NHS
The Leeds Teaching Hospitals NHS Trust

Leeds Teaching Hospitals NHS Trust: Update for LPCN

20 March 2019

Palliative Care Team

LTH: setting the scene

Local & specialist services for local population of 770,000 & regional specialist care for 5.4 million.

2113 inpatient beds across 7 sites with 504 outpatient clinics/week.

The trust employs approximately 17,900 staff.

"Staff responded to patients physical and emotional needs in a compassionate and timely manner, involving relatives and carers where appropriate." CQC

In the last 3 years, LTHT has moved from the bottom 20% to the top 20% in the NHS staff survey.

" Results from the Friends and Family Test were positive and based upon a higher than average completion rate." CQC

Rated as a ***good*** by CQC

"Trust values and vision ("The Leeds Way") was strongly embedded with staff across services and locations." CQC 2019

Palliative Care Team

Palliative Care Team

LTHT response to service pressures

- GPs in A&E
- Frailty unit
- Villa care wards
- Integrated working reducing “super stranded” patients
- Medically optimised wards

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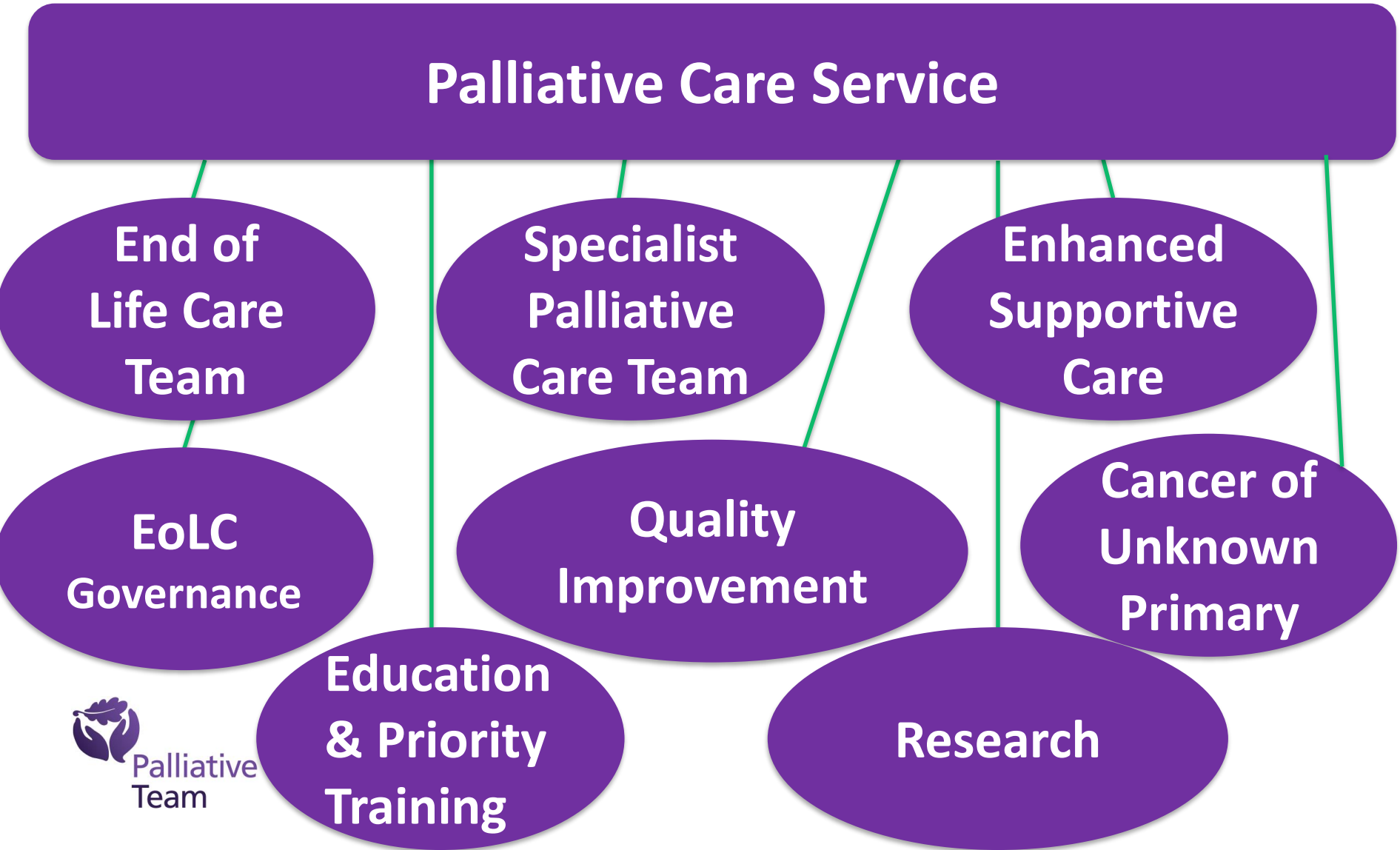

