Leeds Palliative Care Network

Seacroft
Dying Well in the Community Project

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Presentation to LPCN Group
27th March 2024

Background

- Dying Well in Leeds Project - the aim of the project is

To improve the transfer of patients between all providers to ensure continuity of care and patient experience

- Three key action areas after Phase 1
  - Updating the service offer
    - Working to integrate community services in local areas
    - Developing a glossary of terms
    - Ensuring that all staff are able to recognise and support people who are at the end of life
  - Scoping Citywide Single Point of Access for Palliative and End of Life care
  - Working to maximising efficiency and increasing resources available to support death in the community

Why Seacroft?

- we knew this was too big to try city wide
- Seacroft had a range of factors in its favour
  - LCP and PCN were well developed
  - there was real enthusiasm for EoL
  - there had been a meeting between senior leadership in the PCN and the hospice
  - there was an active third sector
  - it was coterminous

Despite this

- project process – getting people engaged took longer than expected
  - there was great commitment from senior management but people are busy
  - project support was needed
  - core group changes
  - started looking at the very end of life but needed to look earlier – as last few weeks often works well
  - recognition that it is a small part of primary care's work

Project progress

- a core group of professionals meeting monthly
- a grant was obtained to run Death & Dying conversations with the Seacroft Community
- respiratory City-wide work gave a focus and patient stories have been developed
- strong third sector and mature links with community members/citizens - the strength of communities and community methods

LS14 Trust
& Seacroft pantry

Our target population is 3 LCPs in IMD1 – this is the size of that population

11790 people recorded as End of Life and/or living with severe frailty

4756 people had a hospital admission

of these

1081 admissions (23%, nearly 1 in 4) were due to a respiratory condition

of these

365 (34%) living within IMD 1

of these

Data going forward will be based on these 231 people

64 People Crossgates PCN

95 People Middleton and Hunslet PCN

72 People Seacroft PCN

20 people within IMD 1

70 People within IMD 1

38 People within IMD 1

Whole population – 231 people

IMD1 – who we want to focus on most of all

2022/23 data

Purpose of the engagement plan

The overarching question is 'is it possible to reduced admissions for people at the End of Life for Disease of the Respiratory System with a particular focus on Seacroft, Cross Gates and Middleton and Hunslet LCP areas and how could we do this?

The hypothesis opposite were developed in a workshop focused on this question in January. The aim of the engagement is to look to validate these further through:

- Understanding the views of people
- Understanding the views of staff
- Understanding the patient journey
- Further analysis of the data

We also want to consider how we could get people out of hospital more quickly.

End of project appraisal

Several views

- qualitative and quantitative
- interviews with key players on lesson learnt
- gather “soft” intelligence what is working differently
- a stakeholder survey to establish
  - what has changed/improved in 12 months
  - the ongoing partnership infrastructure 'the project legacy’
  - ongoing pieces of work
  - the ingredients needed for organisations to better support people to die well in the community
  - what can be 'lifted and shifted' and applied across Leeds

Some emerging themes

- (how close to) the end of life – started out looking at the last two weeks but moved earlier
- focussing on a specific EoL cohort – respiratory work was a blessing
- locality models of working is powerful
- third sector infrastructure (it's not what you know...)
- don't separate the clinical and the social - social prescribing and care coordination needs embedding in a clinical team
- strong third sector and mature links with community members/citizens - strengths of communities and community organising methods

Project legacy

- partnership and relationships
- awareness of solutions within the community – who does what
- partnership infrastructure
- agreed areas to develop – coming from the patient stories and a degree of trust to work together

09:19 5G

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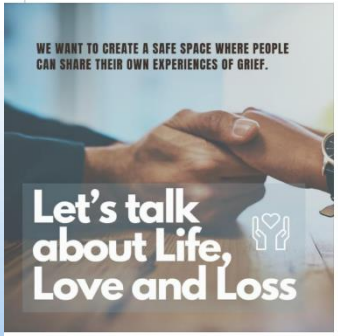
1 Dec ·

🌟 This week, we had a great event to talk about life and loss. Our aim was to create a safe space where people could share their own experiences of grief. Co-produced with Jo and Laura from Projecting Grief. A front room feel, wrapped in comfort and warmth to try and normalise talking about grief ❤️

🖼️ A snippet of their exhibition is on display in the pantry.

🤝 Are you currently looking for support?

We hope to be able to run another event soon!



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Local Care Partnership ensuring the project legacy

- emerging themes from the clinical work – to repeat with other areas of end of life and LTC
- potential investment in an end-of-life care coordinator
- third sector empowered (and paid) to support the work of the core group
- core group members to continue meeting
- PCN and third sector holding community death and dying cafes with different themes each month
- community grants and local support groups and buddies being tested