Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 14 July 2021

TB2021.53

Title:	**End of Life Care Annual Report**

Status:	**For Information**
History:	

Board Lead:	**Chief Medical Officer**
Author:	**Dr Mary Miller, Consultant in Palliative Medicine**
Confidential:	**No**
Key Purpose:	**Strategy, Performance**

Executive Summary

1. Focus was on clinical service provision in 2020/21
2. The National Audit for Care at the End of Life 2020 (NACEL) did not take place due to the pressures of the pandemic.
3. Funding for a 0.5 WTE medical lead role for 2 years has been secured with the option to extend for a further year. This funding is offered by Sobell House Hospice Charity.

Recommendations

4. The Trust Board is asked to:
   - Receive the report for information.
   - Note that funding has been made available by the Sobell House Hospice Charity due to the identified need for medical senior leadership to enable further progress to be made and maintained.

1. Purpose

1.1. This paper serves to share work and progress with regard to palliative and end of life care (PEoLC) across Oxford University Hospitals.

2. Background

2.1. The COVID-19 pandemic had a significant effect on the focus of work in 2020/21.

2.2. The palliative medical consultant team offered additional sessions and, alongside medical colleagues from Katharine House Hospice and Helen and Douglas House, provided a 7 day a week consultant service in the JR for 2 months during wave 1.

2.3. The palliative care team welcomed one person returning to work from retirement and several redeployed nursing staff during wave 1

2.4. This enabled additional service provision, adoption and dissemination of national advice regarding the management of symptoms in those dying of COVID-19 and development of local advice on the intranet, including advice regarding discharge medication

2.5. Additional staff enabled provision of teaching that was requested ranging from at the elbow to larger group teaching, supporting clinical care, communications skills, ethics and treatment escalation plans / advance care planning.

2.6. Bespoke staff support was provided to an area with a large number of deaths.

2.7. A review of practice in caring for those dying of COVID-19 in OUH was conducted and published. This is one of seven studies conducted internationally (published in English)[1]. The team also conducted and

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[1] ***Palliative Care During COVID-19: Data and Visits From Loved Ones***
Results: Referral was made in the last 2 [1-3] days of life. Common symptoms were breathlessness (84%) and delirium (77%). Fifty-eight percent of patients received at least 1 "as required" dose of an opioid or midazolam in the 24 hours before death. Sixty percent of patients needed a continuous subcutaneous infusion and the median morphine dose was 10 mg S/C per

published a rapid systematic review of symptom control therapeutics[2]. This research contributes to the knowledge base in understanding how to care for those dying of COVID-19.

3. Specialist Palliative Care

3.1. Paragraph Specialist Palliative Care is provided by teams whose sole focus of care is care of those who are dying and those important to the patient and / or care of those with life limiting illness who need care at an earlier point in their illness.

3.2. The Department of Palliative Care in the OUH, Sobell House, provides adult palliative care across OUH and outreach into the community. The Clinical Lead is Professor Wee.

3.3. Children’s specialist palliative care is provided and fully funded by Helen and Douglas House whose staff hold honorary contracts with the OUH.

3.4. Adult face to face service provision is available during day times, 5 days a week in the Churchill, NOC and Horton hospitals. A daytime telephone advice line is available at weekends and on bank holidays. Specialist medical advice is available 24/7 via the OUH switchboard.

3.5. There is a daily face to face service for adults on the JR site. This service prioritises patients in the emergency department and emergency assessment units at the weekend.

3.6. The End of Life Care programme manager post was funded by Sobell House Hospice Charity until September 2020.

4. OUH End of Life Care Strategy Group

4.1. The strategy group has not met in 2020/21. Initially, this was because of the clinical workload during the pandemic and latterly because of the lack of personnel to support the meetings and work of the group.

