# End of Life Care Plymouth

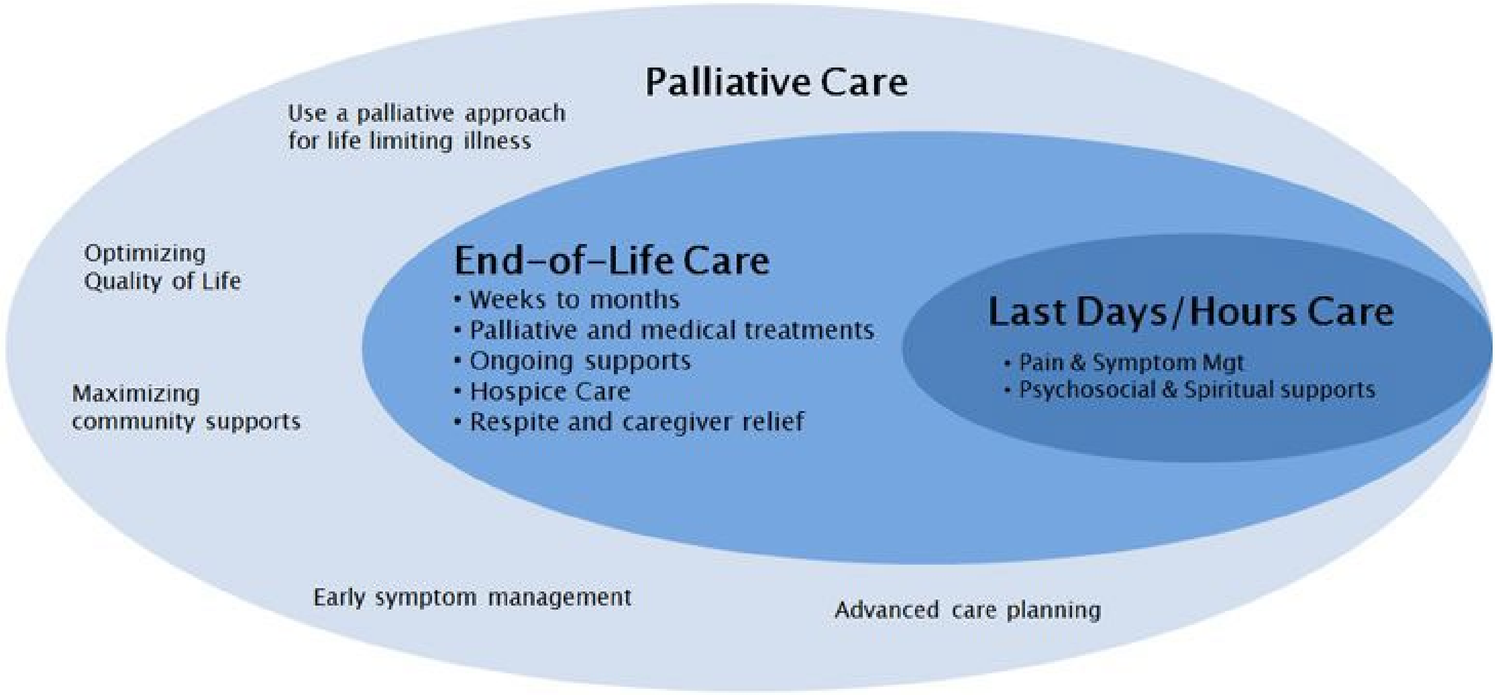
October 2024

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

# Recommendations - March 2024

1. **Update on performance against the End of Life Care Improvement Plan**. This is to include delivery of the Palliative Care framework, findings of the Estover Pilot Project, and additional information on the below recommendations.
2. NHS Devon and Partners take into account and record people's preferences for place of death.
3. NHS Devon and partners return at a future time to report on falls prevention measures being undertaken and related performance.
4. Work to **reduce the delay in testing and diagnosis** to enable maximum choice for patients spend their remaining time in the way/location that they wish.
5. Adopt processes to include patients' relatives in the planning and administration of care for their loved ones (where applicable, and consent given). This includes consultation in the development of a Treatment Escalation Plan (TEP).
6. The Council, in partnership with City organisations and individuals, seek to promote and recognise St. Luke's communication of "**Care in the community" and "the hospice coming to you**", rather than the misconception of patients having to be admitted to a hospice.
7. The Cabinet Member for Housing, Cooperative Development and Communities (Cllr Penberthy), ensures that the **Housing Needs Assessment** considers housing standards, and their appropriateness, for individuals with a variety of medical needs (Accessibility and quality).