Palliative Team

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Palliative Care Team

Based in Robert Ogden Centre SJUH, but cover whole LTHT

(Regular LGI presence Thurs am.)

Office hours: 8.30am-4.30pm M-F

Weekend service since Nov '15 (CNS led)

Supporting telephone advice (cons)

24hrs a day, 7 days a week

Core SPCT:
3 x consultants:
Suzanne Kite
(Lead Clinician, SPC/EoLC)

2x SpRs, 2x SAS
10 x CNS's, 1 x pharmacist

End of life care team:
Liz Rees (EoLC Lead Nurse) +
2 x EoLC nurses,
1 x bereavement nurse (+ Consultants)

Palliative care discharge facilitator
Deborah Borrill

Contact: 0113 2064563; on-call via switchboard; Please note a wealth of information & guidance is available on our intranet page!

LTH: *It's Everybody's business*

Engage

Educate

Empower

Palliative Care Team

Collaborative QI

- Deteriorating patient collab.
- Mortality review
- ILD clinic work
- CUP service
- ReSPECT/EPaCCS
- ESC
- Comfort Care Packs
- CoPD MDT/ SOB mapping
- RDP/ToC ED
- BotB: OPC/terminal agitation
- Link nurses
- LD project
- Heart failure project

LTH: EoLC

"Staff involved people in their care and treated them with compassion, kindness, dignity and respect." CQC

83% of bereaved carers thought their relative died in the right place, BCS

3,000 inpatient deaths

"Staff were committed to ensuring a rapid discharge for people receiving EoLC who wanted to go home or go to a hospice as their preferred place of care." CQC

86% of bereaved carers satisfied/v . satisfied with pain relief, BCS

93% of dying people had an individualised care plan for the last days of life, EoLCA

Rated **good**, CQC

LTH: SPCT Activity, 18-19

- 1602 patients seen (1760 referral episodes)

