Leeds Palliative Care Network

Annual Report 2022-2023

Prepared for

West Yorkshire Integrated Care Board in Leeds

June 2023

Foreword

The Leeds Palliative Care Network, now in its seventh year, is firmly established as a key facilitator of palliative and end of life care (P&EoLC) in Leeds; working with the End of Life Care Board to inform and deliver citywide population outcomes.

Central to this success is the spirit of co-operation and innovation that underpins the network's collaborative approach and comprehensive programme of work.

The LPCN supports over 20 initiatives that map to all seven outcomes in the 2012-26 P&EoLC strategy from personalised care to compassionate communities. Significant progress has been made in key domains such as timely recognition of people approaching the end of life, targeted interventions to address inequities, and focused delivery of citywide education and training.

Leeds has good reason to be proud of its P&EoLC infrastructure: 24/7 access to generalist and specialist support across all settings, digital advance care planning, a dedicated palliative care ambulance, cross sector carer and bereavement support and a committed Dying Matters collaborative. Nonetheless, there is more do.

Nationally, Leeds is one of the best performing localities with regards to minimising disruptive unplanned hospital admissions in the last months of life. Most adults who specify their preferred place of death are cared for in their chosen setting. Yet only half all adults are recognised to be approaching the end of life and supported to participate in digital advance care planning. City-wide access to digital advance care plans remains hampered by limited interoperability between electronic systems.

Whilst public feedback from Healthwatch and the Bereaved Carers Survey demonstrates high levels of satisfaction with many aspects of care, improvement is required to: enhance the co-ordination of services, make it easier for the public to navigate care and ensure symptom management and psychosocial support are of a consistently high standard wherever care is received.

There is more work to do with the diverse communities of Leeds to understand and meet their P&EoLC needs. Existing feedback and analysis of routinely collected data has started to shape an understanding of inequities in Leeds. Moving forward it is critical that public engagement genuinely reflects the whole population, big-data is linked and utilised effectively, and missing data such a sexual orientation is sensitively explored and routinely included in P&EoLC datasets.

The work described in this year's annual report reflects the commitment of P&EoLC providers and partners to work collaboratively to drive improvements in care, despite significant capacity, workforce and resource constraints. As the financial challenge intensifies this collaborative and innovative approach is vital to ensuring the Leeds P&EoLC pound is spent as effectively as possible supporting essential services in a sustainable and equitable way.

Dr Adam Hurlow, LPCN Chair

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LPCN Annual Report 2022-2023

Introduction

As a collaborative partnership group, Leeds Palliative Care Network (LPCN) is committed to the highest quality, consistent, equitable and sustainable care in the final phase of life. It brings together health, social care and academic professionals across Leeds, provides strong partnerships and transcends traditional boundaries to bring about systems wide change. LPCN is constituted as a Managed Clinical Network.

The purpose of this report is to provide the ICB in Leeds with ongoing assurance of the effectiveness of Leeds Palliative Care Network as a delivery model for the improvement of services for the people of Leeds. Leeds End of Life Population Board will also receive the report.

The report will be useful for LPCN partners to be able to evidence the benefit and impact that we have collectively. It provides a report of activities and achievements during 2022 / 2023 and highlights plans for the future.

The year remained challenging for all partners as the health and care system balances the impact of the Covid pandemic and recovery from it, increased service demands across the system, recruitment and retention of a skilled workforce and managing industrial action.

Capacity to deliver frontline services and maintain a programme of service improvement has therefore required commitment, dedication and acceptance of some delay, at times, to planned activity.

Throughout, the LPCN continued to provide facilitation and direct support through the administration of system wide meetings, securing additional people to support the project work and the continued development of additional guidance and learning materials hosted on our website, which is accessible to all.

Maintaining Effective Governance and Communications

During 2022/23, the LPCN along with all its partners adapted to the changing governance infrastructure as the West Yorkshire Integrated Care Board came into effect. This brought about a change in aligned commissioners and a new Leeds End of Life Population Board (the Board).

The Chair of LPCN is a key member of this Board enabling LPCN to provide insight, inform and influence strategic planning and decision making for the future. LPCN functions as a clinical reference group for the Board.

It also saw the creation of a West Yorkshire ICS level Palliative, End of Life Care (PEOLC) group, and sub groups, which the LPCN have ensured its members, have attended to maintain input, influence and strong wider partnership links. Once the ICB became a formal structure LPCN updated the governance page of the Terms of Reference and shared with the key partners.

The LPCN also links closely with the regional Strategic Clinical Network receiving regular updates from the national team.

There have been some changes to LPCN Executive membership this year.