# Refresh




| 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%** |

# End of Life Locality Plan

| Milestone Description | Owner | Milestone Update - 17/9/24 | Status | Due date* |
|---|---|---|---|---|
| Consistent use of a tool to **identify of End of Life phase** and embedding DCCR End of Life register | NHS Devon | Task and finish group started to embed use of tool locally | Off track - recoverable | 30 /09/ 24 |
| Ensure the End of Life care service offer is universally understood with a **central information point for individuals** and system partners | St Lukes | First iteration of EOL Care Co-ordination hub for St Lukes patients has started | In Progress / On track | 31 /03/ 25 |
| Undertake **demand and capacity analysis** for End of Life care, including assessment of needs and gap analysis | All partners / NHS Devon co-ordination | Information received and being reviewed and added into Devon wide workplan | In Progress / On track | 30 /09/ 25 |
| Complete an options appraisal and develop commissioning intentions to meet any identified needs | NHS Devon | Part of NHS Devon EOL review - task and finish group leading work | In Progress / On track | 31 /12/ 24 |
| Use the National Audit of Care at the End of Life (https://www.nacel.nhs.uk/) to ensure priorities for individuals are being met and use this audit to evaluate any service improvements | UHP and St Lukes | Audit underway in Autumn 2024 | In Progress / On track | 31 /12/ 24 |
| Ensure **specialist end of life support** is embedded in the local coordination hub for urgent and emergency care (7 days 8am-8pm) | NHS Devon | Care Co-ordination hub provider moving to Practice Plus Group mid October 2024<br>NB: please note action above: SLH Coordination hub remains on target and will offer local solution. | On hold | 30 /11/ 24 |
| Development and implementation of an **End of Life care communication and training resources** on Hive which includes implementation of a data capture process to monitor End of Life care training uptake | Training partners | Series of webinars being held over 6 month period - joint initiative UHP / LSW - Hive pilot underway to small group of organisations | Off track - recoverable | 31 /12/ 24 |
| Developing a strategy for working with communities to expand ‘death literacy’, building on community assets and the Compassionate City programme | all partners | Plymouth Compassionate City work is being showcased as exemplar of Good Practice at Hospice UK National Conference, Nov 2024: (insert slide of Poster) | In Progress / On track | 30 /09/ 24 |

# Estover Project

# What we wanted to achieve

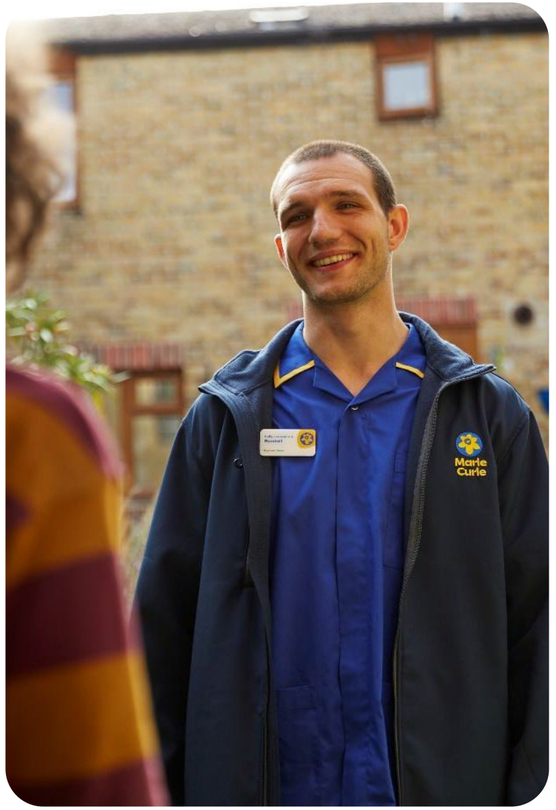
1. Improve the knowledge and culture around dying, death, and bereavement
2. Improve the identification of people nearing the end of their lives
3. Improve the wellbeing of residents and reduce feelings of social isolation
4. Take a proactive approach to Advance Care Planning
5. Aim to work with 200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

## What we have found

- **Terminology –** What do we mean by end of life?
- **Recognition –** What is the difference between being frail or having deteriorating health and someone approaching the end of their lives?
- **Conversations –** Whose "job" is it to discuss what matters to people nearing the end of their lives
- **Holistic care -** health and well-being are influenced by a wide range of factors

## What we have done

- Community engagement approach
- Senior nurse embedded in GP practice
- Over **70** patients supported and assessed



# Estover

## Community Engagement - Place Based Project

- Improve knowledge and culture around dying, death and bereavement.
- Improve wellbeing of residents, reduce feelings of social isolation. Recruit volunteers. Introduce Advance Care Plans.
- Improve identification of people nearing end of life.

