End of Life Care Plymouth

February 2024

Proud to be part of One Devon: NHS and CARE working with communities and local organisations to improve people's lives

Agenda

Part One

- NHS Devon Responsibilities
- One Devon Improvement Activity/Commissioning Intent
- Ambitions for Palliative and End of Life Care
- Local Data analysis
- Local care provision against ambitions
- Feedback from Medical Examiner Office

Part Two

- Future developments
- Compassionate City
- Shared education programme
- Early identification and care
- Marie Curie - Estover pilot and Care Home support

Part One

Chris Morley, Tricia Davis, Rachel O’Connor, Ian Lightley

ICB System Responsibilities

National Guidance

Integrated Care Systems (ICSs) have a key role to play in ensuring that people with palliative and end-of-life care (PEoLC) needs can access and receive high quality personalised care and support and **there is a duty for ICBs to commission palliative care services** within ICSs'. (Palliative and End of Life Care Statutory Guidance for Integrated Care Boards (ICBs) (2022)).

An amendment has also meant that 'palliative care services' is included in the section which specifies that ICBs have a legal responsibility to commission health services that meet their population needs. ICBs should have a clear vision of how the package of services they commission locally deliver against **the Ambitions Framework** and should actively seek out commissioning resources to achieve this.

People with palliative and end of life care needs should be supported by **a whole system approach**. People's palliative and end of life care needs, and the complexity of their needs, will fluctuate throughout their journey, and this means that a flexible model of care is required.

There must be **sufficient workforce in place** across all settings, with the knowledge to deliver the care required

Professionals work as **part of multidisciplinary teams** providing the service directly to the person with need, and those important to them, and/or supporting other care teams to do so.

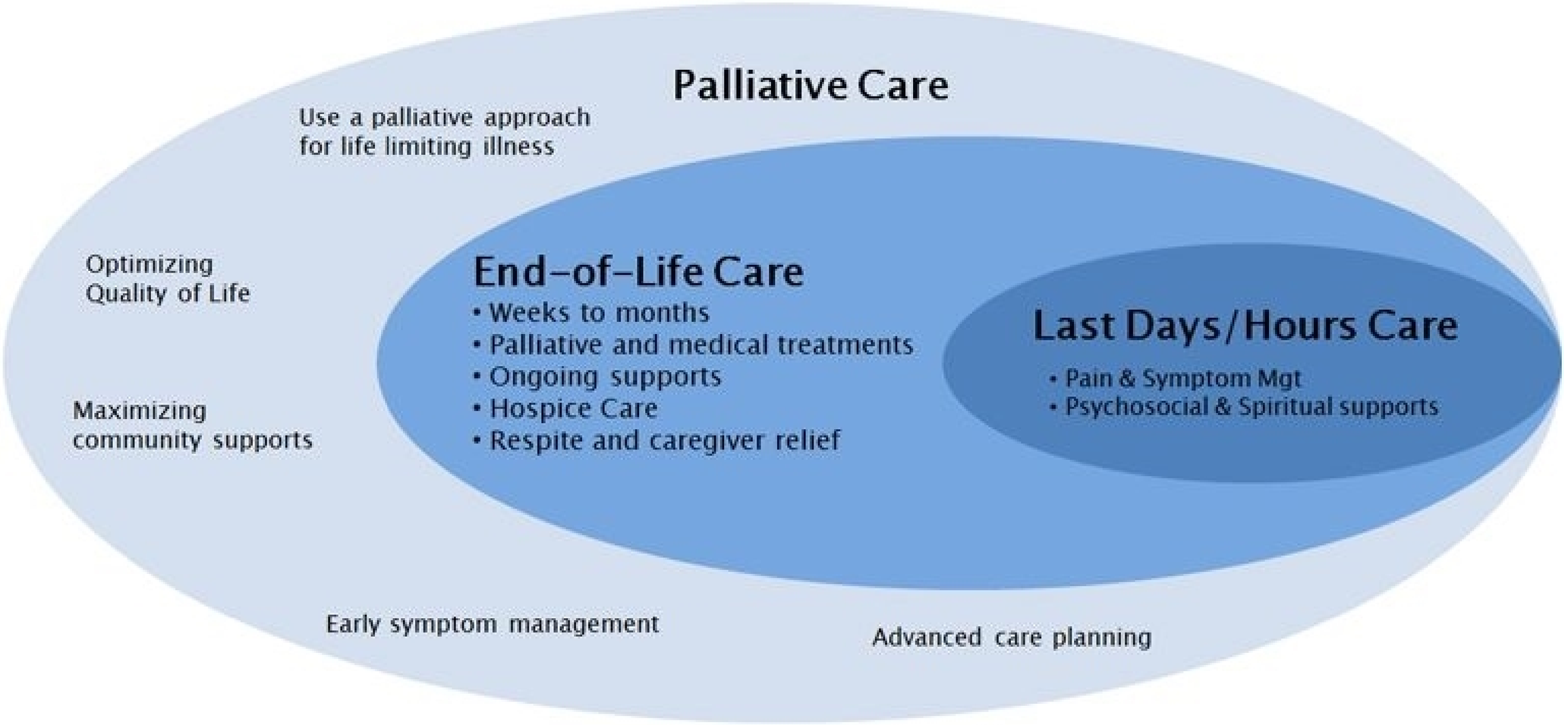
Governance & Oversight

- Locally, Devon has an established county-wide multi-organisational, multi-Disciplinary end-of-life care steering group. The Devon end-of-life care steering group oversees, monitors, and makes recommendations to NHS Devon on the delivery of end-of-life services across Devon.

- NHS Devon uses its decision making, advisory and facilitative functions to deliver end-of-life care services that meet national, local and best practice guidance.

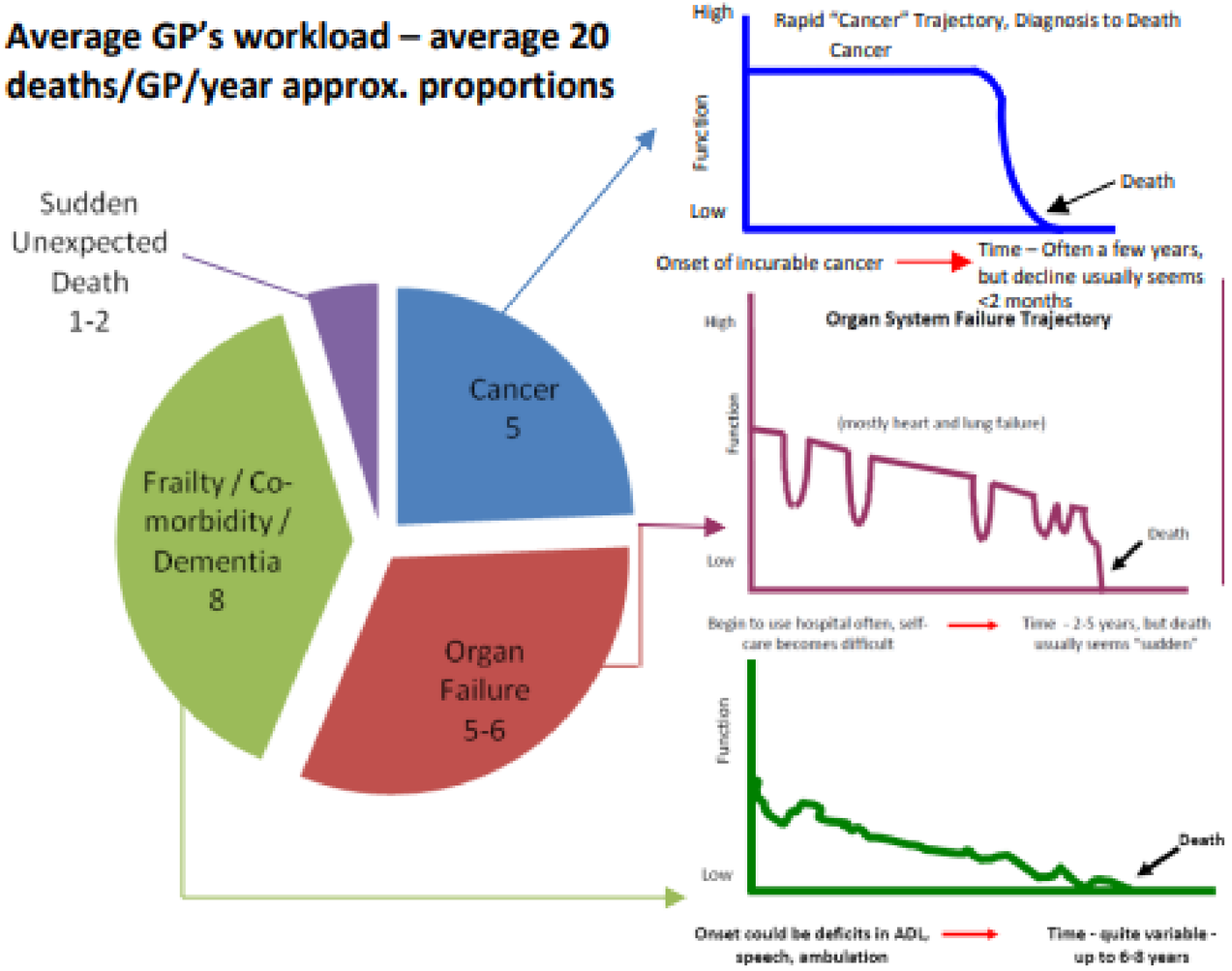
- The Plymouth locality has an established end-of-life care locality meeting, which brings together representatives from multiple sectors to discuss local and county wide issues, guidance, and best practice and delivery of end-of-life services.

Definitions



Gold Standards Framework

Average GP's workload – average 20 deaths/GP/year approx. proportions



Population statistics – Census 2021

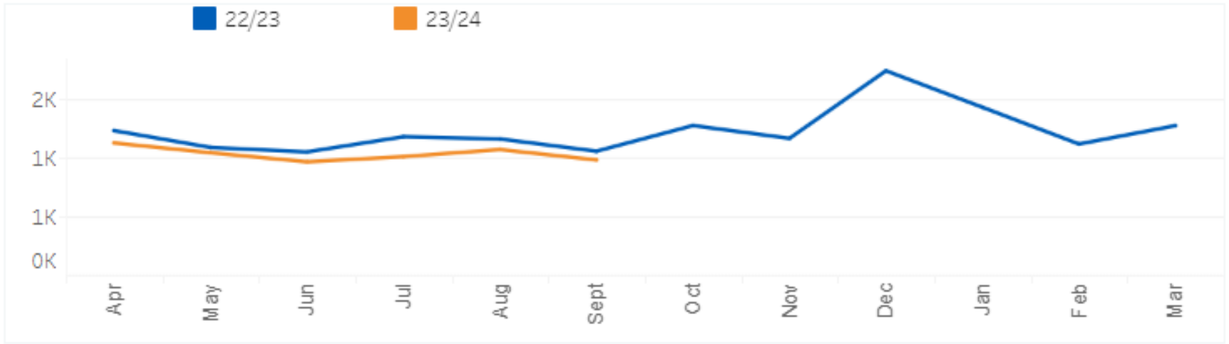
Expected deaths	Population	Expected death rate	Cancer	Organ failure	Frailty	Sudden death
Plymouth CC area only	264,700	2647	662	794	1059	132
			25%	**30%**	**40%**	**5%**

Note: University Hospitals Plymouth covers a wider area and we expect that there will be approximately 4200 deaths for this geographical footprint

Summary of End of Life Care - NHS Devon Integrated Care Board

Integrated Care Board

NHS Devon Integrated Care Board



Financial Year of Death

- [ ] (All)
- [ ] 21/22
- [x] 22/23
- [x] 23/24

Quarter of Month of death

- [x] (All)
- [x] Q1
- [x] Q2
- [x] Q3
- [x] Q4

Total deaths

20,868 deaths

Avg days known to services

70

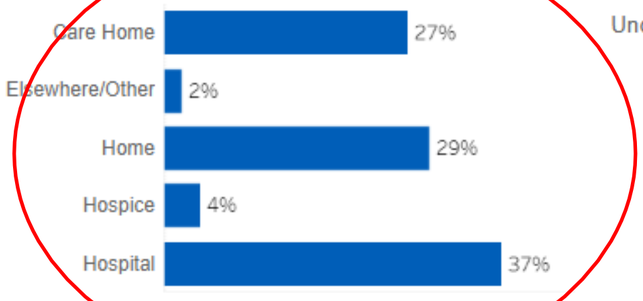
Avg contacts per person (last 90 days)

3.5

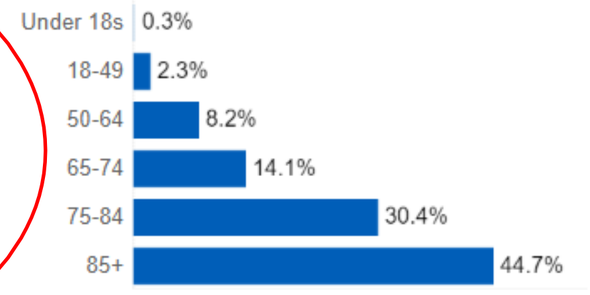
Palliative Care Register 22/23

4,764 (prevalence 0.37%)