There have been changes in Leeds Community Healthcare Trust LPCN Executive role resulting in Sarah McDermott re-joining as their representative in November 2022. Chris Bonsell became the new Medicines Management lead in April 2022.

Taking account of the phased start of term in office and ensuring continuity of business during a time of change Dr Adam Hurlow has kindly agreed to remain as Chair and Clinical Lead for a further year; enabling a managed approach to succession planning.

The LPCN Group saw continued increase in membership, particularly from colleagues within the third sector and new professional roles and maintained good attendance.

LPCN maintains a **risk register** to note all risks for the LPCN and a **systems issues log** that enables partners to highlight issues of concern that require collaborative action to resolve. These are discussed at every LPCN Executive and LPCN Group meeting and have, for example, resulted in supporting system resilience, purchasing and distributing syringe drivers to care homes with nursing, collecting data and sharing information about anticipatory medicines and medicine shortages, working to improve data and interoperability, helping find funding solutions for at risk services. Partners are also able to share incidents that require cross organisation responses to resolve.

LPCN Executive team reviewed its projects to agree priorities and monitored actions against the strategic outcomes throughout the year.

LPCN Communications

Twitter Analysis

	1 April 2022 – 31 March 2023
Followers	455
Impressions	3410
Likes	31
Retweets	11

Web stats

	1 April 2022 – 31 March 2023
Users	5,700 users
Page views	30,107
Most popular pages:	End of Life Care Learning Outcomes Advance Care Planning Medicines Management Respect Training Resources Resources Service

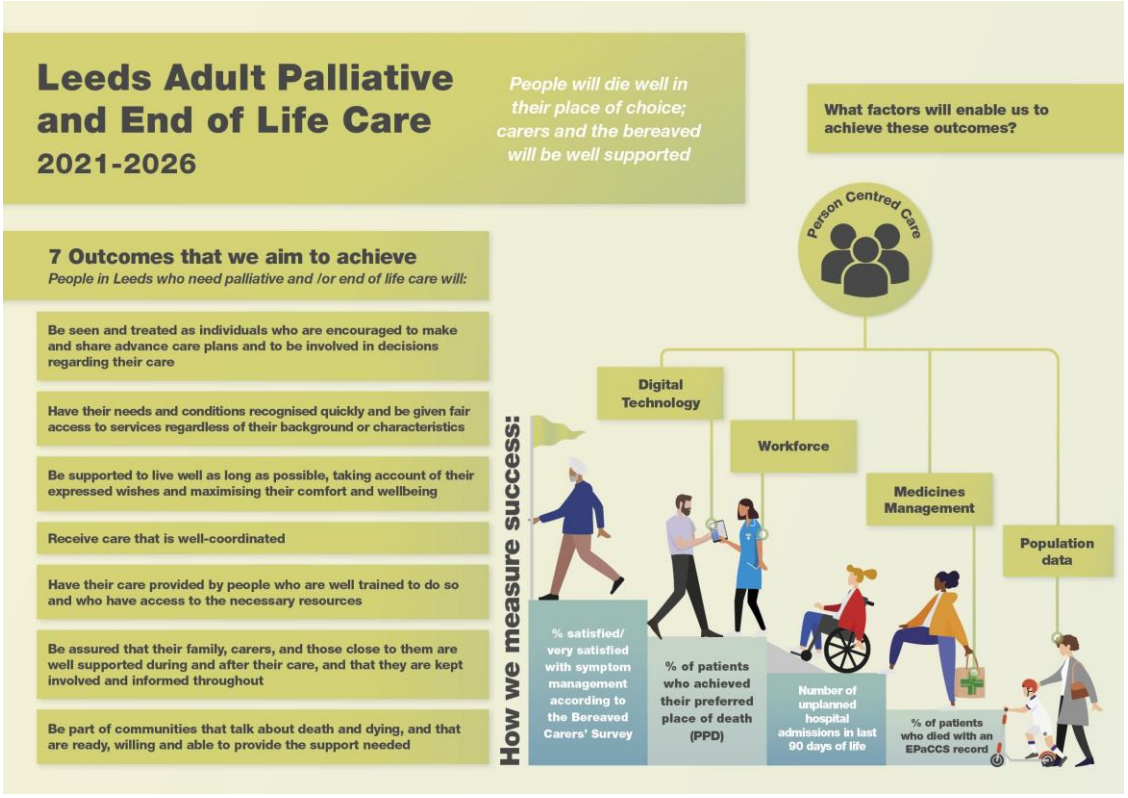
Highlights for the year include:

- In total 63 new downloads were added to the website including programme updates, guidance, training resources and news articles.
- Six news bulletins issued throughout the period to the 132 subscribers on our mailing list.
- The LPCN website was migrated to a new platform in December to ensure it is secure for the future, with the potential for ongoing development work to be completed.
- LPCN conducted a citywide EOLC communications review to assess current patient leaflets and online information. LPCN's own patient leaflet reviewed to ensure it is accurate and the information is succinct and accessible. The new leaflet expected alongside an easy read version in 2023.
- Our communications work supported and promoted the Bereaved Carers Survey, the Team Leeds work programme and Dying Matters Week by sharing information on social media, on our website and through our bulletins.

