HARINGEY PALLIATIVE CARE

Haringey Integrated Community Palliative Care Service

ANNUAL REPORT

1st April 2022- 31st March 2023

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NHS North Middlesex University Hospital NHS Trust

North London Hospice

St Joseph's Hospice

NHS Whittington Health NHS Trust

Marie Curie Care and support through terminal illness

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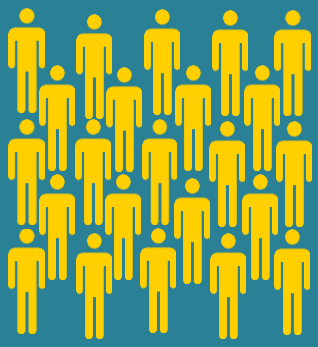
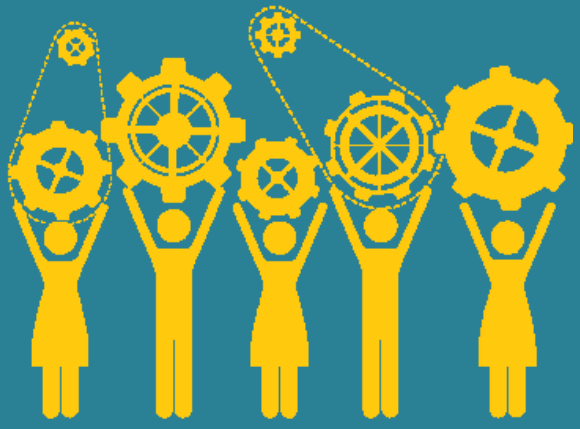
HARINGEY PALLIATIVE CARE

Haringey Integrated Community Palliative Care Service

567 new referrals seen in 2022/23

3.4% increase from 21/22





Collaboration of 5 Palliative Care Providers

PCSS via NLH: provided hands on care for **76** patients at home.

Total **229** nights of care.

67% of referrals triaged within **2** days. The average time from receipt of referral to referral to community team is 1.7 days

85% of patients died in their preferred place of death (where PPD is known)

46% Increase in GP Palliative Care Meetings attended

Reaching **27/35** practices

170 clients supported by St Joseph's Hospice's **Bereavement Service** in **1343** support sessions

96% of carers and patients report they were treated with dignity.

Haringey Integrated Community Palliative Care Service

Who Provides the Service:
Lead Provider: North Middlesex University Hospital (NMUH)
Main Provider: North London Hospice (NLH)
Provider: St Joseph's Hospice (SJH)
Provider: Whittington Health (WH)
Provider: Marie Curie Hospice Hampstead (MCHH)

Where Team is based: The Laurel's Health Centre, St Ann's Road, Tottenham

Acknowledging the range of needs as well as the range of service providers in a central London borough, and based on the gap analysis led by Haringey CCG in 2014, the Haringey Integrated Community Palliative Care Service was set up as an innovative collaboration to combine the specialist skills of three hospices and two acute Trusts. Aims were to provide an excellent, NICE-compliant 24/7 Palliative Care Team, a bereavement service and importantly, support and a regular monitoring option for patients who might not have specialist palliative care needs.

Service Aims: The core of the service is the multidisciplinary **Haringey Palliative Care Team (PCT)** which will support and coordinate the care of people with advanced, life-limiting and incurable conditions, who require palliative care above the level provided by primary care. The set-up is in line with national recommendations and HCCG's End of Life Strategy.
All referrals for patients at the end of life (defined as "last year of life") will be processed by the Triage Service, and if not suitable for outpatient or community specialist palliative care will result in direct advice, onward referral or signposting to other services. In addition the PCT is supporting GP's Palliative Care meetings and works in close collaboration with the Haringey District Nursing Team.
Since 2015 the **Bereavement Support Team** is offering counselling to families of Haringey patients. This is provided by a professionally led team of trained volunteers. In the first phase only for families of patients known to the Haringey Palliative Care Team, the bereavement support is now available to all families of Haringey patients who died from a terminal illness.
The PCT is running a continual **education programme** for Health Care Professionals in Haringey linked into existing teaching programmes in the area, and offer further training according to identified needs.