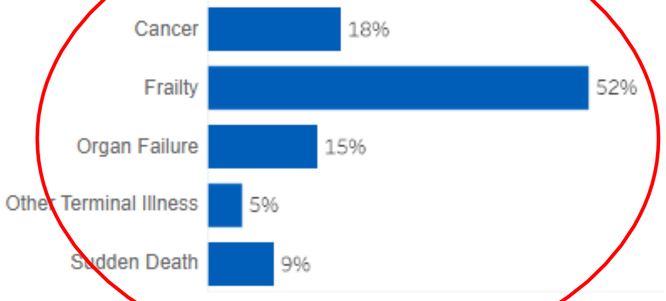
Place of death *% of total*



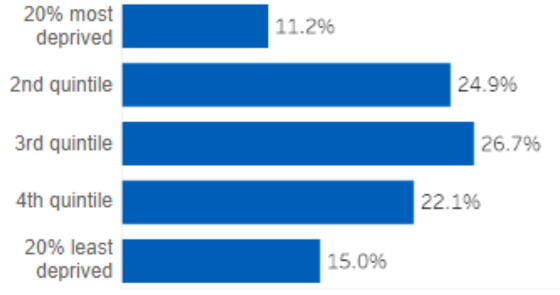
Age at death *% of total*



Cause of death *% of total*

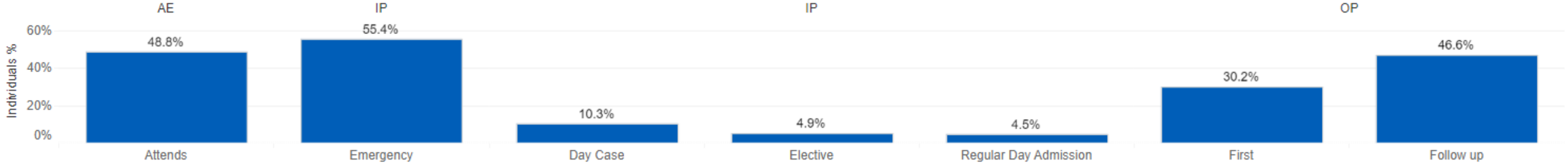


IMD quintile *% of total*

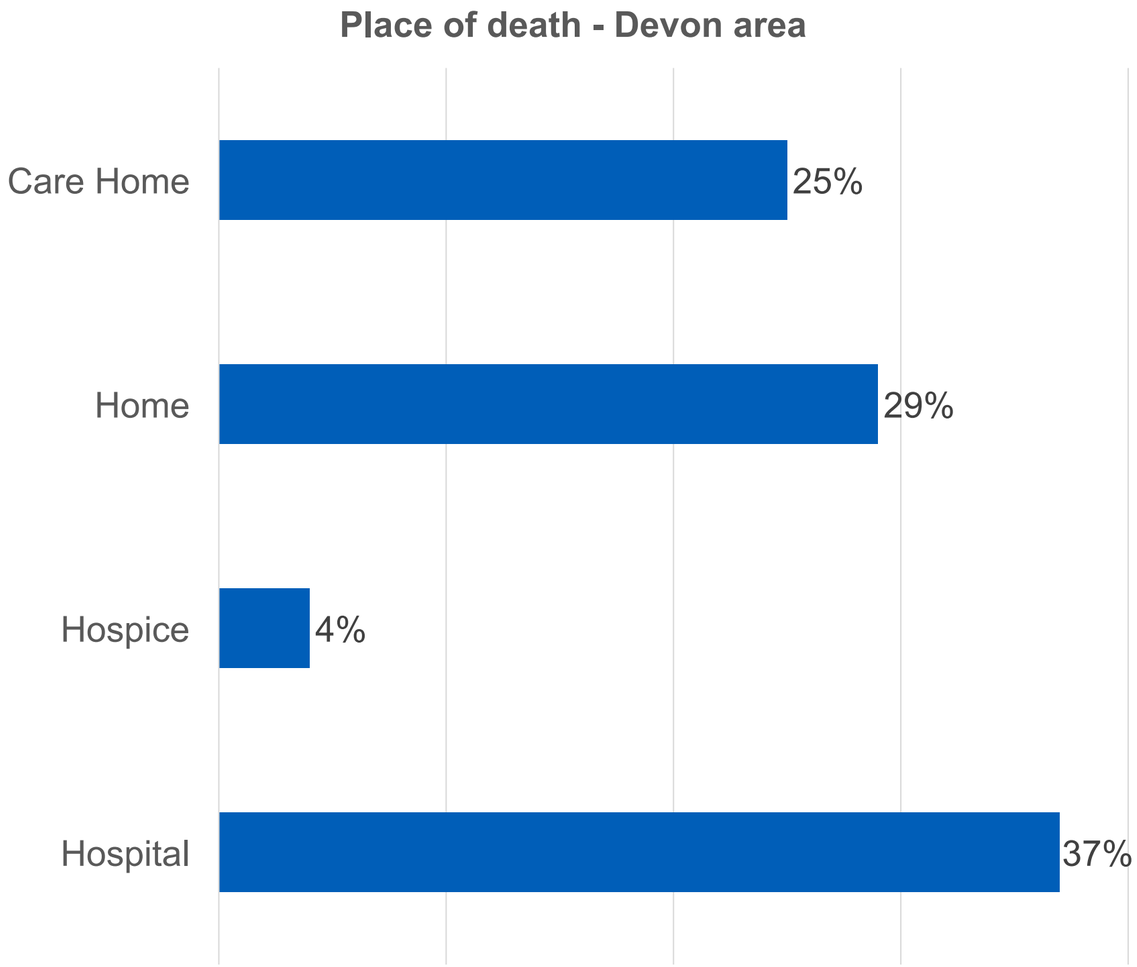


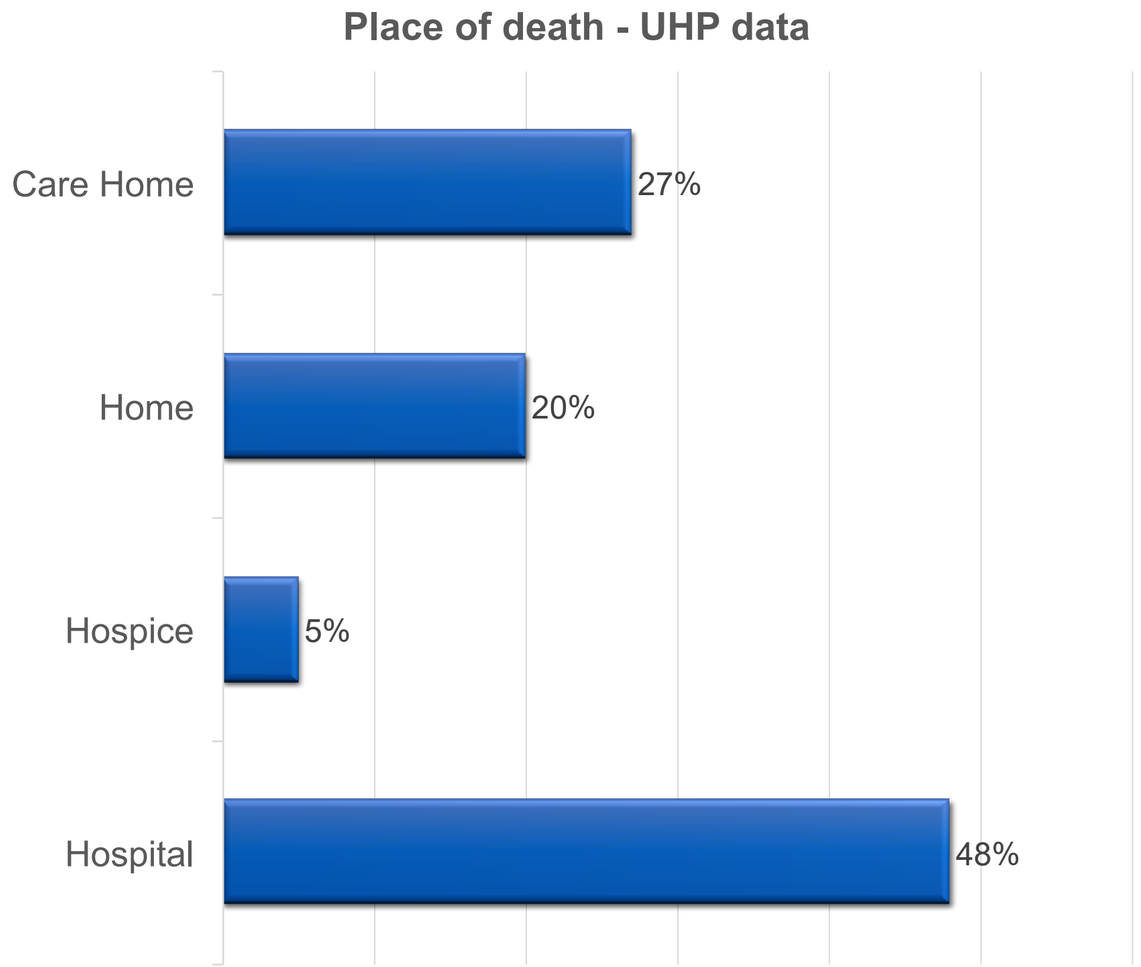
Percentage of cohort in contact with services

Activity attributed in the last 90 days



Place of death – Devon comparison with UHP



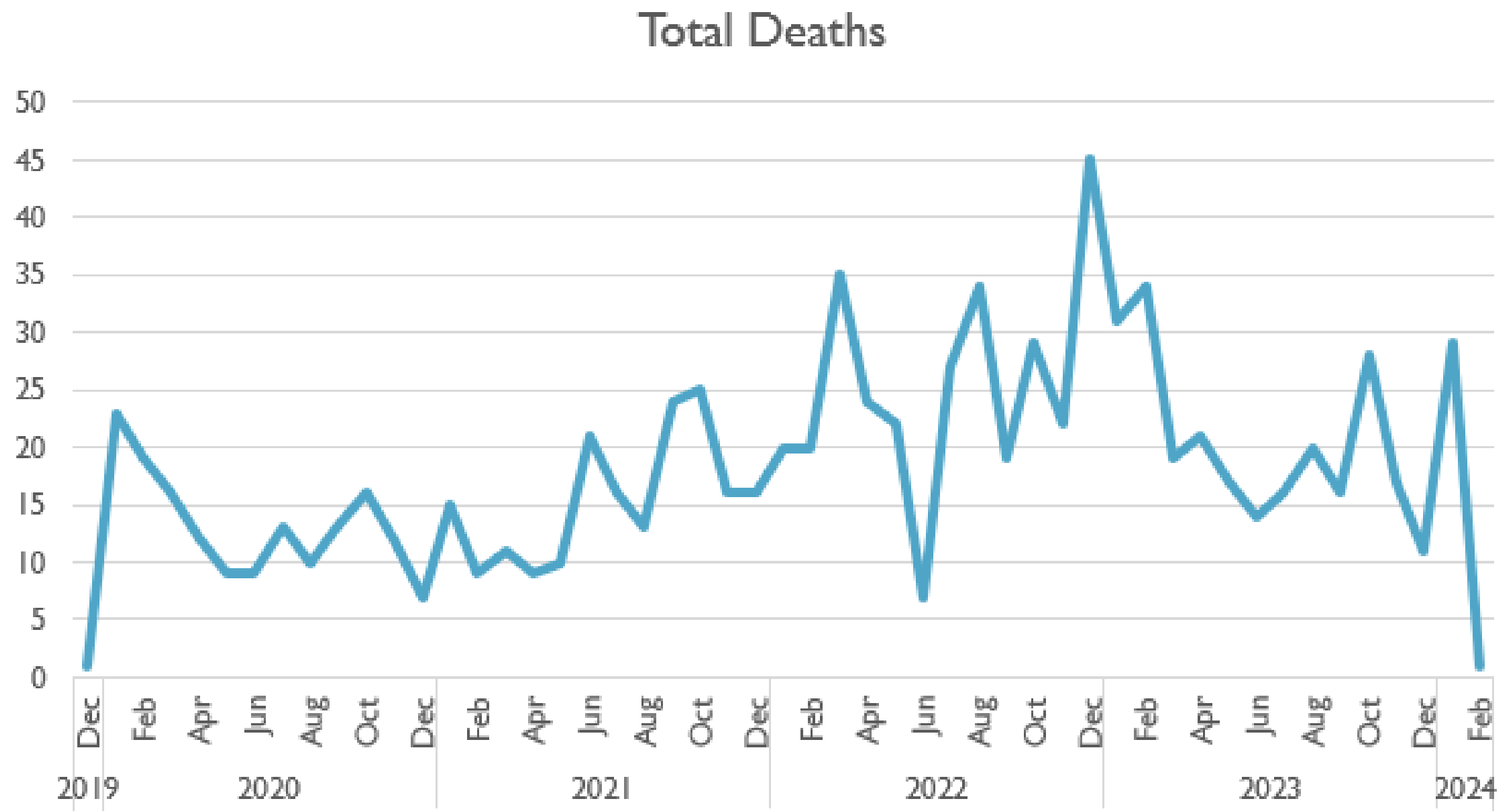


Data Analysis

- Data shows that in Plymouth and surrounding area more people are dying in hospital than at home in relation to rest of Devon footprint
- However University Hospitals Plymouth has seen a **drop in number of people dying in hospital** in 2023
- There is **significant variation within the recognition and recording** of End of Life
- Dorset ICB shows **0.82% of people** on a palliative care registers, compared to Devon's **0.37%**
- It is nationally recognised that **1% of the GP-registered population will be in the last year of life**

