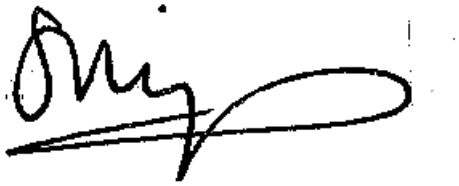
North Herts Specialist Palliative Care Multi-Disciplinary Team Annual Report 2021-22

Annual Report agreed by:

Dr Sarah Bell, SMDT Chair
Rachael Dinnage, SMDT Deputy Chair
Julie Watson, SMDT Coordinator

This annual report has been agreed by:

Position: Chair of the Herts & West Essex ICS Specialist Palliative Care Clinical Advisory Group **Name**: Dr Sarah Klinger **Organisation**: Peace Hospice Care and West Herts Hospitals Trust **Date Agreed**: 26/08/2022	
Position: Lead Clinician of the Multi-Disciplinary Team **Name**: Dr Sarah Bell **Organisation**: Garden House Hospice Care **Date Agreed:** 22/08/2022	
Position: Deputy Chair of the Multi-Disciplinary Team **Name**: Rachael Dinnage **Organisation**: Lister Hospital **Date Agreed:** 22/08/2022	
Position: SMDT Co-ordinator **Name**: Julie Watson **Organisation**: Lister Hospital **Date Agreed:** 22/08/2022	

1. Introduction

This report outlines the activity undertaken by the North Herts Specialist Palliative Care (SPC) Multi-Disciplinary Team (SMDT) between 1st April 2021 and 31st March 2022

2. Key Achievements of the North Herts SPC SMDT

- Links maintained with the Herts & West Essex ICS Specialist Palliative Care Clinical Advisory Group which is regularly attended by chair, deputy chair and SMDT coordinator.
- Adaption to changes in healthcare services secondary to the pandemic and staffing issues, enabling a seven day service to continue in both acute and community sectors, including the out of hours period. Continued use of a blended approach to assessment methods, included a combination of face to face, virtual and telephone mediums, particularly in the community setting.
- Maintained good links with the Hospital Chaplaincy Team, with continued regular attendance of the Chaplaincy Team at meetings.
- Regular attendance at meetings by a member of the Clinical Psychology team.
- Increased efficiency around meetings by continuing use of teleconferencing for meetings, started as a necessary response to pandemic measures.

Garden House Hospice Care (GHHC)

Achievements can be categorized under our four strategic objectives:

Everybody

- Raised awareness of Compassionate Neighbours service receiving 254 referrals, including 30.3% self-referrals
- Continued to work in partnership with Herts Community Trust (HCT) and Clinical Commissioning Group (CCG) to provide the North Herts Palliative Referral Centre (NPCRC) and to support the development of the Single point of access (SPA)
- Continued Medical Specialist Palliative Care support to community patients
- Continued professional Palliative Care Consultant support to Isabel Hospice through weekly Inpatient ward round and remote support to medical team
- Provision of Frailty Clinical Nurse Specialist (CNS) support to nursing and residential homes in North Hertfordshire
- Increased support to communities through GHHC Compassionate Neighbours project at five weekly Community Wellbeing Hubs taking place across the locality in: Royston, Stevenage (2), Hitchin and Letchworth
- Launch of a brand-new website and intranet site resulting in improved communications both internally and externally. Resulted in increased self-referrals to clinical services and better internal and external communications
- Received 302 referrals to GHHC Family Support Services team - an increase of 21% in 2021 – 2022
- Herts Bereavement Support –completed new work alongside Herts County Council to deliver emotional & practical support to those directly affected by a Covid-19 death
- Enabled more clients to be supported with available resources - staff & volunteer counsellors delivering sessions via telephone or remotely
- Continuation of support face to face sessions for counselling in hospice, prioritised for patients on IPU and community patients who cannot access services remotely
- Provided spiritual care, supportive calls or formal counselling sessions as required
- GHHC Dementia CNS received, accepted and registered: 36 referrals and provided telephone support and advice to 76 non-registered individuals who have made contact
- Complimentary Therapy and support for staff implemented alongside the service for patient's families and carers

Excellence

- Systems in place to manage and monitor the prevention and control of infection (IP&C) in line with Covid-19 GOV.UK guidance. East and North Herts Trust IP&C audit conducted March 2022
- Staff updated in the use of personal protective equipment via training and written updates
- Regular reviews of and updated visitor guidance issued to enable safe visiting to patients on the IPU, Hawthorne services and to the Garden House Hospice Care site
- Weekly incident management review meetings embedded, to review and agree actions from all reported incidents
- Active recruitment of staff across all clinical services resulting in success recruitment into key posts
- Maintained Covid-19 staff testing programme in line with GOV.UK guidelines
- Sustained compliance of staff and volunteers attending mandatory training
- Continued to utilise the NICE endorsed Establishment Genie tool to support review of staffing
- Provided and facilitated training for 228 Compassionate Neighbours supporting the Hospice work, an increase on last year
- Access to seated exercise and social activities at out Hubs supported by our Day Hospice team, taking place in Royston, Stevenage (2), Hitchin and Letchworth - regularly attended by 141 people
- A total of 2,532 interventions completed by Family Support Services team
- Spiritual care volunteers enabled to return to the IPU in line with GOV.UK guidelines as soon as allowed
- Policies reviewed and updates communicated to all staff through internal intranet news page
- Representation at local, regional & national meetings continued
- Reviewed end of 3 year strategy and developed new 3 year strategy with clinical senior team and boards of trustees prior to launch
- Continuation of the regular 1:1 support for staff and appraisal completion programme