The Leeds Palliative and End of Life Care Strategy was finalised and published in June 2021 with LPCN executive members being key authors.

The strategy brings together diverse people, professions, perspectives and possibilities to help deliver a care system that is fit for the people of Leeds and to deliver the vision:
“People will die well in their place of choice; carers and the bereaved will be well supported”

The population outcomes developed for this strategy have continued to direct the work plan for the LPCN.



LPCN quality improvement projects and work streams continue to support delivery of the outcomes and report into the Board.

LPCN Quality Improvement Programme Updates

The programme of quality improvement work continued in line with the agreed Strategic Population Outcomes and Enablers shown above. The programme overview is collated monthly reporting project updates.

Unsurprisingly a few of the improvement working groups and projects have been put on hold due to Covid-impact and reduced capacity; others have continued but have seen some delays.

Below is a short summary of achievements over the last year that support each Outcome. Most projects influence more than one outcome but are highlighted against the one where the main impact is most likely.

Outcome 1 – People that need P&EOLC will be seen and treated as individuals who are encouraged to make and share advance care plans and to be involved in decisions regarding their care

LTHT Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Audit

Initially delayed due to IG issues and the need to have a data sharing agreement in place. Transferred anonymised data to University of Leeds for 24,700 unique patient records, once the DSA agreed. The data has undergone provisional analysis and final report expected shortly.

Improving Planning Ahead

This work is ongoing to improve the personalised approach to planning care through use of What Matters to Me, ReSPECT and the Electronic Palliative Care Coordination System (EPaCCS).
The Professionals Records Standards Body published the national information standard for end of life .
The working group reviewed Leeds templates against this standard, making recommendations and changes that were required; changes were minimal as the templates and tools used meant we were already essentially compliant.

LPCN commissioned a further audit of community ReSPECT and citywide patient experience. Initial planning is underway to design the audit process with academic colleagues.

The group also supported and informed work led by Leeds Public Health colleagues to develop a pre-advance care planning booklet entitled 'What if things change' , which can be used by any member of the public with professionals directing people how and when to access it.

The advance care planning (ACP) and ReSPECT training pages on the website were updated and improved to support clinical practice whilst significant training to enable use of all the Planning Ahead tools has been delivered.

Outcome 2 - People that need P&EOLC will have their needs and conditions recognised quickly and be given fair access to services regardless of their background or characteristics

Equality Diversity and Inclusion

Established to support strategic objectives to identify and address inequities in P&EoLC this new group developed an initial work plan and started to collate information about potentially marginalised communities.
The group actively supported a bid for health inequalities funding to undertake development work to be able to monitor sexual orientation and gender identity. Sue Ryder Wheatfields Hospice is leading the project that will trial a mechanism for gathering data as well as training professionals.
The Marie Curie Dying in Poverty Report was debated taking account of the current cost of living crisis and recommended to the Board for further debate.
Ensuring adequate capacity to undertake all aspired actions and lead the group has been difficult. An extended meeting in May 2023 will discuss plans on how to maintain the group and move forward.

Timely Recognition of EOL

The project aims to develop a digital search tool embedded in primary care electronic patient records that enhances recognition of people approaching the end of their life to use in the community in Leeds. The Yorkshire Strategic Clinical Network and the Leeds Ageing Well Fund supported it.
A senior Clinical Lead and three other clinicians are working with Central Local Care Partnership to test the tool. An EMIS version of the searches trialled successfully and a System One version is now ready for testing. Data sharing agreements are in place and colleagues from the Academic Unit of Palliative Care are in the process of gaining ethics approval to enable effective evaluation and validation of the tool.

If the tool proves to be useful in supporting primary care to recognise and support people and their families at end of life and enable increased advance care planning and holistic support, LPCN will support the broader implementation to primary care in Leeds.

The project group have also been sharing their learning and experience with a regional group and partners across West Yorkshire.

