Leeds Palliative Care Network

Celebration and Planning Event

27 November 2019

Mercure Parkway Hotel

Celebration

Welcome and Introduction – Dr Mike Stockton, Chair / Clinical Lead, Leeds Palliative Care Network

Good morning and a very warm welcome to this day designed to celebrate what has been done and achieved over the past year, and also focussed towards developing the next palliative and end of life care strategy for Leeds. Hello my name is Mike Stockton and I am the current chair of the Leeds Palliative Care Network. The network has been responsible for initiating and organising this event.

Today is an important day. Thank you so much for taking time out from your busy schedule to enable us to bring together a diversity of people, professions, perspectives and possibilities. It is only together we'll we produce a strategy and care system that is fit for the future and fit for the people of Leeds.

Part one: this morning we will hear about and celebrate the work that has gone on across the Leeds palliative care network. The network only delivers and develops because of the people within it and that includes providers and others across our city. So I and the executive team wish to pay great thanks to all those who have given of their time, energy and self.

Part two: we're also here to challenge ourselves and challenge the parts of the strategy. This afternoon we will have an opportunity to hear about some of the data that we have, how we fit within the Leeds plan and then will have an opportunity to take areas of the strategy to clarify, expand or contract and importantly to prioritise so we know what is most important for the next 1 to 5 years.

It seems amazing that we are now a year older since we had the engagement event at Weetwood Hall. At that point we were beginning to talk about population health management, some of the significant challenges that lie ahead, and Brexit. We are still faced with and challenged with much of the same.

However there has been progress. There has been solid and concrete developments. We are on the cusp of being able to put together the strategy for Palliative and end-of-life care in Leeds.

The vision and values of palliative and end of life care remain constant: High quality person and family centred care to enable people to live and die as well as possible. And support those that remain. What has changed is the complexity and volume of need, expectations and standards, plus the challenges of workforce capacity and capability.

But there is hope and optimism…Leeds has a long and successful history of developing and delivering high-quality palliative and end of life care. We have a service we can be proud of. We will build on that to make services equitable, reduce unwarranted variation, high-quality, evidence-based and sustainable, that is integrated into all health and social care systems where people require it. How can we go from good to great?

Quick summary of the challenge…

In Leeds, there are around 5000 deaths per year that have a known palliative phase and would benefit from palliative care approach.
There is only one chance to get it right, and this is our opportunity.
There are a number of patients who do not access formal palliative care at all. May be up to 2000 people per year.

The majority of the population would prefer to be at home for both care and death. However around half of all deaths still occur in hospital.
People in the last year of life make up 1 in 3 emergency admissions, 30% of all hospital inpatients and utilise around 20% of all NHS costs.

By 2040 there will be a 25% increase in actual deaths in the UK, which will occur across all care settings.
Deaths in the community may double by 2040.
Care homes are predicted to become the predominant site of dying over the next 20 years.
If there is no change to our current community capacity and resource then there will be a reversal in the trend of people dying out of hospital and there will be an increased number of people beginning to die within our hospitals.

This projected rise in deaths will have a significant impact on the whole health and social care system.

A cross-system approach is urgently needed to address existing inequalities of access, and to ensure the sustainability of quality palliative and EoL. This why we are here today.

The NHS Long Term Plan references EoLC within the personalised care agenda, urgent community response and recovery support, out of hospital care, carers' agenda, enhanced health in care homes, personal health records and digitally enabled care.

To reduce variation in EOLC, we need:

- A system and method of identifying patients in their last year
- Conversations to enable people to state their preferences
- A system to share this across all providers
- 24/7 health and social care available in all settings
- 24/7 advice and support
- 7 day specialist palliative care advice
- Carer support
- Staff in all settings with the confidence and skills to care for patients at the EoL
- Agreed metrics
- Consistent care after death

We hope this and more has been highlighted and captured in the strategy work.

A few words about the Leeds Palliative Care Network:

The Leeds Palliative Care Network is a collaborative partnership of all those who have a responsibility or an interest in a palliative and end of life care. This includes clinical staff, social care staff and academics; in and out of hospital, NHS, third sector, YAS, social services, carers and care homes. We aim to rise beyond traditional boundaries, support collaborative efforts for cross Leeds system change, and to help prepare the city for the future.

We have two broad aims. One is to do better what we already do and already know: continuous quality improvement. The other broad aim is to stimulate and facilitate more transformative and imaginative thinking and development to enable us to better manage the unprecedented changes for the future.