The Haringey Palliative Care Team (PCT) is a multi-disciplinary team which works in partnership with Hospice inpatient and outpatient services, other primary and secondary care teams and other health and social care providers. The team consists of Clinical Nurse Specialists (CNS) and a CNS team leader, further nursing roles, medical consultants, social workers and administrative support. The triage team at the NLH also forms part of the team.
The overall management of the service is through the NLH Associate Director of Clinical Services, whose responsibility include the Barnet and Enfield PCTs. We provide a 7-day visiting service and out of hours advice is obtained via the NLH inpatient unit staff and a new designated OOH CNS service. This, as well as the Palliative Care Support Service, are funded separately to the Haringey Service, and run by NLH for patients in Haringey.
Part of the team, employed by St Joseph's Hospice, is the Bereavement Coordinator, who is leading the volunteer counselors' team.

Haringey Integrated Community Palliative Care Service

Together with the District Nursing Team and supported by the 3 local hospices, the PCT forms the **Haringey Integrated Community Palliative Care Service (ICPCS)** which operates alongside and supports the primary care services (GPs, nursing homes, community specialist nurses, medicine of the elderly community services etc.) to provide high quality care for patients approaching the end of life. The service will be easily accessible and will strive to adapt to the clinical and educational needs of the care providers.

Objectives: All people approaching the end of their life will:

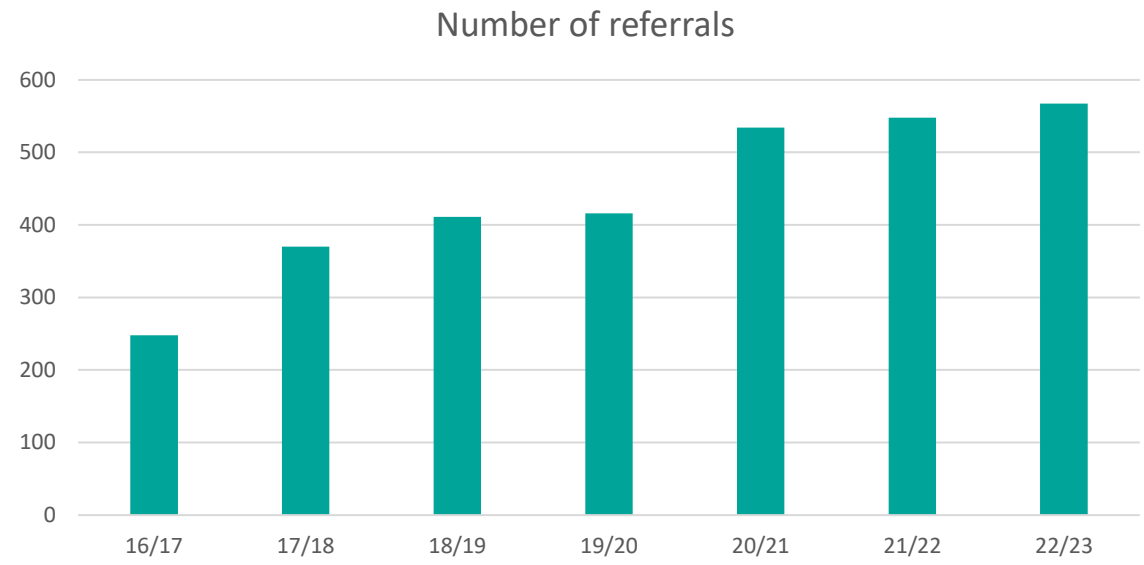
- receive high quality care, treatment and support to meet their assessed needs, including patients with dementia or frailty syndrome;
- have the opportunity to make informed decisions about their care and treatment, in partnership with health and social care professionals and with their families and carers;
- will receive support appropriate to their needs to enable them, wherever possible, to die where they wish;
- not suffer from unnecessary pain and other symptoms and will be able to access specialist palliative care advice if needed in earlier stages of their disease.
- And carers and families (including children) of people approaching the end of life should have their own needs assessed as part of the patient's holistic assessment and regularly reviewed, and will be offered support appropriate to their needs and preferences, including after a patient's death.