Homelessness / Inclusion Service

This new service has seen a steady growth in demand and caseload size. An agreed service model enabled successful recruitment into a full time Nurse Consultant and part-time CNS post. Recruitment for a Peer Navigator is ongoing in collaboration with Leeds Community Healthcare. The Nurse Consultant is developing a standard operating procedure and data suite to ensure consistency of service offer and ability to monitor impact.
LPCN funded a training programme for third sector providers to this vulnerable population. This will enable 120 frontline staff to be able to recognise when someone is deteriorating and know how to access help required in a timely way.
There is no recurrent funding for this service, now considered at risk. Existing non-recurrent funding will enable the service to continue during 2023. Partners will work to identify a solution.

Outcome 3 - People that need P&EOLC will be supported to live well as long as possible, taking account of their expressed wishes and maximising their comfort and wellbeing

Bereaved Carers Survey

The Bereaved Carers Survey was open from February to the end of April 2023; with responses expected until the end of June. The survey content and process was further improved taking account of the changes this year in death registration processes.
The Registrar's Office and Healthwatch Leeds provided support. The survey will report in the autumn.

Actions identified following the 2021/22 survey were completed and found here.

Respiratory / EOL Pathway (New)

The CCG asked LPCN to take over this group during transition to ICB. It first met in July 2022 and has since agreed Terms of Reference, secured a Clinical Lead / Chair (Alison Boland), has an active membership from all key partners and held a facilitated workshop to review pathways for people with breathlessness and advanced disease.
Outputs from this workshop will identify where changes have been made since 2018 and where there are opportunities for further improvement. The group then hope to scope out and share each partner organisations service offer and see if further integrated working would add value; building on the existing MDT.

Heart Failure

Palliative cardiac MDTs continued monthly throughout the year. The consultant is planning an evaluation on how to evidence benefits of the MDT for patients. Leeds Teaching Hospital Trust Specialist Palliative Care team are to discuss referral pathway for inpatients.
The group identified a need for ACP training for cardiology staff and the consultant is seeking resource.
Dr Jason Ward has written new symptom management guidelines for patients with Advanced Heart failure. They are now for circulation via LPCN evidence into practice group to finalise and ratify. There is a plan to map this Leeds service against Hospice UK recommendations and identify gaps.

Leeds Palliative Care Ambulance

Despite challenges with meeting due to capacity, the operational group delivered significant improvements during the year:

- The Palliative Care Ambulance patient information leaflet was finalised and published and a poster created.
- A new algorithm was developed and agreed to support booking the ambulance with different categories removed for ease of planning and transaction.
- St Gemma's AUPC delivered training to the palliative ambulance crew on end of life care and management.
- Yorkshire Ambulance Service YAS governance procedures are ratifying the refreshed SOP prior to circulation.
- The annual improvement plan has been RAG rated and updated.
- Quarterly activity reports shared with all partners.
- The LPCN logo now features on the newest palliative ambulance, with a second replacement ambulance expected soon.

Demand has outstripped capacity on occasion with the need to use other PTS or emergency transport. There is now consideration within YAS administration and booking team on how they can capture requests for transfer that they have to decline due to capacity and time limitations.

Evidence into Practice (New)

Following review of activity against the strategy LPCN agreed to start an Evidence into Practice Group. This group, as it becomes more established, will serve to ensure Leeds wide practice is utilising up-to date evidence, revising and updating existing guidance, identifying evidence and guidance gaps and providing a forum for clinical and academic partners to discuss and disseminate current research findings.

The group first met in November 2022 and have agreed to meet quarterly to enable review of guidelines due for review. It has agreed its terms of reference and membership.
The group has updated the patient information leaflets for community management of seizure and for palliative patients at risk of bleeding. These will be published by July 2023 on the website and Leeds Health Pathways. LTHT Medical Illustrations Team provided invaluable support to this work for which LPCN are grateful.

The Group have commenced a review of current anticipatory practice following consideration of new academic evidence produced by teams in Southampton and the University of Leeds about improving access to medicines in palliative care .

Dementia

The group oversees and supports three key work streams:

Advance Care Planning (ACP) – This year has been about input into the development of local and regional tools that support clinical practice and people in the community to engage in discussions, record their wishes and plan for future care. We have promoted these tools, including an 'easy read' version, widely via our network, twitter and the website.

See Planning Future Care page and Advance Care Planning page .

End of Life Admiral Nurse post(s) for Leeds – The final proposal is with the ICB and commissioning colleagues. The group agreed to monitor the impact on the system and peoples experience of other new Admiral Nurse posts appointed with funding support from Dementia UK; two nurses are in primary care to support newly diagnosed patients with planning and care, and two nurses in LTHT to facilitate discharge.

Pain and Symptom Group – The sub group continues to develop a NHIR grant application to secure funding for research into tools that support pain and symptom management and their use in clinical practice.