We have developed key important relationships across Leeds. The Leeds Academic Health Partnership, the Leeds Clinical Senate, Leeds Informatics Board and the Leeds GP Confederation. We have more recently connected with the Health and Wellbeing Board and the Adults and Health Senior Leadership Team. This has promoted and ensured our presence on the Leeds Plan.

There is a real challenge and a real opportunity for the taking. Focusing on improving the care of people at the end of life does not only improve their outcomes and experience but it has a broader positive effect on the whole system. Improving end of life care is good for the patient, good for those who remain, good for the system and good for the city of Leeds.

Across Leeds the importance of palliative and end of life care is being increasingly recognised and realised. This is our time to be ambitious, bold and imaginative, to be logical and evidence based, but not constrained by that. It's hard for us all to let go of how we do things now and conceive of things differently. Today and through the strategy I'm hoping we'll have a chance to do that.

Leeds is a great place to live, for most but not all, and Leeds is striving to be a great place to grow old.
It is our aspiration that Leeds is a great place to live out the final years and months and weeks of life, to have great confidence in your care and comfort and to have the assurance you will die with dignity and peace.

There has been a recent debate in the medical journals about whether palliative care is having an existential crisis…through integration and education and system wide programmes, palliative care is somehow losing its identity and its meaning and its value.

Here is my summary response:

Whist there is existence there is death.
Whist there is death, there is the possibility of suffering.
Whilst there is the possibility of suffering there is a body of knowledge and a system of care that strive to relieve.
Long live palliative care!

Thanks once again. Your contributions are welcomed and valued. Please give generously.

A Short Summary of Celebratory Presentations and Questions Raised.
(All presentation slides are available on Leeds Palliative Care Website at:
https://leedspalliativecare.org.uk/professionals/resources/lpcn-documents/)

Palliative Care Ambulance - Ann Marie Kelly, Yorkshire Ambulance Service

Highlights:

- 967 palliative patients reached their destination without any delay due to the palliative care ambulance in Leeds.
- It offers patients a dedicated pick up time and personal service.
- Excellent feedback from staff and patients.
- Allows us to fulfil special requests and patient wishes such as a working men's club trip for Donald and a visit to Leeds Bradford Airport for Ina.
- The service is highly thought of and a beacon of best practice.

QUESTION: Is the palliative care ambulance sustainable?
ANSWER: The ambulance is currently funded through Leeds CCG and this is expected to continue.

Learning Disability Service - Michelle Evans – Leeds and York Partnerships Foundation Trust

Highlights:

- We provide support to services to help professionals to care for someone with a Learning Disability.
- We provide staff training, easy read materials, assistance and one to one support.
- We bridge a gap between services.
- Free materials and support – unique to the UK.
- Our aim is to empower individuals to tell us about their needs – whether that's extra time, a quiet environment etc.
- Our pain communication toolkit will be available soon – it supports pain assessment for people with learning disabilities including body maps and sensory maps.

Medicines Management - Moira Cookson, LPCN Medicines Management Lead

Highlights:

- We've implemented consistent branding across all of our documents.
- Work with anticipatory medicines.
- Selected to produce a poster for Palliative Care Congress in April 2020.
- Conducting an audit in January into the last 7 days of life to assess where the trouble spots are and what happens to the medication after death.
- Introduced the EPMA on inpatient unit in St Gemma's, Wheatfields and Kirkwood Hospice.

Dementia - Trish Stockton, LPCN Education Lead on behalf of **Jane Chatterjee**

Highlights:

- Key partner in the Leeds Dementia Strategy - Chapter 8; see slide

Dying Matters - Carole Clark and Liz Messenger, Dying Matters Leeds

Highlights:

- We are working together to engage in conversations around death, dying and bereavement.
- Working with local employers and businesses to help support staff and colleagues.
- Dying Matters Week runs from 12 May 2020. The theme of the national campaign is Dying to be Heard.

QUESTION – what happens at a Death Café?
ANSWER: No agenda or speakers. People are free to speak about any aspect of death, dying or bereavement. We provide signposting to support.

COMMENT:
James Woodhead – Leeds City Council Adults and Health
Highlighted the Grief Series – using arts and creativity to support conversations.

