Innovating for Improvement

A pilot project to develop and implement nurse-led beds for end of life patients within a hospice in-patient unit.

St Gemma's Hospice, Leeds

Project title:

A pilot project to develop and implement nurse-led beds for end of life patients within a hospice in-patient unit.

Lead organisation:

St Gemma's Hospice, Leeds

Project leads:

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Part 1: Abstract

Project Aims

Many end-of-life patients express a preference to die in a hospice but are unable to because they do not have specialist palliative care needs and thus do not meet eligibility criteria for admission. Others are unable to access a hospice bed at an appropriate time due to limited medical capacity to admit them. In-patient hospices originally set up to provide care for the dying have evolved into specialist palliative care (SPC) units, with an increasingly medical focus.

This project has involved developing and piloting a nurse-led service that offers end-of-life care to dying patients with generalist palliative care needs within a hospice environment. St Gemma's Hospice is a 32-bed specialist palliative care unit. The monthly average for the number of admissions, based on the last two years, is 46. All in-patient beds were previously medical consultant led. Under this initiative 4 beds have been assigned as nurse-led and designated to the care of people with a limited prognosis (days to a short number of weeks), but without complex symptoms that require medical input. Whilst there are examples of nurse-led rehabilitation and respite services within hospices, nurse-led end of life care is novel. This project involves experienced hospice nurses admitting, assessing and prescribing medication for dying patients with ultimate accountability resting with a Nurse Consultant rather than a Medical Consultant.

The project has enabled patients to die in the place of their choosing, improve the quality of end-of-life care received by patients and their families, reduce in-hospital deaths, maximise the use of hospice beds, reduce hospice waiting times, and develop nursing skills and knowledge.

Testing intervention

Objectives of the project

- To achieve the patient's preferred place of death
- To improve the quality of end of life care received by the patient and their family
- To maximise the use of in-patient hospice beds
- To reduce Hospice waiting times
- To widen access to Hospice Beds
- To develop the knowledge and skills of the nursing staff, supported by End of Life Care Competencies and End of Life frameworks.

Model of the project

- Nurse Consultant (NC) accountable for care of up to 4 patients in end of life care (EoLC) beds
- NC, Ward Sister, Advanced Nurse practitioner are Non-Medical Prescribers
- Team of Registered Nurses and Healthcare Assistants delivering care
- Patients are admitted by nursing team. Individualised care plan developed which includes prescription of medication
- All patients seen once by a doctor to satisfy death certification regulations.
- Access to medical support and advice if required
- Access to multi-disciplinary team (MDT) and bereavement support as required
- Currently five day service for admissions.
- Aim to offer full 7 day service by end of pilot phase (recruitment underway July 2016).

What has gone well?

- Development of the nurse led end of life care beds has opened up Hospice as a choice for end of life care to patients without specialist palliative care needs, particularly those patients with a non-cancer diagnosis.

- The project team at St Gemma's and our partner organisations (Leeds Teaching Hospitals NHS Trust, Leeds Community Healthcare NHS Trust, Hospice Leadership team, Sue Ryder Wheatfields Hospice & GP End of Life Lead) have worked collaboratively and enthusiastically to ensure a successful project with the following achievements:

We have:

- ✓ successfully piloted a safe, high-quality model
- ✓ received positive feedback from patients, relatives and referrers
- ✓ provided a responsive service to referrers
- ✓ increased bed occupancy and maximized use of hospice beds
- ✓ reduced in-hospital deaths and saved 132 hospital bed days
- ✓ developed and implemented a staff development program
- ✓ developed nurses' skills, knowledge and confidence (details provided in Section 2)

Challenges

- The project was threatened by a shortage of registered nursing staff. Due to staff leaving the organization, at the beginning of our project our nursing establishment was short by 25% which led to temporary bed closures across the in-patient unit (IPU). We had to delay the opening of our EoLC beds by 6 weeks. We prioritized a successful high-profile recruitment campaign which meant the project was back on track.
- For patients in the acute Trust the referral process relied on the ward referring to hospital's specialist palliative care team to assess each patient. We were concerned that this would lengthen referral time potentially delaying patient transfer.
- The project relies on nurse non-medical prescribers (NMP). It takes at least 9 months to train a NMP and register them with the Nursing and Midwifery Council (NMC) as a NMP. We had only 1 trained NMP at the outset of the project.
- There is ongoing need to balance competition for beds between specialist palliative care and end of life care patients.

Outcomes and impact

- 50 patients achieved their preferred place of death and would not have had this option prior to this project.
- We demonstrated that skilled nurses can safely deliver excellent end of life care
- We produced a replicable model of care
- We implemented a sustainable model which has, and will, widen access for patients with a non-cancer diagnosis and for a higher number of elderly patients
- Broadened choice of the preferred place of death for patients and their families.
- Nursing staff involved report increased levels of skill and confidence relating to care of the dying.
- Increased knowledge and skills of nursing staff involved in project.
- We produced a high quality video to capture our project which will be used for promoting our service and disseminating and spreading our project.

Learning

- We need to provide a 7 day service with non-medical prescribers (recruitment underway to increase the number of non-medical prescribers in August 2016)
- We have recognized that a dedicated cohort of beds would open access further when referrals for patients with end of life care needs are presented with those with specialist palliative care needs.
- We learnt the power of story-telling by first hand users of a service and have begun

to use stories successfully in our project and beyond.

- We have furthered our expertise in project management and implementation and feel proud that we have successfully implemented a high-quality project.

Part 2: Progress and outcomes

Intervention to Date

We predicted that we could admit 100 patients over the one year pilot. This was based on 4 beds admitting from September 2015. As we had only 2 available beds between October and December, a reduced number of admissions are to be expected. We realised also that we were overly ambitious and hadn't considered the time it takes to promote a new service so that potential referrers are aware of it. However, we did admit sufficient patients to enable a robust evaluation of the project.

Data was collected on admission and at the point of death for each patient.

To the end of July 2016 we have received 66 referrals, admitting 52 patients into a nurse led end of life care beds. Of those 52 patients admitted, 2 were transferred into a medically managed bed soon after admission. The remaining 50 remained in nurse led EoLC beds. One patient was discharged into a nursing home having improved significantly during her hospice stay and 49 have died in the Hospice. Details of the 14 patients not admitted and the reasons why can be found on page 9.

Equity

We aimed to widen access to our service for groups who traditionally have poorer access to in-patient hospice services. Of the 50 patients admitted 29 (57%) had a diagnosis of cancer and 21 (42%) had a non-cancer diagnosis. For the hospice in general, the split of cancer/non-cancer referrals (for all services) is 80% cancer 20% non-cancer.

