"END OF LIFE CARE PROVISION IN REDBRIDGE" – Redbridge Faith Forum Network Meeting 25 April 2017

Redbridge Faith Forum held its second quarterly network meeting on 25th April 2017 in the Gloucester Room of Redbridge Central Library –47 people attended this very informative meeting to learn more about end of life care provision in Redbridge.

Phil Butcher, vice-Chair of RFF welcomed everyone to the meeting and explained that the speakers were each going to be allocated 10 minutes to make a short presentation and these presentations would be followed by time for questions from the floor.

Presentation 1 – Julie Fanning, LBR Integrated Strategic Commissioner

Julie informed the audience about the Draft Joint Plan for End of Life Services for Adults in Redbridge 2017-20 **"One chance to get it right**" which is currently in consultation period. The council would welcome thoughts and ideas on the Plan – comments can be emailed to myview@redbridge.gov.uk or completing an online survey at consultations.redbridge.gov.uk/end of life.

The plan outlines practical action to improve end of life care and is based on an ambitious framework produced by government whilst also taking account of other local plans. It highlights that it needs to be a partnership approach with family/NHS professionals and the wider communities. The council has worked with Redbridge Faith Forum previously to produce the Faith Directory which is an informative guide to be used by health professionals to help them provide appropriate arrangements at end of life.

An End of Life Social Practitioner Lesley Grainger has been appointed and is willing to come and meet and speak with local groups. Lesley is also arranging workshops and forums as the key is communication. The plan recognises that it is everyone's responsibility to have conversations and talk to each other about end of life but this is a two way process and it is important that everyone is encouraged to be willing and is able to discuss this topic, therefore there is a need to train staff to be able to hold difficult discussions.

End of life care is care that "Helps all those with advanced, progressing, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes manage of pain and other symptoms and provision of psychological, social, spiritual and practical support"

It includes people who are likely to die within the next 12 months due to:

- Advanced progressive incurable conditions
- General frailty
- Existing conditions if they are at risk of dying from a sudden acute crisis
- Life threatening acute conditions caused by sudden catastrophic events

The Vision is "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)". In order to achieve this six ambitions have been developed:

Each person is seen as an individual
Each person gets fair access to care
Maximising comfort and wellbeing
Care is co-ordinated
All staff are prepared to care
Each community is prepared to help.

It is recognised that there are things that need to be in place to achieve these which includes personalised care planning and shared records so everyone is aware of the person's wishes.

Presentation 2 Dr. Vaibhav Mathukia, Macmillan GP

Vaibhav explained that few aspects of primary and community care are more important and rewarding than enabling a patient to die peacefully and that most GPs are prepared to go above and beyond the call of duty to try to help co-ordinate care. Patients can be scared and think that palliative care is a death sentence but in reality is the start of the planning process and not that treatment is stopping.

The role of the GP is

- exploring the patient's wishes and needs around end of life
- working to maximise the quality of the patient's remaining time
- working to ensure a "good" death as far as possible, in the place and manner of the individual's choosing
- working with the family and significant others, and addressing their worries and expectations
- more broadly, commissioning services, and balancing very limited resources.

15 years ago a GP came up with the Gold Standards Framework for end of life care – this is a model of good standard care which all Redbridge GPS are trained in and the recommended standards are being implemented to improve quality and consistency.

GPs aim to identify the 1% of patients who they would not be surprised if the patient died within the next 12 months and then these patients' names are put on a register to start discussions. The aim is to assess what the needs, wishes and expectations of the patient are in order to do advance care planning which will include desired place of death and resuscitation status – patients can change their mind at any time and have their revised wishes recorded. The aim is to be proactive and not reactive and hence avoid crisis situations.

Communication between the patient, the family and the GP is most important and usually a GP would not have these sort of discussions during a standard 10 minute surgery consultation but if they are aware it is an advanced care planning discussion will arrange a longer consultation time and possibly a home visit.

The audience then had time to ask questions of the first two speakers and then break for refreshments and networking.

Presentation 3 – Rev'd Tim Coleman, BRH NHS Trust Chaplain

Tim explained that he had worked in local hospitals for some time and currently works across Queens and King George Hospital. He explained that all patients have spiritual care needs but some also have religious care needs defined as follows:

Spiritual Care -Finding out what is important to people – and responding to this.

