St Lukes Hospice and Community Palliative Care

Background and the Present
• St Luke’s is a charity which puts caring for people in our community first
• We are a business too
• We have a big impact on people in our city
St Luke’s

- Sheffield’s only hospice
- Founded by Professor Eric Wilkes – a Sheffield GP and leading light in the formation of hospices and palliative care, with Dame Cicely Saunders
- Opened in 1971 – 43 years of caring – in that time we’ve supported 60,000 patients and touched 250,000 across the city
Impact and care

• Provides specialist palliative care to adults in Sheffield with life-limiting illness – free of charge

• Individualised care to patients each year, and their families & carers – about 5,000 supported in all each year

• 60% of patients cared for ‘at home’ - and around a third of the patients treated at the hospice are discharged

• We support patients from all areas of the city - of all religions, of all needs – and not just cancer

• Our tagline is ‘Adding Quality to Life’ – we promote and deliver unique hospice care that is focused on the whole person and those around them, not just their main condition.
Our business and model

• Restructuring in 2010 and 2011 owing to financial challenges saw us reduce costs by 17% – but now we do more for less!

• £7.5m income needed per annum; only one third from NHS – have to fundraise £4.5m each year in Sheffield; a huge amount

• 180 employees, over 600 volunteers, 11 shops and thousands of donors

• We train doctors, nurses, health professionals and junior members - plus BTEC students, placement students, apprentices

• St Luke’s is by Sheffield, for Sheffield – a relationship of care that puts carers, donors, volunteers and supporters together.

Adding quality to life
Our new development

- We embarked on a major new development programme in 2013 - to save our In Patient services for future generations
- Our main building was 40 years old, and was out of date and failing - we needed a radical transformation.
- Care Quality Commission reviews praised the exemplary care at St Luke’s - but noted that the building failures need to be addressed soon.
- St Luke’s has transformed its In Patient care through a £5.5m development programme to create a new In Patient Centre – with a £5m Capital Appeal
- This provides majority single rooms, with en-suites and sleepover facilities for loved ones – improving dignity, privacy and quality; as well as meeting rigorous new standards for infection control and patient environment.
St Luke’s In Patient Centre

Adding quality to life
Being relevant for the future

• When hospices were first set up, death was usually ‘acute’ i.e. an event occurred and death followed fairly quickly.

• Now, and in the future, death has become more chronic – a process with a series of conditions that eventually lead to death; this process can last for a hugely variable time period.
In future, care will be:

• In multiple settings with **home** as the focus
• Across a longer time period
• Needing more monitoring and identification of trigger points
• Requiring of more skills in different settings
• In need of better signposting, information and liaison between care partners
• Funded based on outcomes and impact – and avoidance of ‘hospitalisation’
Beyond the Hospice Walls: 7 day Community Specialist Palliative Care

Debbie Saunby
Laura McTague
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Jo Lenton
Development of an Integrated Team

- Clear and aspirational team structure with accountability
- Strong and Visible leadership with clinical expertise and strategic vision
- Building capacity and widening access
- Rapid response
- Consultants and junior medical team
- Prescribing
- Home Visits
- Partnership working with primary care
St Lukes Community Team

- 5 Lead Band 7 Specialist Nurse Roles – advanced practice
- 8 Band 6 Specialist Nurse Roles – practitioners – development and aspiration
- Community Development Manager
- Lead Consultant
- Project Coordinator
- Caseload management and stratification
- Integrated working
Zone Teams

• Leads have been working on allocating practice population and the Care Homes that fall within geographical areas
• 5 nurses for each zone
• Delivering service and maintaining stability
• Working on efficient and effective processes
Workload Management

• Daily “Board Round”
• Whole caseload approach
• Leadership and peer support
• Effective allocation of resources
• Development of follow up schedules based on clinical need
• Standards which can be measured.
Board Round – Productive Team Work

• Content and layout designed by team and still evolving
• SBAR handover & Presentation
• Safety
• Equitable allocation of work
• Opportunity to discuss patients/get advice