In addition to the partnership the North London Hospice along with the ICB fund the provision of the Palliative Care support service PCSS

Haringey Palliative Care Team KPIs

- Extension of Specialist Palliative Care services to reach at least 75% of residents whose death is predictable **600** new patients per annum
- **Consistent triaging** of all new referrals and response times that are in line with degree of urgency. Referrals are triaged into RED (seen within 24 hours), AMBER (seen within 3 days), GREEN (seen within 14 days)
- An increase in the % of patients under SPC who **have a UCP record**
- An increase in the % of patients who **die** under SPC who have a **UCP record**
- An increase in the % of **GP practice Palliative Care meetings** attended to support increasing indentification of those in the last year of life
- An improvement in the number of patients known to SPC who **die in their preferred place of death**
- An improvement in the number of patients receiving care from SPC Team who **report high quality care**
- An improvement in the % of people closely affected by a death who report high quality care
- A **reduction** in the % of borough residents **dying in hospital**
- A **reduction** in non-elective admissions of patients in the **last 90 days of life**
- **Review and maintenance of Urgent Care Plans (UCP but previously known as CMC)** for patients referred to SPC services to ensure that they are relevant to the patient's care

Haringey Community Palliative Care Team- Referrals



Key Performance Indicator

There was a significant increase in the number of direct and indirect (advice only) referrals in 20/21 due to COVID but referral rates have risen a further 2.6% in 21/22, 3.4% in 22/23

567 Referrals to the Community Palliative Care Service between **April 2022 and March 2023**

55% were for patients with a cancer diagnosis and 45% were patients with a non-cancer diagnosis

First Contact Team at North London Hospice

In 22/23 there have been xxx First Contact referrals to ALL NLH SERVICES on behalf of Haringey Patients.

67% **First Contact Referrals triaged for Haringey within 2 working days (some patients delayed in hospital). The average time for processing all referrals was 1.8 days (2.28 days 21/22) (excluding w/e and BHs)**

Key Performance Indicator

RAG	No referred	% visited within timeframe
RED Seen within 24 hrs	31	77% (100% of delays non staffing related reasons)
AMBER Seen within 3 days	281	50% (98% of delays non staff related reasons)
GREEN Seen within 14 days	195	77.4% (98% of delays non staff related reasons)

Reasons for patients who are not seen within timeframe are captured including deaths before being seen (DBBS), staff related delays and non staff related delays. All DBBS are investigated.

46% increase in GP palliative care meetings attended in 22/23

Key Performance Indicator

	REACH=TOTAL 35 GP PRACTICE MEETINGS	TOTAL No GP MEETINGS ATTENDED
21/22	18/35	65
22/23	27/35	95

The team have continued to meet regularly with GP Practices to discuss Palliative Care patients and plan their care. The meetings ensure vital communication across services and encourage GP's to identify a palliative care register. All practices continue to be offered regular meetings.

Haringey Community Palliative Care team- Patient Outcomes

In 2022/2023

319 Patients on Community Palliative Care Team case load died (380 21/22 ,344 20/21)

61% Died in their usual place of residence either home or care home (69% 21/22, 50% 20/21)

24% Died in hospital (13% 21/22, 14% 2020/21)

11% Died in hospice (13% 21/22, 14% 2020/21)

Key Performance Indicator

85% of patients known to the community palliative care team die in their **Preferred Place of Care**

(known to PCT who are recorded)

There is an unexpected increase in hospital death rate this year. This may not indicate a trend however a audit of these 78 deaths is underway to provide a narrative

81% of patients died with a UCP in place during 22/23 cf **81%** 20/21

Overall **80%** died in a place *outside* the acute sector. Where patients have a UCP care plan **20%** die in hospital; nationally **47%** die in hospital*

*National End of Life Care Intelligence Network, NEOLCIN, 2015-16

PCSS funded by CCG and NLH Not part of Haringey service

76 Haringey patients received care from the PCSS service. A total of **229 nights** of care was provided

In 2022/23 **81.5%** (260/319) of patients died with an Urgent Care Plan cf **80.8%** (307/380)in 21/22. The total number of records created was lower this year due to issues creating records when the platform transitioned from CMC to UCP in Q1

Summary

1. **Haringey Palliative Care Team working to increase numbers on caseload who consent to UCP creation**
2. **GP/PCT meetings and GP educational events ideal place to promote use of UCP**
3. **DN's now have access to UCP**
4. **DN Palliative care meetings being held regularly and are ideal place to influence use of logins/access UCP**
5. **GP SPIN programme with local surgery who have run Early Identification toolkit and are inviting patients for ACP/UCP discussions from the palliative care register.**
6. **Focus on updating and quality of UCP records in addition to the number created via audits and sharing best practice**
7. **LAS pathway and access to clinical support has been updated by NLH**
8. **Overall as a system NCL is creating UCP plans that exceeds the numbers of 'expected' deaths in the year. This is the first time this has happened since the invention of CMC in 2011**

Out Of Hours 20.00 – 08.00

On 1st February 2023 ,the North Central London Palliative Advice Service (NCLPAS) was launched with the North London Hospice as the lead provider. Providing out of hours advice and support to palliative care patients living in the London boroughs of Barnet, Enfield, Haringey, Camden, and Islington. (See Flyer) The service is provided in partnership with the NCL integrated Care Board

North London Hospice **no longer provide an overnight visiting service**

Out of Hours 17.00 – 20.00

Telephone advice and support is available from a Clinical Nurse Specialist for patients and professionals.