ESTOVER COMMUNITY

**Advanced Care Plans**

ONGOING…
- Referral route?
- Delivery?

**Stakeholder Communications**

- Improving Lives / Mannamead Wellbeing Hub
- Plymouth City Empowerment Manager
- Estover Local Councilor
- ElderTree
- Elm Wellbeing Hub
- Runnymede
- Asda
- Leypark Court
- Estover Library
- Christ Church
- University of Plymouth and Marjon's University - student placements
- Eldertree
- St Lukes
- Pie Club
- Veterans – RBL
- Plymouth Community Homes

**** Socially Isolated, Homebound, Minority Groups**

- Plymouth Community Homes – direct contact between tenants and housing officer.
- Estover library – home visits, read and natter. Dates arranged with Runnymede – new service
- YOUNG MINDS event Local Pub
- Plymouth City Community Digital Volunteers – home visits, new service
- Plymouth Pie Club - befriending
- SART student and refugees together
- Veterans RBL
- Improving Lives Mannamead Hub

**Community Events /Static Displays**

- Dying Matters – Let's Get Talking
- Pentillie Castle – Celebrating Volunteers and Sponsors
- Elm Community Hub – Relaunch
- Static displays - Marie Curie Information and Support: Asda, Runnymede, Leypark Court, Marjons University, Consort House, Estover Library
- Local Pub – Young Minds TBC

**Volunteer Recruitment/Advertising**

- Plymouth University and Marjon's University: Negotiations in place to explore recruiting volunteer student nurses.
- Recruitment and Life Café posters displayed: Asda billboard; local businesses socials/website, Marie Curie socials, Plymouth City Empowerment, Elm Wellbeing Hub; Runnymede newsletter, Christ Church newsletter, Pentile Castle, St Lukes retail shop, Consort House… ++

**Community Engagement**

**Elm Wellbeing Hub:**
Networking – XL poster FOC displayed on Asda grounds. Dying Matters – in partnership with St Lukes. Marie Curie stall – Hub relaunch.

**Christ Church:**
Networking -Compassionate Friends training (St Lukes)
Use of room FOC

**Asda Superstore:** Display table/area offered, FOC.
Staff training rooms, FOC.
Will provide snacks and light refreshments

**Estover Survey / Life Café evaluation**

Impact and Evaluation in progress.

**Inclusivity/Diversity ****

SEE **

**Life Café Sessions**

Runnymede Assisted Care Home

Estover Library + drop by. I&S Display

Leypark Court PCH date tbc

**Staff Training: Consort House, Eldertree date tbc, Leypark Court provisional date.**

## Interim Evaluation results

- There has **been more timely access to appropriate support for people living with a terminal illness**. The work undertaken in the GP surgeries has provided support including assessment of those on the palliative or end of life registers and holistic support for their wellbeing.

- Although we have not had direct feedback from patients, GP surgery staff felt that **the work of the SN addressed patient wellbeing** through talking about their worries and concerns. This can be illustrated through the holistic work enabling a patient to be able to access their outdoor space.

- At least one patient **avoided an ED admission** and the GP surgery staff felt that the demand for appointments would reduce as the SN addressed worries and concerns and reviewed all patients on the palliative and end of life register.