[2] ***Pharmacological strategies used to manage symptoms of patients dying of COVID-19: A rapid systematic review*** *Conclusions: A higher proportion of patients required continuous subcutaneous infusion than is typically encountered in palliative care. Doses of medications required to manage symptoms were generally modest. There was no evidence of a standardised yet holistic approach to measure effectiveness of these medications and this needs to be urgently addressed.*

https://journals.sagepub.com/doi/full/10.1177/02692163211013255

4.2. The group will be able to restart with the progression of the senior leadership role which is being funded from the Sobell House Hospice Charity..

5. Education

5.1. Education is provided directly and indirectly to staff across the OUH by the specialist teams.

5.2. Virtual PEoLC education is now included in medical and clinical induction days across OUH.

5.3. The e-learning programme ‘End of Life Care for All’ (e-ELCA) modules are available on OUH’s electronic learning system, which makes them easily accessible for all staff across the Trust.

6. Quality Improvement

6.1. The guidance developed for the end of life care section of the structured judgement review (SJR) to support a consistent approach in reviewing this phase of care was expanded to include unexpected death.

6.2. A survey of 75% of SJRs in 2019/20 was completed and presented to Mortality Review Group. It demonstrated improvement in the assessment of care following the introduction of the quality indicators.

6.3. The focus for learning is on diagnosing dying.

7. Audit and Research

7.1. The National Audit for Care at the End of Life (NACEL) was cancelled in 2020.

7.2. The Palliative Care department is leading a unique NHS cohort study (SUPPORT) looking at outcome metrics and cost effectiveness of pro-active palliative care for those over age 75 admitted to medicine via the emergency department. The study was paused during wave 1 and has closed. Evaluation is ongoing.

8. Charitable Support

8.1. OUH is fortunate to have support from Charities to support and enable its work in caring for patients for patients approaching the end of their lives, those patients who are dying and those important to the patient both within the Trust and across the Healthcare economy of Oxfordshire.

8.2. Sobell House Hospice Charity provides substantial funding to OUH annually supporting the palliative care department to deliver care services in the hospital, hospice and community as well as bereavement care.

8.3. Sobell House Hospice Charity pump primed the hospital quality improvement project between 2016 and 2019. It continues to provide some funding to enhance care across the Trust.

8.4. Helen and Douglas House Hospice funds the staff to provide specialist palliative care for children within OUH as well as providing care in the community, in their Hospice and bereavement care.

8.5. Katharine House Hospice provide inpatient beds and community palliative care for patients in the north of Oxfordshire the county and bereavement services.

8.6. Oxford Centre for Education and Research in Palliative Care (OxCERPC) provide a significant amount of not for profit education to the OUH, designing bespoke programmes of education for specific groups of staff e.g. HART, Renal, South Central Ambulance Service, GP's.

8.7. SANDs is a significant provider of support to children's families.

9. Next Steps

9.1. Progress discussions to appoint to a 2 year 0.5 WTE medical lead role for EOLC in OUH. Funding has been secured and will be provided by the Sobell House Hospice Charity for 2 years in the first instance, with a further year extension available.

9.2. Conduct National Audit of Care at the End of Life in 2021

9.3. Support the quality improvement project to implement ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) in Oxfordshire. The ReSPECT plan is created through conversations between a person and their health professionals and creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices. Further information can be found here https://www.resus.org.uk/respect/

9.4. Further develop the integration with Katharine House Hospice building on the successes achieved to date:

- Offering patients and families a choice of the first available hospice bed regardless of geography

- Embedding EPR to support clinical care
- MDT cross service 'sit rep' and handovers twice daily
- Merged senior medical on call rota

9.5. Await the outcome of the expression of interest submitted by OUH to Social Finance. This affords the opportunity to embark on system change to support the care of a greater number of people to remain at home when dying.

10. Conclusion

10.1. The pandemic has shifted focus to understanding how to provide care for those dying of COVID-19.

10.2. In 2021 the palliative care department will continue working to further improve care, seek to understand patient's wishes and make those explicit across Oxfordshire.

11. Recommendations

11.1. The Trust Board is asked to:

- Receive the report for information.
- Note that funding has been made available by the Sobell House Hospice Charity due to the identified need for medical senior leadership to enable further progress to be made and maintained.