

Cover Sheet

Trust Board Meeting in Public: Wednesday 13 July 2022

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Title: Oxfordshire Rapid Intervention for Palliative and End of Life Care (RIPEL) Project

Status: For Discussion
History: A patient story and perspective is presented at each Trust Board

Board Lead: Chief Nursing Officer
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Confidential: No
Key Purpose: Performance.

Executive Summary

1. The purpose of the paper is to
 - Provide an overview of the RIPEL service.
 - Share the story of families and their experience of end-of-life care. This is a nationally available story.
2. Three national reports have highlighted the need for end-of-life care to reflect patients and their family's needs and preferences.
3. This national backdrop has been the catalyst for the development of personalised, person-centred palliative and end of life care.
4. The aim of the RIPEL project is to provide enhanced integrated palliative care and support for adults with advanced life limiting illness, in conjunction with existing services provided by primary care, community services, secondary care and specialist palliative care teams in Oxfordshire and South Northamptonshire so that people have fewer avoidable unplanned bed days in the last 12 months of life and a better experience of care.
5. **Conclusion:** This paper has introduced the RIPEL project including the specification, vision, and collaboration between the Trust's Palliative care service and Acute General Medicine. A palliative care nurse involved with the implementation of the service has shared her reflections.
6. **Recommendations:** The Trust Board is asked to note the contents of the paper.

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Oxfordshire Rapid Intervention for Palliative and End of Life Care (RIPEL) Project

1. Purpose

1.1. The purpose of the paper is to

- Provide an overview of the RIPEL service.
- share the story of families and their experience of end-of-life care.

2. Background

2.1. Three national reports, the Ambitions for Palliative and End of Life Care: A national framework for local action¹, the NHS Long Term Plan², the 2021/22 Priorities and Operational Planning Guidance³ have highlighted the need for

- people receiving the right type of care, in the right place, at the right time and by the right people to reflect person's needs and preferences.
- boosting 'out-of-hospital' care, redesigning and reducing pressure on emergency hospital services and more personalised care.
- transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay.

2.2. This national backdrop has been the catalyst for the development of personalised, person-centred palliative and end of life care. By tailoring the patient's care around what really matters to the person and their family, it is hoped that a family can have a better experience.

3. Oxfordshire Rapid Intervention for Palliative and End of Life Care (RIPEL) project

3.1. The Oxfordshire Rapid Intervention for Palliative and End of Life Care (RIPEL) project seeks to address critical gaps in the provision and coordination of community-based services for people at the end of life.

¹ The Ambitions for Palliative and End of Life Care: A national framework for local action, first published in 2015 by the National Palliative and End of Life Care Partnership and refreshed in 2021.

[FINAL AmbitionsforPalliativeandEndofLifeCare 2nd edition.pdf \(england.nhs.uk\)](#)

² The NHS Long Term Plan published in January 2019. [NHS Long Term Plan v1.2 August 2019](#)

³ The 2021/22 Priorities and Operational Planning Guidance issued by NHS England and NHS Improvement in March 2021. [Briefing template \(england.nhs.uk\)](#)

- 3.2. This is an innovative collaboration between the Trust's palliative care service at Sobell House and Katherine House Hospices and the Acute Medicine and Rehabilitation (AMR) Directorate within Medicine Rehabilitation and Cardiac (MRC) Division. This collaboration is key in the delivery of patient and family centred care as it supports the expanse of specialist end of life care knowledge and expertise across the Trust. Additionally, the service provides the practical and emotional 'wrap around care' for both the patient and the family. This is an aspect of care that is highly appreciated by patients and their families who are looked after at Sobell House and Katherine House, and the team are pleased to be able to extend this approach to care for families at home.
- 3.3. The aim of the project is to provide enhanced integrated palliative care and support for adults with advanced life limiting illness, in conjunction with existing services provided by primary care, community services, secondary care and specialist palliative care teams in Oxfordshire and South Northamptonshire so that people have fewer avoidable unplanned bed days in the last 12 months of life and a better experience of care.
- 3.4. Macmillan⁴ describes how poor patient experience can impact on a person's health, link to poor recovery, and bring negative emotions resulting from a lack of support. In contrast to this, they describe 'good' patient experience as feeling supported, respected, and meaningfully involved in decisions about their care, from diagnosis onwards. The RIPEL project aims to deliver this approach to good patient and family experience at a very challenging and sad time for them.
- 3.5. The key objectives of RIPEL are:
- To enable care at home in the last days of life through provision of hands-on care and support with specialist level oversight.
 - To enhance palliative care at home through rapid intervention for crisis assessment, management, and support.
 - To facilitate early supported discharge from hospital where this is the preference of patients and their families.
- 3.6. The RIPEL service focuses especially on the needs of two cohorts of patients:
- People who are likely to die within a short time scale and who need more intensive hands-on care at home
 - Patients known to the specialist palliative care service who experience a crisis in the community and whose needs cannot be met sufficiently

