



Housing LIN

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Case Study 162

Better Lives, Better Endings: A collaboration between extra care housing and a hospice

JUNE 2021

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Introduction

This case study describes a project undertaken in partnership between Octavia and St Christopher's with the aim of identifying how both staff and residents in several extra care housing schemes in West London might be empowered to improve experience of end-of-life care for everyone.

Context

According to NHS England (NHS, 2015; NHS, 2019) long term conditions (LTCs) are now a central focus of the NHS as an increasing number of people are living with more than one LTC, known as multimorbidity. This includes people living with ageing and/or frailty, and those in the last 12 months of their life who may have several non-reversible conditions such as dementia, advanced heart disease or progressive neurodegenerative disease.

The NHS recognises that, due to the scale of the challenge, a shift is needed away from the 'medical model' of illness towards a more holistic model of care which acknowledges the expertise and resources of people with LTCs and their communities. Dying is not just a physical reality, but a social event too and it is important to address the emotional, social, cultural and spiritual needs of people, their families and of those providing the care (Housing LIN, 2013).

The links between poor housing and ill-health are well known. Well-planned housing with appropriate additional features can significantly assist people with LTCs to remain independent (Housing LIN, 2021). 'Extra care' housing varies but usually comprises, purpose-built independent housing units with additional common or social spaces and facilities and, importantly, supportive individualised care services provided as needed.

The National Voices (NHS, 2013) definition of person centred, coordinated care, developed by people with long term conditions states,

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."

This ambition requires a partnership with people over time rather than providing single, unconnected "episodes" of care, helping people with long term conditions to live well, age well and die well (NHS, 2013).

Most residents of extra care housing schemes see it as their home for the remainder of their life and the staff are best placed, through ongoing relationships, to support individuals to consider their preferences and make future plans. According to the Housing LIN (2013), fewer people living in extra care housing move onto institutional care towards the end of life than people living in the community with domiciliary care. However, as the Housing LIN (2013) acknowledges, providing effective, high-quality care for someone as they approach the end of their life, including facilitating conversations, is a skilled role and a challenging one.

Background to Project

Octavia is a not-for-profit organisation that provides homes, support and care to thousands of people in central and west London. Founded by the Victorian philanthropist Octavia Hill in the 1860s, they support Londoners of all ages, giving them opportunities that will help them lead a better life.

St Christopher's Hospice is a charity, providing health and social care for people approaching the end of their lives. The organisation was established by Dame Cicely Saunders who is credited with establishing the modern hospice movement over 50 years ago.

The relationship between the two organisations began in 2017 when St Christopher's was approached to train staff in Octavia around aspects of end of life. That initial collaboration highlighted an opportunity for further work together, focused on building additional skills and confidence in staff and others supporting people in extra care housing around:

- important conversations about end of life,
- development of care plans describing choices and preferences on the part of residents,
- partnership working across and beyond the housing sector to enable residents' wishes to be honoured.

That work led to the development of a shared vision for a further project that would facilitate conversations, decisions and plans related to how and where people want to live in the last years of life. In so doing, the foundations that support appropriate and tailored care for older people and those with advancing LCTs living in extra care housing can be created.

To do this effectively, we recognised that we must draw on the voices and experience of people living in housing provided by Octavia in addition to the views and skills of staff working in Octavia and St Christopher's. This then became a primary objective of the work we proposed.

Our underpinning premise is that, if individuals coming to the end of their lives have identified their ambitions and goals for the last years of life and articulated them clearly, then people around them (staff, volunteers, family members, friends and the people they live with) can help them achieve them. They will have greater choice and feel greater control. Similarly, all involved will feel empowered in their efforts to help these individuals live well.

Our overall intended outcomes are to;

- Encourage older people living in assisted housing to adopt a proactive approach to planning the rest of their lives including its end, drawing in people around them to help them achieve their ambitions as necessary
- Empower extra care housing staff resulting in greater choice and control for residents at end of life
- Establish a network of relevant stakeholders who will adopt and continue to develop the tools, training and relationships established beyond the end of the funded project

- Encourage hospices to see the housing sector as a key strategic partner in their efforts to improve end of life for their local populations.