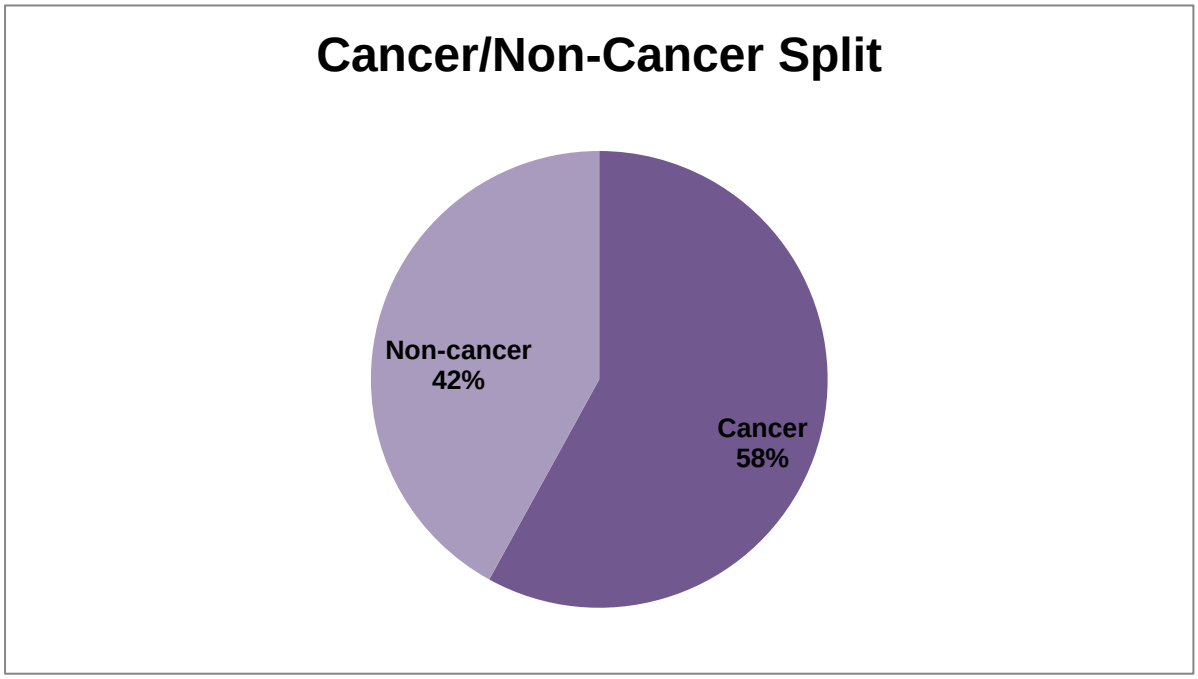

Table 1

Non-Cancer Diagnosis Breakdown	
Bowel obstruction	**1**
Stroke	**4**
End Stage Heart Failure	**3**
Mesothelioma	**1**
End Stage Heart Failure & Renal Failure	**3**
Brain Haemorrhage	**1**
Sepsis (Infected Leg)	**1**
Chronic Kidney Disease	**5**
Old age and frailty	**1**
Vascular Dementia	**1**
Total	**21**
Secondary diagnosis of Dementia	**5**

Table 2

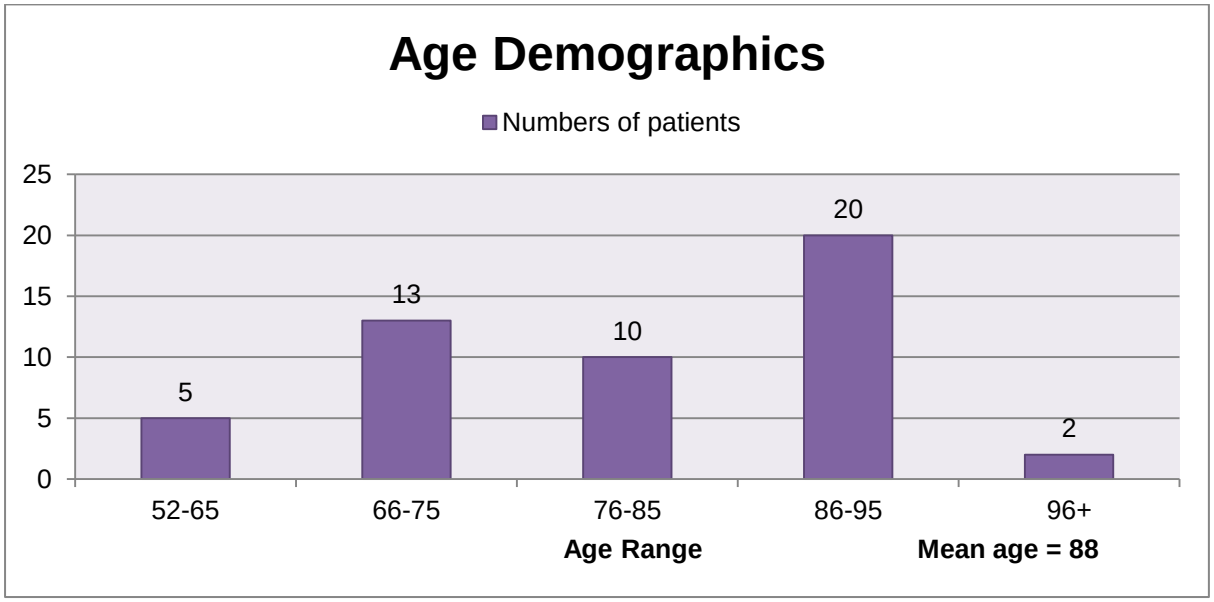

Table 3 AGE DEMOGRAPHICS OF THE PATIENTS ADMITTED

This graph highlights the fact that an older group of patients are accessing EoLC beds. Mean age of patients admitted to the Hospice in general is 71.

Timeliness- Referral Sources

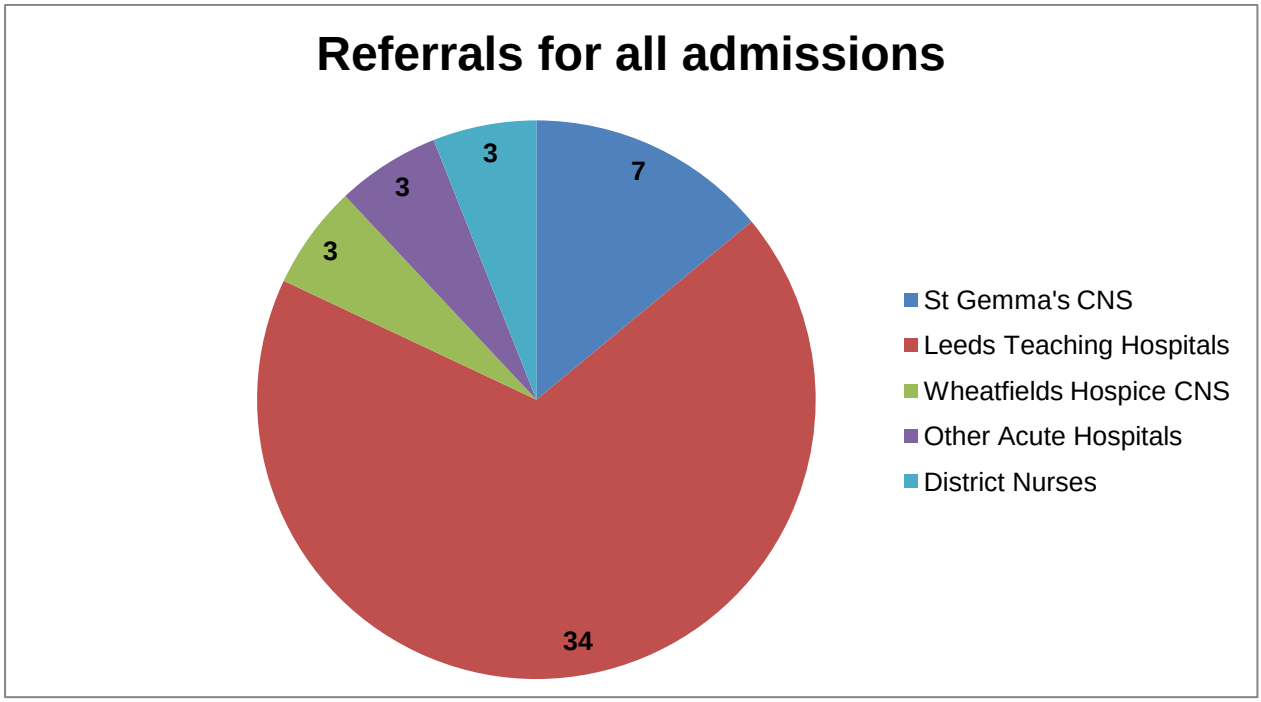

Table 4

(CNS = Clinical Nurse Specialist)

