'It's about our life, our health, our care, our family and our community'

End of Life Care

Presentation to the Health and Wellbeing Board

19th November 2015

LLR End of Life PROGRAMME BOARD

LLR END OF LIFE PROGRAMME BOARD GOVERNANCE AND REPORTING STRUCTURE

ORGANISATIONS	LLR END OF LIFE PROGRAMME BOARD	BETTER CARE TOGETHER

LLR EoL Programme Board membership is a partnership with all stakeholders, NHS, voluntary sector, and patients to support the agenda to improve the EoL care pathway

LLR End of Life PROGRAMME BOARD

3 x LAs
UHL
LPT
EMAS
LOROS
PATIENT REP
LCCCG
ELRCCG
WLCCG
Macmillan

LLR EoL Programme Board meets monthly to LLR EoL Strategy

The Programme Board reports into the LLR Better Care Together Delivery Board

Rutland County Council
healthwatch
Leicester City Council
Leicestershire County Council
NHS

LLR End of Life Care Pathway

Step 1	Step 2	Step 3	Step 4	Step 5	Step 6
Discussions as the end of life approaches	Assessment, care planning and review	Coordination of care	Delivery of high quality services in different settings	Care in the last days of life	Care after death
Open, honest communication	Agreed care plan and regular review	Strategic coordination	High quality care provision in all settings	Identification of the dying	Recognition that end of life care does not stop at the point of death
Identifying triggers for discussion	Regular review of needs and preferences	Coordination of individual patient care	Acute hospitals, community, care homes, hospices, community hospitals, prisons, secure hospitals and hostels	Review of needs and preferences for place of death	Timely verification and certification of death or referral to coroner
	Assessing needs of carers	Rapid response services	Ambulance Services	Support for both patient and carer	Care and support of carer and family, including emotional and practical bereavement support
				Recognition of wishes regarding resuscitation and organ donation	

Information for patients and carers

Support for patient and carers

Underpins the pathways

- Governance and Assurance
- Workforce capability and capacity
- IM&T integrated systems
- Active and empowered Patients
- Interagency to share training, guidelines, etc

LLR End of Life Examples of Good Practice along the pathway already implemented

Step 1 – Discussions as the end of life approaches
- Communication training delivered and ongoing
- ACP being promoted in all settings
- The SPICT Tool being used

Step 2 – Assessment, care planning and review
- Unified LLR Care Plan and SPN
- Unified alert system for patients with care plans
- Care plan prompts to assess the needs of carers
- Audit of care plans – training and review of template

Step 3 – Coordination of care
- Coordination has been built into the in-hours and OOH services through electronic sharing of the care plan
- Coordination of individual patient care has been achieved through the unified care plan

Step 4 – Delivery of high quality services in different settings
- Learning lessons report provided recommendations for all organisations

Step 5 – Care in the last days of life
- New guidance and care plans have been developed for patients in their last days of life
- Updated authorisation for medication in the last days of life

Step 6 – Care after death
- Bereavement Project at UHL

Key areas of need

- **Co-ordinated care 24/7 for people at the end of life and those important to them**
  - Enhanced services benefits patients and their families
  - Mapping and development of services across all settings
- **Care Planning for people at the end of life and those important to them**
  - Greater opportunity to discuss
  - Better coordination of care plans

Why co-ordinated 24/7?

- OOH care fragmented
- Poor access to up-to date patient information
- Increasing number of patients dying in their usual place of residence rather than hospital
- Symptom control at home – particularly pain
- More likely to fulfil patient wishes and avoid unnecessary admission to hospital
- Improved experience for carers and patient

healthwatch

Current situation

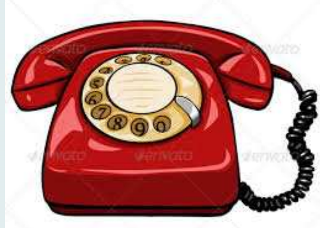
3pm

GP

LOROS

SPA - DNs

999



HatH

Patient V – Lung Ca. with mets, lives alone, daughter nearby, hospital bed at home, but still mobile, Care plan discussed, PPD = home, has seen hospice nurse once, has one care visit daily, Main symptom = breathlessness managed with oramorph prescribed by GP, **now has new pain**

11pm

A&E

UCC

WIC

999

111

OOH

SP

LOROS

healthwatch

Patient V

now has new pain

- How many times will she have to repeat her medical history?
- How many organisations will know she has a care plan and what it contains?
- Who is available to give clinical support / advice to generalists if needed OOH?
- How likely is Patient V to be admitted at 2am?

Patient V
now has new pain

What if she could…. ?

Phone a single number, where someone who had her history and care plan could put her through to an OOH GP / Palliative care nurse / ambulance / urgent social care, as appropriate

There was access to specialist palliative care advice from a nurse/consultant available throughout the night and weekend

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Why care planning?