By the end of the project we aimed to have developed the following;

- A report that confirms opportunities to improve the last years of life of people living in supported care housing – as a case for change
- A tested programme of training for residents to enable them to become involved in their plans for the last years of their life if this is their wish
- A training programme for staff working in extra care housing that builds their skills and confidence around difficult conversations, advance care planning and engagement with the health system and others to enable residents to achieve their wishes. This should include a ‘train the trainer’ programme that would ensure sustainability beyond the project
- Information for organisations delivering extra care housing about physical facilities and policy required to facilitate good care at the end of life
- Details of a range of stakeholders that would benefit from involvement in end of life and housing in the future for inclusion in related training events.

Project progress Sept 2019 – March 2020

The project made good progress in its first six months. A project team was created with co-leads from St Christopher’s and Octavia, and a project facilitator appointed. A project Advisory Group was established - some members brought a national perspective from bodies such as the Housing LIN and Skills for Care; others came from parts of the health and care system interfacing with Octavia’s extra care provision in West London: the London Ambulance Service, St John’s hospice, Westminster and Kensington and Chelsea adult social care, and NHS West London CCG.



Bridgewater House, London

The project started with scoping visits to six Octavia extra care housing schemes, followed by interviews and small group discussions with 28 staff at four schemes. We found that extra care staff form long-standing relationships with residents, and get to know them well. However, when residents are seriously ill or dying, staff are often anxious and fearful, and lack the confidence to play a leading role in caring and advocating for the resident. This results in staff feeling disempowered and experiencing frustration, sadness, anger and guilt about the care of dying residents. When residents die, staff grief can be strong and lasting; this is sometimes heightened by weaknesses in organisational acknowledgement and lack of systematic support or debriefing.

We also found a need to strengthen the quality of interactions and interface with external agencies and professionals, especially when residents are seriously ill or dying. There is often poor understanding of respective roles and poor communication, resulting in extra care staff feeling side-lined, and their deep knowledge of the resident and their needs and preferences going untapped. This in turn can result in poorer quality care for residents.

There were varied responses from staff to our project and its premise. Some staff were eager to have more open conversations with residents about death, dying and their future wishes. Some expressed reluctance, either because they themselves would feel uncomfortable, or because of concerns about upsetting residents and their families. Many saw it as their role to be comforting and reassuring towards residents, rather than to introduce potentially distressing issues. And some thought such conversations were not needed or not appropriate for Octavia staff - saying that this was a role for GPs, or only for scheme managers but not other staff.

"When you find out someone has gone to hospital and died, you might say a prayer, grieve in silence. The next day you just get on with the job. Sometimes you feel really and utterly helpless. You think, could I do anything more?"

"With palliative care, the communication is very difficult. We have a resident who has one-to-one care on a 24-hour care package, and an outside care agency comes in to provide this. We are left aside, but we still have to give the medication, but the doctors, the hospice staff, they do not communicate with us, we are left aside. We do a lot, we administer the meds, we check their wellbeing, but the hospice staff talk to the care agency worker but not us. There is a lot of miscommunication."

"It has not come up. Because it is a very sensitive issue, you don't approach the person to talk about it [residents' wishes for the future and end of life]. You have to let the person talk about it themselves, and it hasn't happened."

"I find it hard to have that conversation. I had a resident who said they were going to die. I don't know how to reply to that."

We then held conversational interviews with 16 residents at three extra care schemes. There was considerable diversity amongst the residents: we spoke to a mix of men and women, ranging in age from mid-50s to 90s. There was diversity in culture, nationality, country of origin and languages spoken. Some had aphasia or difficulties speaking or being understood; some could not easily read. Some had cognitive difficulties or impairments, and residents had a variety of physical and mental health conditions. Some had close family, some distant family and some no family. None of this was

a surprise, but this significant diversity had implications for our work in terms of the variation in people's perceptions and relationship to own mortality, their degree of interest to take part further, and the kinds of kinds of approaches and activities that might be engaging and successful.