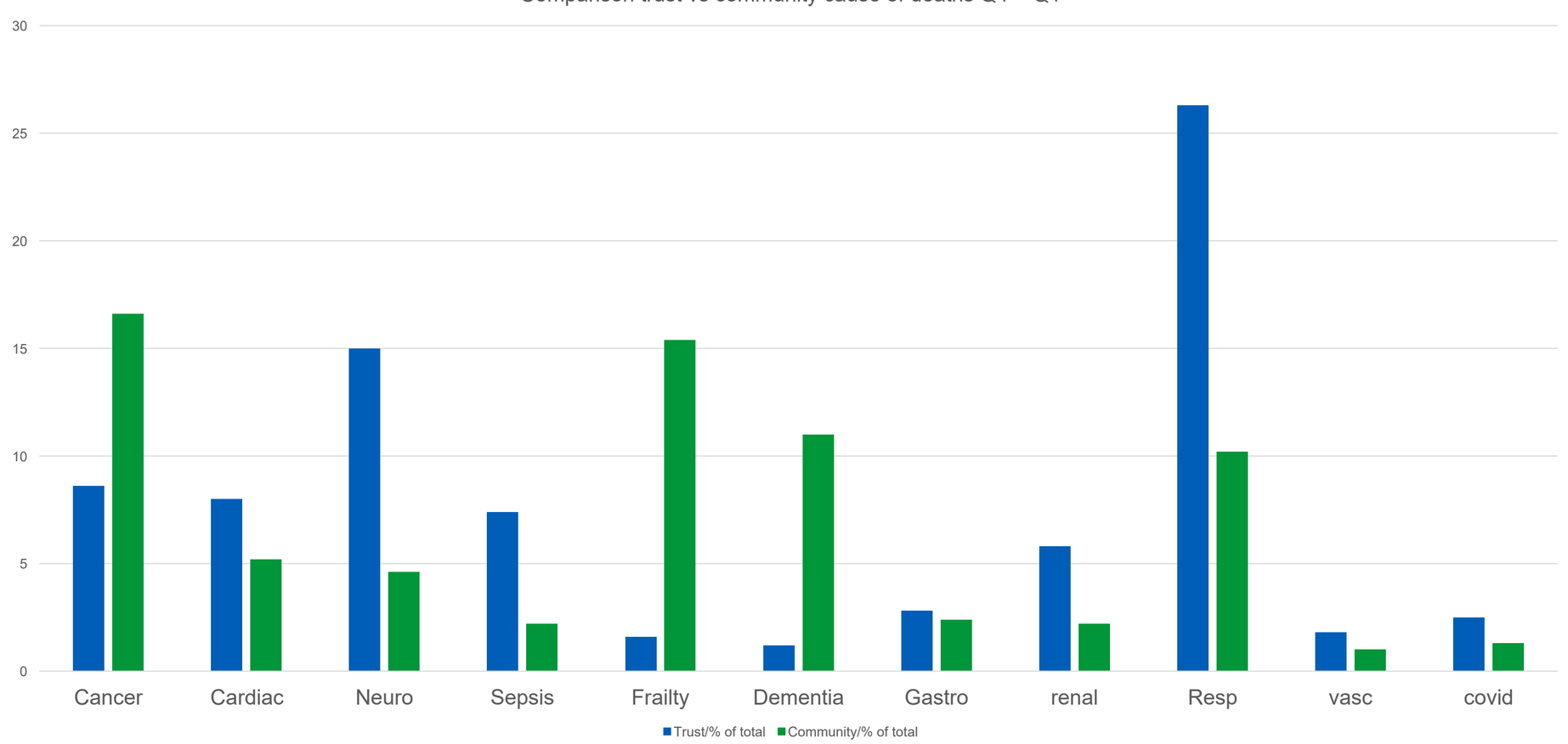
PLYMOUTH MEDICAL EXAMINER SERVICE

Emergency Department Deaths

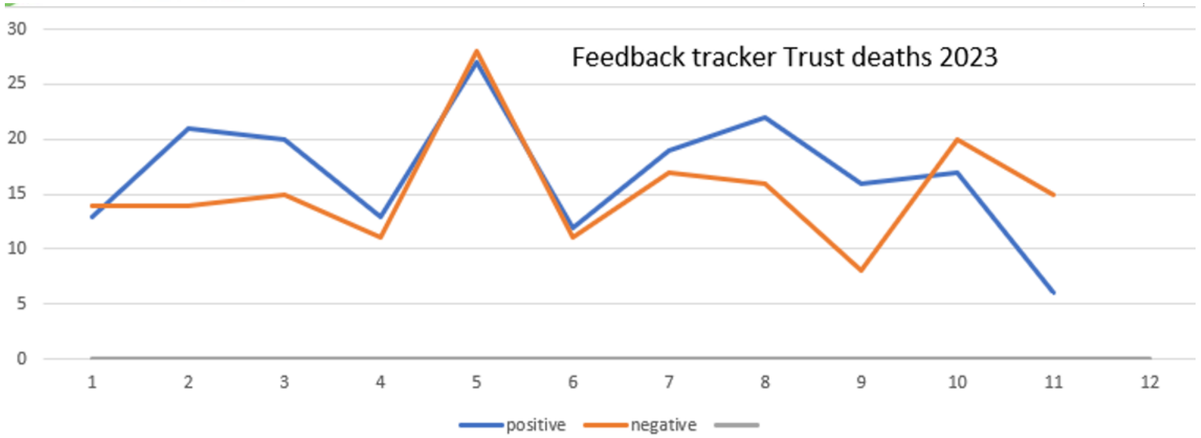


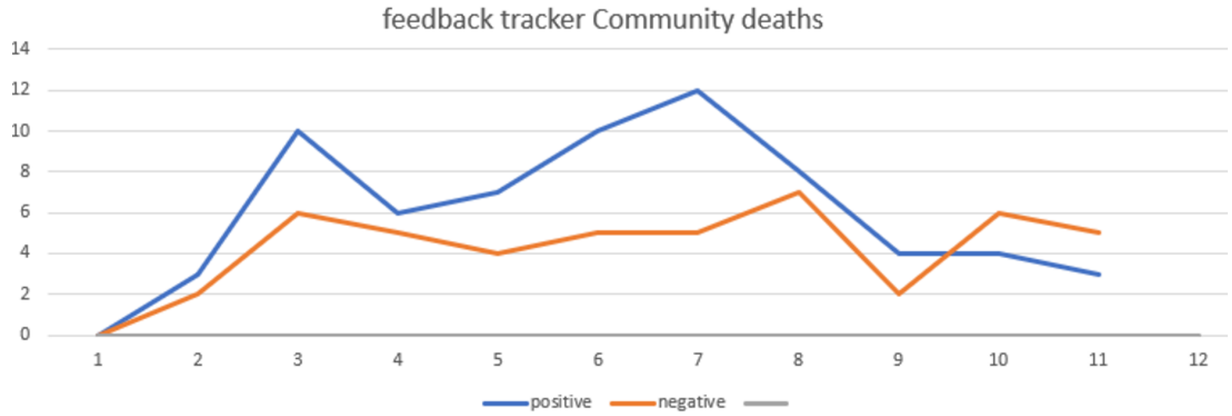
The data held is not complete yet (until the ME service is statutory) when our data started for those using the service (St Lukes Feb23, 70% of GPs from March 23

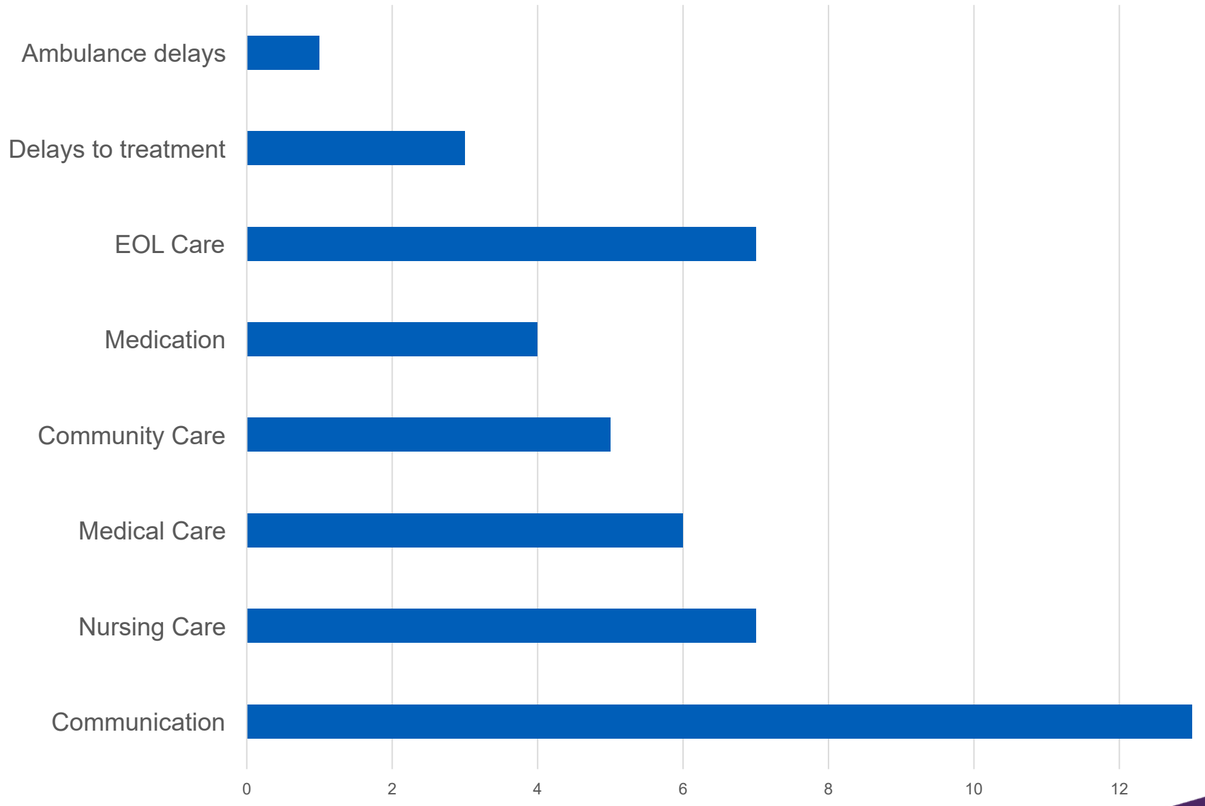
Comparison of causes of death trust vs community Q4 + Q1



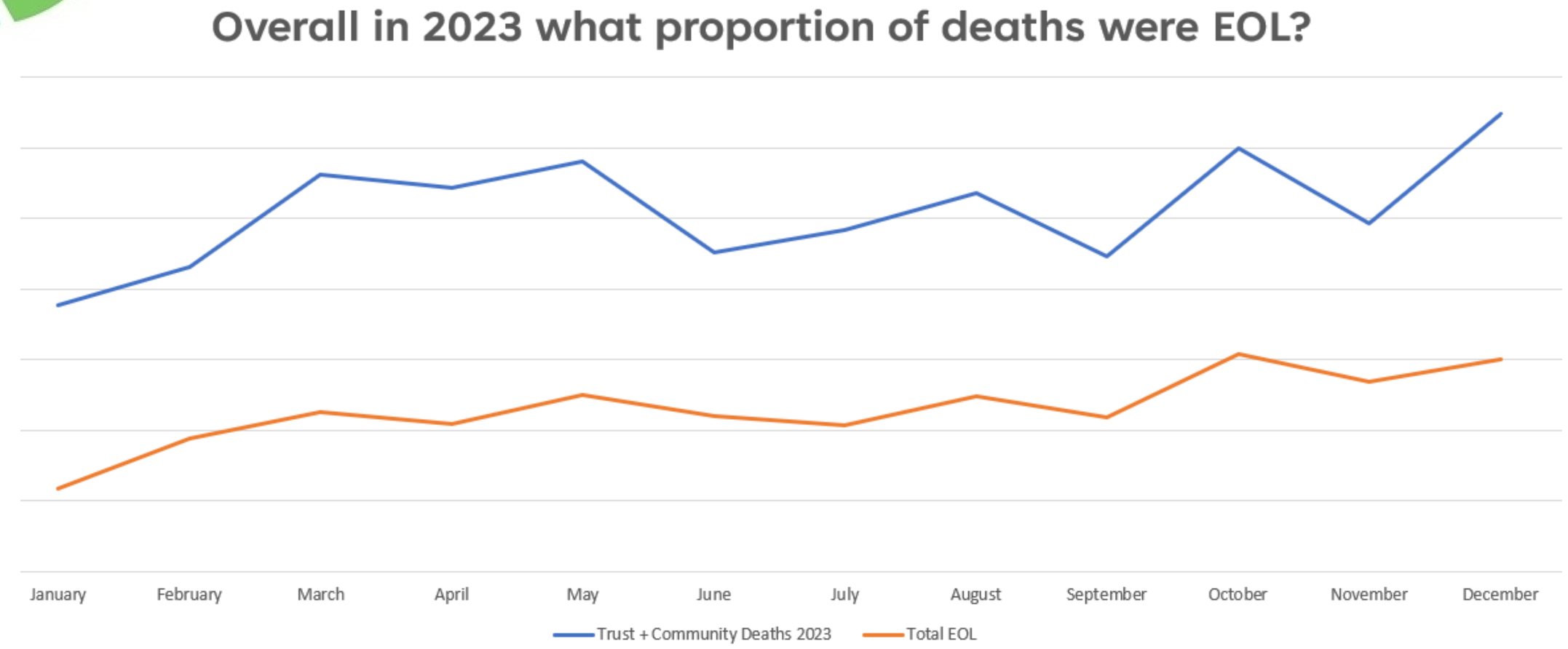
Feedback from bereaved families







Deaths in comparison to people identified as EOL



One Devon Strategic Improvement

- We recognise that there is further work to do to ensure we are delivering against national best practice and enhance the experience for individuals at end of life

- As part of the Devon End-of-life Commissioning review, it was recommended that a Devon Service Specification was designed that would focus on equity of access and experience for all residents and their families when requiring End of Life Care

- Through monitoring patient safety event reports at an ICB level, NHS Devon has highlighted Devon-wide issue with the administration of Just-In-Case (JIC) Medications. To support this, a review of the administration process in underway with an aim of amending the literature that accompanies the medication. This will ensure that the correct advice and contact details are provided to patients and their families directing them to the most appropriate teams when the JIC medications are required.