Days Waiting for Admission

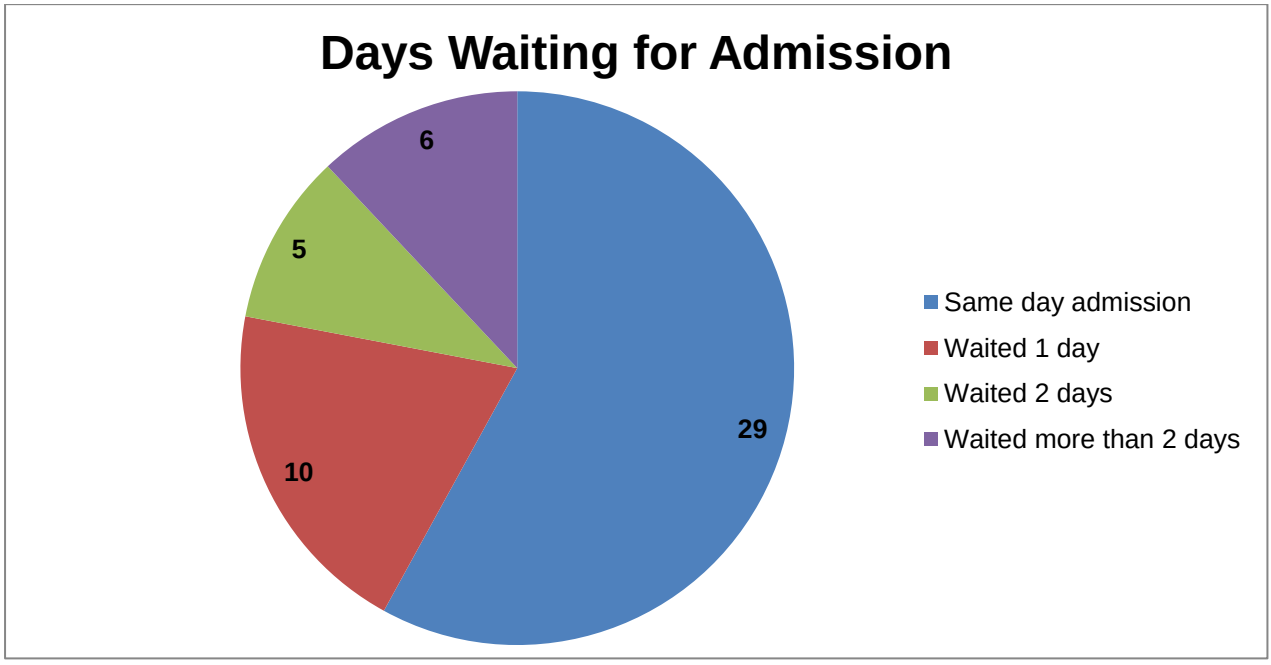

Table 5

One patient waited 7 days due to long waiting list of patients with specialist palliative care needs. For patients who waited more than two days this was because the referral came on a Friday and there was no provision at the time to admit at the weekend.

Detail of Patients Not Admitted to the Hospice

14 patients were referred but not admitted (details listed below.) This data highlights further the need to be in a positon to admit 7 days a week and for beds to be ring-fenced for end of life patients. Currently EoL patients are prioritised along with all specialist palliative care patients at the daily admissions meeting. To ensure equal access ring-fenced beds would provide a clearer picture of availability. This data also highlights the need to be very responsive due to patients' rapidly deteriorating condition. With the addition of a 3rd trained NMP to our team, we are looking at staggering start times to enable us to admit over a longer period of the day enabling more same day admissions.

DATE OF REFERRAL	DATE BED OFFERED	PATIENT DETAIL
09.11.15	**10.11.15**	**Patient died before transfer**
13.11.15	**N/A**	**Family wished for patient to go to Nursing Home as previously planned**
07.12.16	**08.12.15**	**Patient too unwell to transfer**
30.12.15	**30.12.15**	**Patient too unwell to transfer**
11.01.16	**13.01.16**	**Patient requested a side room non-available, too unwell to transfer when one available**
12.01.16	**13.01.16**	**Patient too unwell to transfer**
18.01.16	**20.01.16**	**Patient had died before admission**
25.01.16	**25.01.16**	**Patient wanted to think about admission, bed held, patient too unwell to transfer**
18.02.16	**22.02.16**	**Family requested side room, patient had died when side room available**
11.03.16		**No non-medical prescribers available to admit, patient died the same day as referral received**
08.04.16	**11.04.16**	**Referral received Friday no bed available, bed offered Monday patient too unwell to transfer**
17.06.16	**20.06.16**	**Referral received Friday no bed available, bed offered Monday patient too unwell to transfer**
30.06.16	**30.06.16**	**Patient too unwell to transfer**
05.07.16		**Patient died before bed was available**

Table 6

Outcome Measures

A number of outcome measures are routinely used within the Hospice to determine patients' phase of illness, health and performance status and level of dependency. In total, a suite of 6 measures are used under the term OACC (outcome assessment and complexity collaborative.) All 6 are extensively tested and validated for use in palliative care.

We applied these measures to all project patients and demonstrated that on admission patients were very sick with rapidly progressing disease, heavily dependent and in the

deteriorating or dying phase of their illness. This gives us confidence that we are triaging patients appropriately and admitting patients that meet our eligibility criteria. (For further detail see Appendix 1 point 6.

One patient was discharged. Her OACC data indicated that she was fitter than other patients. This information along with ongoing clinical assessment findings helped us identify that she was appropriate to discharge and she continues to live in the nursing home we discharged her to.

Average Length of Stay

The mean length of stay for the 50 patients admitted was 6 days (median 4 days) the range was from 25 minutes to 28 days. This data proves that we are admitting patients who are clearly in the last days of life. For the patients admitted from hospital the time from admission to death saved 132 hospital bed days.