CNS 7 day visiting service including Bank Holidays 08.00 – 17.00

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Out of Hours Service North London Hospice

Between **2022/23** the out of hours service (**17.00 - 20.00**) dealt with **1244 calls and carried out 41 visits** for Haringey residents. This is an increase in telephone calls and a decrease in visits from 21/22, however the visiting service ended on 01/02/2023. the new NCLPAT service will be reviewed to support the development of the service for the future. We are also monitoring where a visit would have been needed.

Our out of hours service is the first point of contact for London Ambulance Service (LAS) when LAS are called to a patient who is identified as being for end of life care they will contact our out of hours service. The aim of the service is to support people in their preferred place of care and prevent unnecessary/ unwanted hospital admissions.

For **22/23** the overnight service had **245** contacts with LAS staff across Barnet Enfield and Haringey

Palliative Care Support Service (PCSS)

Provide overnight care to people at the end of life or for crisis intervention. The service provide either a Health Care Assistant or a Registered Nurse depending on the individual patient need. The service aims to support people to stay and die at home if this is their wish and to support their loved ones.

The PCSS staff offer practical and emotional support, personal care and the R/Ns can administer medications as needed.

The **PCSS** service cared for **76 people in haringey 22/23:**

48 of patients were referred for end of life care

28 for crisis intervention

The total number of nights covered was **229**

128 Nights were provided by a HCA

101 Nights were provided by a Registered Nurse

Service user surveys sent April 2022-March 2023:

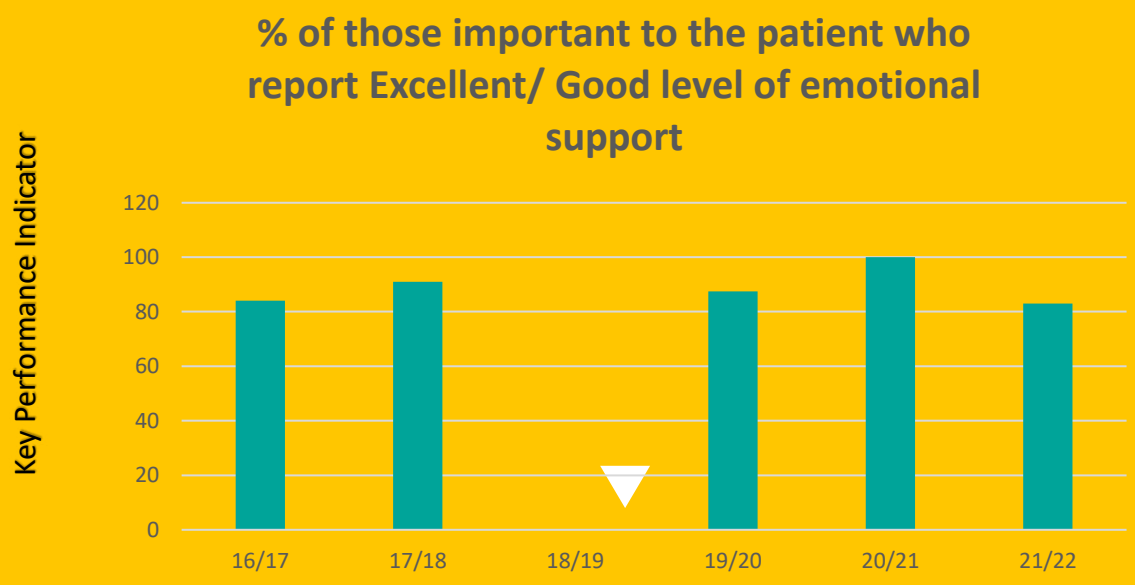
Number Sent:

- 426 Patient surveys
- 248 Carer surveys

Number Received:

