Hello everybody, this is Gita Prasad, I'm deputy director of Business and Partnerships. This is the Fit for the Future podcast on System Partnerships. And today we are talking about an integrated project which is about working with St Helena Hospice on a rotational workforce approach. This involves EEAST paramedics working with St Helena Hospice on a rotation and it's within a health and social care integrated framework. I'm going to introduce colleagues that we've got in the room. We'll start with Daniel.

Daniel: Hi, my name's Daniel Richardson and I'm one of the current hospice rotation paramedics.

Gita: Thanks, Daniel. Rachel.

Rachel: I'm Rachel Hunt and I’m one of the sector clinical leads and I hold the regional portfolio for palliative and end of life care for the organization.

Gita: And Pete.

Peter: My name's Pete Bumphrey and I’m the Business and Partnerships lead working with Gita for these partnership programs that we have in the organization.

Gita: Thank you. And I'm Gita Prasad and Deputy director of Business and Partnerships for EEAST and I lead a team of business and partnership leads, which is where we work with our clinical colleagues and our operational colleagues in each of our six areas in the region to work patient redesign pathways. And also, we are interested in lots of different workforce integration models.

The concepts and how the hospice rotation came about is that most integration projects or underpinning really good integration models nationally and internationally is that it's around a patient cohort and in this case, we know that palliative and end of life care patients are really vulnerable cohort where we want to be able to work more with our partners and to the benefit of that patient group.

Also, again, good integration models involve a form of co-location or joint working, and in this case it's about joining the workforce. And one of those ways is a rotational workforce approach, which is what we're going to be talking about today. The other really good part of an integration model is the learning that we either get from partner to partner by being the workforce with another organization and in this case, it's really unique because we're working with the voluntary sector, as in we're working with the hospice sector. What we're really keen to do as well and we'll get on to this during our conversation, is think about how we're learning, how we're creating, how we've had an agile approach to this project and also how we want to hear the patient's voice.

But that's enough for me. I'm really interested in hearing from the colleagues who have made this happen, and I think what might do is, is just ask Rachel initially to tell us from the clinical perspective why you thought this is a good idea and how we worked with Suffolk and North East Essex Integrated Care Board to get this off the ground.

Rachel: So for part of my role, I work closely with all of the hospitals across the east of England and I had become aware that a lot of them had some staffing issues. They were struggling to fill posts and they were branching out looking at paramedics. Paramedics have a unique skillset and quite a valuable asset. I was aware a project in Wales where paramedics had been rotating through the hospices and so made contact with colleagues over at the Welsh Ambulance Service like to see what they were doing that was working fantastically. I went down to spend some time with the paramedics who were working within the hospice in Wales to see how their model had worked and I took the ideas back to North Essex and approached St Helena Hospice with a project proposal and we worked out what would work for this particular area and what services were available to have the maximum impact for the patients within North east Essex In Suffolk.

Gita: So, St Helena Hospice were very open I think, weren‘t they? I think they were interested already in working in a different way. You know, like as you said with the paramedic skill set. We'll get some on and ask Daniel a bit more about what that means in practice. But in terms about setting up the project, I think they were keen what they to work with us.

Rachel: Absolutely. And I think that I could see the benefit of having a paramedic as part of their multidisciplinary team, bringing in those new skill sets which haven't previously existed within their team. And I think that that learning to have both ways. So the real value, I think from just taking a paramedic and pulling them into a post within a hospice, having this dual role with a paramedic working 50% of the time for EEAST and then 50% of the time for the hospice, they're taking what they're learning and by setting so both ways, is that cross learning?

Gita: I think it's also really exciting and we really ought to say as well that the rotational workforce projects, we've been exploring those in different areas for the last few years within EEAST and one of them is actually working in GP practices and we've been exploring that and working closely with partners for a long time. But the working the hospice was a different proposition and I think we all thought, okay, this could be possible, and it wouldn't be that difficult to to try and actually get it off the ground. However, I'm pretty sure there was quite a bit of hard work involved, Rachel, on your part and also with our operational colleagues in SNEE.