⁴ [the-people-behind-cancer-care \(macmillan.org.uk\)](https://www.macmillan.org.uk)

quickly or fully by the core specialist palliative care services, the Ageing Well Urgent Community Response, or other existing services.

- 3.7. The focus and approach are in line with, and supports, the national Virtual Ward programme, in which NHS England and NHS Improvement's stated ambition is to have developed 40-50 virtual wards per 100,000 population by December 2023.
- 3.8. There are three inter-related service components (Please refer to Appendix 1):
- Home Hospice for dying people
 - Community Rapid Response and Hospital Rapid Response
 - Palliative Care Hub. The Hub works as a coordination point. It provides an initial assessment, help and advice using remote access and technology in the first instance, escalation for senior medical advice where needed, and deploys the right professional from the right part of the service as quickly as possible to meet the patient's need in person where required.
- 3.9. There are three phases for implementation
- **Phase 1:** From on 1st April 2022. The service hours for the Home Hospice service will be 8 am – 10 pm seven days per week.
 - **Phase 2:** Introduction of the Community Rapid Response service
 - **Phase 3:** Extending service hours for the Palliative Care Hub and Community Rapid Response to 8 am – 8 pm and Hospital Rapid Response to 8 am – 6 pm.
- 3.10. Referrals can be made by
- *For patients in the community*
 - ✓ GPs, district nurses, community matrons and community based AHPs
 - ✓ Senior doctors/nurses/AHPs in the Hospital at Home, Urgent Community Response and Hub Bed services
 - ✓ Paramedics and NHS 111
 - ✓ Patients and unpaid carers
 - ✓ Managers and senior staff in care homes, residential care and domiciliary care
 - ✓ Social services and voluntary sector providers, including homelessness case workers (via GP)
 - ✓ Neighbouring hospitals, hospices, and partner providers

- *For patients in hospital*
 - ✓ Consultants/senior doctors, advanced nurse practitioners/clinical nurse specialists/senior nurses, senior therapists, and discharge coordinators

3.11. Staffing

- The Home Hospice care staff will remain under the line management of the OUH Acute Medicine Directorate. They will be an identified cohort within a wider Acute Medicine team delivering the Ageing Well Urgent Community Response, so that cross-cover and resilience can be better assured.
- Most of the staff for the Rapid Response and Palliative Care service will be integrated members of the OUH Palliative Care multidisciplinary community and hospital teams and allocated to Rapid Response or Hub duties on specific days. A few staff may work solely within the RIPEL project, e.g., the service manager and some administrators. All these staff will be line managed through the Oncology and Haematology Directorate as part of the OUH Palliative Care service.
- By the time Phase 3 is fully rolled out, it is anticipated that there would be 75 WTE additional workforce.

- 3.12. Medicines Management: the usual prescribing practice in the community and hospital will predominate. However, in a crisis in the community, the Rapid Response team may be required to prescribe and administer as-required medication and/or to set up a subcutaneous infusion, recognising that good practice dictates a separation of responsibility between prescribing and administering wherever possible. Arrangements are in place to enable them to do so.

3.13. Discharge and handover of care

- It is vital that if a patient requires a more prolonged period of care at home than the Home Hospice service can provide, arrangements will be made to involve other care teams, including Continuing Health Care Fast Track. The daily Board Rounds facilitate early identification of this need to enable timely plans to be made with the patient and their carers.
- Patients who require the Community Rapid Response service are likely to need this only for the brief period of the crisis or urgent situation. They may need a few more days of support from the Hospice at Home team to stabilise and restore confidence. Thereafter, their needs may be able to be met by the primary and

community care teams, and existing specialist palliative care team. There will be times when the patient will require more intensive management, including investigation, in an inpatient setting – in that case, a planned admission to the hospice or hospital will be arranged.