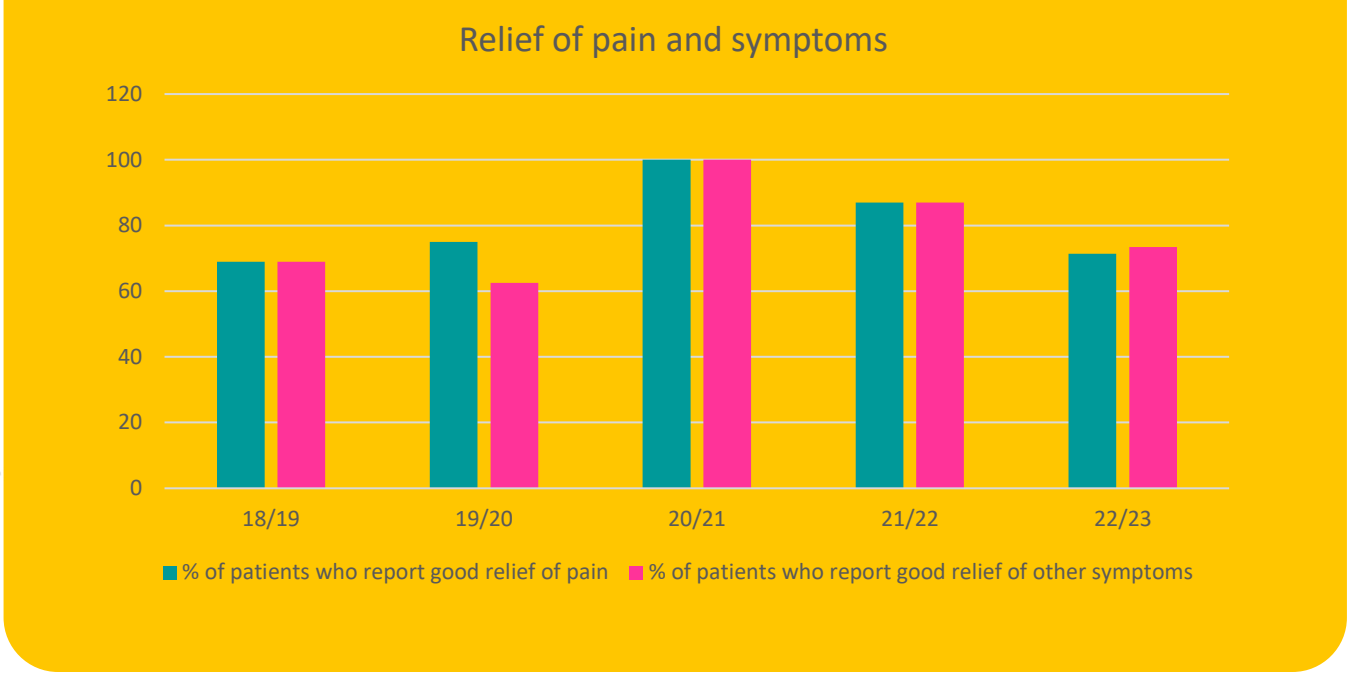
50 Patient surveys– response rate 12%

53 Carer surveys were returned – response rate 22%



Haringey Community Palliative Care Team- Service User Survey Feedback

Key Performance Indicator



Haringey Community Palliative Care Team- Service User Survey Feedback

haringey.cns@nhs.net

An improvement in the % of people closely affected by a death who report high quality care
KPI Target 80%

Key Performance Indicator

	2022-2023
% of patients who report communication and care delivered by SPC team as excellent / good	Communication - 100% Care - 94%
% of patients who report that they were treated with dignity and respect by the SPC team always/ most of the time	* Dignity - 96% Respect - 98%
% of patients who report that control of pain and other symptoms by the SPC team was excellent or good	Control of pain - 71% Control of other symptoms 73%
% of those important to the patient who report Excellent /Good Communication and care for patient by SPC team.	Communication 94% Care 94%
% of those important to the patient who report Excellent /Good relief of pain and other symptoms by SPC Team.	Relief of pain - 90% Relief of other symptoms 90%
% of those important to the patient who report that the patient was treated with respect and dignity by SPC team always/most of the time	** Respect - 98% Dignity - 96%
% of those important to the patient who report Excellent/ Good level of emotional support	90%
% of those important to the patient who report Excellent/ Good level of spiritual support	96%

Haringey Community Palliative Care Team- Feedback from Users we received 31 compliments

'Thank you for all the team who helped and supported our dad, we can't thank you enough… he got his wish to die at home and we wouldn't have managed without you … thanks again you are amazing…'

'Thank you' to the social worker for the support over the past months' This relative felt so alone, until the social worker took time to listen to her '

'..I want you to know how grateful I am for the support you gave my brother and I, ….you do your job with such compassion, care and understanding…'

'….Your care and kindness was amazing you made my loved one feel so comfortable..'