## What next?

- Extend to all surgeries in Sound PCN
- Proactive management of EOL / Palliative Care registers
- Convert Senior Nurse post to Advanced Clinical Practitioner
- Seek funding to extend pilot
- Explore joint working with local volunteer delivered services

University Hospitals Plymouth NHS Trust

# ED & End of Life Bed Base at Mount Gould (Patient Outcomes)

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

# Achievements and Outcomes

University Hospitals Plymouth NHS Trust

## End of Life Education

**30 non-medic colleagues trained** to complete high quality Treatment Escalation Plans in the Trust

160 colleagues educated in **better recognising and supporting the dying patient**

Redesigned mandatory end of life eLearning package and all staff Trust induction

**Supported 150 colleagues** across the locality in the roll-out of electronic Treatment Escalation Plans

**900+ colleagues** have received end of life education I the last year because of Nicki's appointment

## End of Life Care at Mount Gould

Flexed position of end of life **4 beds** (2 on Kingfisher and 2 on Skylark)

**147 patients transferred** to Mount Gould end of life bed

**Average length of stay** of 9 days

**1329 bed days** provided away from acute bed base

131 patients **died on site**

16 discharged for **onward care**

Average of **14 patients per month** supported

## End of Life Care at UHP (Main Site)

Received **1621 requests for specialist advice** from healthcare colleagues

**Supported 698 deaths in the Trust** with specialist advice, symptom control and emotional support for patients and carers

Provided 4,434 face to face contacts with patients

Managed a changing caseload, where predominantly those supported are dying from a **non-cancer related illnesses (55%)**

## End of Life Care at ED

In 15 months, **440 patents have been supported** by the service

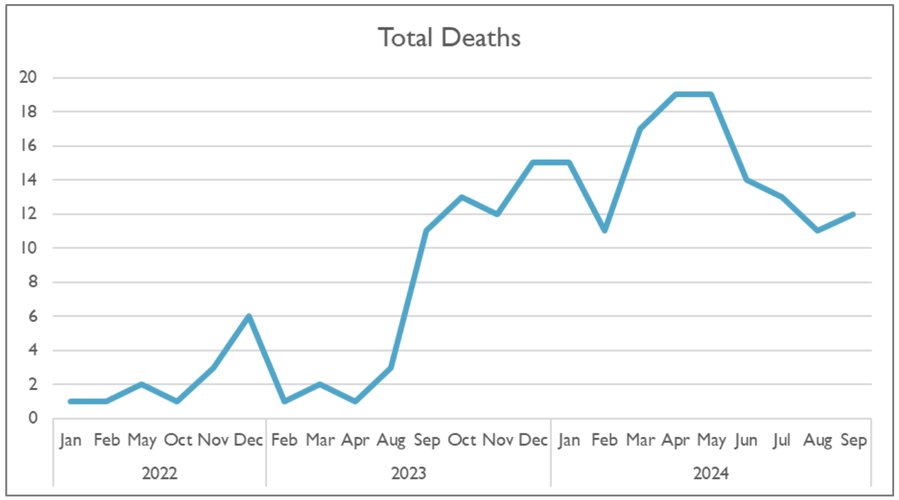
Of this group of people, 86% were supported to die **away from our ED**

In the last three months, **20% of those patients were transferred to Mount Gould** for End of Life care and/or onward care planning

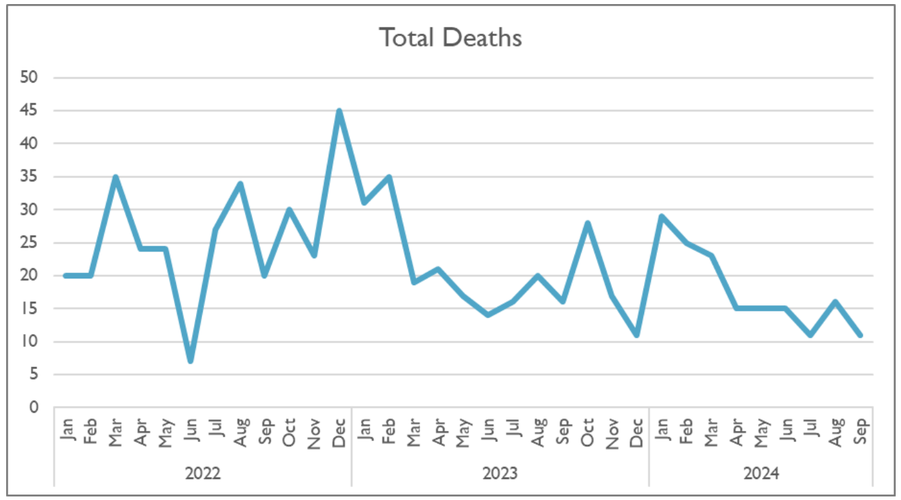
77% of patients **receive review of the TEP** documentation, supporting appropriate onward care