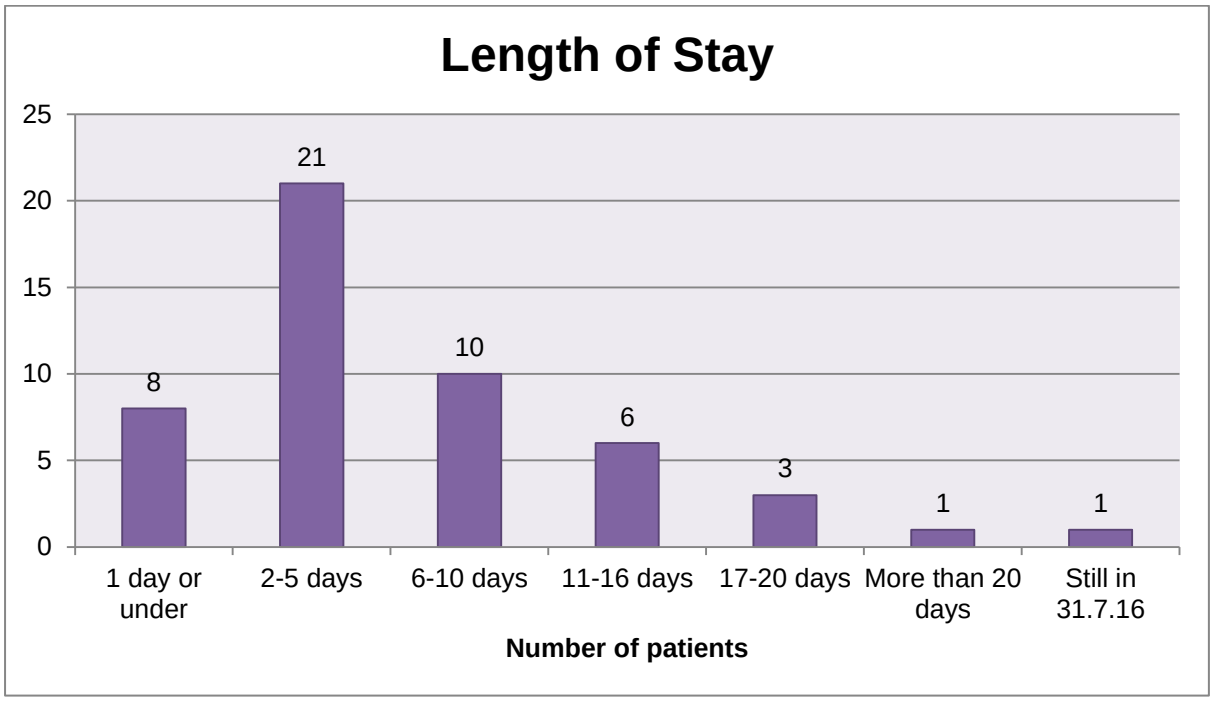

Table 7

Person-Centred Care - Patient Choice

This project aimed to open choice to patients and those important to them who may have had a Hospice as their preferred place of death but did not fit the referral criteria. The chart below details the preferred place of death choices of the patients admitted. For patients whose first choice was home there were care reasons as to why this couldn't be realised

8 patients deteriorated from an acute event (e.g. large stroke) and were too unwell to express a preference. In these cases, family chose hospice on their behalf. In real terms this means that all the patients or families achieved their preferred place of death.

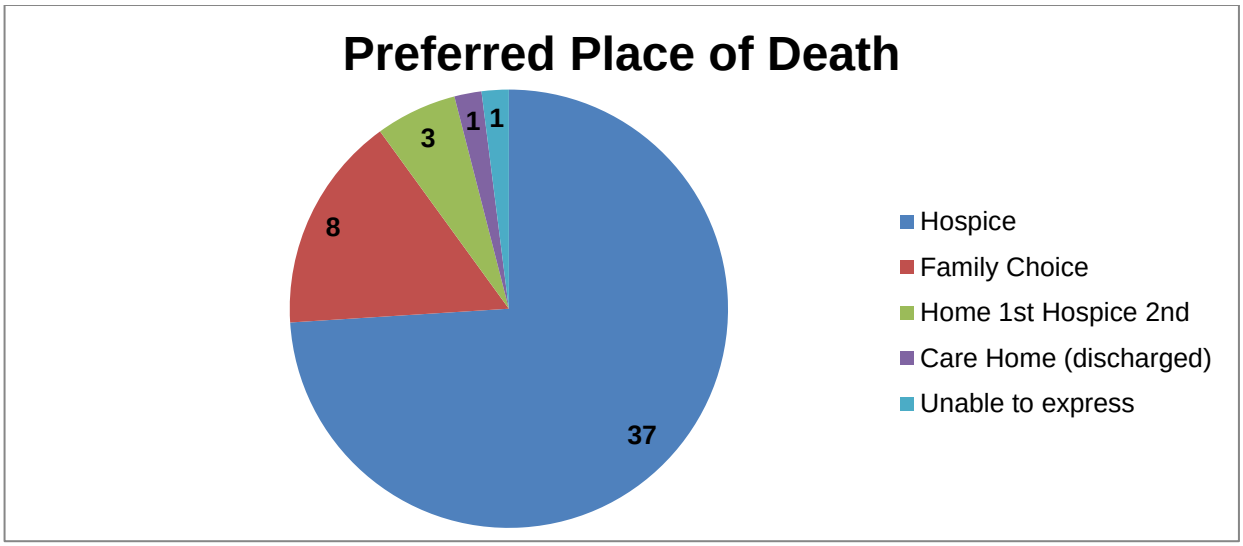

Table 8

Safety

The patient safety issues for the 50 patients admitted to the end of life care beds is detailed below in line with the Hospice's key performance indicators. We are proud that only 1 patient has developed a pressure ulcer as these patients are hugely vulnerable

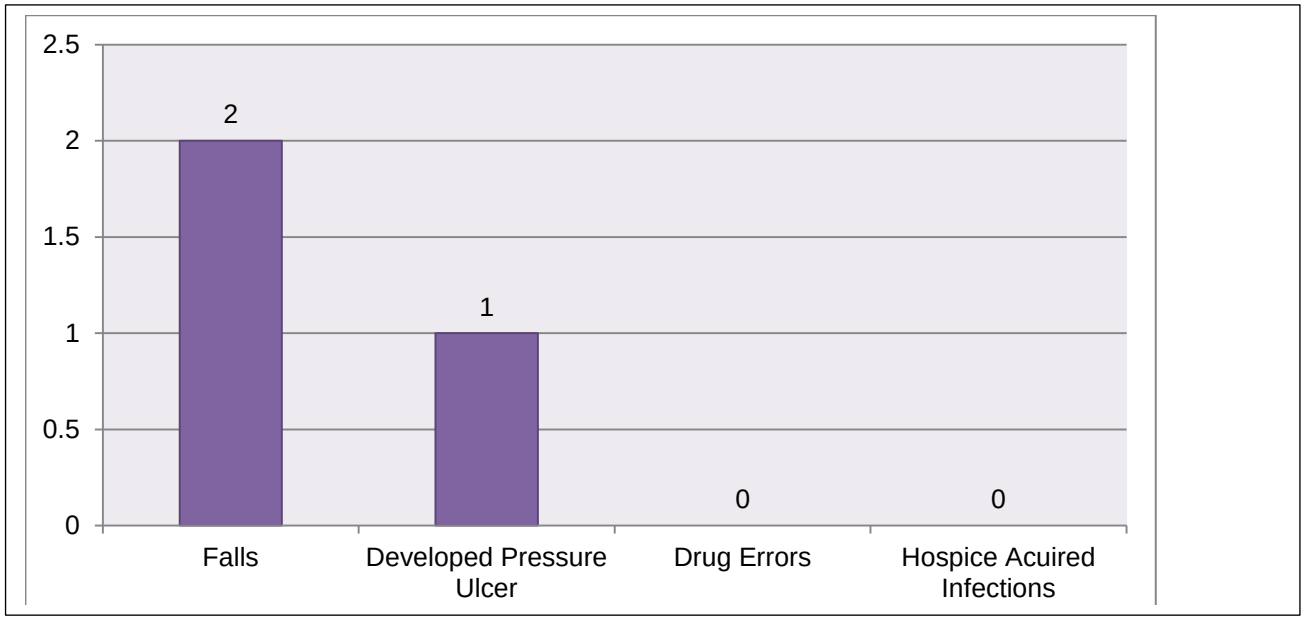

Table 9

Balancing measures:

We have logged the medical intervention required by nurse-led patients in order to ascertain whether a nurse-led team can safely care for this patient group and to help determine whether this model is effective. The level of medical intervention required so far is captured below:

1 routine review in line with policy in order to meet death certification requirements	Medical review in the absence of a non-medical prescriber (at weekend)	Medical advice sought by NMP	Transfer of care to Medical Consultant
N= 22	N= 22	N= 6 This included advice regarding diuretic titration, insulin prescribing, antipsychotic prescribing in Parkinsons disease and to review a patient who fell.	N= 2

Table 10

All patients admitted to our end of life care beds must see a doctor once in order to meet legal requirements that a doctor certifies patient death. The figures above suggest that the majority of patients have had needs that can be managed by a nurse led team with access to one medical review soon after admission. However, 22 patients have required review or admission at times when we have not had non-medical prescribers available (in particular weekends). This is evidence that we do require sufficient non-medical prescribers to cover a 7 day rota. Two patients were transferred to a medical bed soon after admission as it was clear that they wished for active treatment rather than comfort measures/end of life care and this is beyond the scope of our service.