QUESTION: Can Dying Matters support care homes?
ANSWER: We did contact care homes but had minimal response. We will look to do so again in the future. We can help develop Conversation and communications skills

Advance Care Planning - Adam Hurlow, Sarah McDermott, Gill Pottinger, Leeds teaching Hospitals NHS Trust
Highlights:

- Advanced care planning – we are looking at decision making, planning for the future, and sharing the outcomes appropriately.
- Focussing on what's important to me as a patient?
- We are working on plans for developing integrated advanced care planning for people of Leeds

Education Update - Trish Stockton, Jason Ward, St Gemma's Hospice

Highlights:

- Continue to deliver a lot of training despite workforce challenges
- Celebrating a key initiative called ECHO. A web and phone based conference learning facility.
- 13 practices have committed to the first phase.
- Curriculum is formed by the group.
- Allows us to share specialist knowledge by moving the knowledge, not the people.
- Different method of education which is fulfilling our strategic goals.

QUESTION: Is there a limit to the number of people who can dial in?
ANSWER: Yes – around 14 is maximum.

QUESTION: Does the info stay live?
ANSWER: Yes – the videos can be seen and uploaded to the website.

QUESTION: Is there scope to share ECHO more widely?
ANSWER: Yes, St Gemma's can be used as a hub but others can access the method and information.

Gypsy and Travellers - Hannah Wilson, Wheatfields Hospice and Liz Keat, Leeds Community Healthcare NHS Trust
Highlights:

- We know gypsies and travellers have a lower life expectancy, are more likely to die in pregnancy, suffer a child bereavement, commit suicide or have a long-term condition.
- We are not going in to cure people – gypsy and travellers have a very close communities which care for each other through dementia, illness and disability.
- There is still a huge amount of stigma and racism.
- We need to challenge ourselves to think differently.

Bereaved Carers Survey - Helen Syme, Leeds Teaching Hospitals NHS Trust
Highlights:

- This year's survey was more focussed with organisation specific questions, available online and on paper.
- Supported by Healthwatch and Academic Health Network.
- 30% response – 204 responses.
- Using the responses to improve action plans.
- St Gemma's are running the survey all year round.
- New survey is running in Q4.

QUESTION – would you consider involving a third sector organisation in the survey as experience can be varied? Can we do something together? It has a major effect on families**.**
ANSWER: Yes – invite Val Hewison from Carer Leeds to the group.

EOL Health Needs Assessment Refresh 2019 - Liz Messenger, Head of Public Health
Highlights:

- EPACCS record improvement**.**
- Half of the people who die in Leeds do not have that record, which we are working on.

QUESTION – How often would we intend to do a full health needs assessment?
ANSWER: The refresh has given us lots of useful information. A three-year timeline for the next one would be ideal.

Health and Wellbeing Strategy, Leeds Health and Care Plan and End of Life Care –

Paul Bollom, Head of Leeds Plan, Leeds City Council.
Highlights:

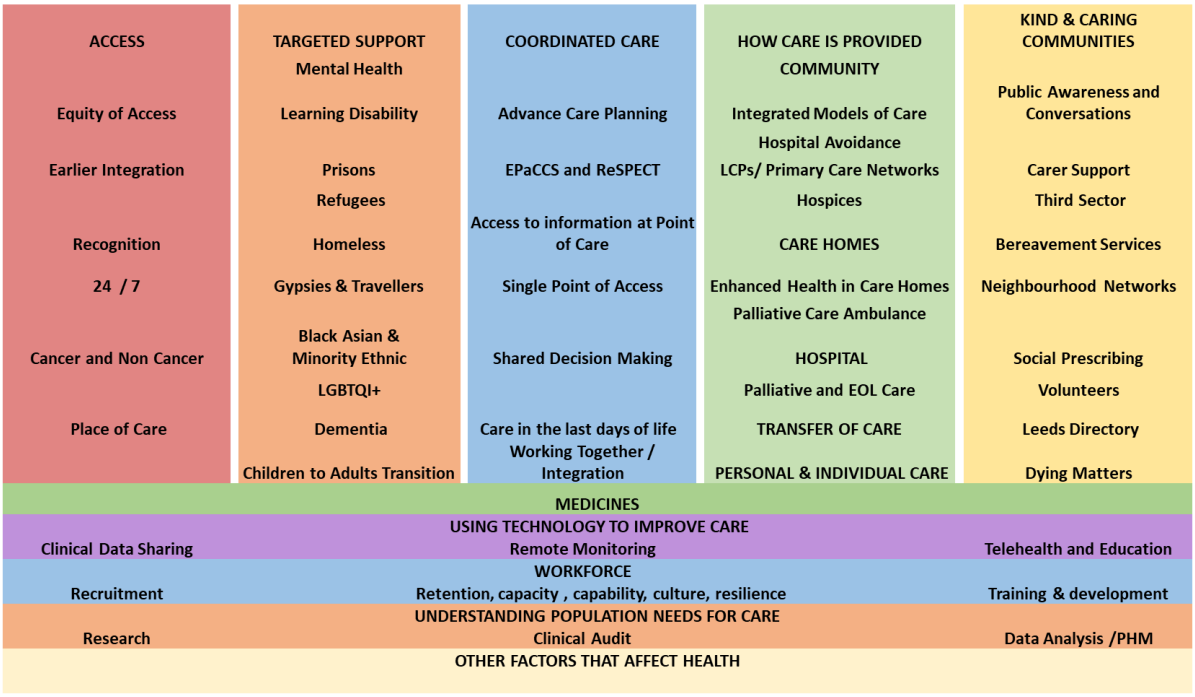
- Dying well. We need to frame conversations around dying and put it at the front and centre of family conversations.
- Turning the strategy into operational outcomes – the Leeds Plan. Summary of outcomes agreed.
- Prevention in everything we do.
- Personalisation – driven by our values, wrapping care around people