Devon Wide End of Life Commissioning Improvements

The following key areas have been highlighted through the Devon End of Life Commissioning review as key areas for improvement and form the basis of our commissioning intentions and improvement activity over the coming year:

Care home education:

- Support the rollout of educational material and opportunities for staff training
- Co-ordinate an equitable approach to training and education
- Support the launch of NHS Devon's new end-of-life Webpage

Packages of care / fast-track continuing healthcare (CHC)

- Ensure the funding and packages of care are made available in a timely way to ensure the following
- Speedy and safe discharge
- Support to individuals and family to ensure their loved ones are cared for
- Review and amendment to package as needs change

Devon Wide End of Life Commissioning Intentions

System wide projects: e-TEP / Advance Care Planning / JIC meds

- Promote the use of TEPs and ACP documentation within care homes
- Support staff to ensure they are confident to have these conversations
- Ensure appropriate medication and stocks are available for PEOLC residents / patients

End-of-Life Care service specification

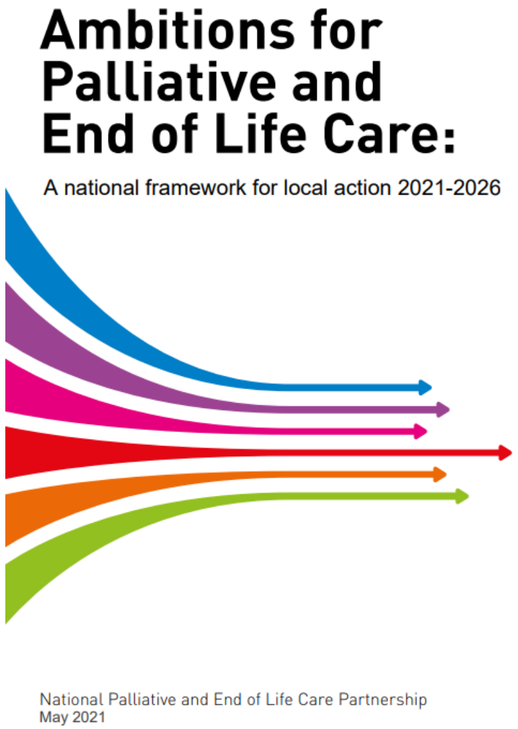
- Contribute to the end-of-life care service specification and the aim of an equitable service across Devon

Equipment

- Appropriate equipment is available when required (syringe drivers, falls hoists)

National Framework

- **Ambitions for Palliative and End of Life Care: A national framework for local action (2021-2026) – NHS England**



Each person is seen as an individual

Care is coordinated

Each person gets fair access to care

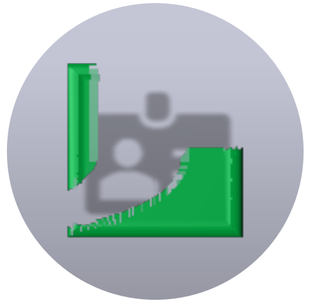
All staff are prepared to care

Maximising comfort and wellbeing

Each community is prepared to help

What does good look like for Plymouth – Links with Vital Signs (NHSE project starting in January 2024)

Choice: Preferred place of death



Identification: End of Life register

Coordination: Advance Care Plans Visible & used

Care: Support at final stages

Vital Signs:

How healthy are our palliative and end-of-life systems?

South West End of Life Network

NHS South West

January 2024

Vital Signs

Taking the ‘temperature’ of the system

Measuring the ‘health’ of our End of Life Care systems

Using a few ‘core’ measures to reflect the health of a system

Creating the measures…

Recognition:

Identify patients on register, identify carer and family members

Experience:

How's it going?

How's it gone?

Activity:

Outpatient attendances, 999 calls, ED attendances, Acute admissions,

Place of death

University Hospitals Plymouth

End of Life Care at University Hospitals Plymouth

NHS University Hospitals Plymouth NHS Trust

In Our Hospital

The Hospital commission St Lukes Hospice to provide an advisory service providing in Hospital palliative/end of life care support to patients, staff and carers.

Whilst we receive regular positive feedback in relation to end of life care, we are aware we don't always get it right, and we continue to strive get it right, and learn from these to continue improve our care and experience for patients, their loved ones and staff.

In most cases, end of life care is facilitated in a side room; at times of high demand (covid/infection control) the demand for side rooms can exceed availability.

- *In 2023, as an average, 138 patients died each month in the Trust*
- *The hospitals pastoral care team support patents and carers; they also extensively support our staff who have been impacted in the delivery of end of life care.*

Trust Carers Bereavement Survey Feedback 01.08.22 - 31.08.23

94.2% 'strongly agreed', or 'agreed' with the statement:
"Hospital staff showed the right level of respect to my relative/ friend including their attention to privacy and dignity"

Of those who responded:
55.2% were cared for in a side room at end of life, 31% on a ward, and 13.8% in the Emergency Department

83.9% regarded the care and support as 'excellent' or 'very good' when asked:
"Overall, how would you rate the care and support given to your friend/relative by hospital staff, during their last days of life?"

93.1% either 'strongly agreed' or 'agreed' that
"Hospital staff communicated sensitively and compassionately with me"

The Need for Improvement and the Case for Action

University Hospitals Plymouth NHS Trust

Issues and Opportunities to Improve Care

Escalation in the number of deaths, with peak of 45 deaths in December 2022 within the Emergency Department

Notable complaints in 2023 regarding the experience of dying in the Emergency Department; one such case investigated and feedback from patients as how we can improve and lessons learnt. We invited the family and ED team to present this to our boards as one of our patient stories

- *In our locality 2022, 51% of those who die, die in Hospital*

The National Audit of Care at the End of Life highlighted a need for the Trust to 'recognise dying earlier' in the Trust

- *Earlier recognition reduces unwanted or needed interventions, and can facilitate high quality family/carer interactions before death*

Coronial deaths in the Trust meant that patients weren't always permitted the space and holistic environment that should be provided during the dying process, due to prioritisation of single room space

Key Actions and Projects Providing Opportunity for Change

- electronic Treatment Escalation Plan (eTEP)
- Mount Gould EoL Beds
- Emergency Department End of Life (EoL) Practitioner Role/team
- Substantial increase in EoL Education in the Trust (including non-medical TEP training)
- 100 Day Challenge – a cross organisation project to support care homes who most frequently use the Emergency Department (supporting alternatives to conveyance and understanding system challenges)
- Reimagining/reinvention of the Trusts End of Life Committee Meetings

Put people first
Take ownership
Respect others
Be positive
Listen, learn, improve

Projects in Support of Service Improvement

University Hospitals Plymouth NHS Trust

End of Life ED Practitioner Role – Inception April 2023

Supporting those nearing, or at end of life; role dedicated, and solely based the Emergency Department. Initially a 5 day a week service, this has recently been expanded, with extended daily operational hours, covering 7 days a week and most weekends.

Providing time, hands on care, advice, support and onward care planning; supporting patients carers and families in the Emergency Department.

Specialist clinical review and triage of patients into appropriate locations of onward care in the hospital or supporting co-ordinating their onward care to more suitable locations i.e. Mount Gould end of life bed, St Lukes Hospice, Home or Care Home, ensuring as far as possible, we meet needs and wishes.

Project Impact:

- *167 patients have been supported by the role (Apr – Dec 2023)*
- *128 Treatment Escalation Plans updated*
- *Out of 167 patients seen by the post holder, only 13 of these people died in the Emergency Department*
- *Ongoing structured education, and 'side by side' practical education for the wider team in the Emergency Department*
- *Additional specialist staff role introduced February 2024*
- *Additional Marie Curie Nursing Assistant added end of January 2024*

Mount Gould End of Life Beds – Inception August 2023

Facilitating end of life care in a welcoming and calm space, facilitating holistic patient and carer support, away from a busy Emergency Department or Hospital ward space.

Cautious pilot phase of two end of life beds, rising to four beds latterly, after safety and integrity of pathway established. The pathway now 'flexes' between 4 and 6 end of life beds.

Admitting patients from UHP wards (Derriford), and direct admissions from the Emergency Department, to Skylark and Kingfisher wards at Mount Gould.

Settled, en-suite, single room environment; no structured visiting times, easy parking in a modern and geographically central site.

- *60 patients have been supported by the pathway (up until Jan 24)*
- *9 patients discharged to onward locations of care*
- *631 days of end of life care has been provided on the Mount Gould site, as opposed to main UHP wards or the Emergency Department*
- *Overwhelmingly positive feedback from patients and carers*

Informational Video:

The ED End of Life Practitioner Role and Carer Experience of End of Life Care at Mount Gould

End of Life Education and electronic Treatment Escalation Plans (eTEP)

University Hospitals Plymouth NHS Trust

End of Life Education

In response to feedback in the National Audit for Care of the Dying 2022, and colleague feedback, an additional full-time education post was introduced, funded by St Lukes Hospice (two-year funding), adding to existing provision.

- *In 2023 Trust began running Treatment Escalation Plan training for non-medics, to allow colleagues (nurses and allied health professionals) to have end of life planning conversations with patients and families, documenting preferences.*
- *We are nationally the first acute Trust to run the European Certificate in Essential Palliative Care (internationally recognised qualification).*
- *In 2024, we launched a joint end of life learning forum, with Livewell colleagues, bringing acute and community colleagues together to hear and learn about end of life best practice*

eTEP: Why do we need it? and its Advantages

What is a TEP form?
A TEP form records decisions about a person's care which will include guidance regarding ‘resuscitation’. Information recorded on the form will be completed in discussion with the patient/carers. Unavailable TEP forms cause confusion, unwanted admissions and/or investigations and treatment which may not align with good end of life care practice

Electronic TEP will:

- Ensure the physical form does not ‘get lost’
- Provide one source of ‘truth’, recording decisions regarding a person's care which, are available to care providers in community and inpatient settings (instantly viewable)
- Allow for easier audit and offers ability to view previous versions (so those who view can see and build on earlier versions/conversations)

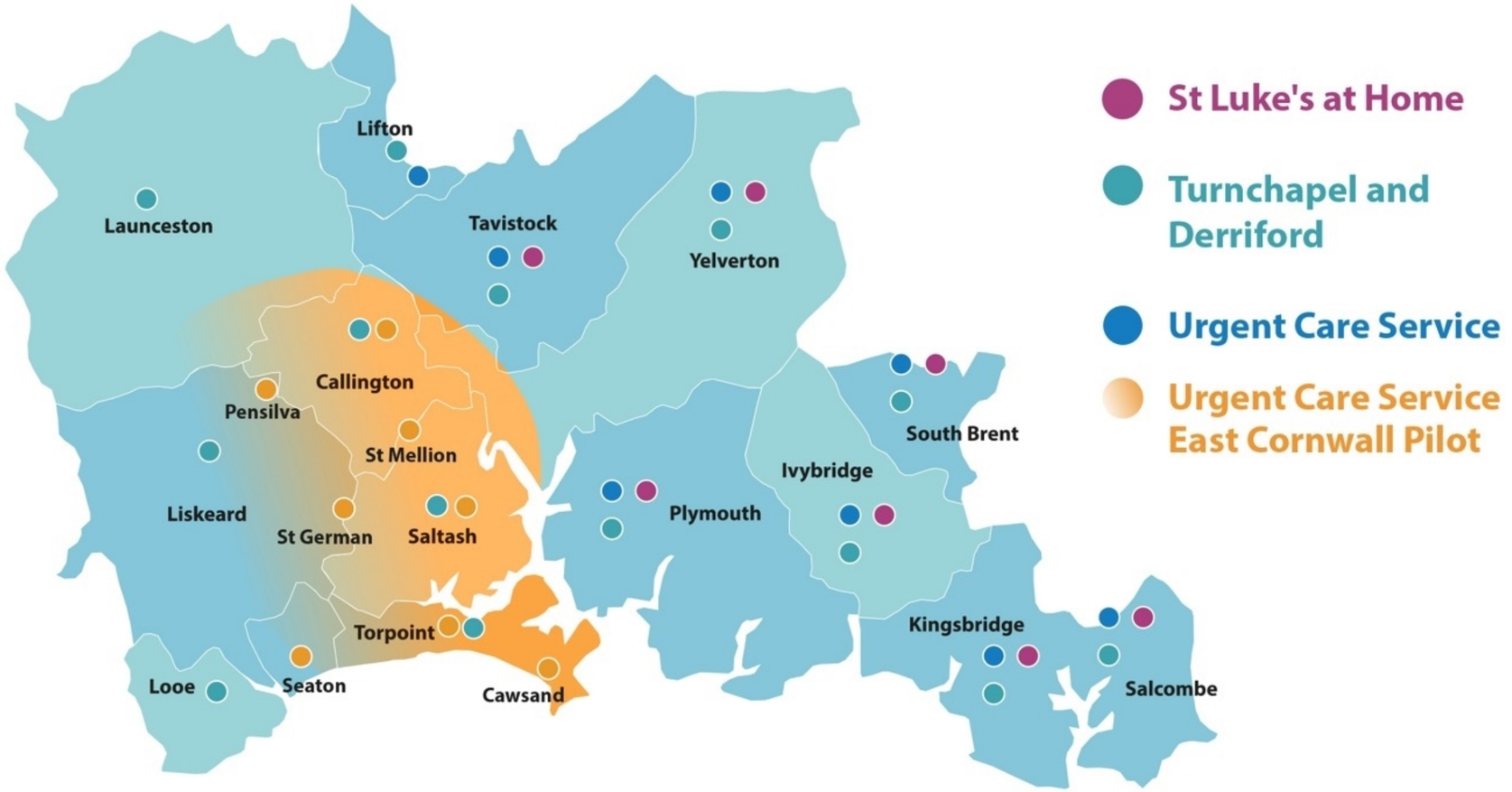
Put people first
Take ownership
Respect others
Be positive
Listen, learn, improve

St Luke’s hospice

Tricia Davis

Where do we see our patients?