Effectiveness - Family and Carer Feedback

We had planned to use the “Views on Care” patient questionnaire recommended by King’s College London, a 2 part questionnaire which is initiated on the day of admission and repeated 3 days into Hospice stay. Although the tool is validated for Hospice use, our experience has been that the majority of these patients have been either too unwell to complete the questionnaire at all or too unwell 3 days after admission to complete part 2. Instead we have largely had to use relatives as proxies to provide feedback. We have sent a questionnaire to all families of patients who died in the end of life care beds. The questionnaire used a validated format taken from the national ‘Voices’ survey. The questionnaires were sent out approximately two weeks after death and to date we have received 13 completed questionnaires from a total of 41 sent. This is a 32% response rate which is a positive response for a sensitive questionnaire sent to newly bereaved families. Please note due the dates of patients deaths some questionnaires have yet to be sent out.

The questions were aimed to provide robust feedback on the family or carer’s experience.

The first question ascertained who had completed the questionnaire.

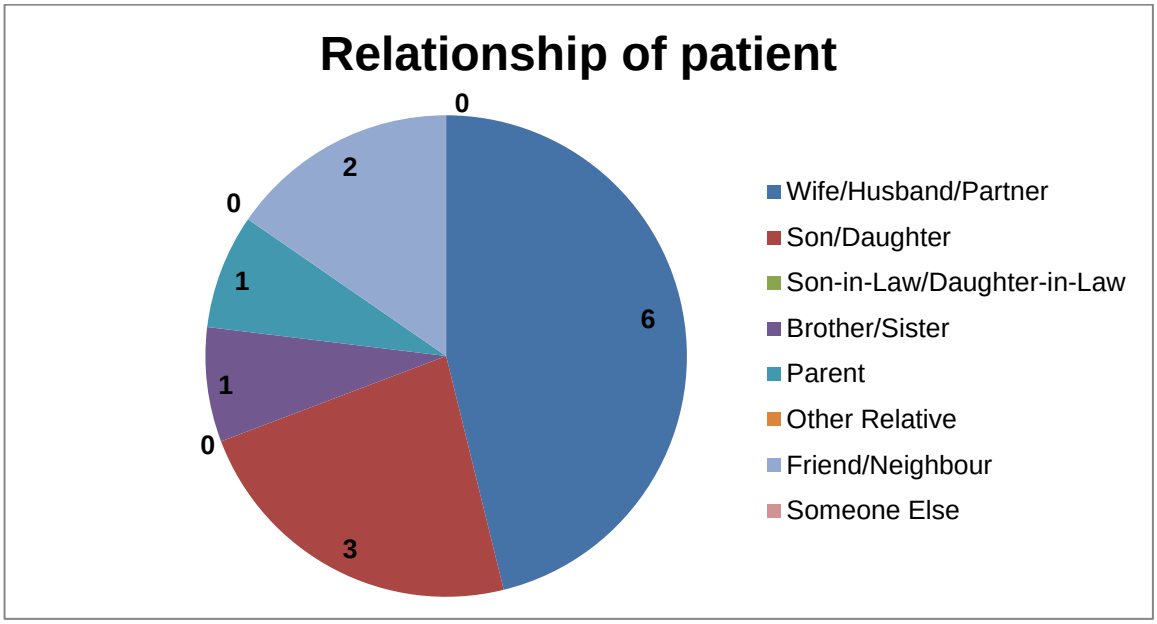

Table 11

The next questions focused on the patient's involvement in decision making about their care. The one respondent identified as 'other' in the table below was asked to provide further detail. This was added in the free text box where they stated "while the word die was not used we were all aware of the implication that the conversation meant".

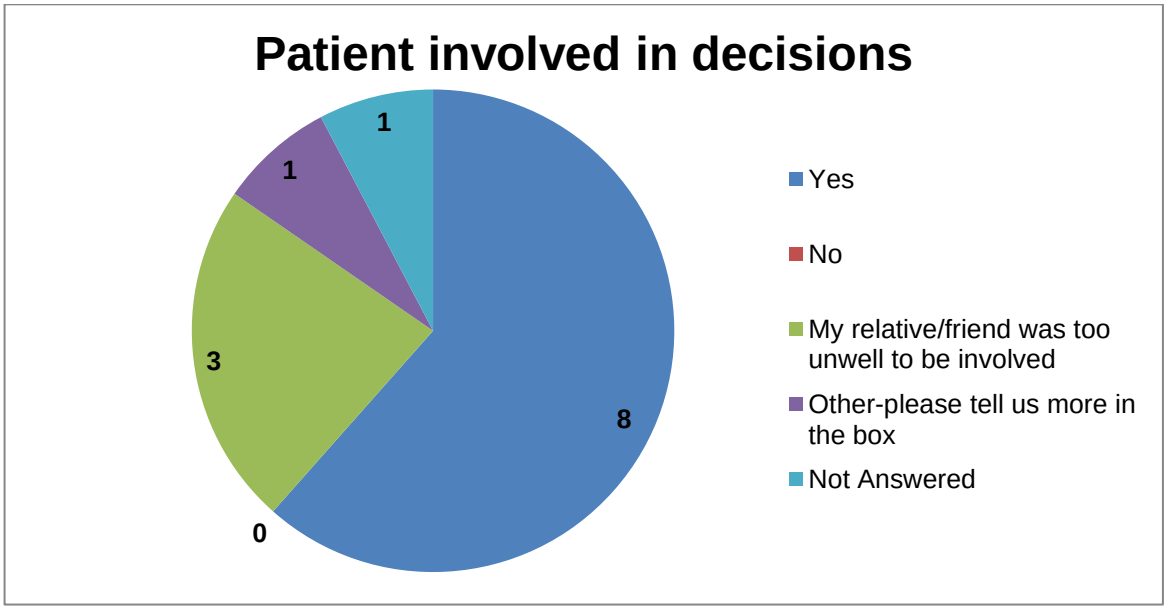

Table 12

The next series of questions asked about satisfaction with care and communication related issues and is summarised in the following tables.