'…You are doing a wonderful Job…'

'Thank you for responding so promptly… your team came within hours of a referral and eased my father's symptoms and calmed us down, … from the triage to the first visit I cannot fault the team and will be forever grateful for the kindness … I take comfort that he was peaceful at the end thanks to your team…we were listened to and treated with such compassion.., thank you '

'your team were so supportive and provided excellent care throughout'

There were 5 formal complaints to the service between 22/23

You said

The team were not responsive when a visit was requested by a family and the patient was not prioritised.

We did

We have recruited to vacant posts within the team, carried out a reflection with the staff to share learning, discussed prioritisation with the team, to ensure patients visits are continuously prioritised on individual clinical need throughout the day.

You said

We did not provide adequate symptom management for a patient at the end of life, who was not prescribed the correct dose of medications and there was no syringe driver available to the district nurses. Family were unable to get end of life medications out of hours.

We did

We have clear guidance for anticipatory prescribing end of life medications in place, all staff were reminded of the guidance and reflection was carried out to share learning with the staff involved . Syringe Drivers are supplied by Whittington health who have agreed to ensure there are enough syringe drivers available for patients. The NLH have a syringe driver for emergency use in the haringey office.

You said

We did not communicate effectively with the District Nurses(D/N), we did not follow up emails with a telephone call to speak directly with district nurses. We said district nurses would visit within an hour and if they didn't visit we did not visit either.

We did

We responded to this complaint jointly with the District Nurses we have reminded our staff that we cannot give a response time for other services. We now have an escalation plan in place if district nurses cannot respond to requests to visit, then the palliative care team are aware of their responsibilities to respond. The team will be delivering end of life care training to the district nurses June 23. Communication training for all staff planned for 23. emails to D/Ns will be followed up by telephone contact especially when requesting visits to provide end of life care/administer medications.

Haringey Community Palliative Care Team- Highlights and challenges 2022/2023

1. For the first time, the team have been fully staffed.
2. Outcomes from joint working: Regular joint MDTs with Enhanced Health in Care Homes (EHCH team), Respiratory team, Learning disabilities team & Complex neuro forum

3. Teaching and training- successful cross sector educational event created by Dr Louise Restrick(Respiratory WH) and Dr Gabi Brogan (Palliative Care) to engage community palliative care/ respiratory services WH NMUH and facilitate joint working. Following from this joint working in the management of community patients has improved.

4. 'Just in case leaflet' for patients and relatives has been designed by the team following feedback requesting more information about EOL just in case medication