An easy guide to where our teams see their patients



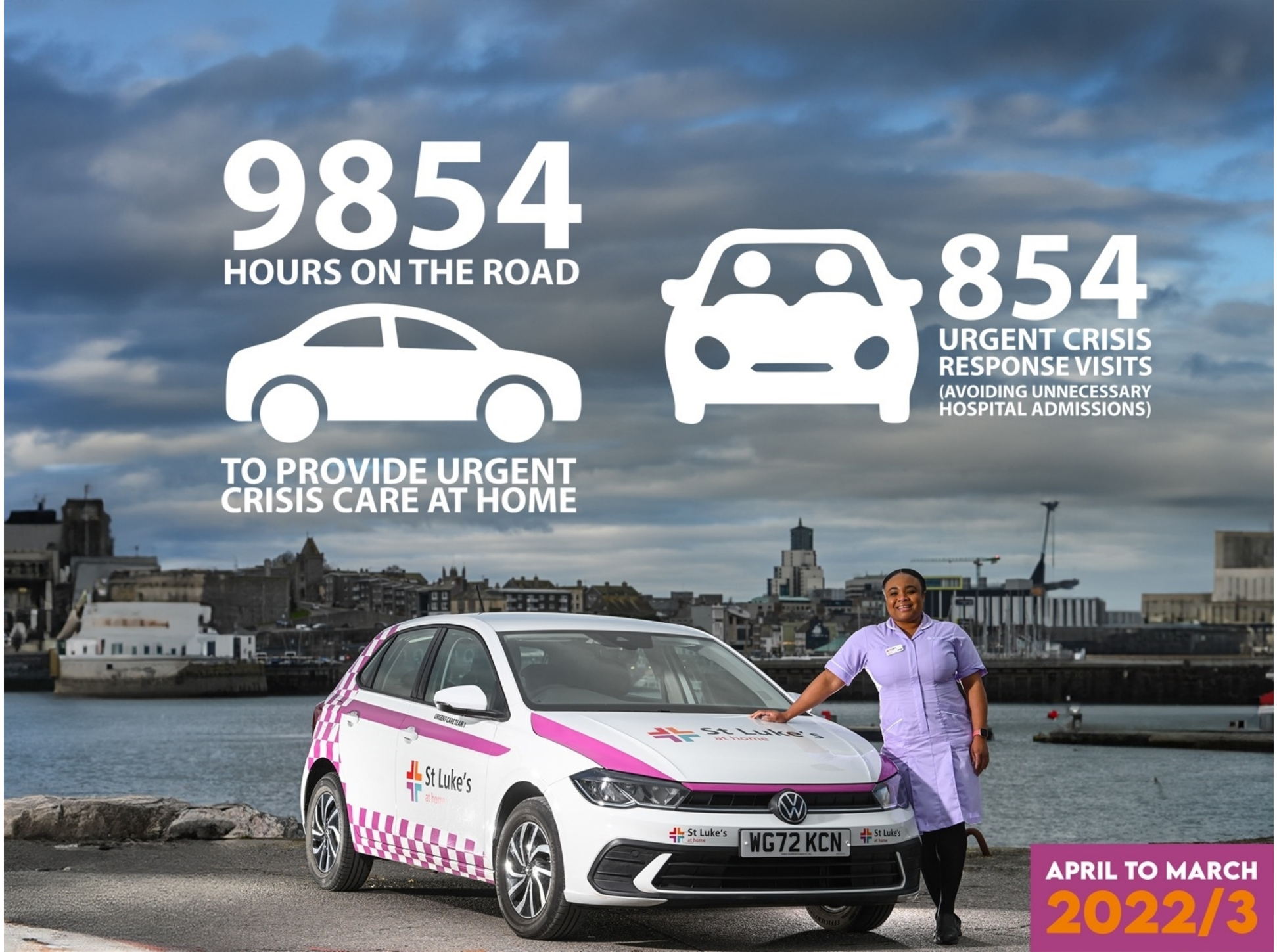

57%
HOME
35%
HOSPITAL
8%
TURNCHAPEL
WHERE DO
WE SEE
OUR PATIENTS?
2097
PATIENT REFERRALS
CARING FOR
300
PATIENTS
AT ANY ONE TIME
EMOTIONAL SUPPORT FOR
1972
DEATHS
IN THE LAST YEAR
APRIL TO MARCH
2022/3


WE CARED FOR
1196
PATIENTS AT HOME
4396
FACE TO FACE
CONTACTS
WITH PATIENTS AT HOME
St Luke's
Alice
APRIL TO MARCH
2022/3

iWantGreatCare ★★★★★

“The St Luke's at home teams were exemplary, not only did they offer first class care to our mother, but continual support to us as a family. This enabled our mother to remain in her own home for her EOL care, while reducing the stress and anxiety for us.

The teams were always available for help and advice, not only in a professional capacity, they also offered a real human touch..... never a stupid question!! They also link up really well with the other healthcare professionals involved, who I might add were equally as good, meaning that care is seamless, which is really important at such at a time and really relieves the pressure from family members. They really exceeded our expectations, went above and beyond and for that we are most thankful.”


9854
HOURS ON THE ROAD
TO PROVIDE URGENT CRISIS CARE AT HOME
854
URGENT CRISIS RESPONSE VISITS
(AVOIDING UNNECESSARY HOSPITAL ADMISSIONS)
St Luke's at home
WG72 KCN
APRIL TO MARCH
2022/3

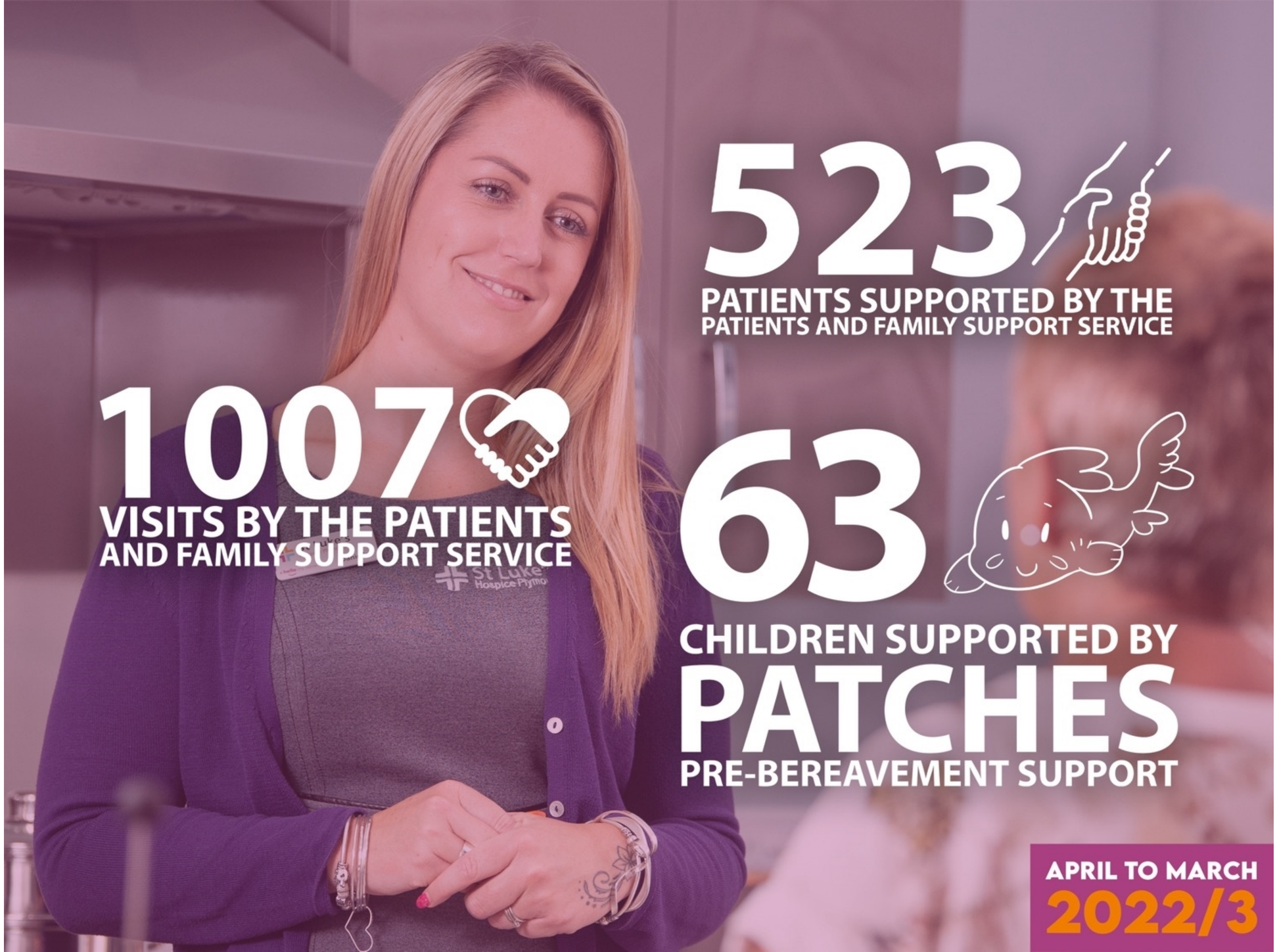

iWantGreatCare ★★★★★
“The urgent care and community team were an incredible group of people making the end of my dad's life a little bit easier. The support was brilliant - the hugs we'd get when they walked through the door, the honesty, the smiles they put on our face. Two of the team sat with us for hours after their shift when he passed away to make sure we were okay - they go above and beyond and we will be eternally grateful for you all.”

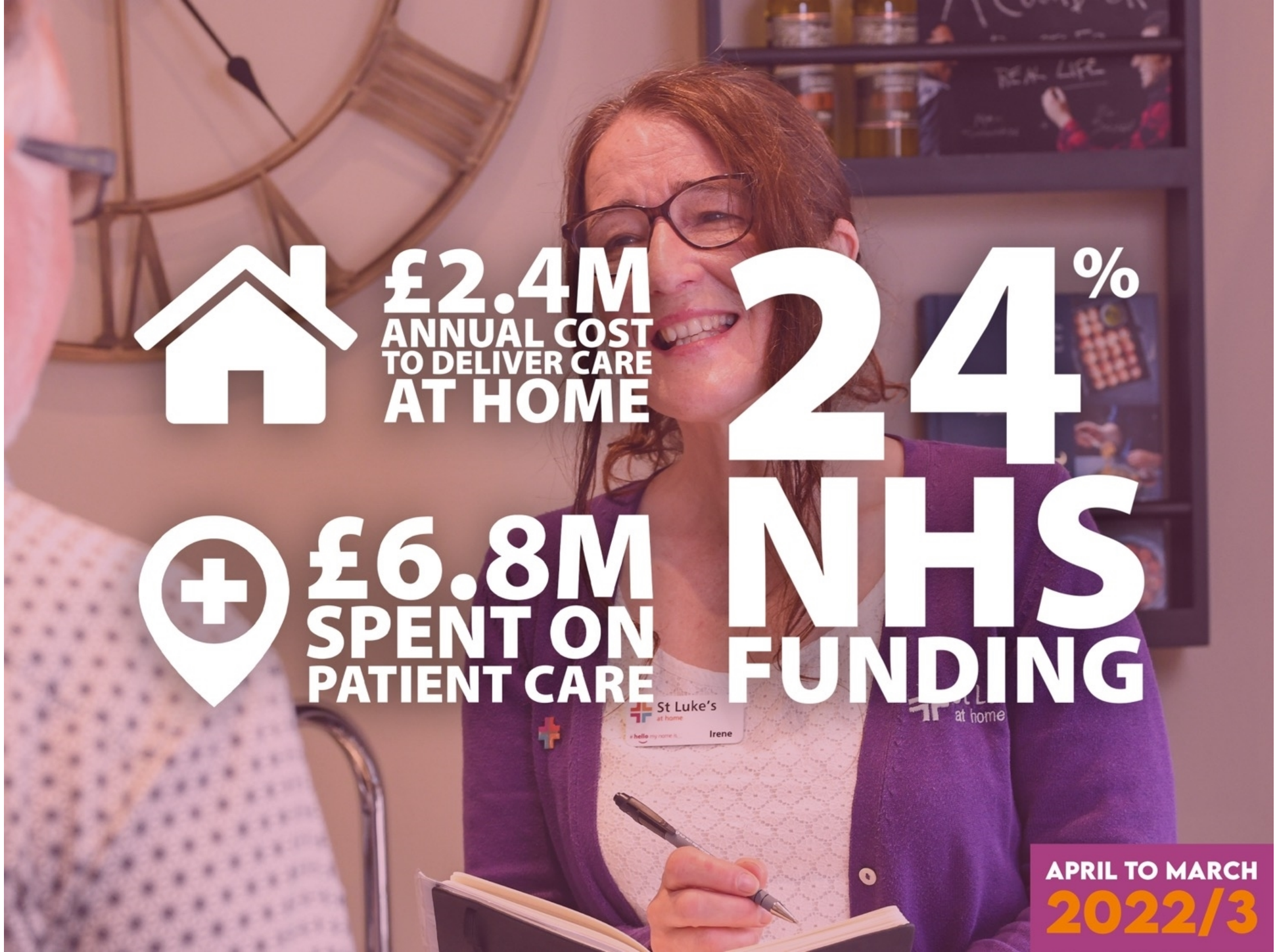

1423
PATIENTS
SUPPORTED AT HOSPITAL
4411
WARD VISITS
IN HOSPITAL
St Luke's
at Dernford
St Luke's
at Dernford
APRIL TO MARCH
2022/3