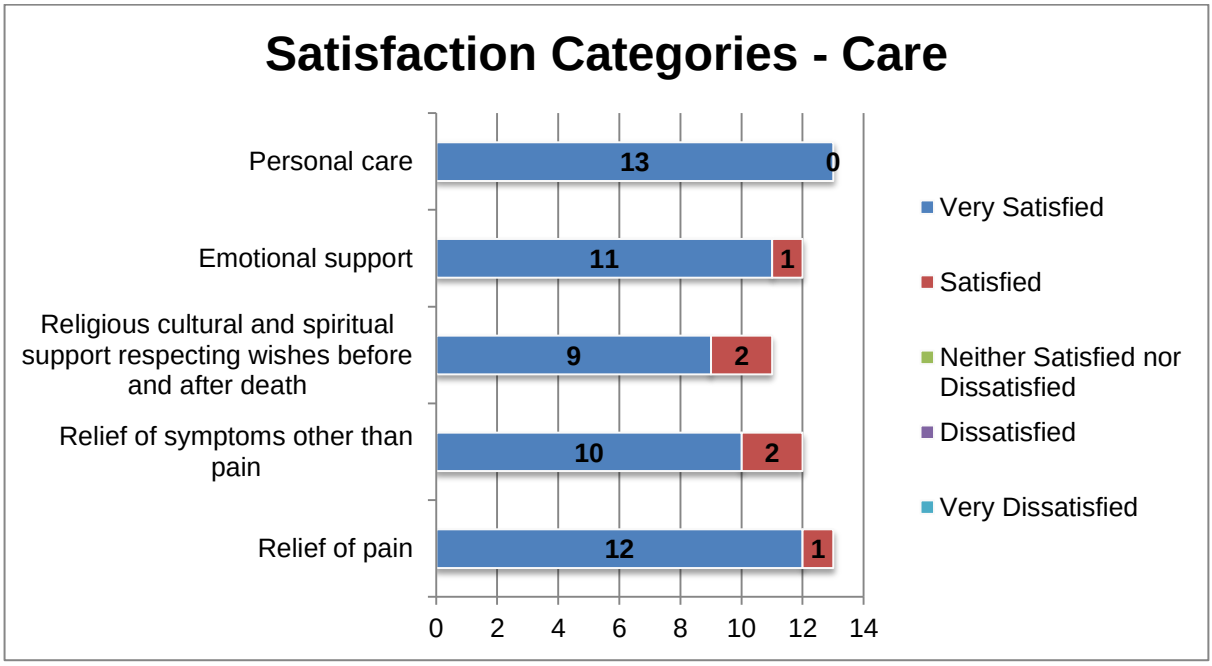

Table 13

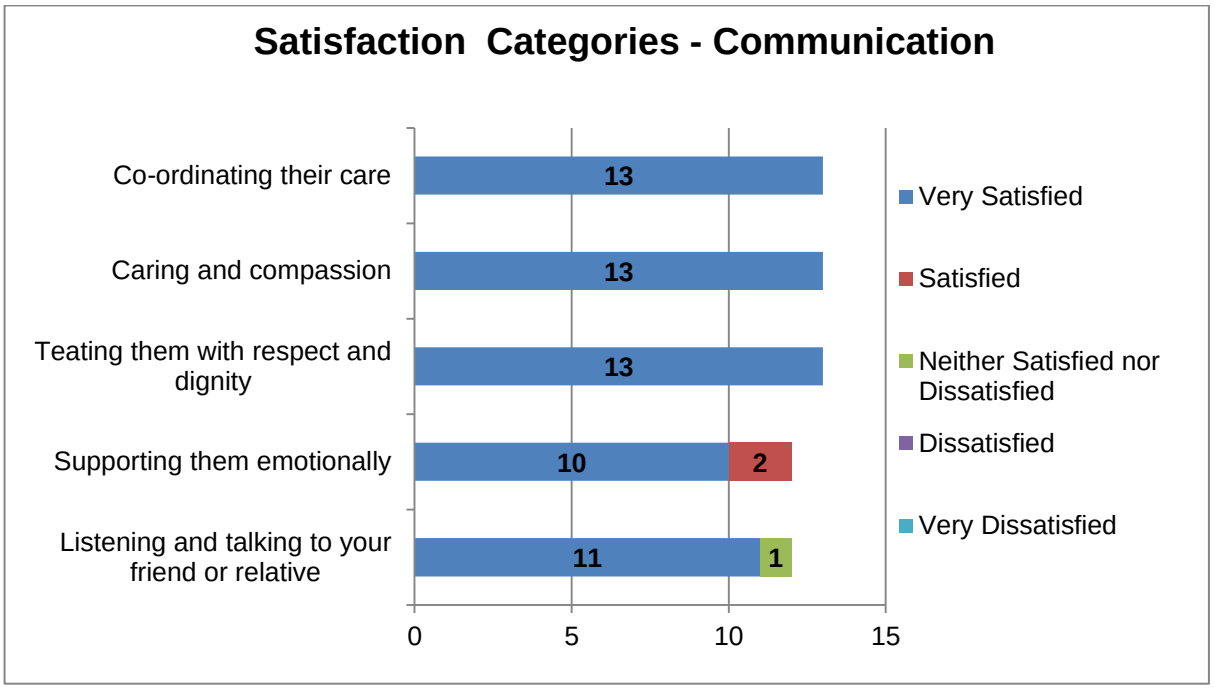

Table 14

Staff Development

The following questions were asked of the Registered Nurses (RN) and the Healthcare Assistants (HCA) who worked with the Nurse Consultant as the team nurses for the end of life care beds. The questions were asked before and after their six months as part of the project.

Each staff member was asked to mark the questions out of ten against three headings knowledge, skills and confidence. The same staff were also benchmarked by the ward Senior Sister against the same criteria. Seventy was the maximum score for each nurse. There were five RN's and 4 HCA's as part of the first team.

The questions were:

Complex communication with patients

Complex communication with families/carers

Admission assessment of patient

Ongoing assessment of the patient

Care of the dying patient

Supporting the family of a patient who is dying

Symptom management

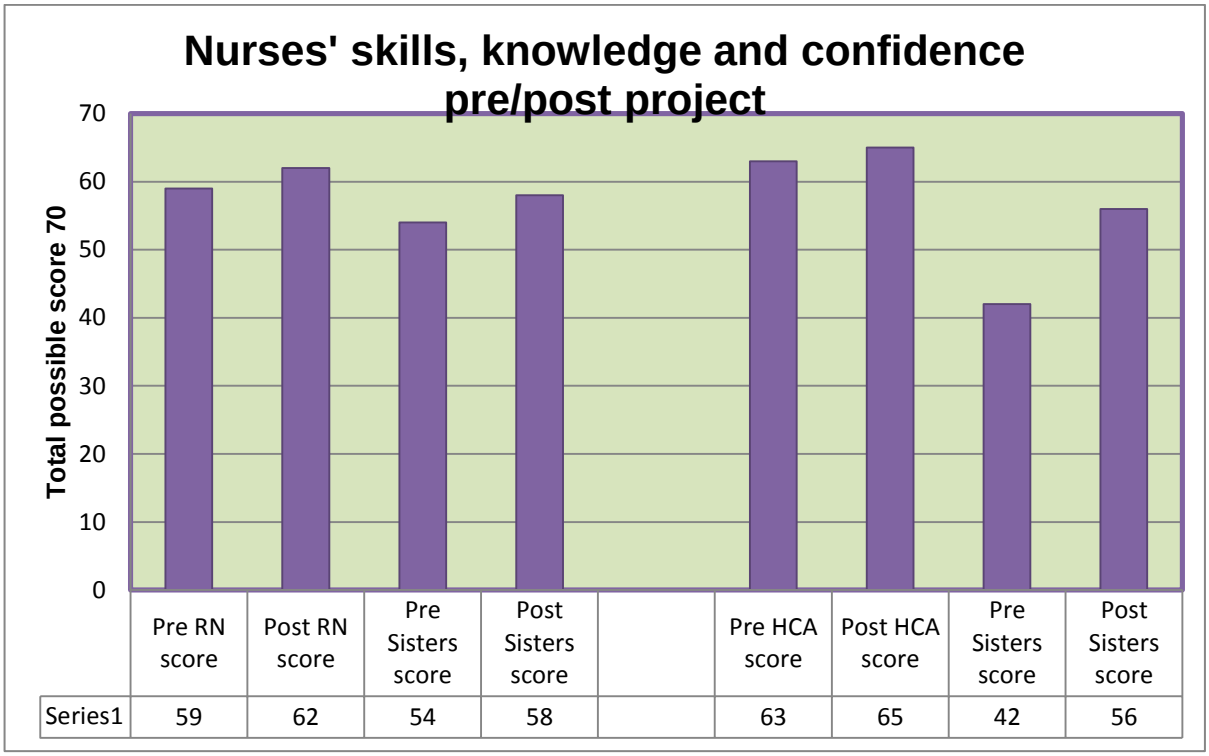

Table 15

Post their six months as part of the project the staff were asked for their individual feedback based on a series of questions, listed below.

What has been your experience of the Nurse Led EoLC beds?

Good experience

Often challenging as families are unaware of what may happen over the coming days/weeks – not prepared by the acute hospital

Would have enjoyed all EoLC patients

What have you enjoyed?