Religious Care - Spiritual Care with Prayer and a Shared Belief

The BHR Department of Pastoral Services is composed of a people from different faith backgrounds: Anglican, Baptist, Roman Catholic Jewish, Muslim plus approximately 30 volunteers from Muslim, Sikh, Buddhist and Christian faiths. There are currently not any Hindu volunteers.

Inpatients can ask a nurse to contact the department to request a chaplaincy visit but it is import to state which faith and what you want to discuss in the visit. Alternatively requests can be made by email or phone. There is an on call service out of hours for emergencies.

Email: chaplaincy@bhrhospitals.nhs.uk

or Phone through switchboard 01708-435000 asking for 'Chaplaincy'

The hospitals do have prayer room facilities.

Maximising comfort and wellbeing is the aim of the BHR End of Life Care Strategy which means each patient should have a holistic assessment and individualised plan of care. The 5 priorities of end of life care are:

- The possibility that a person may die within the coming days and hours is recognised and communicated clearly, decisions about care are made in accordance with the person's needs and wishes, and these are reviewed and revised regularly by doctors and nurses.
- Sensitive communication takes place between staff and the person who is dying and those important to them.
- The dying person, and those identified as important to them, are involved in decisions about treatment and care.
- The people important to the dying person are listened to and their needs are respected.
- Care is tailored to the individual and delivered with compassion – with an individual care plan in place.

Confidentiality is always observed with strict boundaries and guidelines in place. A referral to a faith leader will only take place with the individual's consent.

It is advisable that staff refer patients requesting prayer to the chaplaincy team who know how to work safely in the environment and are always mindful of vulnerability.

Finally Tim reminded the audience of the urgent need for organ donation – I must emphasis the urgent need for more organ donors especially in the minority ethnic groups and said that most world faith scholars are supportive of the concept of being able to donate an organ(s) from a patient that is going to die (or is dead) to a patient who otherwise will not live. The principal of the preservation & value of divine-given life is paramount to all faiths.

Presentation 4 – Jason Demant, Pastoral Care Team Leader, St Francis Hospice

Jason started his talk by asking the audience what descriptions spring to mind when the word hospice is mentioned. The description peaceful and caring where suggested by several people. Jason explained that the hospice movement was founded by Dame Cecily Saunders in 1967 linking expert pain and symptom control with compassionate care. Some people think of hospices of being places where people go to die but in fact they offer very many services and in fact only about a third of inpatients choose to die in the hospice. A lot of inpatients will come for a stay to have their symptoms assessed and treatment adjusted.

St Francis Hospice employs many clinical nurse specialists to oversee specialist palliative care and also provides an out of hours telephone support service to Redbridge 5pm-9am every day. The clinical nurse specialist work very closely with GPs, district nurses and other healthcare specialists.

The hospice has award winning gardens and grounds with 3 ponds and a thriving day service with activities such as craft activities, music therapy, complementary therapy, physiotherapy, occupational therapy and social workers with an holistic approach.

Treatment is free and the hospice is 27% NHS funded. Referrals can be made by GPs and there is a dedicated referrals co-ordinator who can give more information (tel 01708 753319)

The hospice services are available to patients of any faith and none and there is a very informative website www.sfh.org.uk.

The audience then had the opportunity to ask questions of both speakers – some members were surprised to learn that patients can have short stays in hospices and that admission did not necessarily mean that they would not be coming home again. A question was asked about the volunteer's role in the BHR Chaplaincy service – Time explained that all volunteers have to undergo a 10 week training period and then will be assigned to a ward where they will make themselves known to inpatients

Phil thanked all the speakers and requested the audience complete evaluation forms - analysis of these confirmed that 94% of the audience agreed that by the end of the meeting they :

Were better informed about how to access pastoral support in local hospitals.

Better informed about the Redbridge End of Life Plan

Had an increased understanding of the role of the GP in end of life care

Save the date for the _next RFF Network Meeting will be held in the Gloucester Room 11.45am -1.30pm on Tuesday, 25th July 2017.