We found there was clear appetite from some residents to talk about preferences and aspirations for the end of their life, and to have these documented so they can be acted on. In addition, we found that for many residents, the predominant concerns were about issues in the 'here and now' - including loneliness, isolation, boredom, pain, limited mobility - that relate to their current quality of life ('Better Lives...').

"I wouldn't want any tests done when I passed away. I wouldn't want anything doing to my body for science, I wouldn't want that. I just want to be laid to rest quietly and then leave it like that."

One woman said: *"We had somebody here, a friend of mine who passed away and they had a lovely funeral, they came by with a coach with horses. I want to have something like that ... I do believe that I shall know. I think the time really comes and you go away. I think you'll know about it. Because people say: 'well why go to all that expense, you're not going to be there?' but I believe that I think you would see it. And I thought that was beautiful the way that was done, very peaceful. And he stopped at the gate for a few minutes, you know, for people to sort of say their prayers. And whilst I am not a very religious person, I thought that was beautiful. I want that to be done for me. Not expensive. Not too expensive, you know. And I would want white horses."* When asked whether these wishes were written down and known to other people, she replied: *"I've got a safe here, I put it in my safe but I don't honestly ... I don't think all the staff know about it."*

A resident in her late 80s who had had a stroke, when asked whether she had any thoughts or preferences about her funeral: *"No. I don't want to know about it, I don't even want to think about it."* Similarly, asked if she'd ever thought about any treatment she might not want if she became very ill: *"I don't know yet. I don't think I have quite got to the place where I am thinking that I am going to die ... I haven't got there yet. I don't think I can say it to you. I will, I will."* But after some conversation about her life and her family, when asked whether she would be interested in further meetings to document her wishes about the future, including relating to the end of life, she responded positively: *"Oh, yes. I thought it was going to be not just today. Good, thank you. I can't do it all in one day."*

A resident in his 80s: *"Lack of social contact is the main issue. I miss it. Nobody visits. There is nobody I know, you see. Staff are all too busy. I would like to have a chat about politics."*

A resident in his 70s whose limited mobility meant he was unable to leave his flat without assistance: *"I'm here. And I'm going nowhere. I'm here stuck. I can't go out because you know...sometimes they help me. Before, two weeks ago, after Christmas, because three weeks without shopping ... I want to go out! Not to stay here."*

In light of these findings, we decided to develop and test a four-step model for resident engagement. Following the first step of the initial engagement conversation to introduce ourselves and explore interest in taking part, step two was a one-to-one session using Conversations for Life™ conversation cards, developed specifically as a tool to support conversations about wishes and preferences regarding the end of life. Step three was to draw on the information shared by

the resident, and support them to express their interests and wishes through making a creative output, such as a collage or scrapbook. The creative output would be created by the resident in a process facilitated by us, and enable them to communicate what was important to them in terms of quality of life and end of life, in a unique and personal way. Crucially, it would also capture important information about the person's wishes and aspirations that could be understood by others, and translated back into formal systems and documents. Step four would be to identify key information from the earlier stages, in particular from the creative output, and translate it into formal systems such as care and support plans, GP files and Coordinate My Care (CMC) records. (Coordinate My Care is a system for coordinating urgent care for individuals using digital records that have been completed by GPs or other health professionals; in some cases individuals can initiate and complete part of their CMC plan. It is now used London-wide by services including the London Ambulance Service, 111, out of hours GPs and hospital emergency departments.)

COVID-19: Obstacle or opportunity?

We began testing the four-step model in February 2020, and a creative facilitator joined the team. Following conversations using Conversations for Life™ cards, on 2 March we held collage sessions with two residents. The sessions went well and were enjoyed by the two residents; we learnt a lot and were optimistic about developing and testing the model further. Little did we know how radically our plans would soon change.