Adding quality to life
Board Round – Productive Team Work

- Triage and prioritise
- Manage escalation and preempt crises
- Sharing experience and learning
- Whole team approach
- Allocate medical visits

Adding quality to life
Referrals

• Main source of referrals is from Primary Care – GPs and Community Nursing/AHPs

• Other sources – Hospital Support Teams, Clinical Nurse Specialists and Long Term Condition Teams

• Over 1500 new referrals 2014-15 and anticipate growth

• Categorise casemix to target response
  – Unstable
  – Dying
  – Deteriorating
  – Stable
Community Medical Visits

- 2012 – 2013 61 Face to face consultant home visits
- July 2013 – July 2014 161 Consultant and supervised SPR home visits
Integrated team approach

- Prescribing
- Interface with GPs
- Supporting primary care with Best Interest Meetings and complex ethical decision making
- Interface with Specialist teams in Secondary Care
Case Study

- 45 year old lady with end stage Huntingdon’s chorea
- Main carer partner
- Teenage daughters
- Extended family – mother and older brother
- Family experience of previous death from the disease – Father
- Negative perceptions of healthcare system
Case Study

• Family support – permissions, liaison, managing complex dynamic
• Advanced Care Planning
• Deteriorating function with increasing distress
• Ethical issues – assessment of capacity to make decisions
• Place of care/death

Adding quality to life
Case Study

- Supported in a Care Home setting
- SLCN supported staff with clinical management plan
- Best Interest Meeting – GP, Family, SLCN, Lead Consultant, Care Home leads
- Remained in place of choice with personalised environment and care
- Peaceful death
- After death care for family – Bereavement support
Rapid Response 7/7 Service - Same day face to face assessment and intervention for Unstable patients

- Expert community MDT assessment
- Lead and support for EOLC at home
- Management and intervention for unpredictable and uncontrolled symptoms
- Avoidance of unplanned emergency admissions
- Management of unstable patients awaiting specialist palliative care beds.
Rapid Response Service

- October 2014 – 84 Rapid Response Visits
- More than double previous average activity
- Initial analysis of visits
  - Complex EOLC where home is PPD requiring prescribing, coordination and leadership including supportive discharge to die at home
Rapid Response Service

– Facilitated planned emergency admission for acute care + symptom management
  • Chemo related sepsis
  • Acute heart failure
  • Assessment for stent

– Complex titration of symptom management – joint visits/review/consultation
  • Ketamine and Methadone
  • Management of Sub acute bowel obstruction
Case Study

- Referral for EOLC
- Telephone triage – distressed family starting to panic
- RR Face to face visit within 30 minutes of call
- Family feeling only option available would be hospital – not what they wanted.
Case Study

• Face to face skilled assessment of patient
  – Very ill
  – Poor performance status and function
  – Symptoms
    • Breathless
    • Respiratory secretions
    • Distress
  – Patient’s express wish to remain in his own bed
Case Study

• GP arrived – also felt only option was 999 and hospital admission.
• RR Nurse
  – Discussed potential for EOLC to be delivered at home
  – Support, reassurance and confidence for family
  – Team working with GP and Community Nursing
  – Symptom management – syringe driver and prn medicines
Case Study

- Symptom control measures instigated within 2 hours
- Community nurse assessment initiated
- Night care booked for that evening to support family carers to rest
- Patient died peacefully that night in his own home which was his preference with his family
Measuring our outcomes

- Complexity at home
- Leadership for teams caring for complex patients
- 7 day working
- Support as if in specialist setting
- Co-ordination of care
- Introducing outcome measures, KPIs and recent CQC inspection
Learning so far and next steps

• Describe and define Rapid Response for direct referral – in progress
• Describe and define specialist service to give referrers clarity – in progress
• New assessment process linked to outcome measures – in progress
Learning so far and next steps

• Implementation of new assessment process and IPOS across whole service
• Research – working with SHU on a proposal to study the clinical caseload matrix we have developed
• Research with Sheffield University on models of delivering care
Thank you and questions