KATHARINE HOUSE HOSPICE

Oxford University Hospitals NHS Foundation Trust

Cover Sheet

Trust Board: Wednesday 12 July 2023

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Title:	**REPORT TO OUH BOARD & KHH TRUSTEES**

Status:	**For Decision**
History:	**N/A**

Board Lead:	**Chief Finance Officer**
Author:	**Jason Dorsett, Chief Finance Officer**
Confidential:	**No**

Executive Summary

1. Attached is a joint report from the Katharine House Hospice Liaison Committee to the charity's trustees and the OUH Board.
2. Operationally and clinically the partnership with KHH has been a success. Since OUH took over running the hospice inpatient activity has increased and the hours that the hospice admits patients have been increased. This means that more people in north Oxfordshire and HGH inpatients benefit from specialist palliative care and there is small benefit in reducing bed pressures at HGH.
3. However, the transition has not been without some issues and the Liaison Committee was set up in anticipation of those issues. The report reflects the constructive tone of current working.
4. The charity has agreed a roll forward of the current £1.4m grant on the same terms for one year. The terms are summarised in the attached report. The Board is asked to approve the grant roll forward. A joint project is underway to agree terms for a new longer term grant starting 1 April 2024.
5. The charity and Trust have now agreed the basis for the refurbishment work at KHH. The contractor which won the tender last year has agreed that it is still interested in the work. The Capital and Procurement teams are agreeing revised pricing and all parties hope that work can start on site in September.
6. KHH Charity has a new chief executive, who has a background in fundraising and it is hoped this will support the fundraising performance of the charity.

Recommendations

7. The Trust Board is asked to:
    - **Note** the attached joint report;
    - **Note** the progress on resolving issues with estates works; and
    - **Approve** the proposed one year renewal of the £1.4m grant from KHH charity to the Trust.

Contents

1. Introduction

1.1. Katharine House Hospice (KHH) has been providing end of life and palliative care in North Oxfordshire, South Northants, and parts of Warwickshire for over 30 years and is a well-respected and supported member of the community it serves. However, the geographic area is relatively small, as is the population, and by 2019 it was becoming obvious to the Board of Trustees that the Charity's financial position – with reasonable reserves but a growing financial deficit – was unsustainable for the longer term. The Board of Trustees therefore initiated a study to look at options to secure the long-term future of the hospice and, having decided that collaboration or merger with another provider was the only realistic course, entered negotiations with OUH to construct a partnership arrangement.

1.2. Discussions took place throughout 2020 and early 2021 with the aim of having the new arrangement in place on 1 April 2021. An enormous amount of work by both parties, with external assistance where necessary (particularly legal), ensured that the whole due diligence process was completed on time and the 1 April target for implementation was achieved. The essence of the agreement was that KHH would enter into a binding contract with OUH to contribute an agreed annual sum to support clinical services at KHH, and OUH would assume responsibility for the provision of those services. The hospice building would remain in KHH's ownership but leased to OUH at a peppercorn rent, with the great majority of equipment being transferred. KHH would remain in the building to continue in its new role as a pure fundraising charity but would retain its strategic aim of being able to enhance services wherever possible. The initial period of agreement was 2 years (ie ending 31 March 2023) and the level of financial contribution was £1.4M for each year. Details of the agreement are in Appendix 1.

1.3. It is important to recognise that the arrangement is not that of a 'conventional' supporting charity (for example Sobell House) but one with formal expectations of delivery and performance by both parties. In recognition of this a Liaison Committee was formed to provide a high-level forum to jointly pursue enhancements to EOL and palliative care in area, and to be the body for resolution of difficult operational issues. The Terms of Reference for the Committee are in Appendix 2. Within the Committee's remit is a requirement to report to the OUH and KHH boards; this document is the first such report.

As noted above, the current collaborative arrangement expired on 31 March 2023. It has been agreed that 23-24 will be based on a roll-over of the 21-23 agreement, whilst the post April ’24 agreement is negotiated, drawing on learning from the previous 2 years within the partnership.