On 10 March we suspended face-to-face engagement with residents and staff because of the COVID-19 outbreak, initially thinking we would be able to resume within a few months. As the pandemic's scale became clearer, we explored possibilities for adapting the project, and for developing online sessions for extra care staff to provide practical and emotional support on issues relating to dying, death and loss during the pandemic. Every part of the health and care system was experiencing unprecedented challenges in spring 2020: Octavia decided it would not be helpful to proceed with the online sessions for staff because of the huge COVID-related staffing and workload pressures, and issues with IT access.

Instead we agreed a different approach to supporting extra care staff during the COVID-19 outbreak. Firstly, from April to July 2020 (the UK's first COVID-19 surge) the St Christopher's project co-lead made herself available to be contacted by Octavia's extra care managers and staff on an *ad hoc* basis for advice and support on end of life care. Secondly, in July 2020, the St Christopher's co-lead developed and ran a short programme: *Ensuring Dignified and Compassionate Care at the End of Life at Octavia*. These were online sessions, using Zoom, for groups of staff at two schemes (three one-hour sessions per scheme). Sessions included reflection and discussion based on real people that staff had cared for.

These elements were a response to the COVID-19 crisis and not formally part of the *Better Lives, Better Endings* project, but the session design was informed by learning from the project to date, and the project facilitator attended the sessions to further inform our work.

Response to impact of COVID-19 on staff experience

The coronavirus pandemic has, in many ways, highlighted the cracks in the wider systems but it has also shown us how unprepared many social care staff are when the physical health of those we are caring for deteriorates and it becomes clear to medical professionals that they may be approaching the end of their lives. However, this realisation does not automatically result in a cohesive and smooth pathway to death.

Case Study

D was in her 80s and had final stage dementia. She had been an extra care resident for several years and attended a day centre run by Octavia. She was well known to many Octavia staff. She had family in Ireland, but was very reliant on Octavia care and support services for her advocacy and wellbeing. At the beginning of 2020 her dementia was deteriorating. She was having problems with chest infections and before lockdown had been admitted to hospital to be treated for pneumonia. She was discharged from hospital as the NHS pressure caused by the pandemic was emerging. Staff were shocked when she returned from hospital, carried on a stretcher. The scheme was not equipped to provide her with continuous nursing care (the stretcher didn't even fit in the lift to get her back into her home). There was an urgent review to increase her to 'double up care' to meet her needs. Though comfortable in her own surroundings D remained unwell and it was thought that she was 'slipping away'. Her GP was involved in making decisions for her end of life care and reported to staff that a 'Do Not Attempt CPR' (DNAR) decision was appropriate and, if possible, to avoid any further hospital admission. Within days D deteriorated, she had become restless and staff felt she may be reaching the end of her life. Because she was very religious, staff took the decision to call a priest to give her the last rights. Shortly afterwards, her breathing became worse and staff called 111. An ambulance was called and because paramedics could find no information on their system about the end of life plan for D, and despite the concerns of our care staff, they took her to A&E. Staff were not able to accompany her and D arrived at the hospital at 10pm and died 45 minutes later, on her own on a hospital trolley.

The undignified end to D's life had a profound impact on the care staff who had looked after her for the last years of her life. They were very upset that she had to die this way and felt disempowered in how the end of her life was managed. Counselling support was made available. All the agencies, the NHS hospital team and her GP, agreed that D was going to die, and how this should best be managed, but because database systems (in London this would be CMC) were not utilised effectively, the system failed D.

This felt like a good time to offer the opportunity to look at some of the issues in more depth from the perspective of teams from individual schemes. Three one-hour online interactive sessions were delivered over three consecutive weeks in July 2020. This opportunity was offered to staff at two of the extra care housing schemes and delivered in the evening via Zoom from 19.00 to 20.00 to enable attendance across all shift patterns.



James Hill House, London

The aim was to reflect on recent events and real cases and identify what might be done better as well as what needs to change or develop to ensure the best possible end of life for residents living in Octavia extra care housing schemes.