- **32% non-cancer**
- **45% 75 yrs. +, 18% 85 yrs +**
- **78% white British**

99.8% triage within 24 hours

- 90% seen within 24 hours
- 3% die before we assess
- 31% die on our caseload

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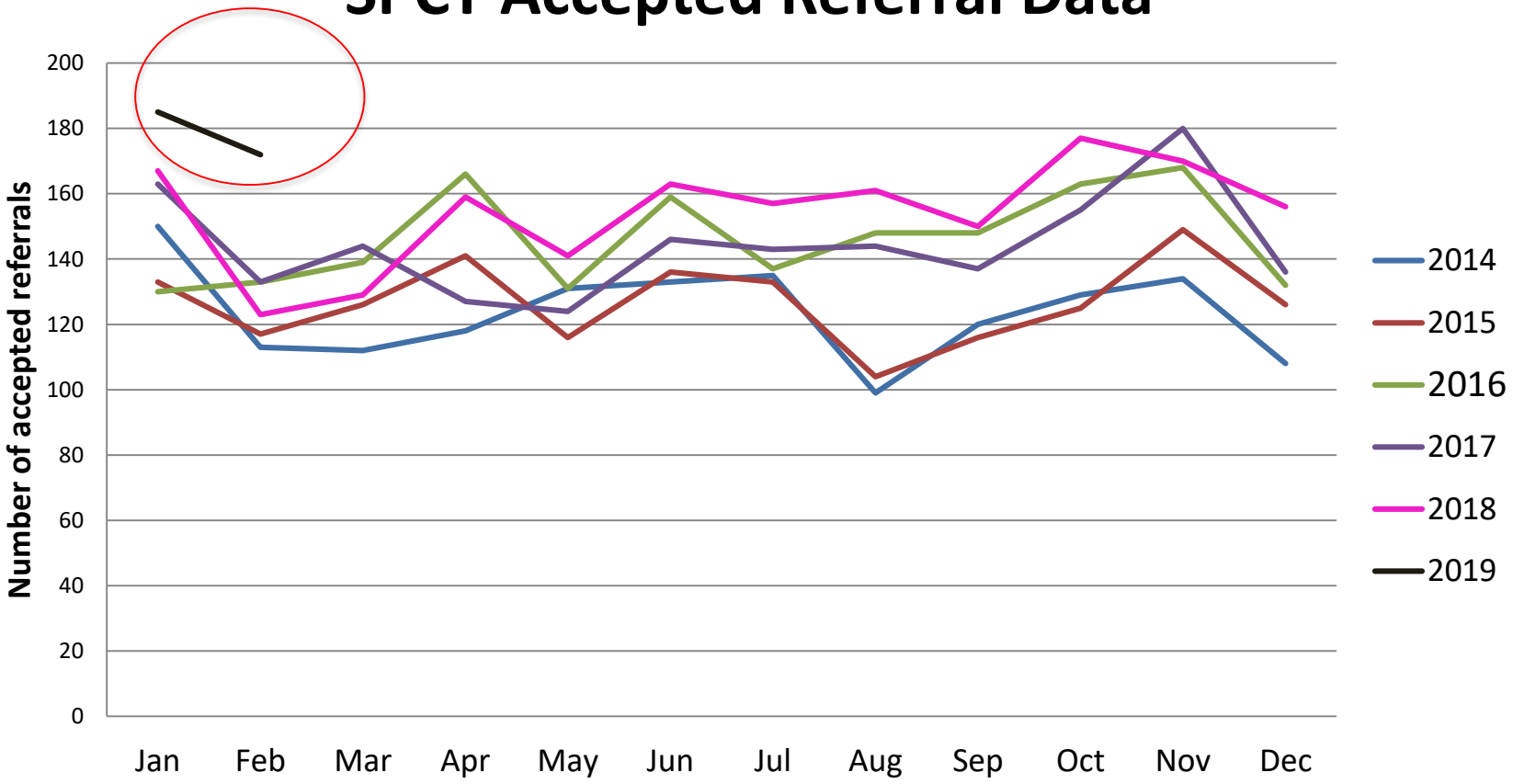
SPCT Accepted Referral Data



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SPCT: response to service pressures:

- Paperlite/digital working
- Streamlining of MDTs
- Clinical coordinator (triage and advice)+ senior doctor of the day
- Board round
- Workforce planning

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LTH: EoLC Team

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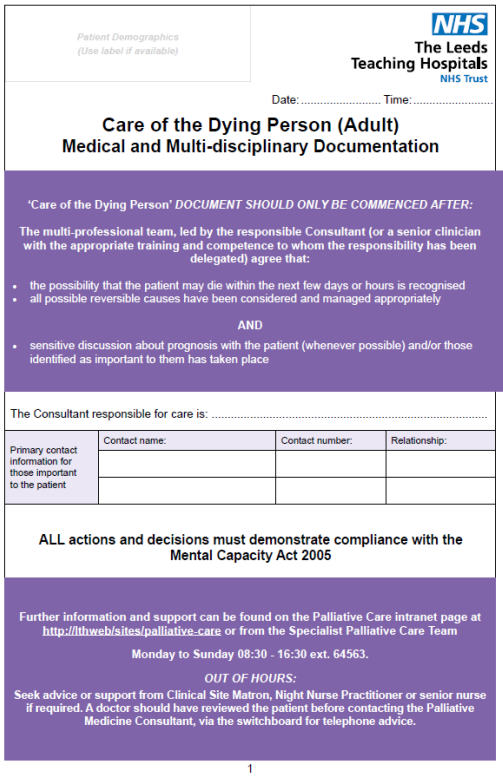
How we support care of the dying person



