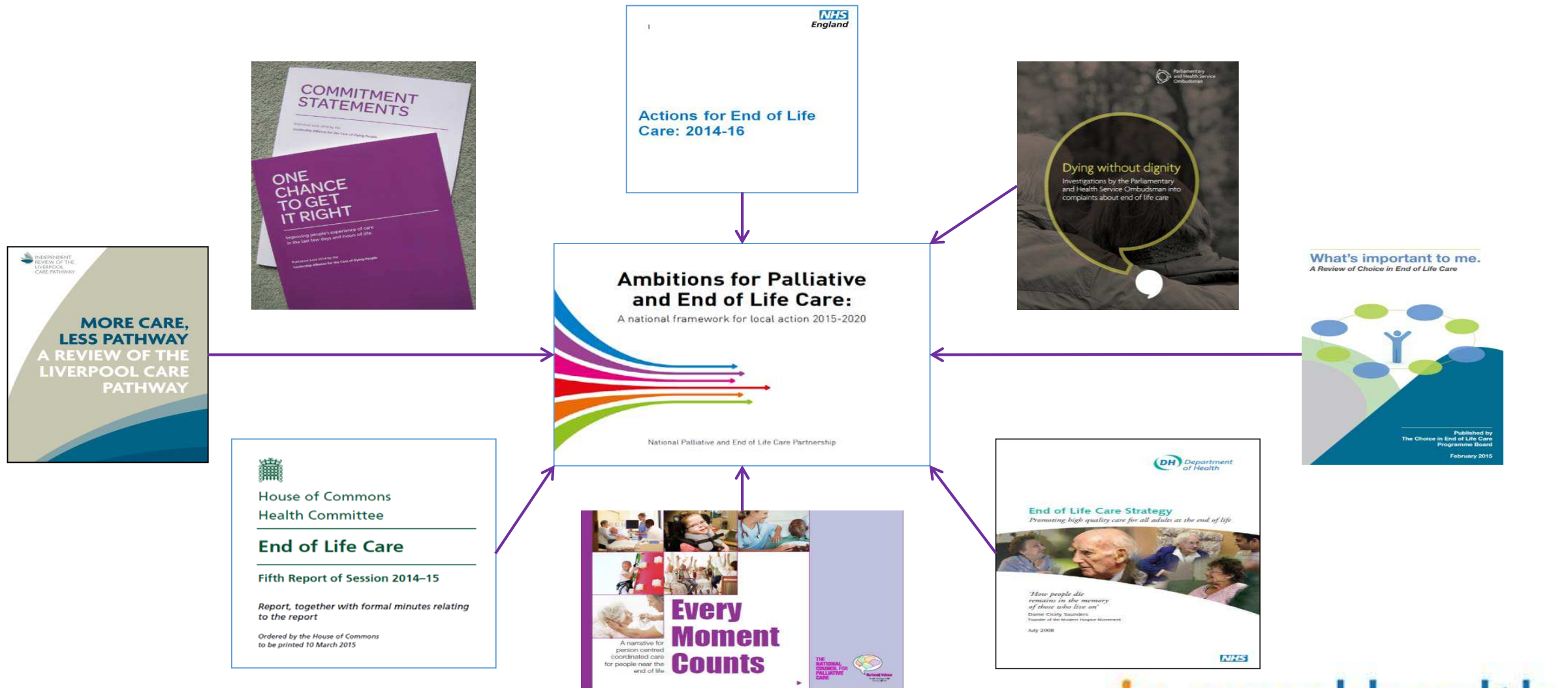




**The Norfolk and Waveney STP  
Palliative and End of Life Care  
Collaborative - an Overview**

**HOSC October 2018**

# Five Year Forward View



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# The ‘ambitions for palliative care’ vision states:

**“Death and dying are inevitable. Palliative and end of life care must be a priority. The quality and accessibility of this care will affect all of us and it must be made consistently better for all of us”**

People living with a palliative prognosis and those approaching the end of their lives, deserve and have a right to appropriate care, compassionately delivered by the health and social care workforce and informal carers. The primary aim is to ensure that all people with palliative and end of life care needs in Norfolk and Waveney can say:

**“I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s).”**



Personalised Care planning	Shared records
Education and training	24/7 access
Evidence and information	Involving, supporting and caring for those important to the dying person
Co-design	Leadership