Outcome 4 - People that need P&EOLC will receive care that is well-coordinated

Transfer of Care – Hospital / Hospice

The group has met regularly and remained proactive.
An agreement to support discharge into hospices through offering patients a choice of hospice for end of life care enabled improved use of available nurse led beds during system pressures and has continued since. Reviewed the SOP that supports discharge. Sharing of outcomes from LTHT Palliative care team support in LTHT Emergency Department led to consideration of further improvements.
Timely access to patient transport has also remained high on the agenda with colleagues from YAS joining the group.
Recent review of the Discharge Checklist has resulted in a plan to discuss the existing agreement regarding which medications are supplied by the hospital to hospices on transfer of care, with reference to the anticipatory medicines audit and a focus on minimising medication waste and optimal prescribing.

Leeds - Dying Well in the Community

This ongoing and significant project used a Whole Systems Approach and active engagement of over 100 frontline professionals and feedback via Healthwatch Leeds from patients and their families.
All the feedback and analysis during Phase 1 resulted in the development of five common themes, with three key actions identified for service redesign during Phase 2 of the project.

Updating the service offer – **integrating local services**
This resulted in a project focused in the Seacroft Locality to consider what opportunities there may be in further integration between frontline staff and engagement with the community / third sector. The group gathered initial intelligence on activity and considered how case studies might support further insight into practice.
Appointment of a Project Lead to ensure project focus, evidence outputs and collate possible service improvements.
The project group have now agreed to focus on:
Workstream 1: baseline understanding of roles and responsibilities
Workstream 2: public and professional information offer and social marketing campaign
Workstream 3: training with links being made to the offers funded by LPCN

A further Local Care Partnership have now agreed to undertake a PEOLC project – Morley. This will commence next year.

Single Point of Access (SPOC) for EoLC in Leeds.
A specifically appointed project lead undertook a full scoping exercise for the need for a SPOC in Leeds. Consideration of the subsequent briefing paper and options appraisal by the End of Life Population Board resulted in recognition of the challenging current financial environment and the need to further maximise exiting resources and relationships to improve 24/7 access and support.
Partners are now considering how best to take this forward taking account of other existing service and organisational change.

Increase in resources to support people being able to die in the community.
Overall, just under half of all adults in Leeds continue to die in an acute hospital setting. The shift from people dying in care homes to dying at home that started during the pandemic persists. These trends reflect the national picture.

The End Of Life Population Board are aware of the increased demands for palliative end of life care across all settings alongside the challenges posed by a shift in people choosing to die in their own home rather than residential settings, and are seeking to monitor activity levels, impact on service capacity and on patient experience.

Outcome 5 - People that need P&EOLC will have their care provided by people who are well trained to do so and who have access to the necessary resources

Training and Education

The LPCN Education Executive Lead had a period of absence this year so the newly appointed Clinical Educator provided additional capacity and support to the LPCN whilst taking forward education plans.

Delivery of Planning Ahead Training continued with 35 delegates completing the training between October 2022 and March 2023; with a total of 150 people now being trained.

ECHO – The Clinical Educator completed emersion training for ECHO delivery. A new ECHO programme for GPs and wider Primary Care Network colleagues is due to commence in June 2023, with 15 people signed up. A further programme for Allied Health Professionals (physiotherapists and occupational therapists) is developing, with a curriculum-setting day planned in June; 13 delegates have registered to join so far.

Care Home Education Strategy – A new group met to agree in principle the scope for the strategy. Write up of detailed insight into existing practice and subsequent issues and gaps following one to one interviews is ongoing. The bereaved carer's survey supported analysis of key themes to focus on in the strategy. Now planning a second workshop to agree the key goals and next steps.

Review of Advance Care Planning Training
Following meetings with partners across the system the Clinical Educator gained an understanding of current resources used and training offered by different partners. Circulation of the subsequent report is due shortly.

Design and delivery of Homelessness training
The homeless team delivered a successful trial training session to third sector colleagues earlier in the year. As a result, LPCN approved funding to deliver 6 sessions to frontline staff working with homeless and vulnerably housed people.

Resources – Syringe Drivers

Partners procured, tested, transferred ownership and distributed 25 new syringe drivers to care homes with nursing. This required essential support from LTHT Medical Physics department. The group continues to meet to ensure distribution of all procured syringe drivers and training in use is delivered for all frontline clinicians.

Outcome 6 - People that need P&EOLC will be assured that their family, their carers and those close to them are well supported during and after their care, and that they are kept involved and informed throughout

Family and Carers Information

A new website and leaflet review group formed. They completed a pathway for information needs and an audit of information help on the website. Gained agreement to improve and add to the information held on the website following review of content.
The group is also redesigning the current patient and carers leaflet so it is simpler and provides up to date information about services available to people at the end of life and their families. With support from colleagues working in learning disability services, there will also be an easy read version developed to promote inclusivity.