Patient Demographics
(Use label if available)

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Date:..... Time:.....

Care of the Dying Person (Adult)
Medical and Multi-disciplinary Documentation

SECTION A

'Care of the Dying Person' *DOCUMENT SHOULD ONLY BE COMMENCED AFTER:*

The multi-professional team, led by the responsible Consultant (or a senior clinician with the appropriate training and competence to whom the responsibility has been delegated) agree that:

- the possibility that the patient may die within the next few days or hours is recognised
- all possible reversible causes have been considered and managed appropriately

AND

- sensitive discussion about prognosis with the patient (whenever possible) and/or those identified as important to them has taken place

The Consultant responsible for care is: .....

	Contact name:	Contact number:	Relationship:
Primary contact information for those important to the patient			

ALL actions and decisions must demonstrate compliance with the Mental Capacity Act 2005

Further information and support can be found on the Palliative Care intranet page at http://ithweb/sites/palliative-care or from the Specialist Palliative Care Team

Monday to Sunday 08:30 - 16:30 ext. 64563.

OUT OF HOURS:

Seek advice or support from Clinical Site Matron, Night Nurse Practitioner or senior nurse if required. A doctor should have reviewed the patient before contacting the Palliative Medicine Consultant, via the switchboard for telephone advice.

1

Care of the dying person Multi-disciplinary documentation

Written information

Car parking permit

Bexley wing hotel & Take Heart Rooms

Palliative Care Team

Palliative Care

- Homepage
- Referral
- Care of the Dying Person
- Rapid Discharge Home
- Rapid Discharge Home A&E
- Car Parking
- Ambulance
- Education & Training
- Advance Care Planning
- Prescribing Guidance & Medicines Management
- Dying Matters
- Documentation
- Guidelines

Links of interest

Rapid Discharge

Palliative Care Team

What is involved in the transfer from hospital to home for end of life care?

Rapid Discharge Plan (RDP)WUN1176 'Supporting Dying Patients to Achieve their Preferred Place of Care' - a nursing care plan to support the Rapid Discharge process.

Click on the link to see a copy of RDP - click here

Medical Guidance to supplement the Rapid Discharge Plan (RDP) - click here

Guidance to support **Nursing staff** with the Rapid Discharge Plan - click here

Frequently asked questions - Rapid Discharge - click here

Rapid Discharge Flow chart

1. The patient has a rapidly deteriorating condition and the condition may be entering the terminal phase.

2. The patient has expressed a wish to transfer to usual place of residence for end of life care (Home/Care Home).

LTH: Enhanced Supportive Care

- To support patients who have received their last palliative chemotherapy and are stable but prognosis is < 1 year
- To promote timely introduction to support services outside the hospital
- To offer opportunities to consider and discuss future care planning beyond chemo
- To identify alternatives to oncology clinic attendances, promote self-management and prevent crises
- To offer a service in line with Macmillan's Recovery Package

LTH: Education & Priority training

78% Uptake

- **Priority training for clinical staff**
  - delivered to >2500 nurses, Dr's, AHP's
  - 250 consultants attended face-to-face last 2 yrs.

- **Offer wide variety of learning opportunities:**
  - Developing innovative eLearning resources
  - Regular collaborative study days/conferences
  - Experiential learning
  - Successful Medical Student placement

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LTH: The future

- Interface working: *JAMA, JONA, SAU, MAU, ED, CDU, PCAL*
- Response to *Shape of Training*
- **Where do you think we should focus?**

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