**Palliative and End of Life Care integration in Seacroft and surrounding areas Local Care Partnership Bulletin update**

We have made a great start on the work to look at Palliative and End of Life Care integration in Seacroft and surrounding areas Local Care Partnership

We think the story of the summer has been that people have been juggling many different priorities alongside taking time to take holidays after such a difficult few years. Richly deserved. We recognise that the winter is going to be another challenging one!

This means we have not been able to meet face to face as often as we had hoped and also that we have not been able to utilise back fill money to free partners up to attend and there’s some reflection that it can be really difficult to backfill people in practice, especially for clinical staff! There’s also a need for local project management to hold the ring on the work and support partners to move at a pace.

We are going to re-visit this and thought that this brief update might help ensure that people have a full awareness of what is going on across all the work areas and to reflect the potential of the Seacroft opportunity.

We met to establish our aims and our focus and agreed that we would:

* Focus on people who are in the dying phase as first cohort
* Focus on 18 years and over (co-terminus with approach in Leeds and acknowledgment that a different group of partners/services would need to be engaged for a focus on children and younger people) whilst acknowledging that different age groups across an adult population will have different needs
* Increase understanding of the pathway and explore pathway redesign and new models of care working with the community, building upon community assets and strengths and enabling better integration across partners
  + To include the role of the GP and senior clinicians in the final phase of life
* Manual of dying/how to have a good death in Seacroft including a glossary of terms (as something the group would like to develop but there may be other things that fall out of the mapping and redesign phase)

To achieve these aims we have several strands of work

**Community assets workstream**

The community assets workstream is moving forward with some momentum. There is a collection of local residents/bereaved residents and local grass roots and third sector organisations (including local businesses/funeral directors / faith groups) who have an interest in supporting the work and sharing what is important to them. The brilliant LS14 Trust / We are Seacroft Alliance are supporting bringing together this group and holding space for meaningful discussions.

We have a recently bereaved lady who is passionate about getting things right for other people –all of her family live in the local streets of the area so provided hands on care at the end.  She feels she can represent her neighbourhood and say that a lot of families want to provide care and work in an asset-based approach but would like upskilling to do so more confidently.

The local church St Vincent’s provide some bereavement support currently but would like to do more - they provide/link local people with much cheaper funeral services, recognising money can be tight, particularly as a result of the cost of living increase.

The ‘We are Seacroft Alliance’ are doing some great work on the cost of living response and ‘Living well in Seacroft’ so the booklet/practical guide that has been discussed around Dying Well in Seacroft could follow the same tone and lay out.   Please see below which will be posted to every household in north and south Seacroft and will be backed up by a community website – we can share when this goes live. We would value your views on whether this would make a good template for a similar “dying well in Seacroft” leaflet in the future.



We have had some really interesting insights about the bereavement offer at St Gemma’s and lack of take up - around most people in Seacroft not wishing to leave Seacroft, even to go into the neighbouring towns / Leeds city centre (even if they have car/access to transport and money). Residents often feel they have everything they need here (schools, shops, cafes).

Looking at how we could support this work, there are some community venues as suggestions for the next phase.

There are also early ideas around hosting a community podcast around death and dying to normalise how we talk about the topic within Seacroft, even with young people. This could be developed with the amazing facilities and expertise withing Chapel FM.

Also finally, there is interest in a face to face event to bring a breadth of partners together to do some live asset mapping around what support is available locally and how people would like to work together.

**Process Mapping and case studies**

A small group undertook an initial process mapping and the output is attached for any further reflection.



Some of the areas of interest and improvement identified were:

Key considerations within any pathway

* Senior professionals involved at the beginning?
* Managing expectations and being clear about the offer – and ensuring that we work with patients and carers so we know what people actually want, how much care would the family like to do themselves

Areas of improvement

* Explore discharge link – potential to link with LCH triage development (could encompass improvements in areas below)
* Management of the expectations of the community service offer on discharge from hospital
* Availability of equipment
* Anticipatory prescribing and availability of medications
* Focus on care homes
* Consistency of language and understanding of terms

We will progress this work but focus it on a real life Seacroft focused case study so we can really map the Seacroft pathway.

**Ongoing review of cases**

We have also started to consider if there are any existing groups where we could effectively add on the discussions around case studies. One group under consideration is the regular Seacroft frailty MDT as this is a collection of partners who already meet together on a weekly basis to build on and widen representation. There is also suggestion that the learning from the mortality review, led by LCH, could be shared more widely.



**Overall governance / Next Steps**

We will set a date for the overall group to meet again after Christmas and we recognise as we move forward it is key that we have a mix of clinicians to do some of the groundwork with some dedicated project management to keep the meetings in the diary and support the great level of momentum under the leadership of the group and support communications.

**Key actions**

* Digest what we have learnt so far to inform moving forward positively
* Explore options for dedicated local project management resource
* Check that we have right partners engaged including people working very locally on the patch
* Explore governance – is there an option to keep a small design team framing the work, whilst supporting a breadth of partners to move forward with key strands
* Set up re-fresh/re-launch meeting

**Partner involvement**

It will be important to engage the wide spectrum of partners across the LCP as the project progresses.

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| **Name** | **Role** | **Organisation/Sector** |
| Dr George Winder | GP and PCN Clinical Director | Seacroft Primary Care Network |
| Joanna Quigley | Care Co-ordinator /Link worker | Seacroft Primary Care Network |
| Lynette Mullikin | Nurse Associate - Care Homes | Seacroft Primary Care Network |
| Dr Mike Stockton | Chief Medical Officer and Consultant in Palliative Medicine | St Gemma's Hospice |
| Jo Neiland  Eileen Clark and Jennifer Fletcher | Head of Community Services | St Gemma's Hospice |
| Chris Jackson | LS14 Trust Operations Manager and link to We are Seacroft third sector alliance and the community | Third Sector /We are Seacroft Alliance |
| Geraldine Montgomerie | Partnerships and Engagement Manager - Swansong Project | Third Sector /Swansong Project |
| Victoria Tate | Clinical Pathway Lead - neighbourhood team | Leeds Community Healthcare |
| Clare Pennells | Clinical Quality Lead - neighbourhood team | Leeds Community Healthcare |
| Carol Atkin | Health Case Management Team | Leeds Community Healthcare /Leeds city council |
| Hannah McGurk | Health Improvement Specialist - Older People | Public health - Leeds city council |