Rachel: So yeah, they required a business case that was written. That was taken through the governance processes of the ambulance service and we took that proposal to the end of life Board, who actually provided half the funding for the project and the other half the funding came from the Hospice first year, which is the pilot year. And the hope is that at the end of this 12 months, this project will continue, the paramedics will continue in post and hopefully develop skills further and further education.

Peter: And if I can come in, for me there was there was that needfor us to branch out into more end of life care. I've been a paramedic for 20 odd years and the shift in change for end of life care is it's really big. And particularly in North Essex, St Helena Hospice have led the way with a single point of contact and had a very strong community service existing already and paramedics had already been able to tap into that. But this this branching out into bringing in our paramedics to work alongside is only going to enhance that service in particular with the knowledge around some of the anticipatory medications, some of the wishes of our patients. Now there is there is a die well domain now within the commissioning world whereby we're trying to improve end of life care and given more choice and given value to that choice but making that choice so it's comfortable for the patient and also for the family. So it's not just about the clinical and medical side. It's also looking at how we can support the patient and the families when that time is coming for the end of their life.

Gita: I think that's a really good point to raise, Pete because having been myself at Norfolk and Waveney, when, as was STP quite a few years ago, Sustainability Transformation Partnership, we implemented recommended summary of plan and emergency care of treatment, which is RESPECT, the acronym which is about anticipatory care and wishes of patients and carers and families, because we know that it really does matter that people have as much choice and control and personalization over their care treatment plans. And so I think that that learning for EEAST is one of the reasons I think we were so keen to get involved in another scheme that supports patients at the end of life.

So I'm really excited that we've been able to do this and one of our colleagues who is doing this, Daniel, thank you for joining us again. I'm interested to know how the service has been operating and for how long and, you know, a few more insights into what it's been like for you working with St Helena Hospice.

Daniel: Certainly. So this pilot year started in November, and there are four of us that are working on rotation. So effectively a paramedic in seven days a week working at the hospice alongside what Pete mentioned is the single point office. So St Helena is really well placed and really well respected in Colchester, but it is only very small in terms of its capacity for patients in the unit. So they have a huge community outreach and they have their hospice in the home team which deals with quite a large geographical area. As a result of that, the single point team was set up, which is a dedicated 24 hour phone line for all of these community patients, and it's access for health care professionals as well. So we're sitting in this office dealing with acute queries and patients who are deteriorating in crisis, supporting patients, health care professionals and family members. And this can be either with advice over the phone where it's appropriate or as a sort of rapid response visit, either working solo or in conjunction with the other members of the team, which includes registered nurses and non-medical prescribers. From the point of their first referral into the sort of palliative care system all the way up to the point of actual end of life interventions, including syringe drivers, anticipatory medication administration.

Gita: That sounds like a lot of new areas to be working in. What attracted you to going for this role? Because I know that we did an internal recruitment to be able to see if colleagues wanted to work within a hospice rotation setting. Was it that learning that attracted you?

Daniel: Yeah, for myself, coming into the ambulance service initially, you don't necessarily think of palliative and terminal care as being part of the role, and it becomes quite evident that when these people do deteriorate as part of their disease, it can become an acute issue and ambulances are regularly attending to these people. And actually so much of our interventions aren’t appropriate, hospital admission, these things to our extending life when somebody does have these terminal diagnosis. So I became quite interested through working on the road. I've been paramedic now... sorry, I've been a paramedic for two years, but I've been in the trust for coming up to six and going out to these patients and seeing the impacts that we can have by implementing the services was quite eye opening and I wanted to, yeah, further that knowledge to see what more we can offer this demographic as so pre-hospital clinicians, certainly emergency care clinicians and basically just improve communication skills. My knowledge around the medicines and supporting emotional as well as physical symptoms.

Peter: And has that built your confidence, Dan? And so, as you know, for me, end of life, it's always been a passion of mine in the sense of the making sure that we we bring the right care at the right time and also in the most appropriate setting. But previously, I felt nervous about leaving someone at home who is actively dying. And, you know, that can be a difficult judgment call for a paramedic. So, from your experience of wanting to bring more to now, how how has that enhanced and built confidence for you and how are you going to be able to spread that confidence amongst our colleagues?