5. Creation of Haringey Services contact sheet to signpost patient's and relatives

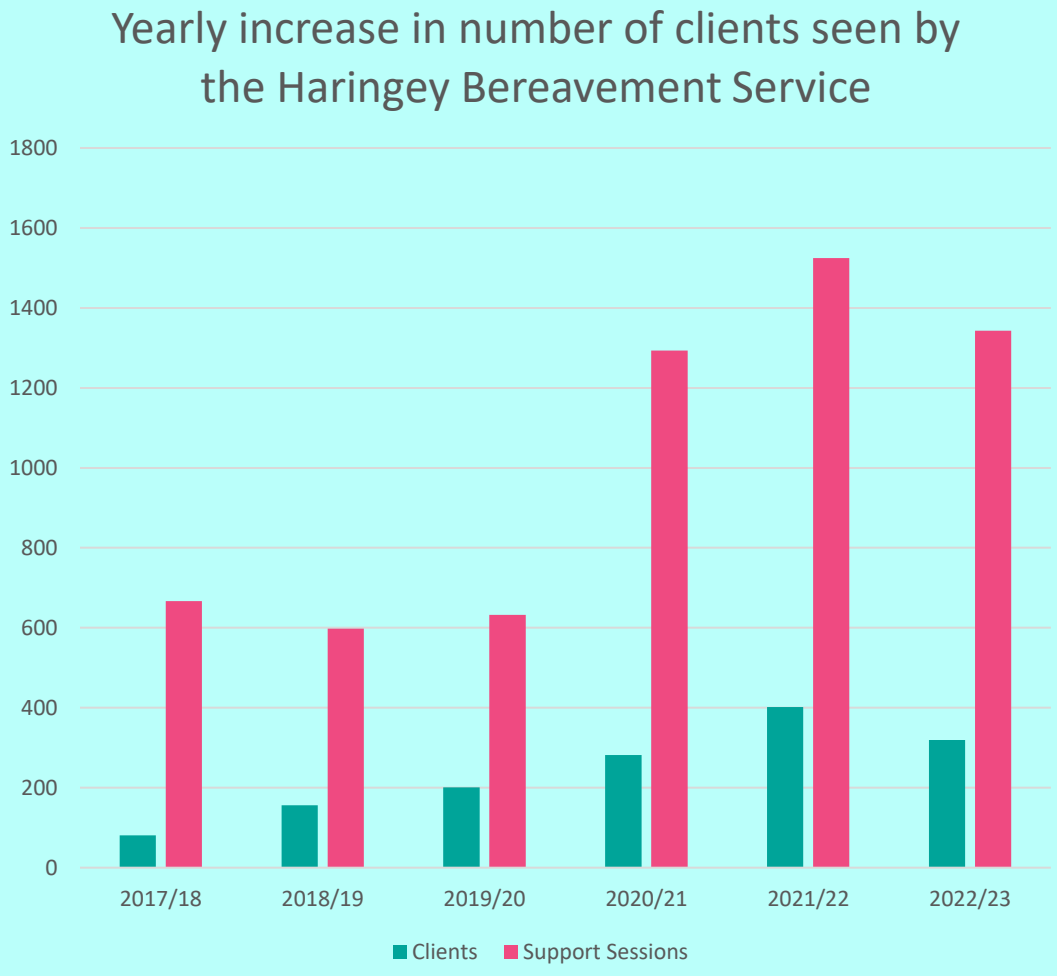
6. Increased number and attendance at GP palliative care meetings (Haringey leads the way across NCL)

7. Ongoing commitment to creating more Urgent care plans and improving quality and influencing GP colleagues- audit and QI project underway
8. Joint working with DNs regarding complaints

Haringey Community Palliative Care Team- Plans for 2022/2023

- We are committed to the ongoing use of UCP and are working closely to increase the number of UCP records and the quality and updating of these records.
- Work with Care Homes in Haringey and EHCH to support ACP/UCP usage
- Continue to encourage GP/Palliative Care Team meetings and support identification of patients on EOLC register.
- Work with DN's to maintain Palliative Care Link Nursing and extend teaching & joint meetings
- Continue to develop the team's knowledge and skills by encouraging attendance at in house CNS teaching, undertaking Physical Assessment and Nurse Prescribing qualifications
- Work on CQC feedback which was received in April 2023 and will be detailed in 23/24 Annual Report

Haringey Bereavement Service



Haringey Bereavement Service

Summary

- With the expiry of a period of enhanced service funding in early 2022 (which enabled the Haringey Bereavement Service to appoint an additional part time coordinator/counsellor and increase volunteer counsellor capacity), the funded staffing establishment reverted to one part time coordinator/counsellor (0.6 WTE) supported by a part time service administrator (0.2 WTE) during 22/23

- Despite a moderate decrease in 22/23 referrals and counselling sessions compared with 21/22, service demand remains twice as high as it was in 19/20. With reduced staffing capacity, this has inevitably impacted upon waiting times (see below). However, changes to the way in which the service is provided (e.g. tightening eligibility criteria, streamlining assessments) has significantly helped in mitigating the impact

- The expiry of the enhanced funding has necessitated a significant change in core eligibility for the service in 22/23; from 'bereavement by any cause' to 'bereavement of someone following terminal illness'. This change is likely to account for most of the decrease in referrals in 22/23 compared with 21/22

- Key figures:

- Total number of referrals in 2022/23: **170**. Total number of support sessions provided; **1343**
- Increase in the average length of time between receipt of referral and assessment from **20 days to 23 days**
- Increase in the average length of time between assessment and first counselling session from **90 days to 122 days**

- The overall client satisfaction rating for the service in 2022/23 was exceptionally high with **91%** of all clients reporting that they coped better at the end of the counselling sessions.

Whittington Health District Nursing Service

- The Whittington Health District Nursing Service in Haringey continue to providing treatment and supporting patients within the local community. Ensuring housebound patients receive safe care in their home and preventing hospital admission. As all services have recovered to pre-pandemic levels the District nursing service continues to work closely with other community services enhancing patients care as referrals are more robust with more MDT involvement.

