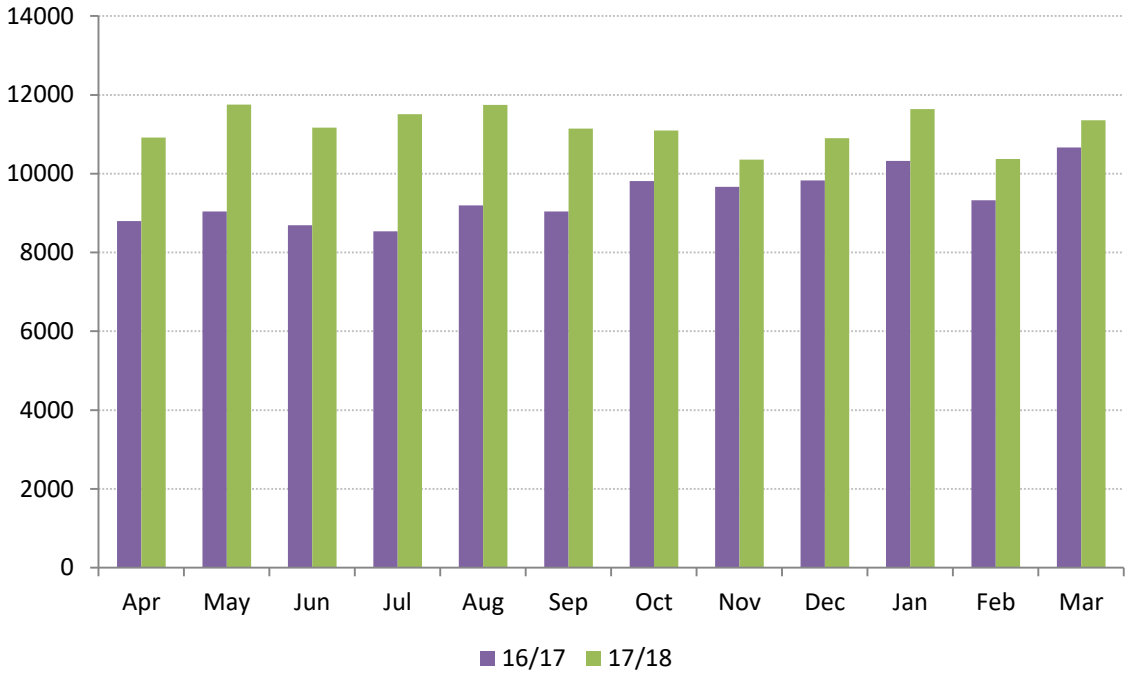
Deaths verified at home 17/18



Palliative care activity

Annual increase:

- 19% in contacts
- 8% per patient



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CQC feedback

Patients …were **consulted** in their **future care** plans, involved in their care assessments, and planning. We observed this happened with patients who were **at the end of life**…

We saw **emotional support** being offered to an end of life patient and their relative. **Staff took time** to **listen** to relatives anxieties and understood the need to discuss their emotions.

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LCH Palliative Care service review

- Impact of NPCL role / improvements
- Business team resource
- Positive feedback
- Retain the role
- Review roles and responsibilities

Priorities for 2018-19: LCH

- Further embed Mortality Review
- NT agenda – Local Care Partnerships / caseload cluster working / triage role / Frailty and EoLC / ‘left shift’ / admission avoidance
- ReSPECT
- MCN projects
- Demographic challenges