2. Clinical Output & Delivery Service

2.1. For clinical staff the transition was generally successful with a transfer to Agenda for Change conditions. There were few immediate changes in personnel and the potential risk of a number deciding to leave was not realised. For the small groups of non-clinicians who transferred under TUPE (catering, IT and facilities) the process was considerably less smooth with final clarification of new terms taking some 18 months.

2.2. There have been significant service gaps in important posts due to the lengthy OUH recruiting processes. In particular the crucial Living Well position was vacant for 7 months and the Chaplaincy post has finally been filled after 13 months. It is not clear that the HR organisation appreciate the vital nature of these positions within a small and remote team where cross cover is difficult and frequently impossible.

2.3. Within the hospice the relationship between the clinical and Charity staffs is fundamentally important, particularly for the Charity to maximise its fundraising activities by being able to reference the success of the hospice’s care services. It is gratifying to report that there is now a stronger connection between the two elements than before collaboration with clear benefit to Charity activity.

3. KHH Charity Performance

3.1. Prior to collaboration the Charity was focussed primarily on clinical service delivery; the makeup of both the Board of Trustees and the Senior Leadership Team (SLT) reflected this. The new organisation effective from 1 April 2021 therefore represented a major change of emphasis and significant adjustment was necessary in the composition of both bodies. By the autumn of 2021 the SLT was entirely new, and 50% of the Trustee Board was also refreshed. The transition was challenging but it is to the credit of the CEO and the SLT that both the culture of the organisation and the changes in working practices have been achieved without significant disruption.

3.2. As noted above, the contractual nature of the partnership means it is very different from that with e.g. Sobell House. It is evident that some OUH staff have difficulty in understanding the implications of the relationship. The Charity needs to have clear visibility of how its financial contribution is

spent, both from a charity governance point of view, and also to provide essential information for fundraising efforts. This is still a work in progress and fundraising efforts will continue to be hampered until this is achieved.

3.3. The wider economic environment has put significant pressures on charity giving which are being felt across the sector and KHH has not been immune to these effects. The partnership in itself has also had a negative impact on philanthropic income – partly due to a public assumption that the NHS is taking over the funding of the service as well as the delivery but also due to a lack of financial data on expenditure to run the hospice, precluding applications to large, multi-year funders and philanthropists. There is significant work to do to move the Charity back to break even position and to cease utilising precious reserves on an annual basis with no ability to replace them. Once the Charity has returned to a break-even position, it will be keen to identify ways of contributing to further enhancement of services.

4. Liaison Committee Performance

4.1. The Liaison Committee has met five times since 1 April 2021. There have been considerable challenges around diary management and the timely production of material which have inhibited successful meeting outcomes. In addition, too much time has had to be consumed trying to resolve low level operational problems which has led to a failure to address strategic development.

4.2. The Committee has recognised that there is a need to identify accountable individuals able to make decisions at the appropriate level rather than introducing delay by having to remit relatively trivial problems to the Committee, primarily for the Finance Director to action. As a result, a Task and Finish Group has been established to address these issues. The problem of providing essential financial data to inform both Charity governance requirements and fundraising activity has yet to be solved.

4.3. There remains a problem with funding of necessary refurbishments at KHH. The 2021 agreement identified essential work required, primarily to meet NHS standards, but the OUH Estates organisation was unable to devote sufficient resource accurately to cost the programme. After 21 months a more detailed assessment was made which increased the original estimate from £385k to £858k. KHH holds the funds for refurbishment and the Board of Trustees was understandably reluctant to agree the very significant increased expenditure without detailed justification (the trustees have a clear legal responsibility to do so). The process has yet to be completed, but it has revealed a lack of understanding by both parties of process and responsibility.

4.4. At the true strategic level there are a number of areas the Committee hopes to consider if freed of the low-level matters that have taken up its time previously:

- The further development of end of life and palliative care strategy to allow the identification of areas for enhancement and increased funding
- The clarification of relationships with the ICBs and the Charity's role within them
- The scope for better alignment of KHH and Sobell House activity

5. Conclusion

5.1. The transition to a new partnership between OUH and KHH has been remarkably successful at a time when Covid and other pressures could have prejudiced implementation; this has been due to the enormous amount of work put into the programme, and the undoubted goodwill displayed by both parties to achieve the goal.