I have enjoyed the support of the Nurse Consultant

Team work is excellent

Being able to make patients final days/weeks of life enjoyable

Giving quality EoL care, looking after patients with different illnesses than cancer

Really enjoyed caring for patients at end of life

What have been the challenges?

The biggest challenge is the patients and relatives are not always fully informed as to what a nurse led bed is (prior to admission.)

Families are not always prepared for the death of their relative (prior to admission)

Hard with EoLC patients and specialist patients in one team as feel pulled in 2 directions meeting differing demands on me.

Need more HCA's

Time, not enough staff

What have you learnt?

I learned a lot from the study days on communication skills

More thorough communication with patients and relatives

To trust own skills at assessing problems and dealing with them

We all give good exceptional EoLC

If we were to start project again what would you do differently?

More nurse prescribers

Patients to be assessed by Hospice prior to admission

Better assessment in hospital so patients and families understand

Extra Healthcare Assistants for this team

Only have EoLC patients in the team and not a mix

Minimise SPC admissions to EoLC beds

Admit EoLC patients into any team but on the same ward

Part 3: Cost impact

St Gemma's Hospice is a charitable organisation. Our services are commissioned, through a grant funding arrangement, by the 3 Leeds Clinical Commissioning Groups (CCGs). Leeds South and East CCG are appointed to act as lead CCG for the management of this arrangement on behalf of all 3 CCGs.

Grant funding provided by the Leeds CCGs, inclusive of non-recurrent project funding, represents 29% of our total running costs 2015/16. The remaining 71% of running costs comes from our local community and includes fundraising, legacies, charitable donations, retail activities and donations.

A recommendation of the Health Foundation at the outset of this project was that we should have a clearer understanding of costs in particular cost per bed. It should be noted that we did not aim to demonstrate any cost reduction or cash releasing savings via this project. Our goals were to enable choice and provide high quality end of life care.

In the process of evaluating the nurse-led beds we have developed a financial model that calculates the cost of our intervention versus the cost of specialist in-patient care at the Hospice. In developing this financial model we have brought together key stakeholders that have helped identify and challenge the direct and indirect costs of providing care on the in-patient unit. We also commissioned an external accountant to support this work. All the financial information used within the model corroborates with our latest statutory accounts

2015/16.

Cost of specialist palliative care bed at St Gemma's Hospice	£397/day
Cost of nurse-led end of life care bed at St Gemma's Hospice	£321/day

Based on the financial model, the cost of nurse-led care within our existing 32 bed In-Patient Unit (IPU) would be £110,960 per year less than our standard specialist palliative care medical model.

We have developed a greater understanding of our costs (and activities that drive costs) and now have complete transparency in the make-up of costs including an accurate assessment of staff time invested across a range of professional disciplines that impact upon patient care. This project has been a catalyst for identifying all the costs associated with providing patient care including the identification and attribution of organisational overhead (support costs, utilities, maintenance etc.). We now have an accurate insight into the total cost of patient care.

The development of this financial model will allow us to better understand and respond to the challenges of the UK palliative care funding review, influence the costing and pricing of bid submissions (to continue to be sustainable and affordable) and improve cost transparency and benchmarking across the Hospice (and within the sector).

In undertaking this project, the project manager has gained a wider understanding of cost analysis via her time spent with Hospice Chief Executive, Director of Corporate Services and Head of Finance. She has also taken part in the Health Foundation economic evaluation webinar.

We had hoped to compare our own costs against the cost of hospital care (due to the fact that in transferring hospital patients we are potentially reducing the cost of their NHS care). We have learnt that comparing our own costs against hospital bed costs is challenging and is not a like-for-like comparison in terms of what is included in the cost quoted. Leeds CCGs pay a set tariff for an admission of up to 7 days regardless of how long the patient was a hospital in-patient. Beyond 7 days, a daily rate is charged. We are pursuing external support to help with this.

As a result, we have begun to record the length of time that hospital patients transferred to our beds had been in hospital as well as the number of hospital bed days saved by their transfer to hospice. To date, we have saved 132 hospital bed days by transferring hospital patients into Hospice EOLC beds.

Health Foundation grant funding has covered the Nurse Consultant's salary in addition to other project costs during the set up and implementation phase. This has allowed us to establish a new service. The ongoing running of the service is now integrated into the job roles of the staff involved and salary costs will be covered by St Gemma's Hospice. In its current form, the project is cost neutral as we have not increased nursing capacity. However, as mentioned, this pilot has demonstrated the need to provide 7 day non-medical prescribing cover. As a result we will be employing an additional Band 6 nurse. 0.6WTE of her time will be dedicated to the service to enable 7 day cover 365 days/year. As the Nurse Consultant is responsible for care of 4 patients, this lessens pressure on medical time and is significantly cheaper than specialty or staff grade doctors.

The majority of implementation costs including staff training and change management activity have been met via the money we have received in our Health Foundation grant (see Appendix 2).

Part 4: Learning from your project

Achievements against our aims and objectives

- We have successfully piloted an excellent model of Hospice based nurse-led end of life care enabling a wider group of patients to die in their preferred place. We have proved that a nurse-led model can deliver high quality, safe care that is highly regarded by patients and relatives who are receiving the service.

- We have successfully widened access to hospice beds particularly for non-specialist patients, non-cancer patients and older patients.

- We are able to triage patients in order to identify those that meet our criteria enabling us to meet their needs.

- We have been successful in reducing in-hospital deaths.

- We have opened up an alternative option of a place of death for hospital patients which was not on offer previously.

- Our success is due to a very productive collaboration between project leads. Supporting each other and being motivated to driving the project forward from its outset, and proactively confronting the challenges. We have had support from our Hospice Leadership Team and Board of Trustees and have ensured they were well informed throughout the project. We formed a stakeholder steering group which was pivotal to joint working and multi-agency teamwork to ensure that the needs of patients were the core priority within the model. Where the model required adjusting or problems arose, we were able to address them openly.

- The Nurse Consultant leading this project has an established reputation within the Hospice and amongst local palliative care colleagues. This proved really helpful. She had a proven track record in terms of her ability to assess and manage patient care safely and competently. She also had good relationships with others which were helpful in terms of assessing the progress of the project honestly and in terms of discussing individual patients with referrers.

- St Gemma's has a culture of embracing innovation and change. Our project enabled us to meet a need identified at a local level and address a Hospice strategic aim. As it has proved successful it will be sustained.

- We ensured staff involvement by a variety of means; staffs were briefed from the beginning. Ward management were involved in decision making. Staff were consulted and updated with feedback as the project progressed. Staffs were involved in the preparation for the start of the project and views were sought as it evolved ensuring their continued involvement.

- Certain groups (e.g. Hospice Board of Trustees, medical staff) expressed caution regarding the innovation. Meetings were held to address their concerns and regular updates were provided.

Please tell us about the challenges and the things that didn't work out quite as planned

- We predicted that we would admit 100 patients during the pilot phase based on population data for the city of Leeds. We did not achieve this aim for a variety of reasons. The delayed and staggered start of our project reduced our capacity to admit. We also learnt that we had underestimated the time and resources required to publicise any new service

in a city the size of Leeds. Having identified this as an issue, we have invested time and resources to promoting the project during the latter half of the project period. This has included face to face meetings, written publications and promotional materials such as quick reference guides, patient information booklets and a promotional video.

- We had concerns that the referral pathway and process which was agreed with our acute hospital trust colleagues potentially delayed referrals or excluded patients who may have benefitted from our service. We have openly discussed our concerns with those colleagues and moved forward in a positive way. As a result of our discussions, we have agreed wider access to publicise our service across the hospital trust.

