Hertfordshire and West Essex Integrated Care System

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Integrated Care Board

PAH -End of Life Discharge Facilitator Post

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Working together
for a healthier future

EoL Objectives Directly Aligning to Priorities

Work area	Priority Objective
End of Life	• Increase the proportion of people who are routinely identified earlier as likely to be in the last 12 months of life & are offered Advance Care Planning / Personalised Care and Support Planning • Reduce the percentage of PEoLC patients suffering crisis A&E attendances and NELs in the last year of life • Improve the quality of the last 12 months of life

The End of Life Discharge Facilitator post supports the alignment to the following:

- The ICB's approved priorities
- Ageing well priorities
- ICS End of Life Clinical Priorities
- Operational Planning Guidance and the UEC Recovery Plan
- Amongst other areas

The pilot is a 'One to Watch' at ICB level to understand the benefits of such a post

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EoL Discharge Facilitator Role – Hard Outcomes

Aims and Objectives	**Outcomes Seen**
To have 2 x EoL Discharge Facilitators plus some Admin support	Recruitment challenges due to short term post – only 1 x Band 7 and minimal Admin
For the postholders to sit within the Specialist Palliative Care Team	Postholder is within the Specialist Palliative Care Team, but works closely with the Transfer of Care Team
To focus on patients who were '*fast* Fast Track'	This is the main focus, but the postholder will support in challenging situations if required
To ensure patients are discharged with up to date information	Interoperability, 'write' functionality. Robust documentation
Improve collaborative working with colleagues and system Partners	Barriers broken down, training needs identified, supportive role
To increase the number of deaths in their preferred place	Enabling packages of care without delay, supporting patients understanding
To increase knowledge and confidence in staff within PAH	Confidence to challenge, training and reflective practice, Gold Standards Framework
To enable changes to pathways to support seamless care	Pathways being questioned
To reduce the number of re-admissions for EoL patients	Demonstrated

EoL Discharge Facilitator – Soft Outcomes and Tracking

To evidence impact we will introduce a KPI patient tracker to capture at patient level:

- Interventions made and steps taken, noting that the first 72hrs crucial in obtaining services in the wider teams and support turn patients round
- Length of time to complete documentation i.e. Fast Track / PEACE plan including if appropriate DNACPR, PPC/D
- Length of stay
- Location discharged to
- Number of re-admissions within 7 days and 28 days of discharge
- Death in preferred place
- Number of carers identified and signposted
- Noting registered GP Practice / Location i.e. West Essex
- Noting place of discharge i.e. person's own home / Care Home / Hospice / other
- Reporting to be sent monthly to support impact

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EoL Discharge Additional Outcomes

- @ End of May 86 patients supported with their Preferred Place of Care
- 49 patients successfully discharged – approx. £57.5k (average 2 x days bed days saved)

<u>Case Scenario 9: L.L.</u>

L.L. was rapidly deteriorating. From discussions, expressed PPD as Home with family keen to get him home ASAP. EoL DF supported by chasing up OT to ensure his equipment ordered for urgent same day delivery, while supporting the ward team that was inundated caring for acutely ill patients and unclear about documentations needed for rapid EoL discharge.

He also had CHC funded BDx1 care package initially agreed but this was no longer appropriate in view of his rapid deterioration hence his previous Fast Track Care Plan was updated by EoL DF and sent to CHC. CHC validated and Care was to start at lunch time the next day but he was discharged home the same day with family bridging on the evening of his discharge and St. Clare's Hospice at Home Team bridging from the morning of the next day while his care package would start at lunchtime the next day. He was also referred to the District Nurses & Community Palliative CNS for a wrap around service in the community.

Successful discharge, with L.L. able to be in his PPC/D. In addition, this potentially saved the Trust several bed days

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Next Steps….

- Ageing Well Funds 23/24
- Continued evaluations
- Continued promotion of services leading to evolvement and education