- Improved patient and carer satisfaction
- It may reduce inappropriate hospital admissions
- Identifies patient preferences for care
- Provides opportunities to plan care in advance

Where are we now?

- ‘Personalised care plans’ already introduced
- Can be completed in different healthcare settings
- Not all patients are offered the chance to complete them
- No single unified form
  - An electronic care coordination system has not yet been introduced

healthwatch

B experienced a prolonged hospital admission with heart failure and had been ‘fast tracked home’. Despite his POC being arranged for discharge, no-one came for 3 days. His partner expressed uncertainty about who to contact, and so provided all his care herself unaided.

‘Routine’ checking of his U&Es led to hospital admission 5 days later by an OOH doctor at midnight.

The balance of controlling his HF vs. improving poor renal function was discussed. He and his family felt the admission had been ‘pointless’.

healthwatch

B’s wishes re: future care were discussed and documented on his discharge letter.

T/call to GP to update – informed that ACP had already been completed by another GP. B had no document at home, did not recall these conversations, and had not discussed future investigations and wishes re: hospital admission.

B and his family declined to stay in hospital longer to address concerns re: POC.

healthwatch

Next steps….

- Optimise Care planning and Coordination
  - Shared care records
  - DNARs
  - Improved communication
  - End of Life medications
- Correct level of services (Specialist, Generalist)
  - 24/7 services
- Workforce
- Education

LOROS Hospice

Karen Ashcroft
Director of Strategy & Development

twitter.com/loroshospice
facebook.com/loroshospice

Registered Charity No: 506120

Aims of the Session

What we are

What we offer

Funding

Raise awareness of services provided
(Hospice & Community)

Challenges

Strategic developments

- LOROS is an independent local charity which provides specialist palliative care and support to the people of Leicester, Leicestershire and Rutland

- Every year we care for over 2,500 people across Leicester, Leicestershire and Rutland

- All of our services are free of charge to our patients, family and carers

What we are

- It has +300 employed staff and > 1,000 volunteers
- It is governed by a Board of up to 15 unpaid voluntary Trustees
- It is regulated by the Care Quality Commission, the Charity Commission and Companies House plus Quality Assurance visits from the Clinical Commissioning Groups (CCGs)

What we are

- **Specialised care for those over 18 with complex problems who are suffering from a terminal illness when cure is no longer possible**

- **Short stay inpatient care for complex symptom management (with help, half of these patients go home)**
- **Specialist care in the last days of life**
- **Outreach support in the patients home**
- **Day Therapy**

- **Education & Research** http://www.loros.co.uk/education-training-research/

What we offer - Overview

- Expenditure on patient care per annum £7.5 million
- LOROS needs to raise £4.5 million
- Proportion of expenditure covered by NHS 1/3rd
- Proportion of charity costs directed to care services 90%

Funding

- In-patient Care 31 Beds – including physiotherapy, occupational therapy, social workers, discharge liaison
- Outpatient Care:
  - Consultant led clinics
  - Pain clinics
  - Breathlessness clinics
  - Complementary Therapy
- Community clinical nurse specialists
- Home Visiting service
- Bereavement care
- Chaplaincy
- Day Therapy
- Counselling
- Complementary therapies
- Lymphoedema (>50% of patients do not have a cancer diagnosis)
- 24/7 Telephone Advice Line
- Education & Research

Care Services

- **NHS – future funding**
- **Competition – Services subject to possible future procurement**
- **Palliative Care Funding Review – tariff development**
- **On-going Recession – income generation, competition with other charities**
- **Ageing Population – Co-Morbidities**
- **Patient dependency**
- **Level of engagement in the health and social care strategic development – small provider**

Challenges

Extend Reach into the Community:

- Extending CNS service – provide 7 day service (weekend & bank holiday advice line) with view to providing 'face to face' visits in the future
- Develop Community Outreach Model – Social, Volunteer led
- Develop Community Outreach Model – Mobile Resource
- Community Consultant in Palliative Medicine
- Explore potential for a LOROS @ Home Service
- Undertake Market Research – what does the community want?

Strategic Priorities & Service Development

What changes do we think will benefit patient care:

- Funded 24/7 advice line as part of a coordinated LLR approach
- LOROS & LPT Macmillan CNS Service as one team to be able to provide 7 day 'face to face' visits
- Greater level of partnership working between LOROS, LPT & UHL
- Enhanced community specialist palliative care provision (consultant, nursing and 7 day working)
- Increased access for health and social care providers to education & training in order to upskill staff
- Funding for LLR wide Lymphoedema service – specialist/primary - LOROS, Chronic - community

http://www.loros.co.uk/