Outcome 7 - People that need P&EOLC will be part of communities that talk about death and dying, and that are ready, willing and able to provide the support needed

Dying Matters

Despite reduced capacity in the Public Health Team, the Dying Matters Partnership continued to meet**.**

Dying Matters week was very successful in 2022 utilising network partners, bus stop adverts, the press and social media to promote the theme 'In a Good Place to Die'. A well-attended public event took place in Kirkgate Market.
Eleven community grants for 2023 worth £5,000 to support events for Dying Matters week in May 2023 were reviewed and approved.

Partners were encouraged to host creative sessions in the 1001 Stories Takeover of the Leeds Playhouse the week before Dying Matters Week, aimed at those over 60 sharing their stories.

A new public resource for people to consider broader areas relating to advance care planning and dying matters was developed. Healthwatch are undertaking a small-scale public engagement. They will report to the Dying Matters Partnership and develop dissemination and training plan.

Enablers

Medications Management

Access to medicines, particularly anticipatory drugs during out of hours, has been a concern this year. Supply via the warehouses of some drugs has been challenging with advice provided on alternative medicines and doses.
Partners have been collating data and reporting to West Yorkshire ICB. A new West Yorkshire pharmacy group has been established to look at how access might be improved and to ensure the new local palliative care drugs service for West Yorkshire meets people's needs.

Anticipatory Medicines Audit
A 3-month audit of use of anticipatory drugs in the community is complete and data is being analysed with support from academic colleagues in the AUPC. A report of findings is being drafted and the anticipatory medicines group will reconvene to consider recommendations made.

E- Prescribing for Hospice Outpatients and community services
This project is on hold pending support and input from The Phoenix Partnership (TPP), the company that provides the patient information management system – SystmOne. We note that Leeds Community Healthcare staff now have e-prescribing access, which is positive.

Population Needs

LPCN is the clinical advisory body that provides advice and support, and informs and influences the activity of the Leeds End of Life Population Board.
All of our collective actions and programme of work supports the delivery of the Boards aspired outcomes. This year LPCN and particularly the Chair has been active in sharing population level data and seeking to help the Board understand this population and their needs.
LPCN continue to host and input into the citywide informatics and metrics sub group. The clinicians support the ICB data quality team in identifying data sources required and interpreting data reported. An expanded data sharing agreement allows more detail of marginalised group service activity.
Quarterly Planning Ahead reports are widely shared, informing local understanding. New data items provide additional information about ethnicity, patient and family engagement in planning, support for different disease groups, ReSPECT status, and prescribing of anticipatory medicines.

EOL Metrics

Planning Ahead reports demonstrate maintained performance against key metrics. Approximately half all adults who die in Leeds continue to be recognised to be approaching the end of life and supported to participate in digital advance care planning; Planning Ahead (EPaCCS) and/or community ReSPECT. Achievement of preferred place of death, for those who have specified as setting in community digital records, remains approximately 80%. In contrast to all people who die in Leeds only a small minority of those with a preferred place of death die in hospital.

National data supplied by the Office for Health Improvement and Disparities shows Leeds to be one of the best performing localities with regards to minimising disruptive hospital admissions for people with a short prognosis, with less than 5% experiencing 3 or more unplanned admissions in the last 90 days of life. The upcoming Bereaved Carers Survey will provide an up-to-date picture of satisfaction with symptom management for people who died in all settings across Leeds and the extent to which progress has been made against action plans linked to the last survey.

Leeds Dataset

Following significant work to resolve data protection issues and finalise data sharing agreements, Leeds hospice activity data is now flowing into the Leeds data model. This enhances information about care provided to people at end of life.

We understand that items within the Planning Ahead data sharing agreement (DSA) are now available for all adults who die in Leeds, rather than just those with Planning Ahead. Now this is available for business intelligence and academic analysis we look forward to gaining to a more comprehensive picture of: access to advance care planning, both Planning Ahead (EPACCS) and community ReSPECT, its impact, completeness and any inequities at a population level.

Despite good progress to resolve P&EoLC deficits in the Leeds Data model, there are further development opportunities. Work is ongoing to agree the flow of data from Leeds Teaching Hospital's digital ReSPECT to provide a complete view of advance are planning across all settings. As new Leeds Teaching Hospital specialist palliative care and care of the dying documentation goes digital there will be opportunities to enhance the Leeds Data Model to reflect access to key P&EoLC services and interventions citywide.