Planning and Prioritisation

Following the start of the Leeds Palliative and End of Life Care Strategy Advisory Group key strategy documents have been drafted; a Strategy Framework and P&EOLC Outcomes document.

Drafting the Framework has been overseen by the Strategy Advisory group and takes account of:

- Priorities for improving end of life care identified at the Future of Palliative Care in Leeds Strategy event (November 2018)
- Ambitions for Palliative and End of Life Care – a National Framework for action (2015-2020)
- NHS Long Term Plan 2019
- Leeds End of Life HNA Review 2019
- Bereaved Carers Survey 2018-19
- What matters most at end of life to people in Leeds
- Strategy Advisory Group and Outcomes working group analysis
- Feedback from Leeds Clinical Senate and Leeds Academic Health Partnership



Each section is considered a building block of the future strategy.

During the afternoon for each block groups considered:

- Is this block still important?
- What else should be in this block?
- What is the content we want to deliver or aspects we want to improve in this block?
- What actions do we need to complete to get there?
- Agreed the top 2 priority actions

This created the top 20 priority action points which all attendees were then able to vote on to create the top priority areas for future work.

The following is a short summary of the block group discussions.

Access

It was agreed that this is an important block with some big areas to address.

There needs to be some revised agreement and definition of who are our patients to ensure a consistent referral approach for the future. This is in relation to knowing that there will be more people who have dementia and frailty and also the increase in non-malignant patients. If we increase the patients who are referred to palliative care then have we got the resources to look after them. This also led to the discussion that can we then always meet their preferred place of care/ death…this is currently a challenge due to workforce issues, bed capacity

Also the challenge of generalist and specialist palliative care – are there are a group of patients not being referred and in hospital they would always go through the specialist palliative care team even though they may not be specialist. This led to the discussion that there needs to be more analysis of the problems around referrals and why they might not happen, when they happen, knowledge of how to do it.

There was a discussion about having more EOLC beds in care homes with support from the Palliative Care Community teams as this is a key place where people are going to die in the future.

There is a lot of confusion for patient's, relatives and staff about who to contact about palliative care referrals or needs at different times of the day. All the group felt very strongly that a city like Leeds should have something similar to the Gold Line in Airedale and provide that central point of access and support in a high quality and individualised way.

The top 2 priorities are:

1. Develop a Single Point of Access
2. Establish a better understanding of what is currently happening around access – who/how/ when/generalist/ specialist/ routes – this would inform processes, systems and resources required

Targeted Support

The group felt this is an important block and considered whether this block should be called Underrepresented Groups. They noted this is about difficulties in accessing services for some people. The group felt that these groups are underrepresented within current service use and that the list is not exhaustive. It should not exclude any group and others could be added at any time.

It would be helpful to better understand (research) the limitations and actual access to palliative and end of life care services for the groups listed. To better understand the barriers to accessing services and receiving good standard of care

The top 2 priorities are:

1. Understanding and overcoming barriers by providing adaptable services
2. Educate, develop, create accessible information and share

Coordinated Care

The group agreed this remains a key block for the strategy. After discussion they added Key worker and empowering people/ carers as new themes. There was also a discussion about the possibility of giving patients and their families Direct Payments as a one off lump sum or regularly during end of life care; via Personal Health Budgets (?).