5.2. Clinical service delivery has increased, but there have been significant challenges in securing philanthropic income to the Charity.

5.3. The resolution of relatively trivial operational level frustrations has beset the effectiveness of the Liaison Committee; these should be addressed by the establishment of a Task and Finish Group.

5.4. It is recommended that the current agreement between OUH and KHH is rolled over unchanged for a further year to allow an in-depth review for implementation on 1 April 2024.

5.5. Operational level frustrations unresolved by Liaison Committee have taken up inordinate amount of time and caused unnecessary friction.

6. Recommendations

6.1. The Trust Board is asked to:

- **Note** the attached joint report;
- **Note** the progress on resolving issues with estates works; and
- **Approve** the proposed one year renewal of the £1.4m grant from KHH charity to the Trust.

Appendix 1 – The Agreement

1. The partnership between KHH Charity and OUH was brought into effect through a suite of legal documents signed prior to the transfer on 1.4.21. These included:
    - Business and Asset Transfer Agreement transferring services, staff and equipment;
    - Data Services Agreement covering patient and staff data;
    - 30-year lease of the site at a peppercorn rent;
    - Underlease of space to KHH Charity for its offices;
    - IP licence for the parties to use the respective brands; and
    - Funding Agreement for two years from 1.4.21.

2. Key Terms of Funding Agreement

2.1 The parties are KHH Charity and OUH.

2.2 The term was for two years from 1.4.21 to 31.3.23.

2.3 The value of the funding was £1.4m per year subject to KHH having sufficient funds.

2.4 The funding was structured as a grant for the services as defined in the "Clinical Model" document. Broadly, this required OUH to maintain the range of service provision as at transfer.

2.5 The agreement noted the existence of the separate CCG Risk Share Agreement which dealt with the circumstances under which Oxfordshire CCG might cover a shortfall of fundraising income by KHHC Charity for a period of two years.

2.6 Funding was not guaranteed after the term and it was expected that discussions for funding after the initial term would commence in September 2022.

2.7 Funding was to be paid quarterly in advance.

2.8 OUH took on redundancy liabilities should the services be closed at a future point in time.

2.9 Other clauses covered record keeping, co-ordination on communication, IP and data, standard warranties and the MoU on wider working.

3. Operation of the Grant Agreement

3.1 The operation of the Grant Agreement has been as expected other than:

- The payment for Q4 of 2021/22 was forgiven by OUH as it has a surplus for the financial year and wishes to allow KHH Charity to carry forward larger reserves;

- The Risk Share with the CCG was “bought out” with a one-off payment by the CCG to the Charity in March 2022.

Appendix 2 – Terms of Reference

1. **Authority**

1.1 The Oxford University Hospitals NHS FT (OUH) and Katharine House Hospice (KHH) Liaison Group is a formal advisory group and reports to the OUH Board and the KHH Board.

2. **Purpose**

2.1 The Group is the strategic level link between OUH and KHH and exists to ensure the two organisations jointly explore the optimisation and enhancement of palliative care services in Oxfordshire, monitors the performance of the service provided, monitors the funding performance of KHH, resolves any strategic differences between the two organisations, and receives reports from the operational group**.**

3. **Membership**

3.1 The membership of the group will be composed of the following members of staff;

- SUWON Divisional Director of Operations or SUWON Divisional Director of Nursing
- OUH Chief Medical Officer/Chief Nursing Officer or Chief Operating Officer
- OUH Chief Finance Officer
- OUH Vice Chair
- OUH Palliative Care Clinical Lead
- KHH Chair
- KHH Vice Chair
- KHH Clinical Trust
- KHH CEO

3.2 The chairmanship shall rotate between OUH Vice Chair and KHH Chair every 12 months.

3.3 Others may be invited to contribute to meetings as required.

4. **Frequency of Meetings & Quorum**

4.1 The Group shall meet on a quarterly basis. A quorum shall be a minimum of three members from each of OUH and KHH.

5. **Recording of proceedings**

5.1 A secretary shall be appointed and a record, with an action log of decisions, of each meeting shall be produced within 10 working days. Papers for

consideration at meetings shall be produced and circulated, along with the agenda, at least 7 days before each meeting.