Whilst the enhanced Planning Ahead (DSA) incorporates a greater of potential drivers of inequity such learning disability, serious mental illness and other longer conditions it remains focused on community advance planning; only one of a number of important P&EoLC services and interventions. In order to obtain a richer citywide understanding of access to, inequities in and impact of P&EoLC more broadly work is underway with business intelligence and academic partners to develop an extended whole city P&EoLC linked data-set including access to holistic needs assessment, specialist palliative care and CHC Fast Track. If successful EDI work to enhance routine collection of missing data – gender identity and sexual orientation-will further enhance our capacity to understand inequities in P&EoLC.

Workforce

Recruiting and retaining skilled and competent workforce remains a challenge, though specialist palliative care remains an area of high interest for clinicians.
LPCN ensured representation at the West Yorkshire ICS PEOLC workforce group. This group have reviewed the ethnicity of the specialist palliative workforce to understand how well it reflects the community they serve. This group has not met for some time due reduction in leadership capacity.
There has been considerable investment in personalisation and advance care planning training, which LPCN has actively advertised and promoted across Leeds.

Digital Technology

EPaCCS/ReSPECT: sharing care and treatment recommendations between electronic patient records

The inability to share real-time care and treatment recommendations between hospital and community electronic records remains an on-going and intractable source of risk. The LPCN continues to support efforts to address this issue at a regional level through the Yorkshire and Humber Care Record (YHCR). Work so far is yet to yield tangible changes for the sharing of critical P&EoLC information in Leeds. The LPCN continues to offer advice for solutions that address Leeds's risks in a timely way whilst supporting the wider goals of the YHCR.

Other Developments and Projects

The LPCN maintain strong relationships with wider partners across the city and links into projects that are led by others but impact on palliative and end of life care.

Winter Planning / Industrial Action

No specific PEOLC group to oversee decisions and actions to support system pressures and the impact of winter was required. Instead, the LPCN Executive had a standing item on the agenda and wider members engaged as necessary via the LPCN Group.
The partners responded effectively when a serious incident in LTHT required patients to move within hours. Reflection post event identified further learning opportunities.
The agreements formulated via the transfer of care group also helped with outflow; to be reviewed in June.
Industrial action resulted in some project group meetings postponement as clinicians moved to frontline delivery, but clinical services in specialist palliative care continued.

Mental Health Therapist Post

LPCN facilitated discussions between providers to gain agreement on temporary funding for this psychological therapy post for next year. Both hospices are contributing 50% each and LYPFT waived their overhead charges.
The post remains at risk however, as no recurrent funding is yet available.

Community ReSPECT Group

This group has been instrumental in the development and roll out of ReSPECT outside of hospital. It is an essential part of all the work across Leeds in improving the Planning Ahead template. The group ended with plans for a celebration of achievements and closure report. The LCH LPCN Executive Lead is now a member of the national RESUS Council ReSPECT subcommittee, ensuring we retain vital links and remain up to date.

Person Centred Care Expert Advisory Group

LPCN has representation on the 'Person Centred Care Expert Advisory Group' and actively supports developments related to personalised care, advance care planning and shared decision-making.

We circulate the Leeds Personalised Care and Support Bulletin across the LPCN.