# Brief Update re MG EoL Bedbase

University Hospitals Plymouth NHS Trust




Skylark and Kingfisher deaths




ED Deaths

- A bed base of 4 End of Life beds represents circa 12.5% of all Trust deaths in recent months (average 17 deaths a month in last 6 months)
- These four beds support a death every other day

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

# High Level Overview – Three Areas of Development

University Hospitals Plymouth NHS Trust

## Front Door ED & Hot Floors

*A team of four practitioners based in ED*

- Supporting better deaths in the department
- Supporting pre-conveyance, with dedicated telephone support, 7 day service, physical outreach where absolutely essential
- Avoiding 260 conveyances pa

*Supported by Marie Curie NA in ED – supportive care for those dying in the department, 7 day service*

## In-Hospital Team Service

- TUPE of St Lukes in-hospital team to UHP management
- Continue to support 1621 (2023/2024) referrals for specialist support and advice (inpatients)
- Providing 4434 face to face interactions and over 5000 contacts (2023/2024)
- 2024/2025 - Further develop support to areas of non-malignancy

*Joined by Marie Curie, 7 day service; dedicated patient identification service for those who do not require use of acute bed. To actively identify and expedite discharge for 624 patients pa*

## Supportive and Palliative Care Beds at Mount Gould

- Co-delivery model with Marie Curie staff working alongside existing UHP Mount Gould nursing team
- Supporting better deaths away from acute bed base, where no other community option suitable/available
- Providing stepped bed availability 4 (6) > 8 (10) > 12 (14)
- Providing 4380 bed days

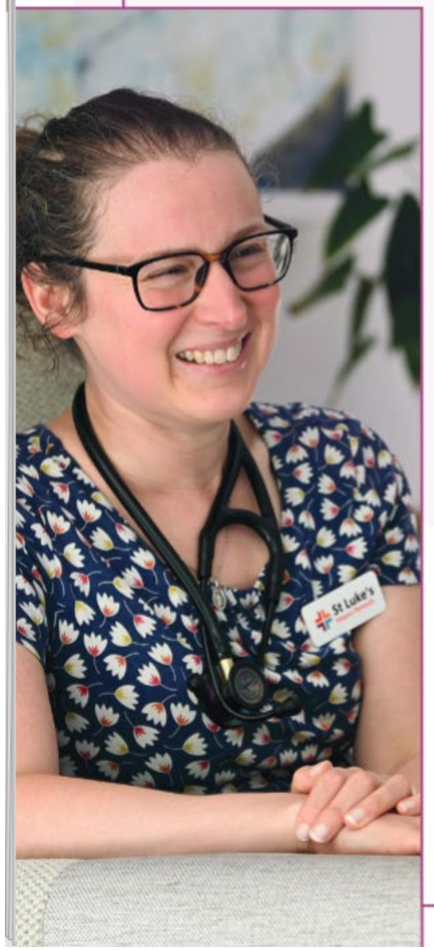
*Specialist in-reach from ED based UHP team and consultant cover from in-hospital team*

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

# St Lukes Hospice “Every Death Matter 2024 -2027



## AIM TWO



Our aim is to provide a strong voice for end-of-life care patients using our expertise to influence health and social care partners and improve services.

### INTEGRATED STRATEGY

Act as a driving force in the creation and implementation of a local end-of-life care strategy which reflects national standards and best practice.

### COORDINATION

Play a leading role with system partners in reimagining the approach to coordinating end-of-life care services which meets the needs of patients and their loved ones.

### FRAILTY

Engage with system partners to shape the role of our end-of-life care services within the context of frailty in a way that meets the needs of our local community.

### NATIONAL INFLUENCE

Explore opportunities for influencing the Integrated Care System and national bodies to improve end-of-life care services and secure the future sustainability of hospice services.



## WORKING IN PARTNERSHIP

### OUR KEY ACTIVITIES WILL INCLUDE:

- Engaging with other health and social care partners to develop a clear strategy for end-of-life care in Plymouth and the surrounding area.
- Establishing a “coordination hub” providing a single point of contact for both patients and clinicians.
- Exploring what geographically dispersed bed provision might look like and develop a proposal for addressing winter pressures.
- Developing a clear role for St Luke’s in providing and/or supporting frailty services in the future.
- Engaging with other hospices to explore opportunities for working together and potentially sharing medical resources.

