Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

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

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Board Lead:	**Chief Medical Officer**
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Confidential:	**No**
Key Purpose:	**Assurance, Performance**

Executive Summary

1. This paper presents the OUH End of Life (EOL) team's workplan for 2025/26. It shares local and national evidence of the need to have early conversations about dying. It reports on work undertaken to improve recognition of and communication about dying.
2. It recognises the utility of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) document to record decisions.
3. It describes robust training and teaching modalities that the EOL team have delivered to improve the care for dying patients, and support for their families.
4. It recognises the work that needs to be done to improve discharge of patients from OUH for end-of-life care at home.

Recommendations

5. The Trust Board is asked to:
    - Support Trust-wide education and training so all staff are confident and competent to communicate and provide care at the end of life to the patient and support those close to them.
    - Facilitate the improvement in the practice of discharge for patients who are dying, recognising the complexity of coordinating this process when time is short.
    - Help drive an increase in advance care planning conversations in outpatients, during all patient encounters and at the end of life so clinical teams and patients, and those close to them, can mutually engage and benefit from parallel planning.

End of Life Team Annual Report

1. Purpose

1.1. This paper describes the work of the OUH End of Life (EOL) team since September 2024. It outlines local and national data that helps inform our action plan. It highlights the objectives and achievements of the EOL team to improve palliative and end of life care in the Trust.

2. Background

2.1. Nationally and locally, we acknowledge that dying is often recognised late such that patients and those close to them are not prepared for this event. When dying is not recognised or communicated within teams, they face the difficult position of continuing treatment and intervention in actively dying patients.

2.2. In the year 2024/25, 3,800 adults died in OUH; 695 died in Katharine House and Sobell House hospices (18% of deaths); an estimated 25% of deaths on non-hospice wards were supported by the hospital palliative care team. An appreciable number of patients who die in OUH, do not receive specialist palliative care.

2.3. Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) has been employed in the Trust's EPR since March 2025. The ReSPECT document and process support conversations with patients and those close to them. It is a single place to record important conversations that will help support advance care planning with an aspiration to improve recognition of dying in the last year of life. Early review of its use suggests that we need to better engage with the components that inform this document. ReSPECT-related conversations should be triggered by recognition of a patient with a deteriorating trajectory, frequent hospital admissions, frailty and/or poor response to treatment escalation. When this does not happen, patients and their families are unable to make informed decisions about the nature and place of their care, and of their death. This also requires an understanding of medical decision making, mental capacity, legislation and guidelines.

2.4. Clinical teams are currently not mandated to engage in EOL training, which risks poor communication and poor symptom management for dying patients.

2.5. Dying at home often requires the complex provision of care, community clinical support, medications, documentation and equipment. Clinical teams often lack the knowledge of these systems leading to poorer

outcomes for patients and their families, such as re-admission, unmet needs at death, and prolonged bereavement.

2.1. The EOL team in OUH was expanded in early 2025 to include a clinical nurse educator (currently 4 hours per week) and administrator (10 hours per week). Dr Victoria Hedges leads the team, while Dr Mary Miller continues to direct on National Audit for Care at End of Life (NACEL) data collection and analysis for OUH and at a national level. These roles are funded by Sobell House Hospice Charity.

3. Objectives of the EOL team

3.1. Increase the number of adult patients, including those with non-malignant diseases, having advance care planning and shared decision making discussions. Support and educate staff about parallel planning (the introduction of palliative principles alongside active treatment).

3.2. Improve recognition of and communication with dying patients and their families in OUH by all members of the clinical teams.

3.3. Support and educate staff to confidently deliver end of life care to dying patients and support families with a focus on discussions about nutrition and hydration at the end of life.

3.4. Support staff to communicate sensitively and effectively with all patients and families, regardless of their primary spoken language and culture.

3.5. Improve discharge planning for dying patients.

4. Summary of evidence of need for improvement

4.1. Evidence for targets for improvement is derived from national and local audits and reporting. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) End of Life Care (2024) report recommends six areas for improvement (Summary report_end of life care.pdf). These align with the data from National Audit of Care at the End of Life (NACEL, 2024), in terms of timely recognition of patients who are actively dying. NCEPOD recommends advance care planning and care coordination of those patients who are at risk of deterioration or dying over a longer timeframe. It recommends parallel planning (integration of palliative care alongside active treatment), and integrated palliative and end of life training at undergraduate and postgraduate levels.

4.2. The EOL team are working with divisional nurses and medical leads to benchmark practice against the NCEPOD recommendations. This work is due to report to the Safety Learning & Improvement Conversation (SLIC) group in December 2025/January 2026.

4.3. NACEL 2024 results demonstrated that care at the end of life in OUH is above the national average for most metrics compared with practice in other acute and community hospitals (Appendix 1). Areas to improve identified by NACEL are:

- Education: focused training on the topics of recognising dying and discussing hydration. Actions to address this are covered above.
- Ensuring equitable access to care at the end of life for patients and families when English is not their primary spoken language. To address this, the palliative care department have started a trial of 24/7 AiVI technology (portable remote video interpretation devices) at the bedside to enable immediate conversations with patients and families.