Finance Report

LEEDS PALLIATIVE CARE NETWORK FINANCE REPORT April 22-March 23									
WORKFORCE									
Roles		**Budget 22/23**	**Q1 actual**	**Q2 actual**	**Q3 actual**	**Q4 actual**	**Actual 2223**	**Actual Left**	**Comments**
LPCN Management Clinical & Admin		£82,645	£22,502	£22,243	£20,178	£20,328	£85,251	-£2,606	
Clinical Practice Educator & Admin		£58,840	£10,276	£12,344	£13,235	£13,112	£48,968	£9,872	
ELM/Comms		£10,507	£800	£1,000	£800	£3,100	£5,700	£4,807	
Sundries / expenses		£1,217		£263			£263	£954	
Website		£2,627			£276	£2,800	£3,076	-£449	
Overheads		£13,530	£4,400	£3,300	£3,300	£3,300	£14,300	-£770	
Inflationary uplift		£4,507					£0	£4,507	
Final amount for recharge purposes 22/23		**£173,872**	**£37,977**	**£39,150**	**£37,790**	**£42,640**	**£157,558**	**£16,314**	
Total underspend regular funding 31.3.22	**£99,499**								
Expenditure from underspend:									
SUPPORTcampaign promotional materials	**-£1,057**								
Seacroft integration project	**-£21,320**								
ReSPECT Audit - Research Grant / Leeds AUPC	**-£15,883**								
Banner Promoting and Supporting Advance Care Planning Conversations	**-£331**								
LTHT CSW's Training	**-£30,385**								
Homeless Training	**-£5,500**								
Increase to contingency	**-£5,000**								
	£20,023	B/F prior years							
Left to spend 2223	**£16,314**								
Remaining balance pipeline bids	**£248,512**								
Total	£284,849								
Balance 2253	£284,849								
PROJECTS									
Title/Workstream	**Q1 22/23**	**Q2 22/23**	**Q3 22/23**	**Q4 22/23**	**Spend to**	**Actual left**			
Citywide Bereaved Carers Survey				£2,500	£2,500	£1,938			
Implementation of E prescribing - Moira Cookson					£0	£4,029			
EPaCCS Planning Ahead training and development				£504	£504	£35,525			
End of Life Dementia Care	£450	£450	£450	£450	£1,800	£1,340			
Project ECHO Hub	£5,390	£4,926	£6,303	£5,404	£22,023	£20,153			
Heart Failure MDT cover	£2,001	£2,001	£2,001	£2,001	£8,004	£216			
PHM programme backfill				£2,569	£2,569	£3,367			
Community Flow Improvement project, inc SPOC	£10,710	£8,010	£7,746	£4,950	£31,416	£52,126			
Timely Recognition Project			£1,876	£9,415	£11,291	£41,233			
Nursing Home Syringe Driver project	£26,064				£26,064	£0			
Leed P&EOLC MH Therapy	£28,709				£28,709	£0			
Contingency fund					£0	£15,000			
Care Homes Clinical Educator role	£2,625	£921			£3,546	£16,454			
Diverse Leadership					£0	£21,000			
SUPPORT campaign promotional materials		£811			£811	£246			
Seacroft Integration project		£21,320			£21,320	£0			
ReSPECT Audit - Research Grant / Leeds AUPC			£15,883		£15,883	£0			
Banner Promoting and Supporting Advance Care Planning Conversations				£331	£331	£0			
LTHT CSW's Training					£0	£30,385			
Homeless Training					£0	£5,500			
Homelessness project	£8,426	£7,910	£6,496		£22,831	£0.00			
Total	**£84,375**	**£46,349**	**£40,755**	**£28,124**	**£199,602**	**£248,512**			

Dynamic financial management means the LPCN budget remains in a positive position; with expenditure on events, travel, sundries, promotional materials etc. reduced due to continued virtual working.

With active engagement in all groups from partners, LPCN has received seven proposals seeking funding, approving six. These include:

- Promotional materials for LTHT SUPPORT campaign
- Seacroft Integration Project
- Research Grant for the citywide ReSPECT Audit
- ACP promotional banners in LTHT
- Homelessness training
- Training of 2,000 clinical support workers in LTHT in EOLC skills

The LTHT clinical support worker funding has not been required yet, but recruitment for the fixed term clinical educator is underway.

LPCN successfully bid for NHSE funding to support the scoping of SPOC work under their 24/7 workstream umbrella. LPCN received £70,000 via the ICB.

The need to urgently identify a new website provider in December resulted in additional spend for the website to be made secure. Further design and development work is now underway.

The contingency fund increased slightly to take account of additional risk for new workforce employment for LPCN by St. Gemma's as the host organisation.

LPCN review underspent project funding to consider ongoing need for the funding and where appropriate reimburse the project fund, enabling funding of further activity.

LPCN anticipate with increases in salary and other services that next year will see some financial challenge on core budget and will review its commitments accordingly.

Future Plans 2023 and beyond

Supporting the whole system at a time of financial challenge will significantly affect plans. Priorities generated by the Board will inform and influence the LPCN programme of work.

Emerging pieces of work for next year include:

- Continued implementation and evaluation of the Phase 2 of the Dying Well in the Community project, focusing on the Seacroft and Morley projects and 24 / 7 support.
- Undertaking the Timely Recognition Tool project, evaluating findings and determining future benefit and possible citywide implementation
- Development of the Evidence in Practice Group to embed best practice and enhance further academic integration within the LPCN
- Development of the education offer to ensure a capable and effective workforce
- Improvement of the website for families, carers and professionals
- Agreeing priorities and leadership support for the Equality Diversity and Inclusion Group
- Continuing the Homelessness service development whilst seeking recurrent funding
- Optimise linkage and analysis of routinely collected data to enable to citywide analysis of access to, inequities in and impact of P&EoLC in Leeds.
- Optimising the Bereaved Carers Survey to increase response rate and ensure it reaches diverse communities
- LPCN will review and updated the Liver and Renal clinical guidance
- A celebration event in June will highlight our work and enable networking with members from the Board.

Beyond this, we will continue to work with colleagues in Public Health and West Yorkshire on the design and plans for a refresh of the EOLC Health Needs Assessment, in line with regional strategic Health Needs Assessment template.


Leeds Palliative
Care Network