### OUR SUCCESS WILL BE MEASURED BY:

- Operating within an integrated end-of-life care strategy that is adopted by all health and social care partners in Devon, including GPs and care homes.
- Increasing the number of patients with access to coordination hub support, advice, and response service by 30% in year three.
- Ensuring that 80% of our patients receiving end-of-life care have been identified as such on their primary care health records.
- Implementation of an end-of-life frailty service developed from national best practice models, for example, Dementia UK’s Admiral Nursing service for end-of-life care.
- 5% fewer end-of-life patients being unnecessarily admitted to an acute hospital and increasing urgent care packages by 5%.

Reflecting the voice and needs of our community

“ End of Life Care services should be better coordinated”

## Strategy Focus this Year

Co-ordination and Earlier Identification are our key areas for development this year.

St Luke's Hospice Plymouth

# System Common Language


| GFS Need | Coordination of Care |
|---|---|
| Blue | Start the conversations - Advanced Care Planning, the Clinical Frailty (Rockwood, Comprehensive Geriatric Assessments / active role within the Living Well MDT |
| Green | Ensure review and update of the above, Special Rules 1 completed to access benefits. Preferred place of care and death documented. |
| Yellow | Review all above and ensure is up to date. Review social network / care needs |
| Red | Urgent Care service to coordinate care |

St Luke's Hospice Plymouth

# Compassionate City

FROM PLYMOUTH TO IPSWICH TO PRESTON:

## COMPASSIONATE COMMUNITIES AWARENESS SESSIONS

ARE THE GIFT THAT KEEPS ON GIVING

### BACKGROUND

Compassionate Communities is a public health approach to palliative care acknowledging that death, dying and loss are everybody's business.

St Luke's Hospice Plymouth created Compassionate Friends sessions in 2018, underpinning Compassionate Champions and Buddies schemes and supporting a Compassionate City Charter.

### AIM

To optimise the impact and reach of compassionate community education by sharing and collaborating across hospices.

### METHOD

St Luke's gifted their initiative to the team at St Elizabeth Hospice (Ipswich) who then developed Compassionate Conversations - online and in-person monthly awareness sessions co-delivered with volunteers.

St Catherine's Hospice (Preston) identified a need to improve death literacy in its community and was gifted awareness sessions and support from the Ipswich and Plymouth teams.

Compassionate Conversations was adapted by St Catherine's and delivered to community groups, nonprofits and volunteers. Sessions are evaluated and qualitative and quantitative data collected.

### RESULTS

St Luke's have trained 850 people. Impact includes securing Charter status and the expansion of the Compassionate Buddies scheme into schools.

Since 2021, St Elizabeth Hospice has trained over 1,150 people, supporting a multi-hospice/partner bid for ICB and National Lottery funding to increase activities across Suffolk. Sessions are freely gifted to local partners, with many ripple effects.

Since 2023, St Catherine's have trained over 180 people. Sessions have supported four new community bereavement cafes and one independent bereavement support group.

Our combined efforts have trained almost 2,200 people.

### CONCLUSION

With limited resources for developing new education programmes in hospices, partnership and collaboration creates a culture of peer-support and maximises the impact of tried-and-tested effective Compassionate Communities awareness sessions across the UK.

As more hospices adopt this Compassionate Communities approach, they can be gifted this ready-to-use awareness sessions, which ultimately increases the confidence and resilience in communities around death, dying and loss.

**To receive your free gift of Compassionate Conversations awareness sessions, please just get in touch and see where this free tried-and-tested awareness sessions will take your communities.**

COMPASSIONATE SCHOOLS FRIENDS, CHAMPIONS AND BUDDIES

99% FEEL MORE CONFIDENT TO TALK ABOUT DEATH AND DYING

LEND (LISTEN, EMPATHY, NOTICE AND DO)

COMPASSIONATE CAFES COMMUNITY OWNED AND LED

500,000 CONVERSATIONS

100% RECOMMEND THE TRAINING

*"I now know how to approach and speak/ empathise with someone who is grieving [and] will speak more openly about dying."*

*"It has made me less hesitant in talking about death or talking to someone who is recently bereaved, to talk about their loved one."*

*"There were lots of people participating and it feels good to know there are so many people that are wanting to improve the support for young people."*

*"I didn't know about Compassionate Cafes before so I now have somewhere I can signpost bereaved people so they can get support in the community."*

1 Compassionate communities: end-of-life care as everyone's responsibility | QJM: An International Journal of Medicine | Oxford Academic (oup.com)
Kellehear A. Compassionate communities: end-of-life care as everyone's responsibility. QJM: An International Journal of Medicine. 2013; 106 (12): 1071–1075