The top 2 priorities are:

1. Single Point of Access
2. Improving advance care planning – amount and quality

How Care is provided

This was a very well attended and lively group. There was recognition that there are strong links between factors in this block and single point of access, rapid response models, virtual wards, and supporting carers.

There is interdependence between hospital avoidance and integrated models of care in the community. There is awareness of the bid for admiral nurses to support people living with dementia and end of life.

There is need for increased resources within the LCH EOLC care homes team to better support care homes. This would improve the quality of planning and improve the skills, knowledge and decision making of care home staff.

There is a need to better celebrate the palliative care ambulance service and gain assurance for future sustainability.

There could be a more proactive outreach support provided by the hospital EOL care team and better use of technology.

The group discussed current projects to improve hospital to hospice patient transfers and the importance of changing culture to support decision making. Everything feels like a priority!

The top 2 priorities are:

1. Care Homes - Enhanced models of care and support
2. Hospital avoidance ↔ integrated models of care in community

Kind and Caring Communities

This was agreed to be an important block that demonstrates essential need for wider community support and the delivery of Leeds left shift.

Public awareness is strongly linked with the dying matters campaign which could be bigger with a higher profile, sharing of information via LPCN and service providers, engagement in public arenas and media campaign; would require more time and resources.

The public conversations should be separate and links to personalisation, better conversations training and the language we use generally.

There are strong partnerships within the third sector – e.g. the Leeds Oak alliance and Forum Central. Neighbourhood Networks are a key part of service provision and supporting volunteers. There is a perceived opportunity to develop EOLC befrienders of death doulas.

We need to better understand social prescribing and what it offers and potential links we could make. Should invite to speak at future LPCN Group; service led by Touchstone.

Workplace / employers should be added as they can affect how families are free to support dying relatives.

The idea of concentric circles of support around the patient was discussed.

The top 2 priorities are:

1. Increase scale and impact of Dying Matters campaign– raising public awareness
2. How do we improve family and carer support?

Medicines

This is an important block for patients and families.

Access to medicine requires sufficient resources to do it well- time and people – and access to good information. There is an opportunity to improve the transfer of medicines with patients between care settings.

Improving digital patient records that are available from all platforms would help with medicines management.

There was recognition that there are currently availability and supply issues nationally with some medicines which requires regular cascading of information to frontline clinicians.

To add 'knowledge of systems' to the block as this is essential for health professionals coordinating care.

Knowing where to find resources is often a challenge.

The top 2 priorities are:

1. Algorithm to support access to medicines – that is time related e.g. showing how to access a medication at different times of the day
2. Prescribing for addiction – understanding variation and developing best practice guidelines

Using Technology to Improve Care

This block was called digital technology which was recognised.

Access to clinical data across all areas and platforms (interoperability) with associated data sharing agreements where required is essential! This should also include care homes.

Developing the Planning Ahead tool as a single accessible decision platform is key to improving care.

Digital development for care homes is a priority. It would be good to know what digital and tech options are available – a directory?

Use of technology within education needs scaling up to reach more people – e.g. ECHO eELCA.

Use of telehealth hubs (SPA) and offering teleconsultations would provide support to patients and professionals delivering efficiency, speed, rapid communication and ease of access.

Is there opportunity around self-care (?) – Individual records, smart homes, wearable '*Alexa*'.

The top 2 priorities are

1. Developing 'Planning Ahead' platform/system
2. Interoperability of all clinical systems (to include care homes)

Workforce

This was recognised as a large and important area with representatives from different areas of health and social care in the group.

Recruitment: some of the group felt that there was an inequity of pay and conditions in key roles/ bands e.g. nursing band 5 in care homes and hospices which did impact on nurses wanting to work there. Also that there was not a clear career progression in palliative care for nursing staff.

Capability: There wasn't a consistent recognised level of knowledge and skills that are required in different roles and grades across the city which meant it wasn't easy to know what each organisation requires or if skills and qualifications are transferable between different providers. We discussed the wider use of the EOLC LO and what was the challenge of implementing this across the city to provide that minimum standard.

Leeds Palliative Care Workforce: we discussed perhaps having a more fluid workforce that are based at an organisation but could work across different organisations depending on where the need was. There is a currently a culture where staff are very much within their own organisations.