- The initial follow up of bereaved families, when the patient dies, will be by the team member, or specialist palliative care staff, who has been most involved with the patient's care. They will be provided with information about how to access bereavement support, either from the palliative care bereavement services or wider community-based bereavement services, if they feel the need for this. Clear arrangements for removing equipment will be made and discussed with the bereaved carer.

4. Funding and Key Performance indicators

- 4.1. The RIPEL Project is funded by a collaboration between the Sobell House Hospice Charity, Macmillan Cancer Support, Social Finance⁵, and the Trust. After three years it is planned to seek commissioning support.
- 4.2. One of the key outcome measures for payment will be the reduction in unplanned hospital bed days in the last 12 months of life for patients referred to the RIPEL service.
- 4.3. Further metrics to monitor progress and drive improvements will be collected. These include feedback from
 - Patients, carers, and families about their experience through surveys, case studies and ad-hoc feedback (compliments and/or complaints)
 - Staff and other services about how RIPEL is integrating with other existing services.

5. Home Hospice Story

This story tells of the experience of a family who were looked after by the Home Hospice team. The first part is told by one of the Home Hospice team and the second part by the family.

Our story: This gentleman and his family were one of our first patients. At the beginning we were worried how are we were going to be able develop a relationship with a family in their most vulnerable and emotional time. We all learned that you develop a tight and close relationship really quickly.

⁵ [It's time to tackle health inequalities at the end of life | Social Finance](#)

One of the biggest challenges we face is supporting a family when they worry their relative may need to move onto being supported by another agency when their loved one is dying. The thing that is different is that we are genuinely are patient and family focused, and so if it isn't appropriate for the family to transfer to be supported by another service, then we will continue to look after them.

We have a team meeting at 12 noon every day of the week. This includes Sobell House, Katherine House, the Community Palliative Care Team and us. We review every patient we are looking after so if we need to put a different plan in place, we can. Most people are supported by two members of the home Hospice team, four times a day. Then the family have additional care and support from the community palliative care team. Communication and team working is central to how we work. It can be traumatic for a family to constantly relive how their loved one is deteriorating, so the midday team meeting call every day is vital. Patients and families can see the difference. They know we do this every day and at the weekend.

The positive impact on the Home Hospice Support Staff is immense. It is so positive as they do all the work supporting the patient and their family.

A couple of people have wanted to die in a hospice as they did not want to be a burden to their family, but their family wanted them to stay at home.

I think the thing that is different about our service is that we think about how we can help and talk with the patient and their family about how we can help and give solutions to problems.

I am so proud to work with them. They pay really detailed attention to what the patient and their family need.

Derek family's story. We were so grateful that Derek was able to stay at home. Derek was always a very positive person and the Home Hospice Team helped us all stay positive.

They were fantastic as they all talked with each other and we didn't have to keep repeating ourselves as that was so upsetting – they took that away, it was amazing. We felt like the left hand knew what the right hand was doing as they talked to each other.

The team gave us the chance to step back a bit from caring for him 24 hours a day and this meant we could spend more time with Derek and to enjoy the time we had left together.

Derek knew he was going to die. His sister stayed with us at home for the last five weeks. Our son does not live very close but was able to pop in with no fuss.

Derek would have loved to a smoke and drink but sadly wasn't able to as his throat hurt. When the Home Hospice Team first looked after us, we were able to

walk into the kitchen every day as we spend all our time in the kitchen, so it was social as much as anything.

Sadly, Derek suddenly deteriorated, and he couldn't get out of bed. He was at home though, in a calm place. Initially we had two visits a day and the team wanted to be able to increase the number of visits we had each day, we didn't want to waste their time.

We felt that the carers looked after us as much as they looked after Derek. Sometimes when Derek didn't need any care, they stayed and talked with us. It was so lovely and kind. They said that they wanted to help relieve any pressure for us.

They increased the number of visits to four a day and very sadly later that day, Derek passed away. They phoned a couple of days later to see how we all were – it was so kind.

I was so grateful to them; I can't put it into words. It just made the world of difference.