Daniel: Yeah. So it's been a big adjustment in terms of how your perspective of these patients and what you can do for them. So typically, a paramedic is all focus towards extending emergency interventions to stabilize people. And here there's a really big shift towards supportive care. And as you say, it's making those judgment calls is about the appropriateness of anything that you're doing. And with the pressures that locally hospitals and other health care services have been under, including GP's and things like that, it does feel sometimes a bit of pressure to keep people out of hospital. And another part of the flipside of that is actually knowing that there are times when it is appropriate for admission just as much as it is for you to support them at home. And as you say, it's still an adjustment, still an ongoing thing, it's been six months now, but sometimes we are going out to these people and you really having to look at the really small details of where they are in disease progression and having the experts within single point. And St Helena has been so beneficial to us as we're sort of learning in this role, being supported in decisions around making the judgment calls around, as you said, disease progression, the appropriateness of interventions when they are coming to end of life.

Gita: And Daniel, do you do think that now, as you said, six months on in terms of that learning, how is it best and I talked about when you come back to your role at EEAST and sharing it with colleagues, but how do you think it's going to be? How are your other colleagues managed, have they had a similar experience to you?

Daniel: Yeah, we've had a couple of opportunities to get together and discuss our experience so far and it's been really positive the team at St Helena are super supportive of us. They're really keen to implement some of the things that we do on a daily basis. Our medical examination is, is different to what they might necessarily be doing. A lot of the nurses who work with us are from district and community nursing backgrounds, so, don't necessarily have lots of diagnostic and assessment skills. Sort of in the pre-hospital setting. So it's been great to share some of that knowledge. But then as you say, on the flip side, what we're bringing back into the community is not always specifically for end of life care, but being able to deal with people who have these terminal diagnoses and actually the communication that we're able to have with people in that there are certain interventions, there are things that we can look for. There are appropriate times for us to go into hospital and have certain tests to see about disease progression.

But ultimately, where are you in your journey? Where abouts is this trajectory and what can we potentially look out for? It’s sometimes managing expectations to a certain extent within the palliative diagnosis and being able to have those discussions and include colleagues that we're working with on the road in that when we're going out to these patients, I think is really good for everyone's learning.

Gita: Yeah, it sounds like it, and also sounds like you’re the scheme and yourself and your colleagues have influenced the hospice as well. That in terms of, as you said, the clinical side of things, but also decision making and bringing two different organizations together, two different worlds together. Has that been 100% good or have there being some moments where you thought, gosh, they do things really differently or at EEAST we do things really differently?

Daniel: Yeah, definitely been a couple of things. Part of the role is the verification of deaths within the community. Obviously, when people die, if we're on the ambulance, we would do a recognition of life extinct assessment, which is generally it's a fairly simple thing because if there are potential signs of life, we're looking to start life support. Obviously, in this instance with people with these terminal of diagnosis, they have that advance care planning in place, do not resuscitate respect forms and there is obviously a structure to an assessment whereby you're doing lots of things on somebody who has died, which we wouldn't do. And that was a real sort of strange sort of shift. But yeah, what we're doing and going out as part of this role, is a lot of our initial visits that we were doing to people at home were joint visits with prescribers, with these of rapid response nurses, and we very much were paying off of each other whereby we might do sort of a medical assessment, they might speak to the family and it's been really nice to work as part of a team, almost like a two person crew similar to the ambulance, but with really different skill sets leading into that. And it's been nice to have people sort of learn from us as much as we've been managing them. It's been really, really good.