- The project has been hugely dependent on good communication and trust. We have faced challenges from hospice medical colleagues at times. Some of these challenges could have been easily addressed through their active involvement in dedicated project steering and operational groups. However, the medical representatives on these groups were often absent. Instead the project team worked hard to arrange 1:1 meetings and address concerns directly.

With your project being an innovative intervention has there been any specific learning on introducing and sustaining innovations in the NHS?

- This intervention has been developed outside of the NHS. We have realised that good communication and collaboration was essential. We have been open to the ideas and suggestions of our NHS colleagues. We have relied on NHS colleagues to share our project amongst their teams and organisations. This would have been harder without the close professional working relationships we have with our NHS colleagues.

Advice for others attempting a similar project

- **Get on and give the project a go!** We could have delayed this project due to severe nursing shortages. However, we were committed to our Health Foundation contract. Whilst staff shortages caused challenges, the project also helped us have a positive goal to focus on. It has been positive in terms of opportunities for nurses and nursing development and as a means of making the Hospice more attractive as an employer.

- **Ensure all the relevant stakeholders are engaged and supportive of the project from its outset**. Whilst this project is led by nurses, it was crucial to ensure we had full support of our medical team and palliative care consultants from across the city and early meetings were arranged to ensure this. Although this project is housed and run at St Gemma's Hospice, we admit patients from home or hospital. It was essential that colleagues from these areas were involved to agree pathways and processes that worked.

- **Ensure all governance arrangements are in place.** As it is relatively novel for nurses to take this level of responsibility for hospice in-patients, it was important that we consulted with our insurers, that our board and clinical governance committee were supportive and that the coroner was involved.

- **Plan for training.** The time taken to train non-medical prescribers took on average 9 months. For this reason, we staggered our project, admitting patients only over 5 days during the pilot and building towards a full 7 day service as NMP training allows.

- **Capture the power of patients/relatives telling their story first hand.** The Health Foundation emphasised the importance of story-telling at each event we have attended. We have used film and audio to capture some patient/carer stories and witnessed the huge impact this can have. Now we are prepared to capture stories "in the moment" and feel more confident to ask patients/carers if they would be willing to do this. Many are keen to help; it costs them nothing and is hugely useful to us. However, in the sensitive field in which we work, such requests have to be handled sensitively. We have recorded a

short film which shares the stories of several involved in the project which we will use for many purposes including promotion, teaching, conferences and evaluation.

Replicability

- Many aspects of this project are replicable in another setting. Non-medical prescribing within the UK is becoming increasingly common and changes to controlled drugs legislation in 2012 have meant that skilled palliative care nurses are becoming NMPs. Utilising NMPs within in-patient hospices widens access and allows greater flexibility to utilise nursing skills and expertise more fully. St Gemma's is similar to many hospices in the fact that it is a small independent sector organisation. This can mean that innovating and bringing around change is quicker and easier. St Gemma's is a member of Hospice UK and we have shared our progress with them. As a result we have had contact with 10 other hospices interested in implementing similar models. Many hospices face similar challenges to those that inspired us to develop this project.

- If we were repeating the same project we would have had earlier discussions with external stakeholders to agree referral processes. The referral process agreed would not have been our preferred option. We would have in-reached into the Hospital in order to assess patients and speak to patients/families directly. We were mindful that this project had potential to impact on the workload of the Hospital palliative care team. This was not the model which we agreed and has required diplomacy and negotiation in order to agree a mutually effective model.

- We learnt that promotion of the service was vital. We could have spent more time publicising the service pre-implementation. This was reduced due to the uncertain start date.

Part 5: Sustainability and spread

Will your intervention be sustained in your organisation beyond the funding period?

Providing nurse led care and widening access to non-cancer patients forms part of the Hospice's Clinical Strategy. As this had been agreed by the Hospice the nurse led end of life care beds will continue. Support has also been given by the Hospice Leadership team to increase the numbers of non-medical prescribers (NMP) in the team to provide a 7 day admission provision. A Nurse Practitioner has been recruited and will join the team in December and undertake her NMP training in January. The NMP training will take 6-8 months delaying a full 7 day service but between the current team it is hoped a 6 day service can be delivered in the short term.

What are the biggest risks and challenges you face in embedding the innovation into routine practice?

The end of life care beds have now become an integrated part of the in-patient unit and the innovation is now routine practice. This element of the project does not cause us any challenges. The challenges ahead will continue to be in nurse staffing and a city wide recruitment shortfall, affecting all admissions and the need to have dedicated beds which

will protect the access for urgent admissions for end of life care patients.

Do you plan to spread this innovation beyond the Innovating for Improvement award ward or site?

Our Nurse Consultant has received many enquiries from hospices throughout the country and she has accepted invitations to speak at national conferences to present the project work. We have been asked to write an update for Hospice UK's online journal.

What do you think is replicable about the project and what is specific to your organisational context?

The project relies on the availability of trained non-medical prescribers who have well developed skills in assessing, admitting and prescribing the care and medications required for a nurse led model of care. Although a medical review is essential at admission to fulfil the legal requirement of death certification the availability of doctors for cover and advice has been valuable. The project can be replicated in other hospices with forward planning and a multi team commitment. The biggest barrier is in the time required to train non-medical prescribers. Other organisations also need to have a Senior Nurse who is a clinical expert in palliative care who can drive forward and lead on the development of in-patient nurse led care.

What additional resources will you need to support this activity beyond the funding period, and from whom?

Additional resources will be required to travel and share the learning from the project and to continue to train the nurses within the hospice as they rotate through the bed base. The two day training course has been invaluable in upskilling nursing staff, team building and enhancing their role.

What are some of the upcoming milestones/ activities beyond our funding?

We will continue to collect the same level of data as we have during the project period with a view to extending the bed base further in the future.

We will continue to review progress, work with stakeholders and develop the project in line with the ever changing population of Leeds and latest national guidance.

We have shared our journey via updates on Hospice UK online journal and presenting at 3 national conferences:

Non-Medical Prescribing in End Of Life Care- Hallam Conference Centre, London May 2016.

International Association of Nurses in Palliative Care Conference. Palliative Care Nursing: The Value of Impeccable Assessment. The University of Manchester, June 2016.

Ensuring Best Practice in Non-Medical Prescribing SPK Events, Manchester, September 2016.

Appendix 1: Resources and appendices

The following materials have been attached as appendices for information:

1. **Patient/carer information leaflet**

   This was developed through the operational group and has been updated and adapted during the project based on user feedback. A copy is given to all patients admitted to the service. Copies have also been distributed to the Hospital Palliative Care Team and Leeds Community Healthcare staff so that they can be given to prospective patients in advance of their admission.

End of Life Care Beds DL Print.pdf

2. **Voices- Views of the Bereaved Survey**

   This is adapted from the National Voices Survey, a validated questionnaire developed to survey the views of bereaved relatives as to their experiences of end of life care.

End of Life Care Survey.pdf

3. **Data Collection Tool**

   This proforma was used to collect project data which was entered into an Excel spreadsheet for evaluation purposes.

End of Life Care Beds Form - Novembe

4. **End of Life Care Beds Film**

   As discussed in Part 4, we realised the impact that service users telling their own story can have. We created the attached short film which evaluates our project from the perspectives of different stakeholders and service users. A shorter version is now on our Hospice Website and is being used to publicise our service.

   https://youtu.be/jkxMkU_cGYQ

5. **Henry's story**

   Henry was a patient admitted to one of our EoLC beds. His daughters (pictured) agreed to share their experience in the audio clip below:

Henrys story.mp4

6. Further outcomes data to support Part 2

Appendix 3- OACC data.docx

If you are interested in accessing any of the above listed resources, please contact Catherine Malia, Advanced Nurse Practitioner at catherinem@st-gemma.co.uk.