Numbers and roles: there needs to be data analysis of the numbers of the workforce and the different roles that are providing palliative care. Also a wider analysis of different workforce models in other areas of the UK and how these may work in Leeds. It was discussed if the LAHP would be able to help with this piece of work to gain a better understanding of the current workforce and perhaps propose some different models of workforce to meet patient need in the future.

The top 2 Priorities are:

1. Recruitment: equality of pay and conditions
2. Capability: Have standardised levels of knowledge and skills across all areas in palliative and end of life care

Understanding Populations Need for Care

This block came out of the need for data and information when considering Population Health Management.

The group agreed there is a continued requirement to understand and model likely trends and changes in demand for care. We should also be able to receive feedback on quality of care experience to influence ongoing service improvements.

The group suggested the system therefore should take account of organisations mortality reviews, Public Health England's end of life care profile data, and patient and career feedback – including the bereaved carer's survey findings.

There is also an ambition to develop and consistently use Patient Level Outcomes to measure impact of care provided.

The top 2 priorities are:

1. Unified public health approach to end of life care data
2. Systematic collection of patient level outcomes

Other factors that Affect Health

This aspect impacts on all health and wellbeing – not just end of life care. Given this the group felt it is important that the network continue to inform and influence other strategy and policy areas.

It was also suggested that the title be amended to 'Factors That Affect Health and Wellbeing'.

This area is multifaceted and might also include substance abuse / addiction, social isolation, culture and beliefs, family dynamics.

The group noted the Leeds Plan aspiration to Think Family First.

Professionals should consider how people live when supporting them with care planning so that care can be adapted to the person's surroundings. There needs to be flexibility in care offers and choices available taking account of levels of risk and creative solutions.

Solutions might include social prescribing and third sector support. There is a need to consider moving care towards a more family centred model; moving away from a medical model.

Often it is the broader factors that resulting in delays and difficulty in delivering care. For example some people may feel vulnerable being discharged to their own home at end of life. Comprehensive and holistic planning is important at the early stages of end of life.

The top 2 priorities are:

1. Influencing other strategies across whole system
2. Developing a consistent comprehensive palliative assessment, encompassing holistic analysis of needs

Voting for Priorities

Each attendee had three spots to vote for their top priority from the top 20. The votes could be split across 3 or all attributed to one. The results of the voting is as follows:

Priority	Number of votes
Using technology to improve care	
Developing 'Planning Ahead' platform/system	*1*
Interoperability of all clinical systems (to include care homes)	*7*
Kind and Caring communities	
Increase scale and impact of Dying Matters campaign– raising public awareness	***8***
How do we improve family and carer support?	*4*
Workforce	
Capability – standardising levels of knowledge and skills in all roles	*2*
Recruitment – equity of pay and conditions across the city	*3*
Medicines	
Algorithm to support access to medicines – that is time related e.g. showing how to access a medication at different times of the day	*0*
Prescribing for addiction – understanding variation and developing best practice guidelines	*2*
Coordinated care	
Single Point of Access (NB - priority in two groups)	***15***
Improving advance care planning – amount and quality	*4*
Targeted support	
Understanding and overcoming barriers by providing adaptable services	***8***
Educate, develop, create accessible information and share	*3*
How is care provided	
Care Homes - Enhanced models of care and support	*2*
Hospital avoidance ↔ integrated models of care in community	***15***
Understanding population needs for care	
Unified public health approach to end of life care data	*7*
Systematic collection of patient level outcomes	*3*
Access	
Establish better understanding of what is happening around access (who/how/when/generalist/specialist)	*4*
Single point of access (NB - Priority in two groups)	***15***
Other factors that affect health	
Influencing other strategies across whole system	*0*
Consistent comprehensive palliative assessment encompassing holistic analysis of needs	*2*

TOP 6

Single Point of Access (NB - priority in Coordinated Care and Access)	***15***
Hospital avoidance ↔ integrated models of care in community	***15***
Increase scale and impact of Dying Matters Campaign – raising public awareness	***8***
Understanding and overcoming barriers by providing adaptable services	***8***
Interoperability of all clinical systems (to include care homes)	***7***
Unified public health approach to end of life care data	***7***

Impact on the Framework

The changes suggested by the event attendee's result in slight changes to the P&EOLC Strategy Framework as below:

Thank you to all who contributed during the planning and on the day!