Rachel: So I've actually done a couple shifts on an ambulance with a couple of paramedics, that are involved in this project and I was taken aback just by how much these people have learned and how many skills they've managed to learn that in a short space of time. And one aspect to the project I didn't initially think about when putting their proposal in, but it's actually really significant is that the paramedics, now that I've been in that hospice rotation, have learned all these skills. When they're back working with the east of England, they're going out to patients and able to identify the patients who may be at the early stages of disease progression, who may be in the last year of life, who previously may be without that knowledge and it to be called. And we could resolve that episode of breathlessness. We would go on back home and then they call again for another ambulance and we'd keep coming out of that cycle to keep repeating that. What I witnessed was actually the paramedic I was working with as part of the rotation could say, actually, I can see this patient is nearing end of life. This is a disease that's going to progressively get worse and have those conversations with the family, with the patient, and was able to put in that support and refer them into a single point and have St Helena help to take that that support over for the ongoing care, which is going to be much, much better for that patient. So that was really great thing to see.

Gita: Yeah, it does sound like there's already been some direct benefits to the wider patient community as well as the patients that Daniel and colleagues in the hospice already supporting. Pete, did you did you want to come in with a question?

Peter: I just wanted to compliment Daniel and the team because one of the things that they have done without any kind of prompt is produce a newsletter whilst they're going through the rotation. and that newsletter is extremely informative and they're put in, in their articles which, which are absolutely perfectly placed with end of life care and wishes, but then put in there as well their experience and what they're learning and, and that's going out to all staff in North Essex and, and that is really spreading the word. So that's a really, really good newsletter. And Daniel, how's that come about? And I think it is yourself who edited that, but it's a really, really good piece of work.

Daniel: Yeah, I did a bit of formatting, made it look a little bit smarter, but it was very much a collaborative effort. We said really early on that because as the rotation is, we aren’t having potentially as much contacts with right staff. We're only doing 50% of our shifts within the Trust, we wanted It's a way that we could reach as many people as possible and I think that putting together some articles focusing on different aspects of palliative care was always going to be something we wanted to look at. And when we break it down in case studies that we've done, I'm highlighting certain emergency palliative sort of crises, things that I wasn't necessarily aware about as an ambulance clinician, or wasn't didn't have a great awareness of exploring some of the anticipatory medications and then highlighting, again, some of the sort of roll out something that's more current, like the respect forms, which we just launched in Northeast Essex as well. But it was just a way of information sharing that we thought would be most beneficial to the sort of the most people.

Peter: And what I've been hearing from the staff is that they're really enjoyed reading it. And I think that's the thing. What we what we are having here is clinicians that we know going through an experience and you're sharing that journey. And that's really important, I think, because clinicians like to read an article from the point of view of a fellow clinician and they can relate to that and they can then embed some of that into their own practice because for me, I absolutely want to see as many paramedics as possible rotate through St Helena, and that's only ever going to enhance the care that we provide to this really important cohort of patients. But what I really like about it, and you've mentioned a couple of times, is about the support that you're given to the family.

Now, I was just wondering, is there specialist charities or groups that you also work with that you can utilize for the families as well?

Daniel: Oh, now you’re asking...there are and for the life of me, I can't recall all of them. But the hospice does have itself a dedicated bereavement service and the council is there. You can actually refer in, even if I'm I think I'm correct in saying that you can refer in to them, even if your loved one wasn't supported by St Helena, they will still offer that bereavement service to you. And if you can self-refer or us as professionals, can refer them into them to offer that and bereavement counselling. So that's the hospice themselves.

Gita: Yeah.

Peter: And it's such a special, such a special kind of cohort clinician. I think those who deal with end of life, I've always seen they are compassionate, caring and kind like, like, like us clinicians. But there is something really, really special about hospice staff and their volunteers and the people who work with them really are the most loveliest of people dealing with the most dreadful of situations. So it's really important that, you know, we tap into that kind of that that emotional support for the families that there are there. Because very often as a paramedic you deal with the patient and you bring your lifesaving skills or whatever. But it's really important to make sure that the family are well supported as well. So I really like that that that piece of support that they put out there. Sorry Gita.