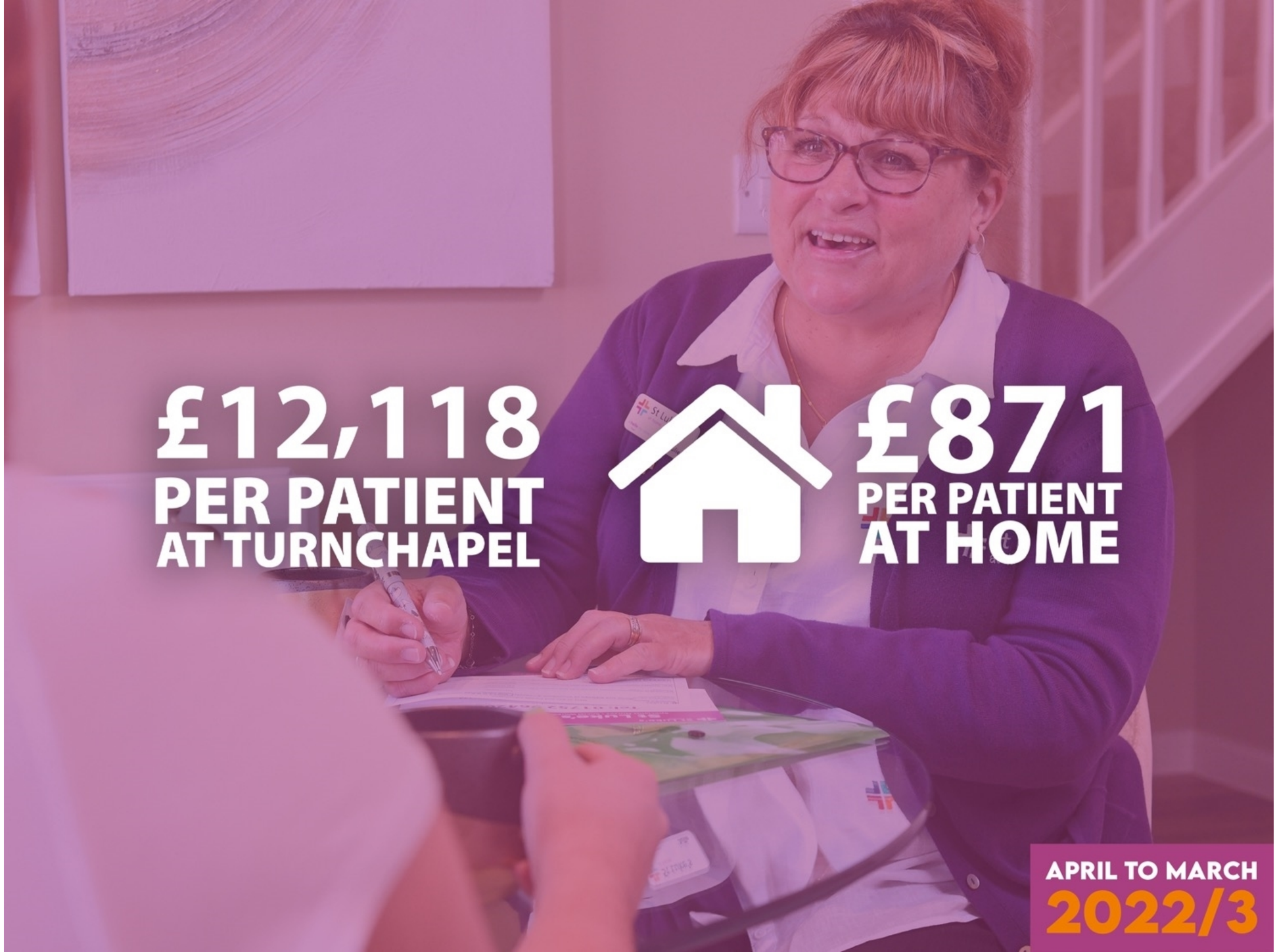

WE CARED FOR
347
PATIENTS AT TURNCHAPEL
St Luke's
at Turnchapel
APRIL TO MARCH
2022/3

iWantGreatCare ★★★★★

“The caring team were loving and gentle in their care, and the nurses were the same, doing all they could before my wife went into the hospice. They also did their best to make sure that I (her husband) was alright. Once my wife was admitted, they cared for her, and gave her the medication to sedate her, give her peace, and freedom from pain”.


523
PATIENTS SUPPORTED BY THE
PATIENTS AND FAMILY SUPPORT SERVICE
1007
VISITS BY THE PATIENTS
AND FAMILY SUPPORT SERVICE
63
CHILDREN SUPPORTED BY
PATCHES
PRE-BEREAVEMENT SUPPORT
APRIL TO MARCH
2022/3


£2.4M
ANNUAL COST
TO DELIVER CARE
AT HOME
24%
£6.8M
SPENT ON
PATIENT CARE
NHS
FUNDING
St Luke's
at home
Irene
APRIL TO MARCH
2022/3


£12,118
PER PATIENT
AT TURNCHAPEL
£871
PER PATIENT
AT HOME
APRIL TO MARCH
2022/3

Meeting the National Ambitions for Palliative & End of Life Care

Livewell Southwest

Livewell Southwest

Livewell Southwest is a social enterprise providing integrated health and social care services for people across Plymouth, South Hams and West Devon.

We care for people in a variety of locations across the community for instance:

- Own homes
- Residential care settings
- Supported living accommodation
- Hostels
- Mobile homes
- Hotels

Wherever people choose to live in the community we will visit and provide care.

We work with system partners to provide packages of care to meet people's individual needs at end of life.

Livewell Southwest services

Livewell services/professionals supporting those requiring care at end of life may consist of:

- Palliative & End of Life Organisation Lead
- District Nurse Specialist practitioner
- Community Nurses
- Advanced Clinical Practitioner
- Frailty Practitioner
- Podiatrists
- Orthotics
- Medical doctors
- Cardiac Specialist nurses
- Respiratory Specialist Nurses
- Physiotherapists
- Occupational Therapists
- Speech and Language Therapists
- Dieticians
- Continence service
- Adult Social Care
- Chaplaincy
- Urgent Care Nursing Service
- Community in-patient Services
- Community Crisis Response Team
- Discharge to Assess team

All working with system partners such as the acute hospital, Primary Care, St Lukes, Marie Curie, Plymouth City Council

Overview of LSW Data

- Between January 2023 & December 2023 Livewell Southwest services cared for **1,335 people** who were entering the last months, weeks and days of life.
- 575 of these people were supported to die in their own home
- 596 died in care homes where patient, families and care home colleagues were supported by Livewell professionals
- 63 people died in the local hospice where their symptoms were able to be better managed
- 65 people died in the acute hospital
- The place of death of 36 people was unknown as this was not documented in the clinical record

Ambition 1

Each person is seen as an individual

- Every person who is referred to community or inpatient services has an **individualised plan of care**.
- Livewell have worked hard to train non-medical professionals to have complex discussion around Treatment Escalation and complete Treatment Escalation plans. We now have **21 experienced community professionals** who are trained to do this with the person and those important to them. This enables people to have timely conversations about treatment they do/do not want and build therapeutic relationships.
- Open and honest conversations start from the first visit for end-of-life care from a community healthcare professional. In most incidences this allows the person time to plan for their future care, taking into consideration what is important to them and their loved ones.
- **Advance Care Plans** are reviewed and amended with the person and those important to them to reflect the person's changing needs and wishes.
- **Chaplaincy support** is offered to individuals within the inpatient units and community staff can contact the chaplaincy service for advice/sign posting for those living within the community setting.
- Livewell End of Life lead has worked closely with partner organisations to develop and implement the **Electronic Treatment Escalation Plan** within the Devon and Cornwall Shared Care Record.
- Livewell End of Life Lead continues to work closely with partner organisation leads to implement further care plans within the Devon and Cornwall Shared Care Record.

Ambition 2

Each person gets fair access to care

- Livewell Southwest services cover a wide area with diverse populations across both rural and inner-city deprived areas.
- Professionals from Livewell Southwest will visit people regardless of where they live in the community to provide care and advice at end of life.
- Each person receiving care from Livewell services receives individualised care taking into consideration individual needs and wishes.
- Individuals are listened to, and choices are respected.
- Every effort is made to communicate with people in a way that they understand with easy read information and interpreters available.
- Patient information leaflet is provided to help reinforce the information given by healthcare professionals regarding what end of life may look like – helps with honest and open conversations.
- Community teams will assess and arrange care within the person's home or arrange care home placement depending on the person's wishes and need. Honest conversations will take place regarding what is available.as it is not always possible to meet the person's wishes where their need is greater than what is available within their own home or where they would like to be cared for in a certain place and places are unavailable at the time.
- Continuing Health care assessments are undertaken in conjunction with NHS Devon.

Ambition 3

Maximising comfort and wellbeing

- Individualised holistic care plans are regularly reviewed and amended to reflect the persons changing needs and wishes. This is undertaken jointly with the person and those they want involved in their care.

- Community nurses and specialist practitioners regularly review **symptom management and medication**, where necessary this is amended to reflect changing need.

- Specialist practitioners can and do review medication and write prescriptions in line with the persons changing need.

- Community nurses and specialist practitioners provide symptom control in the form of stat medication doses or subcutaneous infusion via a syringe driver pump. This is a **24/7 service and patient's nearing end of life are prioritised**.

- Chaplaincy support is offered to individuals within the inpatient units and community staff can contact the chaplaincy service for advice/sign posting for those living within the community setting.

Ambition 3 Continued

Maximising comfort and wellbeing

- All professionals visiting people listen to the person, review physical, emotional, psychological and spiritual needs. Referring to more specialist services where required.
- Community nurses refer to specialist services where there is a need or to seek advice.
- Physio, occupational therapists and specialist services provide care and advice where required.
- Community teams are involved in multi-disciplinary team meetings with partner organisations and the person to ensure people receive best care.
- All professionals offer supportive care to the person and their family/carers.
- With the person's consent information is shared across the local system to ensure continuity of care and the patient's current condition and wishes are known. This will be much more effect now with the roll out of electronic TEP.

Ambition 3 Continued

Maximising comfort and wellbeing

- End of life care extends to caring for the deceased person **including Verification of Expected Death** and last offices to caring for those close to the person and into bereavement. Community nurses undertake verification of death and last offices and provide bereavement care and advice after the death of their loved one.

- Livewell have a service that **offers antibiotic and intravenous fluid** within the person's usual place of residence. Work is ongoing to promote this service across the locality to help maintain people in their home.

- Livewell have been working with partner organisation to reduce the number of people who are nearing the end of life being conveyed to the emergency department (100-day challenge and beyond).

Ambition 4

Care is coordinated

- With the person's consent information is shared across the local system to ensure continuity of care and the patient's current condition and wishes are known. This will be much more effective now with the roll out of electronic TEP but further work is required.

- Early recognition of the deteriorating person or the person who may be entering the last 12 months of life is work that is progressing in Livewell but this needs to happen across the system to be truly effective.

- People are given contact numbers that they can use for help and advice 24/7. This is currently via the district nursing referral hub in hours or 111 out of hours. This would be more effective if there was a **dedicated telephone line** for those people who have a life limiting prognosis or are at the end of life.

- Community teams are involved in **multi-disciplinary meetings** across the system whether that be end of life, frailty, care homes or ageing well. This aides in information sharing and co-ordinating care with the right people involved.

- Professionals involved with a person's care refer to other professionals where needed or for advice regarding a person's care needs. This extends to bereavement care and informing other services when a person has died which helps prevent upsetting visits to the bereaved.