Table 1 - Ensuring Dignified and Compassionate Care at the End of Life at Octavia

Session	Overview	Key Points/Responses
Week 1	Began with an outline of the purpose of the 3-week programme followed by a reflection on experience of death and dying from both a personal and caregiver perspective. Then, in small groups, looked at a fictitious case scenario and critically discussed.	<p>When asked what they would need in order to be able to provide the best possible experience for residents as they approach the end of life, staff spoke about needing;</p> <ul style="list-style-type: none"> ▪ clear DNAR in place (accessible by ambulance service), ▪ clear and detailed care plans, ▪ good communication and partnership working with external agencies, ▪ an understanding of how to identify someone might be coming to the end of life, ▪ what dying looks like, ▪ how to sensitively involve family or close friends, ▪ the right equipment, ▪ the right medications and clear instructions as to how, and who, can administer them.

Week 2

Having defined what we mean by 'palliative' and/or end of life care we focused on a recent case from each scheme. In small groups asked to reflect and answer questions about the person and their end of life care pathway.

Staff spoke very movingly and in detail about the people who have recently died. They clearly knew a lot of detail about who that person was, about their background and what was important to them. It was unclear where this information is documented, if at all, and could help inform care and support plans. Staff were left feeling 'helpless' when the resident was dying due to lack of knowledge and their perception that external medical professionals have control in this situation.

Week 3

Having recapped on definitions of the terms 'palliative' and 'end of life' broke into small groups and asked to discuss the following questions:

Q. 1

What needs to change so that residents can be assured of as good a death as possible in their own home? (Think systems, policies, protocols etc)

1. Sufficient staff cover when someone is actively dying.
2. Funded care packages agreed well in advance of a person needing end of life care.
3. Coordinate My Care (CMC) records completed with CPR decisions and ceilings of care discussed and clearly documented both on individual care plans for staff to access and CMC for London Ambulance Service to access.
4. Development of role description, recruitment and training of end of life care 'champions' in each of the schemes.
5. When end of life is suspected there needs to be a 'case review' with all the agencies and family involved.
6. Supportive mechanisms for whole teams that recognises staff grief.

Q. 2

Who needs to be involved in agreeing these changes? (Think internally and externally.)

1. Octavia senior management.
2. Residents if they have capacity.
3. Commissioners who approve care package funding.
4. GPs who provide cover into the schemes.
5. Scheme managers and deputies.
6. Families and/or people with Lasting Power of Attorney (LPA)s.
7. District nurses (DNs) if involved.
8. Personal care agencies.
9. Specialist palliative care providers if appropriate.
10. Other urgent care professionals.

Q. 3

What do you need to equip and empower you to provide end of life care that you would want for yourself or those you love? (Think training, documentation, anything else?)

1. Training in being able to identify that a resident may be coming to the end of life.
2. What dying might look like (stages of dying).
3. How to care for someone who is dying.
4. Clear accessible care plans.
5. Confidence that the necessary information is recorded on CMC so ambulance service won't take someone to hospital inappropriately.
6. Someone to call if a member of staff is unsure what to do.
7. Explicit team debrief and support after a resident dies.

These conversations reinforced some of our earlier findings, for example, staff sense of feeling side-lined and unsupported by external professionals in situations when urgent action is needed, a lack of confidence to advocate for residents or in their own skills to provide the best care for someone who is dying. However, these conversations gave a new insight into the depth of knowledge and care of staff for the residents, and the very real lack of effective interagency working to enable accessibility of vital information about residents when most needed.