Gita: I think what I was saying is that palliative and end of life care work, when you are involved in it from lots of different angles, very much involves the community and the compassionate sense of community. And it very much makes you reflect upon your own self. It's very personal and it's deeply significant because we are talking about people at the end of life. And whilst I think in the room a lot of us have worked in this field and you become really passionate about it, it can seem unusual to other people who've not either experienced or worked in that area. And certainly I think hospice and St Helena is renowned and really well known. They have characterized this way of working. They've opened their doors up to the community and I think EEAST being a really now supportive partner, colleague as part of this process is a great step in that in that journey. I hope to see in the future that we are able to extend this work to other hospices. Obviously, we need to be very mindful of our workforce, but actually I think from what Daniel said and the way he's talked about the project and also his colleagues, it's enhanced not only skills and knowledge but relationships and our relationship working going forwards with St Helena Hospice will be the better for it and the wider community. We are working so much more closely with community services now that that's how we are going to be working in the future. So I think this project or this piece of work in rotational approaches does show how integration can benefit all those different angles. I was going to ask Rachel or Daniel, I think what we would like to do, we were part of the steering group with St Helena, so it was it's good to mention that there's been a group of colleagues behind this making sure everything happens as it should be. But I think we're also interested in having a celebration day or a learning day to mark the projects, but also all of the things that we're talking about, but the benefits that it can have to our patients and families and carers.

Rachel, do you have an idea of potentially what we might want to do or a celebration day and when it might be?

Rachel: I think it'd be fantastic idea and I think it would be linking back with St Helena seeing how, I think it's only recently the paramedics are kind of feel that confident supporting patients and independently, is that right Dan?

Daniel: Yeah I think that the first three months or so it was it was joint visits. There are some competencies around and things like the syringe drivers and the medicines that we've had to undertake through the verification we had to competency sign offs. So there were certain things that we weren't going to be doing on our own anyway. But we've since been asked to do bits and pieces, so we're training vice versa. So they've requested that a couple of us present at Journal Club in the summer. And then and I know Gita you were really keen to get this this day where we can invite people from both organisations to sort of get together.

Gita: And yeah, I think it's a celebration of integrated working, but also really going back to the beginning, we had an idea of what this would look like, but we didn't overly fix it. We didn't say it had to be a certain way. I think hopefully Daniel, yourself and your colleagues have been able to influence how this is come about. What sorts of areas have been important as you've gone along. It's not been completely determined and I think this is where being able to learn and adapt, learn and adapt shows the trust between both organizations as well. Because I experienced St Helena as a very forward thinking open, but also willing to think. We hadn't thought of that. We didn't know we needed that. And we've had those conversations in the steering group about some of the changes. But as we go into the future, I think we'll have a clearer idea about what this could look like for a new cohort of colleagues starting the rotation and how we might want to use this as a model or a template for going forwards, either in other hospices or in other areas as well, not just in Suffolk, in north East Essex. We know when we were doing the initial research on particular projects that we could do in the region, and Rachel already mentioned the learning from Wales and we also know that in Herts and in West Essex and in Norfolk and Waveney, there are some key projects that we want to get off the ground in the arena of palliative and end of life care work.

So again, feeding this, learning back into new projects, into what we might want to do in the future, I think is going to be valuable. And it's definitely worth celebrating, which is what I think part of talking and having this conversation today is about, but also sharing that learning more wider, not just regionally. We can definitely share it nationally as well. In terms of the future, if colleagues in the Trust listening to this are interested in either knowing more about the rotation or about potentially getting involved, I know that they can contact business and partnerships on our email, but also Rachel and Daniel, are you happy for colleagues to contact you or for us to set up a way that we can ask colleagues to ask questions?

Rachel: I'm more than happy to be contacted and I'm aware that some of the hospices there is there's interest in this, a collaborative project that is currently going on in North Essex. So I think for the future I'm hopeful there will be other hospices looking to do something similar.

Gita: That's great. Thank you.

Daniel: And we've extended this to local staff that of course there are other people that want to know a little bit more about what we've been up to. We have got a group email that goes out to the four of us North Essex Hospice Group so you can search for and the trust directory and drop us a line. If you wanted to figure out a little bit more.

Gita: That's great. Thank you. And you know, I just want to say well done. Really. Congratulations. It's fantastic to see something which from concept the thinking part to actually we're doing it now and it's flourishing. So I'm really, really pleased that we've been able to have this conversation today. Thank you very much.

All: Thank you.