Ambition 5

All staff are prepared to care

Livewell provides the following training to staff involved in caring for those people at end of life and/or their loved ones:

- TEP discussion and writing for senior non-medical professionals within Livewell
- Electronic TEP
- End of Life education for registered nurses within Livewell including early recognition of the deteriorating person, medication, Syringe Drivers, Verification of Expected Death, last offices.
- End of Life education for AHPs and HCA within Livewell including early recognition of the deteriorating person
- Advanced Communication training
- Advance Care Plan (ACP) workshop
- Integrated End of Life Forum – training takes place at these bi-monthly meetings
- Pod Casts
- On-line resources
- Bespoke training within teams
- Supported and funded to attend specific university course and complete modules

Ambition 5 Continued

All staff are prepared to care

- Bite size training for community staff
- Basic Life Support
- Mental Capacity Act
- Safeguarding adults and children
- Equality and diversity
- Information governance
- IT – in relation to systems used within the organisation
- Participation/teaching at local conferences
- Attendance at national conferences
- Bespoke/ad hoc training
- Attendance at specialist training provided outside of the organisation and end of life or disease specific
- All staff have and are encouraged to partake in practice supervision
- Chaplaincy support is offered to individual staff and teams
- Audits of care are undertaken to ensure best care is being undertaken and to monitor where the gaps are.
- All staff are actively encouraged to attend end of life related training.

Ambition 6

Each community is prepared to help

- Livewell is part of the compassionate city working with system partners, looking after the community which includes patients, carers and our colleagues.
- Livewell take part in Dying Matters week to facilitate conversations around death and dying with the public. We have done this at local supermarkets and within the lobby of the Local Care Centre, Cumberland centre.
- Livewell have an end-of-life information page on its website
- Livewell work with the voluntary sector who may be involved in helping someone who is nearing end of life
- Livewell work closely with local and national charities.

Gaps and areas for development

- Strengthening our current care home service (this was set up in covid and has stepped back) but we are keen to work with colleagues to understand what good looks like going forward
- Working on a patient/carer information leaflet across systems to explain to people of what to expect at end of life (rather than individual organisational leaflets)
- Working on the Care coordination hub and spoke development and potential to include specialist end of life support

Testimonials

It is difficult to convey how grateful we both feel for the **care and tenderness** you all showed over the past months

I just wanted to say a huge thank you for the way you looked after my mum in the last few months. Each and every one of you was **absolutely amazing in your care, dedication, professionalism, compassion and sensitivity.**

Thank you for all your care and attention

Thank you for the support you gave to our family. We felt we were being **cuddled by the community**.

You are truly amazing

Thank you **for the outstanding care my dad received** and the support you gave our family. The care was second to none and enabled him to leave this world with dignity. Our family take great comfort in this

Thank you for the care you showed mum you were all so sensitive to her needs, we are really, really, grateful. Every one of you are a credit to your profession

Thank you seems inadequate for all the wonderful care you gave, not only to Mum but support for me also.

Knowing I could **pick up the phone and like angels** you appeared got me through a tough time

Part Two

Shaen Milward, Sharon King, Jane Bullard

Outward Mindset - 100 day challenge

Autumn 2023

The 100 Day Challenge End of Life goal:

To support more people to have a good death in their care home and reduce the number of EoL patients coming to ED from the top 10 conveying care homes by 10%

100 Challenge recommendations

- Set standard of 'What Good Practice' Looks Like for Care Homes for those at EoL
- The creation of an education offer which couples the availability of resources in the locality, whilst also responding to challenges across the care home working environment
- In conjunction with commissioning, PCNs should be encouraged to agree minimum standards of support/engagement with care homes (i.e. ward rounds, visits etc)
- Revisit the Immedicare offer in terms of literature, resources and encouragement to use. Mandate a standardised approach to utilisation.
- Extend the administration and availability of IV Antibiotics and Fluids to care homes and revisit/conceive pathway
- Create end of life support line (and register) for those who are (patients, families, carers and professionals) are in the last 12 months/last phase of life
- Create patient and families information leaflet

Initiatives/Improvements

- Identification of last year of life and person centred plans – sharing of patient wishes (Treatment Escalation plans)
- Death literacy – “Lets Talk…”
- Care Home education
- Marie Curie developments – Estover

NHS Devon

Devon and Cornwall Shared Care Record

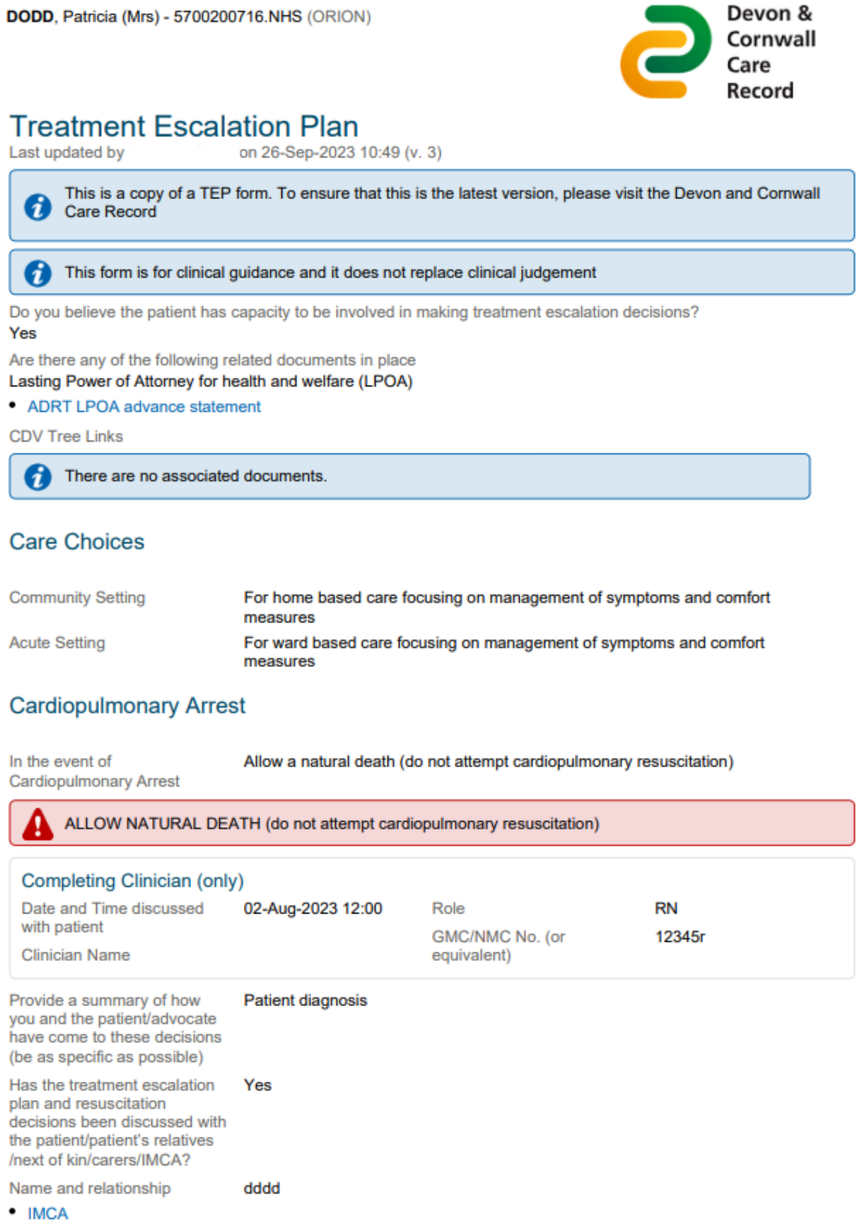
One Devon

Proud to be part of One Devon: NHS and CARE working with communities and local organisations to improve people's lives

New look Treatment Escalation Plan

In Autumn 2023 healthcare providers in Plymouth and West Devon will be able to use the Devon and Cornwall Shared Care Record (DCCR) to complete and edit TEP forms.

This development will mean a single version of the truth that represents patient wishes and improve quality of care



DODD, Patricia (Mrs) - 5700200716.NHS (ORION)

Devon & Cornwall Care Record

Treatment Escalation Plan

Last updated by on 26-Sep-2023 10:49 (v. 3)

This is a copy of a TEP form. To ensure that this is the latest version, please visit the Devon and Cornwall Care Record

This form is for clinical guidance and it does not replace clinical judgement

Do you believe the patient has capacity to be involved in making treatment escalation decisions?
Yes

Are there any of the following related documents in place
Lasting Power of Attorney for health and welfare (LPOA)

- ADRT LPOA advance statement

CDV Tree Links

There are no associated documents.

Care Choices

Community Setting	For home based care focusing on management of symptoms and comfort measures
Acute Setting	For ward based care focusing on management of symptoms and comfort measures

Cardiopulmonary Arrest

In the event of Cardiopulmonary Arrest	Allow a natural death (do not attempt cardiopulmonary resuscitation)

ALLOW NATURAL DEATH (do not attempt cardiopulmonary resuscitation)

Completing Clinician (only)

Date and Time discussed with patient	02-Aug-2023 12:00	Role	RN
Clinician Name		GMC/NMC No. (or equivalent)	12345r

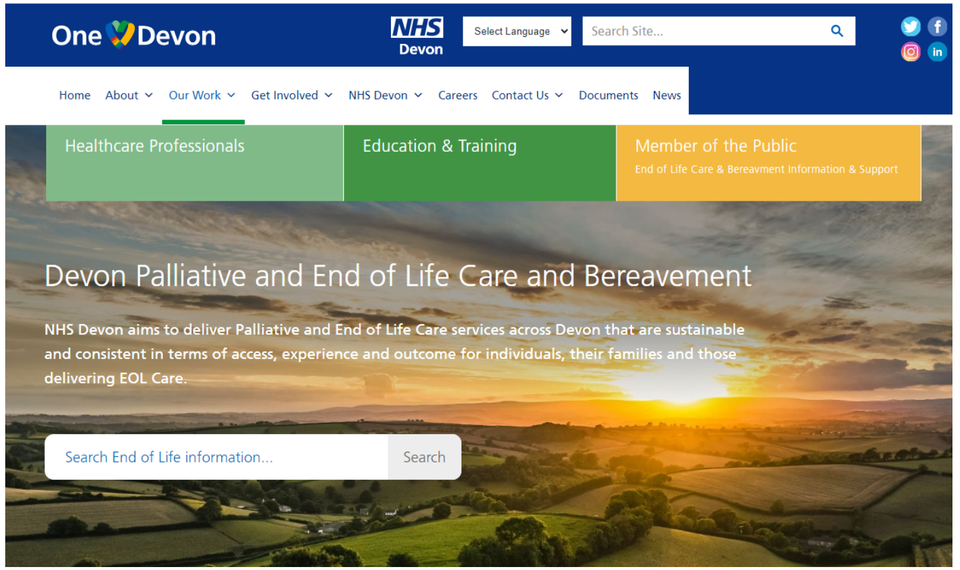
Provide a summary of how you and the patient/advocate have come to these decisions (be as specific as possible)	Patient diagnosis
Has the treatment escalation plan and resuscitation decisions been discussed with the patient/patient's relatives /next of kin/carers/IMCA?	Yes
Name and relationship	dddd

- IMCA

Resources and additional information

Resources

- TEP best practice video for professionals: Overview of TEP
- Patient resources: Public TEP overview
- New EOL website: https://onedevon.org.uk/eol/
- DCCR Resource Library
-



A Compassionate City

A compassionate city is a community that recognises that care for one another at times of crisis and loss is not simply a task solely for health and social services but is everyone's responsibility.

In a compassionate city, we all stand to benefit.

At a conference held in Plymouth in 2018, schools, places of worship, GP surgeries, solicitors and charities – and many other organisations and groups from across the community – called for our city to have an End of Life (EoL) Compassionate City Network and all agreed the following vision:

Our Vision: Plymouth will not shy away from the taboo subject of death, but talks openly about it, in order to create a city that is truly informed and compassionate towards those facing end of life or experiencing loss and bereavement.

We will create a Compassionate City by working towards the international Compassionate City End of Life Charter. For more information, click here.

We're pleased that Plymouth now has a thriving end of life network, with over 90 individuals and organisations already signed up to work towards the key objectives of the EoL Compassionate City Charter which has been formally adopted by Plymouth City Council.