6. **Functions will include but not limited to:**

6.1 Strategy:

- Advise on the strategic direction of palliative care services with the aim of enhancing and improving services wherever funding and circumstance permit, monitor the planning and implementation of strategic changes.

6.2 Finance:

- Monitor the funding provision from CCGs and from KHH via regular reports against agreed budgets and KPIs and make recommendations for any changes.

6.3 Service Delivery:

- Monitor the provision of clinical services by OUH against agreed KPIs and make recommendations for any changes.

6.4 Risk:

- Establish a strategic level Risk Register for the successful delivery of services and regularly monitor the effective mitigation of the risks.

6.5 Dispute Resolution:

- Ensure any strategic level differences of approach are brought to the attention of the Group and are speedily resolved.

6.6 External:

- Be informed and up to date on developments in palliative care and end of life services nationally, consider their applicability to the service provided, and make recommendations for any changes.

Appendix 3 – Clinical & Service Delivery

1. Clinical Output & Service Delivery

1.1 Since the commencement of the partnership on the 1st of April 2021 the Clinical Services based out of Katharine House Hospice have seen significant evolution and embedding into the Palliative Medicine Department at Oxford University Hospitals NHS Foundation Trust. The first two years of the partnership have seen huge change in the services to enable a good level of integration not just operationally but culturally.

1.2 Offering high quality data that summarises the activity is challenging for a number of reasons – not least because the department has a focused quality priority around improving the data we report and act on which has led to serial changes in software and process underpinning this. However, we are now confident going forwards that we can guarantee monthly reporting of combined departmental activity data with a commitment to quarterly disambiguated data reports to both charity partners. Further the aim would be in the coming year to integrate health related outcome measures and regular friends and family feedback into our data work to enable us to report on the impact of our work (rather than merely our activity) and offer more nuanced qualitative feedback.

1.3 It should also be mentioned that the partnership's first two years have played out against the backdrop of the Covid-19 pandemic and its early recovery stages. Pressures on the healthcare system locally cannot be underestimated particularly on those reaching the end of their life. The fact that despite this our staff have remained resilient and dedicated and have flourished in the setting of the profound change asked of them is a huge source of pride to the senior team.

2. Inpatient Unit

2.1 One of the few metrics that can be offered and speaks to the energy that has come into the partnership is that since July 2022 the bed occupancy at KHH IPU (which previously remained static at around 65-70% in previously CCG reported data) has been at least 80%. The inpatient unit team has focused on holding onto the key ideology of the independent hospice as a home from home while embracing the efficiency and clinical rigour of the OUH. Key developments include:

2.2 Development of 24/7 admissions for patients from any care setting. This has enabled a better use of the available resource, less unmet need for patients and families in crisis and potentially avoided avoidable acute admissions. Previous practice would have offered admission routinely 5 days per week before 3pm – however from May to November of 2022 the broadened admissions criteria enabled an additional 37 patients to be admitted (41% of all admissions during that period) the same day as the

request and thus in a truly responsive fashion. Staff have risen to the challenge of enabling this work with a recognition it serves our patient cohort better.

2.3 A focus on use of the whole inpatient bed state flexibly. This has enabled inpatient unit beds to be used across the hospice estate driven by need and patient preference ensuring parity of clinical activity across the units. Prior to the partnership the IPU at KHH was wary of admitting patients who may still have recourse to significant clinical intervention, but this has shifted significantly since partnership with the support of the team within OUH, and with the creation of established pathways around accessing key procedures for patients who can still benefit from a hospice environment.

2.4 Refurbishment. The established plans to bring the estate up to key standards are already offering patients and families a more individualised and appropriate care at the end of life – such as the decommissioning of the onsite mortuary.