List of Attendees:

Name	Surname	Organisation
Samantha	**AUSTIN,**	Leeds Community Healthcare Trust (LCHT)
Paul	**BOLLOM**	Leeds City Council
Deborah	**BORRILL**	Leeds Teaching Hospitals Trust (LTHT)
Diane	**BOYNE**	Leeds Palliative Care Network (LPCN)
Suzy	**BROCK**	Leeds Community Healthcare Trust (LCHT)
Joanna	**BROWNING**	Leeds City Council Adults & Health
Lesley	**CHARMAN**	Leeds Teaching Hospitals Trust (LTHT)
Carole	**CLARK**	Leeds City Council – Dying Matters
Moira	**COOKSON**	St Gemma's Hospice/Sue Ryder Wheatfields Hospice
Ruth	**CORNELISSEN**	Care & Repair
Tom	**DANIELS**	NHS Leeds CCG
Michelle	**EVANS**	Leeds & Yorkshire Partnership Foundation Trust (LYPFT)
Laura	**FLETCHER**	Leeds & Yorkshire Partnership Foundation Trust (LYPFT)
Lizzy	**GASCOYNE**	St Gemma’s Hospice
Suzie	**GILLON**	Leeds Teaching Hospitals Trust (LTHT)
Debbie	**GILMORE**	Leeds Community Healthcare Trust (LCHT)
Ruth	**GORDON**	Ruth Gordon Associates - Facilitator
Helen	**GUNNER**	Leeds Community Healthcare Trust (LCHT)
Val	**HEWISON**	Carers Leeds
Rebecca	**HEWITT**	Leeds City Council Adults & Health
Elaine	**HILL**	Sue Ryder Wheatfields Hospice
Helen	**HOLDEN-MARSHALL**	Leeds Community Healthcare Trust (LCHT)
Kerry	**HUNTER**	Leeds Teaching Hospitals Trust (LTHT
Adam	**HURLOW**	Leeds Teaching Hospitals Trust (LTHT)
Kerry	**JACKSON**	St Gemma's Hospice
Lucy	**JACKSON**	Leeds City Council – Public Health
Elizabeth	**KEAT**	Leeds Community Healthcare Trust (LCHT)
Anne-Marie	**KELLY**	Yorkshire Ambulance Service (YAS)
Catherine	**MALIA**	St Gemma's Hospice
Emma	**MARSHALL**	ELM Consulting
Julie	**MARSHALL-PALLISTER**	Sue Ryder Wheatfields Hospice

Heather	**MCCLELLAND**	St Gemma's Hospice
Sarah	**MCDERMOTT**	Leeds Community Healthcare Trust (LCHT)
Elizabeth	**MESSENGER**	Leeds City Council Adults & Health
Karen	**NEOH**	St Gemma's Hospice
Helen	**NICHOLSON**	Maggie's
Gill	**POTTINGER**	NHS Leeds CCG/Primary CARE
Alison	**RAYCRAFT**	Leeds Community Healthcare Trust (LCHT)
David	**RICHARDSON-WHITELEY**	Villa Care
Michaela	**RYAN**	Yorkshire Ambulance Service (YAS)
Clare	**RUSSELL**	St Gemma's Hospice
Natalie	**SANDERSON**	Sue Ryder Wheatfields Hospice
Joanna	**SAUNDERS**	Leeds Beckett University
Valerie	**SHAW**	St Gemma's Hospice
Jonathan	**SMITH**	Primary Care
Barbara	**STEWART**	Leeds Bereavement Forum
Mike	**STOCKTON**	St Gemma's Hospice
Trish	**STOCKTON**	St Gemma's Hospice
Amanda	**STORER**	Leeds Palliative Care Network (LPCN)
Chris	**STOTHARD**	Leeds Teaching Hospitals Trust (LTHT)
Helen	**SYME**	Leeds Teaching Hospitals Trust (LTHT)
Vanessa	**TAYLOR**	Huddersfield University
Sue	**WADDINGTON**	Sue Ryder Wheatfields Hospice
Jason	**WARD**	St Gemma's Hospice
Gill	**WARNER**	Leeds Community Healthcare Trust (LCHT)
Hannah	**WILSON**	Sue Ryder Wheatfields Hospice
Mary	**WINDSOR**	Leeds Community Healthcare Trust (LCHT)
James	**WOODHEAD**	Leeds City Council Adults & Health


Leeds Palliative
Care Network