Marie Curie – Estover project

January 2024

Proud to be part of One Devon: NHS and CARE working with communities and local organisations to improve people's lives

Segmentation

L L49 L50 L51 L52 L53

L Vintage Value

Elderly people with limited pension income, mostly living alone

6.46% | 4.17%

Who We Are

Age	Household income
66+	<£15k
408 | 75.4%	466 | 76.7%
Household composition	**Number of children**
Single	No children
190 | 75.4%	144 | 99.8%
Tenure	**Residency type**
Council/HA	Flat
318 | 56.2%	204 | 47.2%

Advert Response Channel

76	89	77
51	59	97

Key Features

- Retired singles
- Council/HA tenants
- No qualifications
- Low discretionary income
- Very low-tech households
- Fuel and water poverty

Household Technology

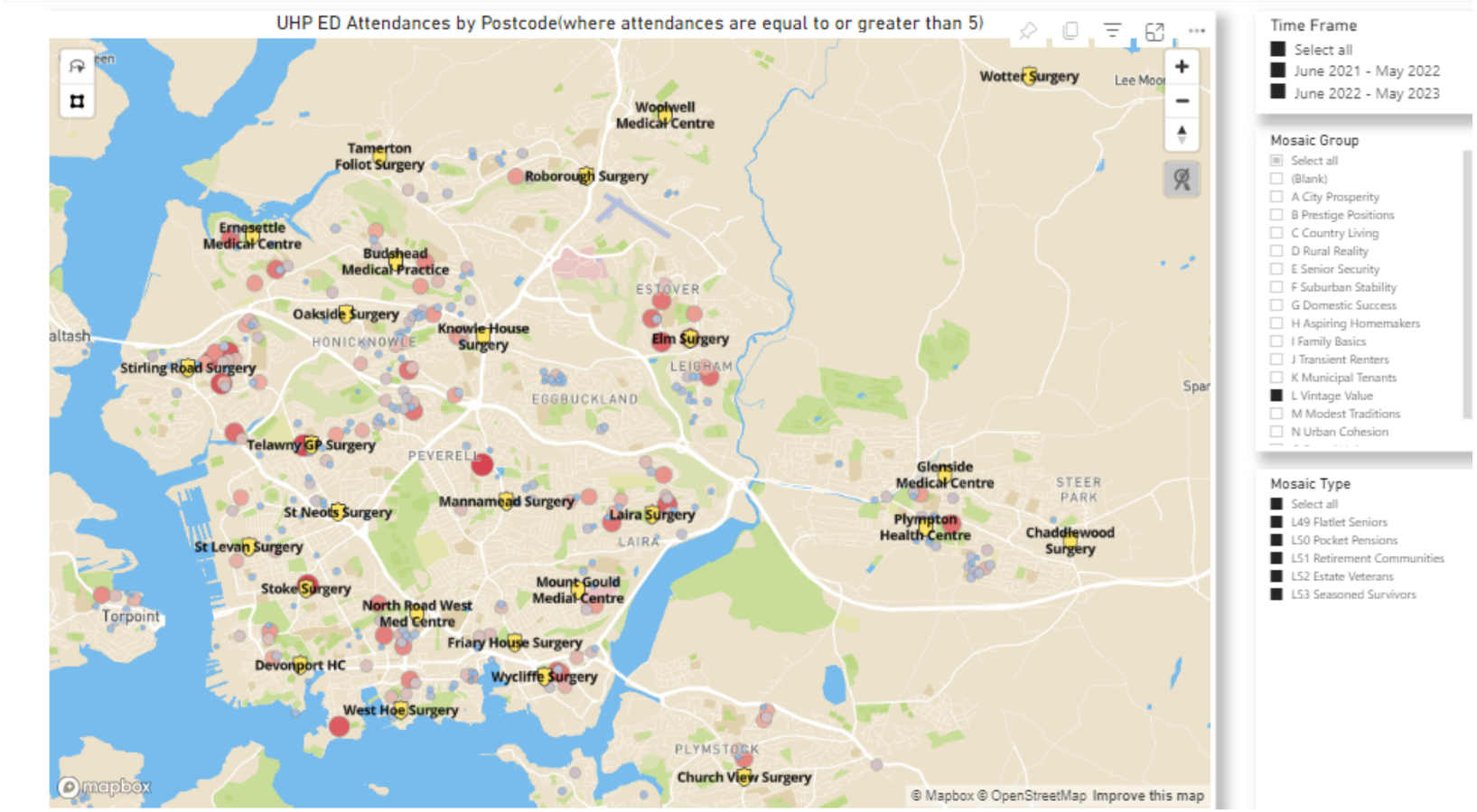
Very Low



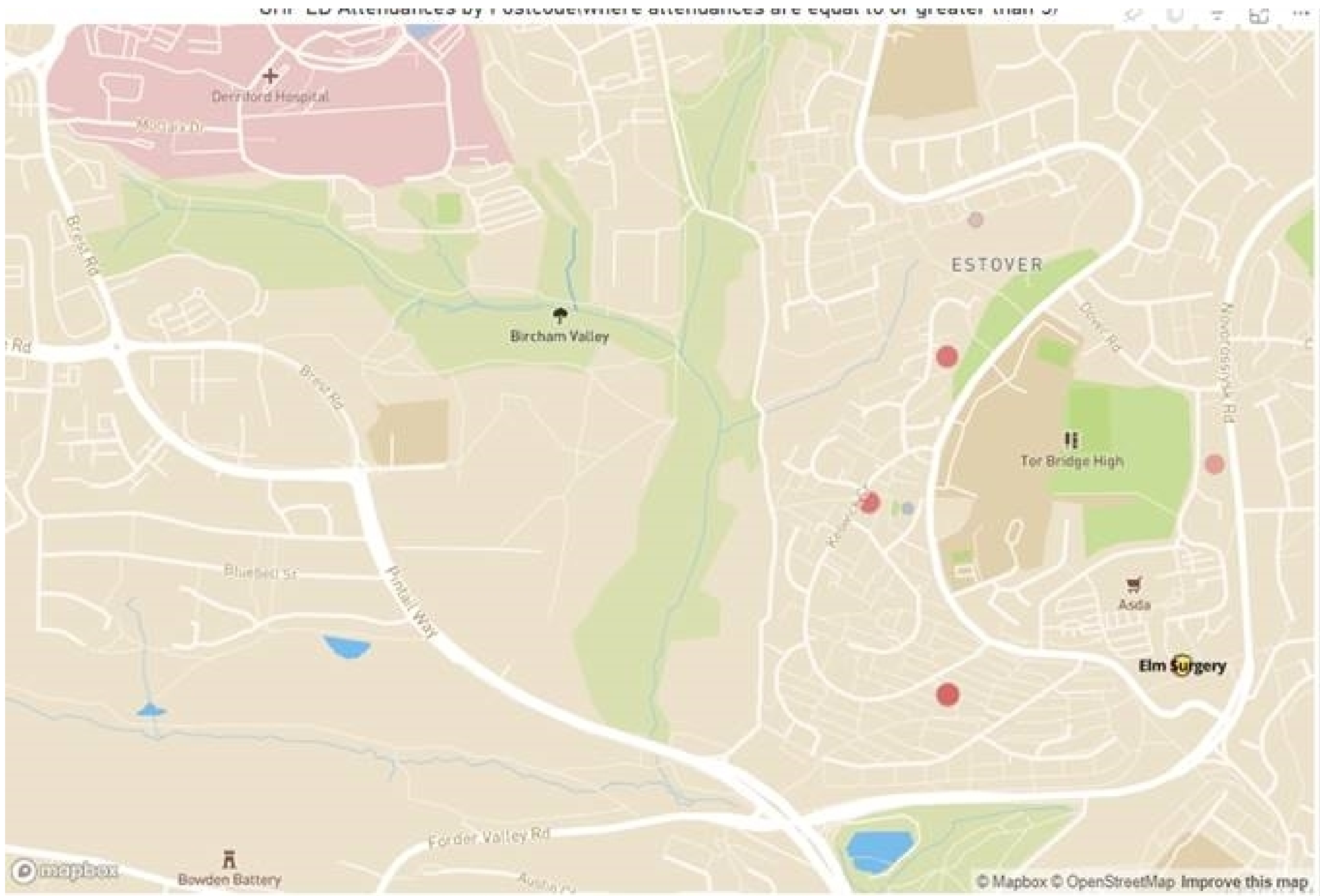



Mosaic UK

Vintage value – both years



Area


Derriford Hospital
Bircham Valley
ESTOVER
Tor Bridge High
Asda
Elm Surgery
Forder Valley Rd
Bowden Battery
© Mapbox © OpenStreetMap Improve this map

Housing stock

Postcode	No. of ED attendances for 2 years	Location
PL6 8UF	85	127 Leypark Walk – Anchor Care Runnymede Court rented housing with extra care has 38 one and two bed retirement apartments with shared gardens and a guest room for visiting friends and family https://www.anchor.org.uk/our-properties/runnymede-court-rented-housing-extra-care-plymouth
PL6 8SL	91	Keswick Crescent – 2 bedroom houses - ?Social housing – not PCH
PL6 8TL	23	Wasdale Close – mixed some owner occupied / some social housing – opposite school and nursery
PL6 8TH	71	Wythburn Gardens – one bedroom bungalows - ?social housing
PL6 8UE	55	Leypark Court – Sheltered Housing – 30 flats run by PCHomes
PL6 8TT	72	Keswick Crescent – near Premier Stores – looks like 2 bedroom houses
PL6 8XB	37	Penrith Walk – some maisonettes and one bedroom bungalows – zero deposits rentals

Estover Cause of Death

Malignant neoplasm of bronchus or lung, unspec	6.5%
Chronic obstructive pulmonary disease, unspecified	6.5%
Acute myocardial infarction, unspecified	4.8%
Malignant neoplasm of pancreas, unspecified	4.8%
Malignant neoplasm of oesophagus unspecified	4.8%
Pneumonia, unspecified	4.8%
Chronic obstruct pulmonary dis with acute lower resp infec	3.2%
Malignant neoplasm, intrahep bile duct carcinoma	3.2%
Chronic ischaemic heart disease, unspecified	3.2%
Peripheral vascular disease, unspecified	3.2%
Pulmonary embolism without mention of acute cor pulmonale	3.2%
Septicaemia, unspecified	3.2%

	East	North	Plymouth	South	West	Devon Total
Malignant neoplasm of bronchus or lung, unspec	4.5%	4.1%	5.3%	4.0%	3.8%	552
Chronic ischaemic heart disease, unspecified	4.7%	4.4%	2.9%	3.5%	4.4%	492
Other specified general symptoms and signs	2.8%	3.4%	3.6%	3.7%	2.2%	413
Vascular dementia, unspecified	3.3%	2.3%	3.1%	3.1%	3.2%	379
Alzheimer's disease, unspecified	3.2%	2.9%	2.9%	2.7%	3.2%	370
Pneumonia, unspecified	2.6%	2.5%	2.2%	2.7%	2.6%	318
Acute myocardial infarction, unspecified	2.5%	2.8%	2.7%	2.4%	1.8%	315
Atherosclerotic heart disease	1.5%	1.3%	3.3%	2.8%	1.2%	275
Chronic obstructive pulmonary disease, unspecified	1.9%	2.3%	2.8%	1.8%	1.6%	259
Chronic obstruct pulmonary dis with acute lower resp infec	1.2%	1.3%	2.6%	2.1%	2.0%	224
Malignant neoplasm of pancreas, unspecified	1.8%	1.5%	1.6%	1.2%	1.6%	191
Malignant neoplasm of breast, unspecified	1.6%	1.5%	1.4%	1.3%	1.2%	178
Heart failure, unspecified	1.5%	1.7%	1.2%	1.3%	0.2%	170
Malignant neoplasm of oesophagus unspecified	1.5%	1.1%	1.0%	1.4%	2.0%	168
Bronchopneumonia, unspecified	1.1%	1.2%	1.3%	1.4%	0.6%	152
Cerebrovascular disease, unspecified	1.2%	1.7%	0.9%	0.8%	1.8%	142
Aortic (valve) stenosis	1.1%	0.8%	0.8%	1.2%	0.6%	128
Congestive heart failure	1.3%	1.8%	0.7%	0.4%	1.0%	124
Septicaemia, unspecified	0.9%	1.3%	1.5%	0.6%	0.6%	124
Alzheimer's disease with late onset	1.0%	0.5%	0.7%	1.2%	1.0%	117
Malignant neoplasm of bladder, unspecified	0.8%	1.0%	0.9%	1.2%	0.4%	116
Intracerebral haemorrhage, unspecified	1.1%	1.0%	1.0%	0.4%	1.6%	108
Malignant neoplasm of colon, unspecified	0.9%	1.0%	0.7%	0.5%	0.8%	97
Other interstitial pulmonary diseases with fibrosis	0.5%	0.9%	0.3%	0.9%	1.4%	88
Chron obstruct pulmonary dis wth acute exacerbation, unspec	0.6%	0.8%	0.9%	0.6%	0.2%	85
Urinary tract infection, site not specified	0.6%	0.5%	0.9%	0.7%	0.2%	81
Gastrointestinal haemorrhage, unspecified	0.5%	0.5%	0.7%	0.6%	0.6%	75
Pulmonary embolism without mention of acute cor pulmonale	0.5%	0.9%	0.9%	0.4%	0.2%	74
Multiple myeloma	0.6%	0.4%	0.5%	0.6%	1.0%	71
Cerebral infarction, unspecified	0.3%	0.2%	1.0%	0.8%	0.2%	71
Other Diagnoses (including uncoded):	24.3%	24.3%	26.2%	27.4%	29.4%	3219

Note: There may be some coding issues and missing data

Marie Curie Project

Started 18th January 2024

1. Improve the identification of people nearing the end of their lives
2. Support to staff and residents to improve the knowledge and culture around death, dying and bereavement
3. Improve the wellbeing of residents and reduce feelings of social isolation
4. Take a proactive approach to Advance Care Planning
5. Aim to work with 200 people over 6 months

Partners engaged to date

- Elm Surgery
- St Luke’s
- Elm Community Builder
- Compassionate City development worker
- Plymouth City Council – Research / Public Health
- Belong in Plymouth
- Plymouth Community Homes
- Eldertree
- Asda

“Remember that death is a social event with a medical component, not a medical event with a social component. The larger part of dying happens outside of the institution and professional care”.

Allan Kellehear