6. Conclusion

- 6.1. This paper has introduced the RIPEL project including the specification, vision, and innovative collaboration between the Trust's Palliative care service and Acute General Medicine.
- 6.2. A palliative care nurse involved with the implementation of the service has shared her reflections, alongside a story of a carer and a family using the Home Hospice service

7. Recommendations

- 7.1. The Trust Board is asked to note the
 - Reflections and learning from the introduction of this patient and family centred service.
 - Innovative collaboration between the Trust's Palliative Care and End of Life Care services at Sobell House and Katherine House with AMR Directorate.

Appendix 1: Service components

Home Hospice

Patients who are at home and expected to die over a period of about 2 weeks may require intensive hands-on care and support through the Home Hospice. They may have no or limited family care, or their family carers may require support and confidence-building to be able to manage this care at home. This service will be primarily delivered by Patient Support Workers (Band 3) following assessment by more experienced Patient Support Assessors (Band 5).

Specialist palliative care expertise and support is provided to back up the Home Hospice staff to ensure that patients receive symptom management and care at the appropriate level. Daily MDT Board Rounds ensure this oversight and support. These will take place at midday every day and attendance will include the Patient Support Assessor, Hub doctor, Hub nurse, Hub AHP (from Phase 1c) and RIPEL service manager.

The Home Hospice team may also be required to provide short term enhancement of care to help stabilise a patient, earlier in their illness trajectory, and restore confidence following the intervention of the Community Rapid Response service. This enhanced support is likely to be required for a few days only but may be critical for enabling the patient to remain out of hospital.

The Home Hospice team would normally expect to provide intensive hands-on care and support for a period of up to 2 weeks. If more prolonged support is likely to be required, timely referrals will be made for other care services including Continuing Health Care Fast Track and other agencies who can be involved for a longer period. This need will be flagged up through the daily review of current and anticipated needs at the MDT Board Round.

This is the only service component of the RIPEL Project that excludes South Oxfordshire for patients already referred to CHC Fast Track because the hospice at home service there is already provided by Sue Ryder for these patients. Close partnership working exists and over time, we will work together towards a more streamlined and consistent offer regardless of where the person lives across the county of Oxfordshire and South Northamptonshire.

Rapid Response

The Hospital Rapid Response service will support those who are in hospital who require early supported discharge in order to achieve their wish to be at home for their last days of life. The team's goal will be to provide a same day assessment to ensure that discharge is safe and optimal, and support family carers who are providing the hands-on care through advice, safety netting and/or home hospice.

Urgent and unexpected palliative care problems may arise which threaten the person's ability to remain safe and comfortable at home. When the problems are more complex than care and support alone, or the Urgent Community Response

team can resolve, the right specialist palliative care staff (medical, nursing or AHP) on duty for Community Rapid Response will be deployed. This service is intended for patients known to specialist palliative care whose crisis need occurs at any time in the trajectory (i.e., not just last days of life). The crisis may be related to physical or psychological symptoms, function or carer need. The stabilisation of this is likely to need the enhanced input for less than a fortnight – these patients are likely to require inpatient hospital or hospice admission otherwise.

The outcome of the rapid response intervention may be a resolution of the crisis, additional short-term support by the home hospice service, arrangement for a planned admission to hospice or hospital, or follow up by specialist or non-specialist community services.

Palliative Care Hub

The Hub provides two essential functions: direct advice and support, and coordination. Patients or their carers/families, and professionals within and outside OUH, will be able to contact the Hub for advice and support provided by a multidisciplinary team. Where in-person assessment or intervention is needed, the Hub coordinates the deployment of the right type of service and member of MDT – Community Rapid Response, Hospital Rapid Response, Specialist Palliative Care team, Home Hospice or other community services according to the patient need and service capacity. The Consultant/Associate Specialist with clinical responsibility for the Hub provides clinical leadership, remote support and supervision for the Community Rapid Response team, along with other senior members of the MDT.

The Hub will work closely with the Oxford Health Single Point of Access, with whom a clear process will be developed to ensure a consistent high quality prompt response to match the patient's needs at the time. This means that it does not matter if referrers are uncertain whether the patient requires a 2-hour Urgent Community Response or any of the RIPEL service components – the team will build effective communication 'corridors' so that there is 'no wrong route' of referral and minimise any potential delay to responding to the patient's needs.

The Hub will be physically located in the hospices (Sobell House and Katharine House) but will function as a virtual hub. This hybrid model was established at the start of the COVID-19 pandemic and works well.