4.4. Review of ReSPECT documents and review of the Rapid Intervention for Palliative and End of Life Care (RIPEL) project provide us with a guide to how clinicians recognise and discuss dying with their patients. Targets for training that emerged were 1) late or no recognition of active dying; 2) lack of parallel planning and advance care planning.

4.5. The RIPEL team reviewed 684 adult deaths (excluding those in maternity, within 4 hours of admission, hospices and emergency departments) and found that in 14% of cases dying was not recognised.

4.6. This data review also found that at least 1/3 of patients referred for rapid discharge home are too sick to be transferred home, pointing to late recognition of dying. Further to this, NACEL data (2022, not repeated) also showed that 60% of deaths in OUH occur less than 48 hours after the recognition of dying.

4.7. Evaluation of advance care planning and utilisation of ReSPECT forms for nephrology patients (July 2025) found that many doctors see barriers or lack confidence in discussing risk of dying their patients. The survey showed that approximately two-thirds of doctors do not use established tools, such as frailty scores, to assess risk of dying. 13% said they were no confident in completing a ReSPECT document.

4.8. Feedback from patients and families, and from OUH teams including the community palliative care team, provide rich information about how we can improve the discharge of dying patients (such as provision of injectable medications, better communication with GPs or community teams), to improve end of life experience for patients and their families.

5. Quality Improvement initiatives by the EOL team

Education and awareness of palliative and end of life care (EOLC)

5.1. A series of activities includes coordinating and developing clinical training to increase competence and confidence in EOLC. Our focus is on recognising dying, discussing dying (including nutrition and hydration) and management of EOL symptoms; use of interpreters. In the year 2024/25, approximately 80 hours of consultant-led training was delivered and more than 50 hours of nurse-led training.

5.2. E-Learning: My Learning Hub modules on end life and palliative care have been grouped into 2 tiers (see Appendix 2). We recommend that tier 1 is for all patient-face staff; tier 2 is for staff in clinical areas where deaths are frequent (1 or more per week) and for palliative care link professionals. The Clinical Education Training Committee (CETC) are undertaking an audience mapping exercise so relevant staff are mandated to complete the modules.

5.3. The EOL team continue to support ReSPECT training following the roll out of ReSPECT at OUH in March 2025.

5.4. The ‘Dying matters’ symposium held on 7 May 2025 was attended by more than 100 healthcare professionals from across the Trust, representing a wide range of specialties and disciplines.

5.5. Study days for link professionals supporting EOLC in their clinical area were held in July and September 2025 with good attendance (over 55 attended) and encouraging feedback.

Resource development

5.6. The Palliative Care intranet page has been redesigned and reviewed for accessibility and usefulness. Resident doctor users have informed the redesign; and further App-based guidance to on symptom management and EOLC is being developed.

5.7. We worked with pharmacy team to developed prompts in EPR for medications and direction to administer (for discharge for EOLC). Development of a leaflet to accompany anticipatory medications on discharge is underway. We have expressed our interest with the discharge quality priority team.

5.8. *What to Expect When a Person is Dying* leaflet is under review (completion expected by end 2025). This provides patients and those supporting them with detailed information about EOL symptoms and about the process that occurs after death, including death registration and the medical examiner role.

5.9. Review of the Sunflower project is underway. The laminated sunflower symbol can be placed on the door of the room to remind ward staff that the patient is dying. It encourages all staff (clinical and non-clinical) to be mindful of the needs of the patient and those important to them. A Sunflower pack is available on the wards/request from the hospital palliative care team. This pack provides information and resources that may be helpful to the patient's family and carers. The review aims to evaluate how clinical areas understand this project; and how often and appropriately it is used. We expect to identify areas where the Sunflower is not used, and these areas will benefit from its introduction and support for early recognition of dying and improved EOLC.

6. Conclusion

6.1. Many education and resource initiatives have been introduced to ensure that dying is recognised earlier, with additional resources for patient-facing staff in supporting dying patients. Communication at end of life is better supported with training and technology (including use of portable remote video interpretation devices at the bedside to enable immediate conversations with patients and families, where English is not the primary spoken language). The ReSPECT document provides us with the foundation to have early conversations with patients and their families about their deteriorating health or increasing frailty. Clinical and supporting teams, such as pharmacy and discharge planners, have a better appreciation of what is required to discharge patients home for end-of-life care.

7. Recommendations

7.1. The Trust Board is asked to:

- Note the work ongoing to address areas for improvement.
- Support Trust-wide education and training so all staff are confident and competent to communicate and provide care at the end of life to the patient and support those close to them.
- Facilitate the improvement of the practice of discharge for patients who are dying, recognising the complexity of coordinating this process when time is short.
- Help drive an increase in advance care planning conversations in outpatients, during all patient encounters and at the end of life so clinical teams and patients, and those close to them, can mutually engage and benefit from parallel planning.