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# Current performance across Norfolk and Waveney

Domain	All ages	England average	Norfolk and Waveney average	Great Yarmouth and Waveney	North Norfolk	Norwich	South Norfolk	West Norfolk
Place of Death	% of deaths in hospital	46.7	44.6	47.2	44.6	47.8	40.5	43.3
	% of deaths in care home	22.6	27.4	25.3	28.1	23.1	29.4	30.6
	% of deaths in own home	22.8	24	25.2	22.6	23.6	24.5	23.6
	Deaths in other places	2.16	2.13	2.17	1.98	2.12	2.23	2.15
	% of deaths in hospice	5.6	1.9	0.2	2.7	3.4	3.2	0.3

Compared with England benchmark:

LOWER	SIMILAR	HIGHER
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Public Health England End of Life Care profiles, 2015 – Place of Death (All Ages)

# Review of system wide complaints (before STP)



- Limited communication skills
- No advance care planning
- Not involved in decision making
- Not wanting to die in hospital but ending up there by default
- No consistent assessment of pain
- Confusion and frustration with the continuing healthcare system
- Delayed symptom management
- Confusion about language used
- Difficulty getting medication – families having to go out and get it themselves when their relative is dying

# What the new service model will look like:

The new service model shall have the following types of palliative and EoL care – as defined nationally:

Specialist palliative care (SPC):



Enhanced palliative care:



EoL care for all relevant care settings:



## Specialist palliative care:

- Inpatient SPC beds
- Community SPC
- Hospital SPC advisory teams
- SPC outpatients and day therapy

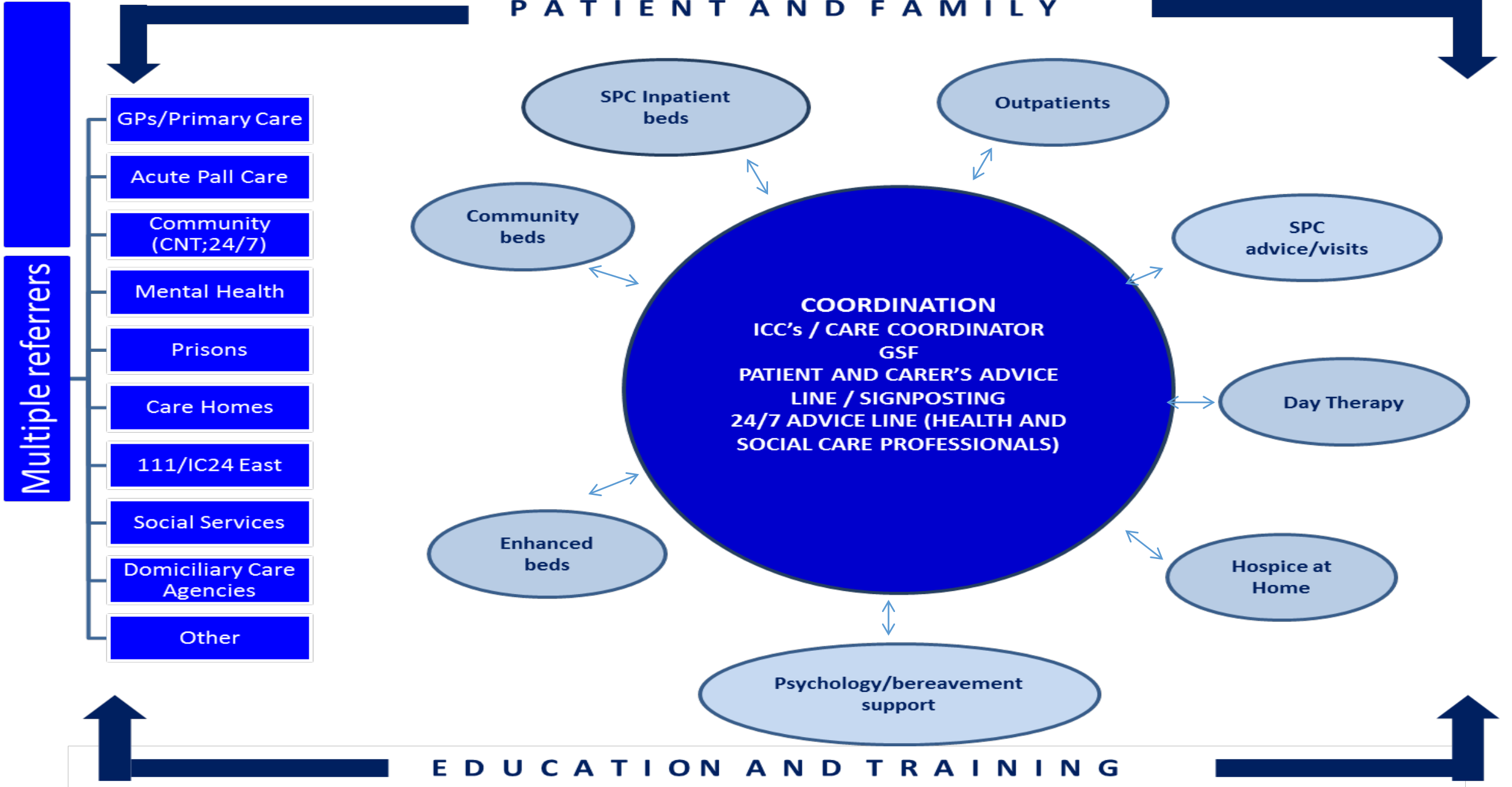
## Enhanced palliative care services:

- Hospice at Home services
- Coordination service
- Enhanced care homes
- Single point of access
- Norfolk Hospice enhanced beds

## End of Life care:

- Supported self-care
- Domiciliary care and Care Homes
- Primary Care/Out of Hours Primary Care
- District / Community Nursing/ Admiral Nurses/ Other LTC Nurse Specialists
- NHS Continuing Health Care (CHC) Fast Track
- Night sitting
- Inpatient acute hospital wards
- Liaison with sheltered housing/supported living
- Care after death
- Bereavement care

P A T I E N T A N D F A M I L Y





# Recent Developments

- **Investment in Hospice at Home Service (£1.4m)**
- **Priscilla Bacon Hospice 2**
- **Carer's Advice Line (Central) – discussions with West**
- **Local Incentive Scheme West Norfolk Education to Care Homes**
- **60 Care Homes Accredited Against National '6 Steps Programme'**
- **Homeless Hostel**
- **Implementation of Individualised Plan of Care**
- **Launch of Community Drug Chart and Relevant Guidelines**
- **Procurement – Great Yarmouth and Waveney**

# Patient case study (2018) slide 1

- **80 year old metastatic oesophageal cancer (sudden deterioration)**
- **Urgent assessment for equipment and symptom control**
- **Joint visit Occupational Therapist Hospice at Home and Community Specialist Palliative Care Nurse**
- **Do Not Attempt Cardiac Pulmonary Resuscitation in situ (GP)**
- **Patient dying on sofa**
- **Wife wanted husband in a bed in lounge**

## Patient Case Study slide 2

- **Too long to wait for bed as the patient only had hours to live:**
  - **Medication given**
  - **Single bed moved to lounge**
  - **Patient moved**
  - **Lots of support for family**
  - **Patient had x 3 visits from Hospice at Home staff**
  - **Support from community nurses**
- **Patient died peacefully the following day**
- **Family very thankful**

# STP Collaborative Workstreams

- 1. Design and Commission a new service model for Palliative and End of Life Care**
- 2. Review relevant documentation across the STP**
  - ✓ **Yellow Folders**
  - ✓ **ReSPECT**
  - ✓ **Thinking Ahead**
- 3. Review and refresh STP approach to workforce planning and training in all generalist care settings**
- 4. Maximise comfort and well being**

# Current Challenges

- **Workforce recruitment across system  
(including Primary Secondary and Community settings)**
- **Variations in care across the system**

# Next steps

- **Develop detailed plans for delivery (January 2019)**
- **Link provider specialist groups for integrated design and delivery (January 2019)**
- **Use opportunities to raise the public awareness of death and dying such as Dying Matters events and promoting end of life planning via refreshed Thinking Ahead documentation (May 2019)**
- **Look at opportunities to promote compassionate communities and involve local people in support and raising awareness (May 2019)**

**“In the end, what gives a life meaning is not only how it is lived, but how it draws to a close”**

***Tessa Jowell, 2018***

**“Cohesive, honest, compassionate, equitable care with dignity”**

***Jane Shuttler, 2018***

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# Discussion

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