The Emerging themes:

1. Need for internal change:

Prior to the COVID-19 pandemic and impacting across all their work, Octavia had undertaken a qualitative staff experience exercise in 2019 with the Tavistock Institute (London) to really understand the impact of caring and supporting older people with increasingly complex needs in extra care housing. The outcomes highlighted the emotional and physical impact of the job on an ageing workforce and the need to address how individuals and teams needed more time, support and space to manage such an array of demands on them. This led to workshops with managers to unpack Octavia's culture and ways that Octavia might be able to transform the service to do this. This included a rationale for new roles and transformation programme investing in a Quality Team to better support front line managers to provide a more holistic service through relationship-based care rather than task-based care. As Octavia's *Better Lives, Better Endings* project co-lead puts it: *"In essence, reminding ourselves we can't do this on our own and really need to get the most out of all the relationships in someone's life, addressing issues of loss, loneliness, anxiety alongside supporting change due to physical health and preparing for the end of their life. This was not just about end of life care, but about supporting better lives, better endings."*

Octavia are now also seeking to invest in more digital capabilities, particularly drawing on learning from the last year, and 'training' to empowerment - rethinking culture change.

2. Need for systems change (national implications):

The NHS (2015), having considered a range of reports and reviews, summarises the barriers to providing great care for people with long term conditions as a failure to provide integrated care around the person. Seven specific barriers are listed including the apparent health and social care divide resulting in fragmented care; lack of *"a whole system approach with social care or other services important to people with long term conditions (e.g. transport, employment, benefits, housing)."* (NHS, 2015)

NHS England (2015) signpost to the 'House of Care' model as a checklist/metaphor to be used by partners to ensure high quality person-centred coordinated care. Four key interdependent components are listed which help inform future direction in terms of;

Commissioning - *which is not simply procurement but a system improvement process, the outcomes of each cycle informing the next one.*

Engaged, informed individuals and carers - *enabling individuals to self-manage and know how to access the services they need when and where they need them.*

Organisational and clinical processes - *structured around the needs of patients and carers using the best evidence available, co-designed with service users where possible.*

Health and care professionals working in partnership - *listening, supporting, and collaborating for continuity of care. (NHS, 2015)*

Although commissioning, listed above, is perhaps beyond the remit or direct influence of this project, local commissioners have been invited and have contributed to our Advisory Group meetings. It is our intention to include them in the circulation of our final report. However, the remaining key components are well within the influence of this project and will certainly inform future direction.

How we plan to proceed:

A year after we deviated from our initial project plans, we have all learned a great deal from COVID-19 and are living in a society more shaped by loss, and more acknowledging of death and grief, than at any time since World War II. Although our plans for *how* we deliver the *Better Lives, Better Endings* project have changed, our original intended outcomes remain the same.

In May and June 2021 we are delivering a *Better Lives, Better Endings* development programme for Octavia's extra care staff, with participation from managers, deputy managers, team leaders and care staff from across the schemes. The programme will be delivered in two-hour sessions, over eight consecutive weeks, online using Zoom. At the first session we will seek input from all participants on what they want to include, continuing with our co-design approach. The contents and design will draw on what we have learnt from the project thus far.

Our online programme is situated firmly as part of Octavia's wider transformation and cultural change programme. It is not just about end of life, but about exploring how staff can better support residents throughout their whole time at Octavia. It is part of embedding the shift from task-based to relationship-based care and support, and of ensuring that care and support for each resident reflects an understanding of what is important to that individual, and their individual needs, preferences and wishes as they age, experience change and prepare for their end of life.

This will not be a traditional training programme. There will be a strong emphasis on reflection, open discussion, practice-based learning and real-life application. Contributions will be sought from relevant external partners such as local GPs, the local hospice and the ambulance service. This will not only give an opportunity to learn from one another but will aim to facilitate greater future collaboration.

As part of the programme, we are identifying a suite of tools, resources and approaches that can be used by all Octavia staff, including to support conversations with residents about death, dying and loss. We will also introduce some activities or exercises for staff to undertake between sessions, and Octavia will allow participants to complete these in paid time. Such activities might include experimenting with a new tool, watching a video or listening to a podcast.

The programme will be evaluated, and this will include seeking feedback from participants on their experience of taking part and what difference (if any) it is making to their knowledge, skills, confidence and practice.