Appendix 1

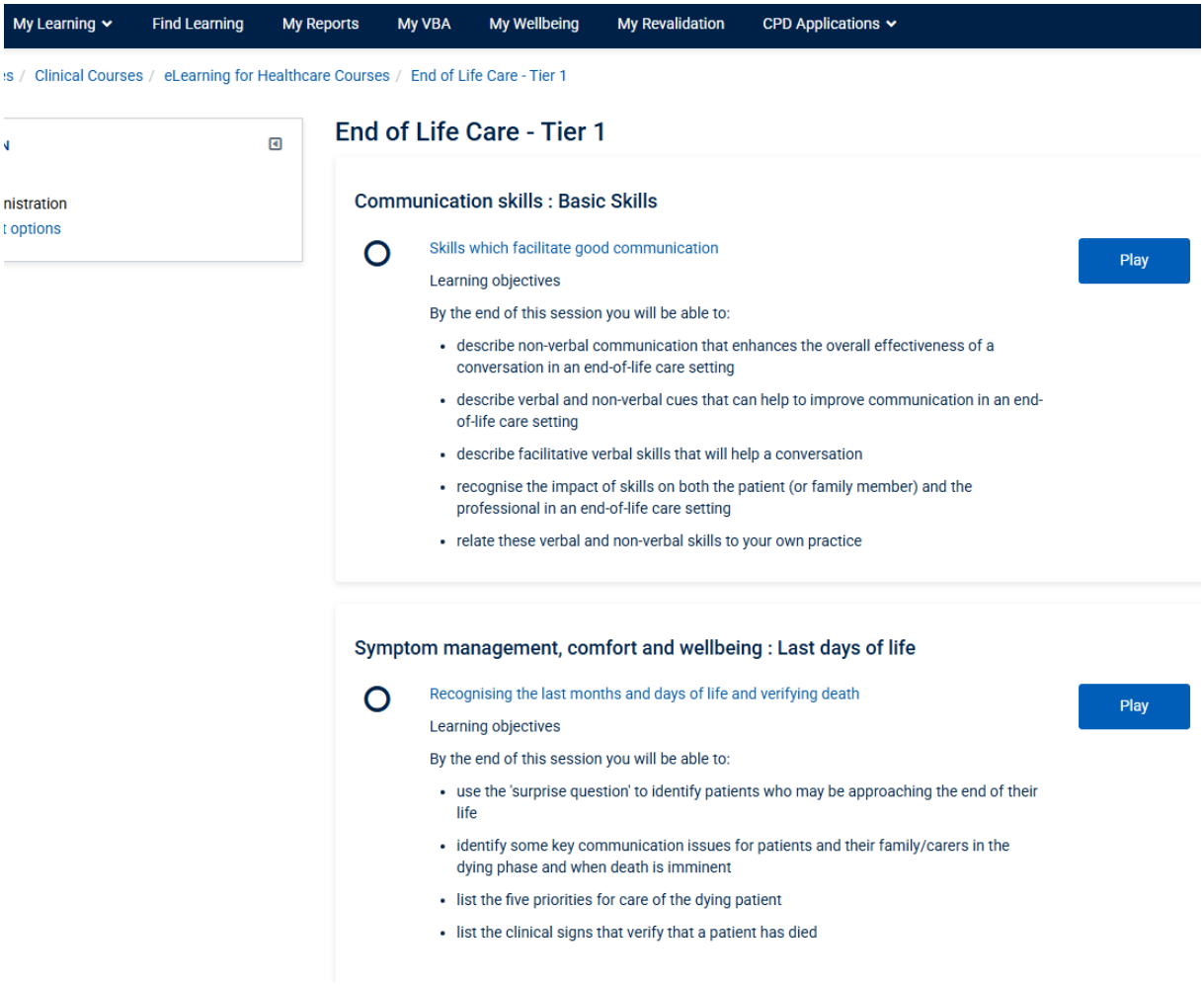
National Audit of Care at the End of Life, January–December 2024, OUH results

- 84% of OUH families, who offered feedback, reported that care was good or excellent. The national average is 75%.
- 88.5% of OUH families, who offered feedback, reported that staff treated the patient with dignity. The national average is 81.5%.
- Training for staff who provide care at the end of life is needed, with a particular focus on recognising dying and discussing the management of hydration and nutrition in dying patients.
- Work with the patient experience team to use ‘interpreters on wheels’, to support discussions with patients and those important to the patient at the bedside where English is not their primary spoken language.
- NB NACEL data collection for 2025 is ongoing in OUHFT. Interim results will be available in February 2026 and validated results in April 2026. National recommendations are scheduled for delivery in August 2026.

Appendix 2

My Learning for Health end of life end module tiers

Tier 1: for all patient-facing staff in OUH (estimated time to complete 50 minutes)



Tier 2: for clinical staff on wards where deaths occur frequently (>1 per week) and all link professionals for palliative care (estimated time to complete 2 hours 50 minutes)