2 https://bmcpalliatcare.biomedcentral.com/articles/10.1186/s12904-022-01032-0
Graham-Wisener, L, Toner P, Leonard R and Gerake, J. Psychometric validation of the death literacy index and benchmarking of death literacy level in a representative UK population sample. BMC Palliative Care. 2022; 21: article 145


# Housing Needs Assessment

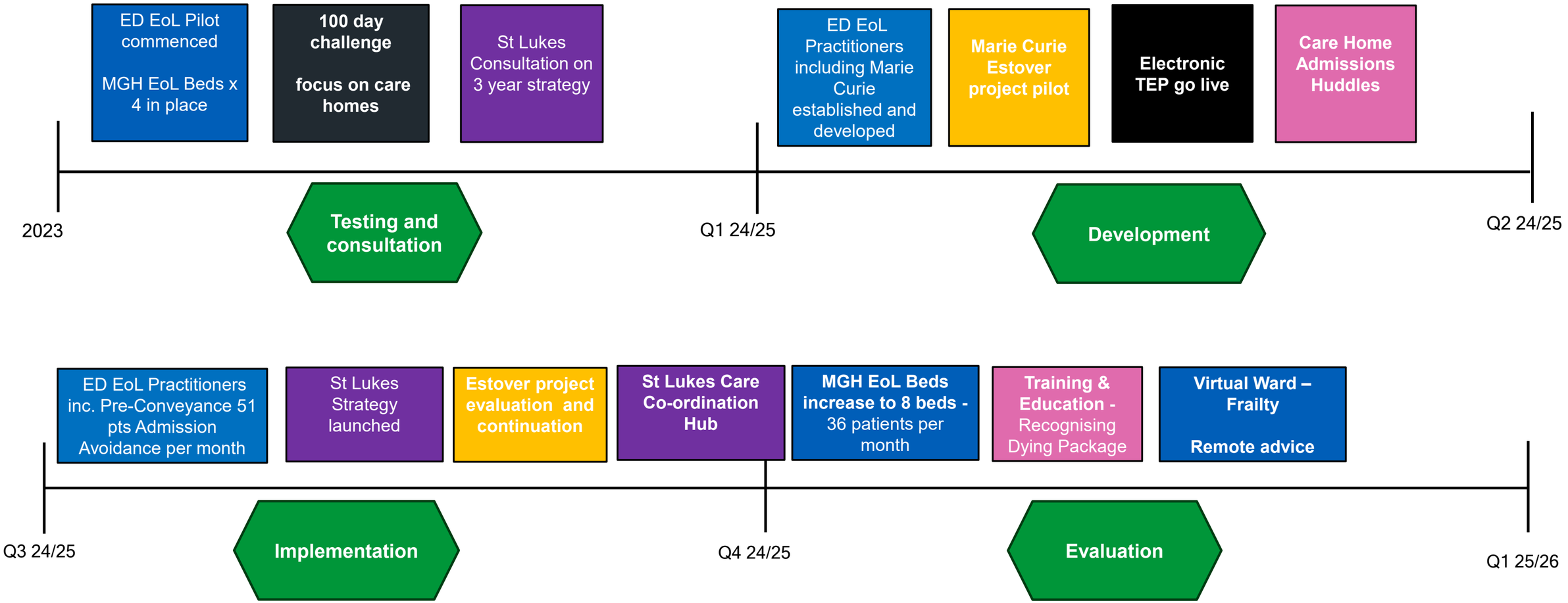
**Recommendations**

- People with housing experience and responsibility can and should be trained and become proficient in supporting people, their carers and families at the end of life – whether this is, for example, by being appropriately informed of good practice in compassionately carrying out their roles, by signposting to appropriate organisations for support or by escalating housing needs in light of agreed person-centred housing policies.

- Our housing system should become a more integrated part of cross-sector collaboration to improve end of life care and experience in Plymouth.

- A number of organisations have shared their experience and good practice online and these should be reviewed for the continuation of learning and improvement within Plymouth.

# Locality End of Life Programme



# Falls Prevention


Funded for 2 years from Population Health Management programme – at least 320 people per year with a focus on health inequalities

[Falls Team | Livewell Southwest]

Funded until Sept 2025
Website with resources and personal falls risk assessment – details of local support

[Welcome to Steady On Your Feet Devon]