After testing our programme, we will produce a publication later in 2021. We intend this to be a useful resource for other providers of housing and end of life care. It will articulate the case for

change to improve the last years of life of people living in extra care, and will tell the story of what we did and what we learnt and include perspectives of residents, frontline staff and managers. It will contain resources that others can use or adapt e.g. the structure, agenda and contents of our programme for staff, and suggested support tools. To conclude our project, we will hold an online event with other providers of housing and end of life care, to share learning on these vitally important issues and themes.

Summary and conclusion

Despite disruption caused by a global pandemic this project has been able to stay focused and on track. This has been due to both the commitment of Octavia management and the motivation and engagement of care staff. It is also thanks to the members of the Advisory Group who have offered sustained and valuable insight and support demonstrating a collective will to find solutions to the challenges faced by extra care housing facilities when providing accommodation to people with complex health needs who would prefer to die at home.

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Note

The views expressed in this paper are those of the authors and not necessarily those of the Housing Learning and Improvement Network.

About Octavia

Octavia has stayed true to its social purpose for more than 150 years as we have continued the pioneering work of our founder, Octavia Hill, in providing homes, support and care for people in central and west London.

Operating in some of the most expensive parts of the capital, we have built on this legacy through our unique offer that puts people and communities first. We seek to be an exemplar in providing good quality, affordable homes that enable people on lower incomes to live in London. We believe in supporting the diverse neighbourhoods we serve so that people can live well, be independent, make connections and thrive.

We deliver equality through homes, support and opportunity, supporting vibrant communities and better lives for all. As stewards of a proud legacy dating back to 1865, we will continue to build and provide sustainable homes and places for future generations to enjoy and be proud of, for the common good.

Octavia provides thousands of people in London with good quality, affordable, sustainable and well-managed homes, alongside care and support services and community projects.

<https://www.octaviahousing.org.uk>

About St Christopher's

St Christopher's Hospice has a vision of a world in which all dying people and those close to them have access to care and support, whenever and wherever they need it.

Each person is unique and St Christopher's tailor their care to meet social, emotional and spiritual needs, as well as manage physical symptoms. Their goal is to help people live well until they die and support those affected by the loss of a loved one. Each year the hospice provides care and support to over 7,500 people across south east London, both at home and in the hospice.

St Christopher's also passionately believe that everyone should have access to the best care at the end of their lives and have an extensive education programme, working with people across the world, to improve and develop hospice care.

The hospice was founded in 1967 by Dame Cicely Saunders and, more than 50 years later, her words still remain at the heart of everything we do: "You matter because you are you and you matter until the last moment of your life."

As a registered charity St Christopher's need to raise £16 million every year to continue to care for people when it matters most. Without the support of local communities this wouldn't be possible.

You can find out more about St Christopher's at: www.stchristophers.org.uk

About the Housing LIN

The Housing LIN is a sophisticated network bringing together over 25,000 housing, health and social care professionals in England, Wales and Scotland to exemplify innovative housing solutions for an ageing population. Recognised by government and industry as a leading 'ideas lab' on specialist/supported housing, our online and regional networked activities, and consultancy services:

- connect people, ideas and resources to inform and improve the range of housing that enables older and disabled people to live independently in a home of their choice
- provide insight and intelligence on latest funding, research, policy and practice to support sector learning and improvement
- showcase what's best in specialist/supported housing and feature innovative projects and services that demonstrate how lives of people have been transformed, and
- support commissioners and providers to review their existing provision and develop, test out and deliver solutions so that they are best placed to respond to their customers' changing needs and aspirations

To access a selection of related resources on bereavement and end of life care, check out the Housing LIN's curated pages at:

<https://www.housinglin.org.uk/Topics/browse/CareAndSupportatHome/EndOfLifeCare/>

And for more information about how the Housing LIN can advise and support your organisation on community-led approaches to shaping your 'offer' for an ageing population, go to:

<https://www.housinglin.org.uk/consultancy/consultancy-services/>

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