- The district nursing service continues to work closely with the NLH palliative team and continue to form links.

- The district nursing professional development team are working with the Haringey palliative team to arrange ongoing palliative training and inviting the palliative team to attend District nurse forums to enhance and share knowledge/updates for better outcomes for all palliative/end of life patients.

District Nursing-Caseload and Contacts

- Urgent response nursing assessment teams within the service are functional, assessing patients within 48 hour of receipt of referral. Awaiting to be fully integrated with other urgent response services as consultations draws to a close.

- Caseload cleansing and management continues within the DN teams with consistent monitoring.

- Establishment of urgent response team within the service enables new patient initial assessments to be completed in a timely manner. Enabling the clinicians within the team time for palliative patients and to ensure all systems including equipment/medication/referrals/education are in place to make the patients comfortable and safe in their homes.

District Nursing-Caseload and Contacts

- The district nursing overnight service covers both Islington and Haringey. The overnight service merged with the rapid response service in July 2020 and continue to work closely together to date. Responding to LAS calls overnight including those that might have been about palliative care / end of life care patients.

- Friends and family tests have recommenced with good response rate from patients and the service working on areas of improvement. The service is working on an additional system to support with patient feedback (QR codes) this is has been trailed in other Trusts and is being considered in the Whittington.

District Nursing-Redesign and transformation

- With the commencement of the Urgent response team patient's needs and risks are highlighted on time. Palliative/end of life medication and charts checked during initial assessment and communicated to the teams and challenges/omissions immediately discussed with the palliative team

- The successful recruitment of substantive staff to the District Nursing service has enhanced the overnight service and has seen an improvement in KPI target of 2hours response time.

- Pall care link nurses have been re-established and closer working between the specialist palliative care team and the DN service.
- Syringe drivers purchased to implement a new system of usage and ownership within teams for quick and easy access
- Staff have access to UCP and ensuring logins are requested as needed
- The District nursing service has gone paper light by moving to digital record keeping. Providing continuity of care and encouraging information sharing between services.

District Nursing Staffing

- Staffing in the DN service in Haringey (and across the service) vacancy rates are currently stable. International recruitment has begun with good interest in the community nursing.
- The Trust continues to support staff development and progression.
- Wellbeing has been a focus within the trust particularly in WRES (workforce race equality standards) and outcome of staff survey to improve retention rates and boost staff moral.
- Safe reflective space being arranged for BAME staff to share experiences away from work environment
- Feedback from the community division of Whittington health of which district nursing makes up a large part of is that wellbeing should continue.

District Nursing- Choice of Place of Death

- Target is currently 70% with 1 teams currently at 100% the service continues to strive to get to 100% in all teams. This is work in progress.

- The service continues to prioritise patient's choice and are working with patients and families on preferences ensuring this is

District Nursing- Summary and next year

- Adult community services re-design includes new Enhanced Home care service and the MACCT (anticipatory care team) both whom work closer with palliative care and district nursing. Ongoing discussions on patients at MDT meetings and continued matron support
- Closer working with pall care team, rapid response and District nursing work in progress
- The Pan London MAAR charts are in use staff have full understanding and continued monitoring
- The palliative team continue to work closely with the District Nurses. There are scheduled meetings within each team to discuss patients of concern and symptom control to improve end of life care for both patients and support for families
- Continued improvement in communication and collaboration between District nurses, palliative team and GP for end of life patients

Haringey Integrated Community Palliative Care Service Summary – Highlights, challenges, future

1. Lead Provider negotiations are in progress and the challenge next year will be to address areas of concern and to improve efficiency of the management of the services. The Operational Board will continue to steer strategic development. Enhanced funding for the Bereavement service is being explored by ICB

2. Recommendations from CQC inspection in April 2023 for service improvement to be addressed

3. Referral rates have increased across PCT, DN, Bereavement and have been met with a responsive service. The challenge will be to maintain further growth with patient safety at the fore.

4. GP Palliative Care Meetings are running across the majority of surgeries and work is underway to further enhance the effectiveness at NCL and local level.

5. Improving relationship and joint working with DN has been a focus following receipt of a joint complaint about responsiveness. There is a motivation between PCT and DN to improve communication and upskilling via regular team meetings, educational events planned throughout 2023/24

6. UCP creation and access is increasing and DN service plan to train staff and facilitate access to UCP for DN's at ground level. Joint palliative care/GP meetings support UCP creation.