2.5 Consolidation of the clinical MDT. With a sharpening of the nursing and medical structure to ensure clear leadership, and a focus on training and engagement, the MDT has been able to develop its team ethos. Benefiting from the broader availability of professional groups within the department than previously existed at KHH the patients have had access to music and art therapy, psychological medicine, consultant pharmacist, dietetics, benefits advice, and occupational therapy not previously accessible. The chaplaincy role that for some months had been left unoccupied is now recruited to and the retirement of the longstanding social worker is due to be reimagined in a re-banded social work post alongside a family liaison and support worker.

2.6 The senior management group in the department is keen to develop the two inpatient units as near peers which can advance care collaboratively, with clear parity of service but an ability to develop their own characters and key strengths. The cross-pollination of key staff in senior medical and nursing roles is a core strand to this.

3. Community Palliative Care Service

3.1 The partnership saw a rapid and absolute integration of the two services previously based at Sobell and Katharine House working as specialist teams across the community of Oxfordshire and South Northamptonshire. Ably steered by Mary Walding as Lead Specialist Nurse who had worked at both hospices prior to the partnership, the team has gone through significant change only partly due to the partnership. The shifting picture of provision of primary care and the unmet need of patients in their own residence, as well as the changing nature of palliative care towards a model less embedded in long term relationship and more focused on need

and crisis resolution have led to a reimagining of the role of the Community Team.

3.2 The team now work across three localities (the northern of which encompasses the previous KHH catchment with additional practices) and in a rolling pattern of planned work (including review visits and assessments), as well as manning a central Hub for calls in and Response shifts to work towards same day crisis management. For some GP practices this has led to some concerns over loss of continuity but what it has enabled is a significant uplift in activity across a seven-day service while maintaining the quality of our clinical care.

4. Hospital Palliative Care Service

4.1 Prior to the partnership the Horton General Hospital had support of a single senior specialist nurse 5 days per week and 2 PAs of senior medical support as part of an SLA with OUH. Thanks to the integration with the broader Hospital Team the patients at the Horton now have access to a bigger and broader team which includes a wider MDT and a 7-day telephone advice service. Integration into the hospital service as a whole is a key part of ensuring the patients at any one of the acute sites gets parity of access and care if they're reaching the end of their life.

5. Living Well

5.1 Having evolved from the previously existing Day Hospice model there were significant challenges over the integration of Living Well into the broader department partly due to the profound loss of momentum caused by the cessation of services in Covid and also due to the loss of the senior leader for the service, and the need to re-evaluate that role and its banding. It has been disappointing that it has taken significant time to regain the energy that previously existed but under the guidance of Natalie Herbert it is now bearing fruit – with patients attending in person multiple days per week and the first Living Well with Breathlessness commencing in April as well as a new Introduction to the Hospice poly clinic launching in March.

6. Lymphoedema

6.1 Integration into the broader OUH team has enabled the service at KHH to withstand staff absence with minimal impact on waiting times, and also offer those patients in the north of the county a louder voice in the conversations about re-imagining the commissioning of lymphoedema services as is currently underway.

7. Bereavement

7.1 The bereavement service has gone through significant personnel change both before and since the partnership and although this has been disruptive at times – the greater pool of administrative support to enable data entry,

and the opportunity to redraw the shape of the service has been extremely useful. Again, ably helmed by Srinder Singh who has worked in both organisations prior to the partnership there is energy to ensure that this service is the right fit for the population need and evidence of this already with the development of well attended and reviewed Bereavement Cafes. It is anticipated that the coming six months will offer a leaner and more responsive bereavement service which will be able to engage with the work it has been planning for some time around supporting children and young adults who are bereaved.

8. RIPEL

8.1 The focus on the introduction of the RIPEL project has offered additional energy to the department but more importantly additional services to the people of North Oxfordshire and South Northants in the form of the Home Hospice Care team and imminently this spring the Community Rapid Response arm.

8.2 The collaborative working between both Katharine House Charity and Sobell House Charity as well as the clinical service and other key stakeholders has enabled this opportunity – and has seen the development of a degree of close working not previously realised. This integrated working for a common aim – that of improving the palliative and end of life care of all those living in this catchment – has been one of the greatest achievements of the partnership and has many successes ahead of it yet.