Empower

- Community Engagement Team and Fundraising team carried out joint and bespoke events to ensure engagement with underserved groups include EDI and LGBT
- Successful initiation of a stakeholder engagement group, including people from across the community to be involved in driving the Community Engagement Strategy forward
- Promoted awareness and access to our Family Support services through introduction of contact information cards internally & externally
- Provided ongoing telephone support for parents and children, through our Family Support Services team working in a variety of ways
- Re-introduced face to face work and visits by our Children and Young People service in schools as soon as Covid-19 restrictions allowed
- Carers' practical care course/support provided virtually and planned to recommence face to face in 2022
- Joined virtual GSF GP practice meetings, highlighting the breadth of our services: encouraging referrals especially from harder to reach groups and patients with non-malignant diseases, as well as those earlier in their disease trajectory
- Supported and implemented individualised plan of care through Advanced Care Planning discussions for all new residents in our allocated Care Homes
- Received an increase in our self-referrals to our Day services team via our new website

Educate

- Delivered, through collaboration with Isabel Hospice, a shared education/training service across both Hospices
- Ensured access to and attendance at induction, mandatory training and in service training/competency programmes
- Provided access to clinical supervision and reflective case studies

- Provided spiritual care support with training internally, externally with health & social care staff & schools including grief & bereavement, resilience and working with children
- Supported staff to extend their role and skills through access to internal and external training
- Delivered education and Hospice placements for Cambridge University medical students
- Provided clinical support and training to care home staff on end-of-life care and Covid-19 Infection Prevention and Control
- Delivered the competency-based programme to inform and upskill staff in all areas of palliative and end-of-life education
- Developed and delivered training and support for carers and professionals in dementia care
- Provided a blend of training opportunities including remote and virtual training to external providers
- Introduced a new electronic mandatory training system and programme for all staff
- Invested in new Learning and Development Manager and restructure to ensure training provision and planned for all clinical and non-clinical staff

Lister Hospital (East & North Hertfordshire NHS Trust)

- The Lister hospital palliative care team have effectively communicated with the hospices and community palliative care teams as a matter of priority in order to achieve seamless care of patients who are discharged from Lister hospital as we cannot enter onto SystmOne
- The team continued to carry out face to face assessments of inpatients in all wards and departments throughout the year despite the Covid 19 Pandemic. The team continues to give support to Covid patients but the majority of the caseload is once again non-Covid patients.
- The palliative care consultant continues to attend and provide support to the upper gastro-intestinal cancer MDT weekly and the monthly integrated respiratory MDT. This provides a good collaborative inter-specialist working between the Multi-Professional team. This collaboration has proven beneficial with respect to quality & quantity of life for the patients and in addition provides mutual support to the multi-professional team.
- Fortnightly Journal club sessions continued for the team, with all team members taking part in facilitating learning and clinical reflective sessions. This can include the Butterfly team.
- Palliative and EOL Care Champions (previously known as Link nurse) training days concerning the holistic aspects of palliative care have resumed following a break period due to Covid and remain a priority in our education provision.
- The team have started planning to have allocated wards to provide support and education for nursing and medical staff.
- Audit and Quality Improvement projects were undertaken by the team.
- Trust Renal prescribing guidelines are now completed
- The Education team continues to offer training in aspects of palliative care throughout the hospital
- The palliative care consultant provides support and education to the junior doctors, NMPs, final year, UCL & Cambridge medical students including reflective seminars and PPG facilitation. Final year student nurses are encouraged to spend a day with the palliative care team as part of their final year
- Symptom management lectures are given to the medical registrars and Foundation Year doctors by the palliative care consultant.
- Teaching sessions on the ‘priorities for care of the dying adult patient’ are provided by the education lead and the palliative care consultant.

HCT SPC Community Team

- 5009- contacts including face to face visits and follow up phone calls
- Review and implantation of triage templates across the community SPC in E & N Herts services to create a standardised, format and process
- Initiation of community SPA for SPC across E & N Herts
- Participation in weekly Care Co-ordination Centre MST meetings to improve end of life access for frail patients
- Created new, easier to complete advance care planning and palliative and last days of life templates across HCT
- Provided education for the implementation of IPOS for community nurses within the new palliative and last days of life template to improve patient outcome measure and holistic care
- Created a new end of life dashboard to monitor patients identified as being last year of life and whether their preferred place of care/death has been recorded and achieved
- Initiated the implementation of ReSPECT within HCT and collaborated with hospice service to educate care homes and GP practices
- Provided education to community nurses for the roll out of the new Body Guard Syringe Pump
- 2 of the team are now Non-Medical Independent Prescribers
- Participation of care homes MDTs
- Participation in ICD task and finish group to improve and standardise end of life care for when deactivating ICDs.
- Attendance at National symptom control conference
- Restart of second clinic
- Popularity of requests to shadow the team including students, nurse associates and trainee GPs and triage health care professionals.
- Ability to order equipment and support CHC applications and support community nurses e.g. with syringe pump management and joint visits
- Increased engagement with the expanded psychological team

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3. Key Challenges

- There continues to be challenges in data collection and sharing due to a lack of integrated IT systems between the three SMDT organisations. Community and Hospice team both use SystmOne while the Lister Hospital palliative care team use Infoflex.
- Staffing levels across all organisations are challenging due to a combination of factors, including on going impacts secondary to the pandemic.
- Enabling equitable access and referral to palliative services for all life limiting diagnoses and socio-economic groups, particularly underserved groups.

4. SMDT membership 2021-22

The SMDT comprises of multi-professional specialist palliative care staff from the East & North Herts NHS Trust, Garden House Hospice Care and Hertfordshire Community Trust.

6. SMDT Activity / Case mix

The SMDT met virtually on 42 occasions in 2021-22 with an average of 10.5 attendees. Ten meetings were cancelled, two due to bank holidays and eight due to the MDT coordinator being unable to attend and there was no admin cover.

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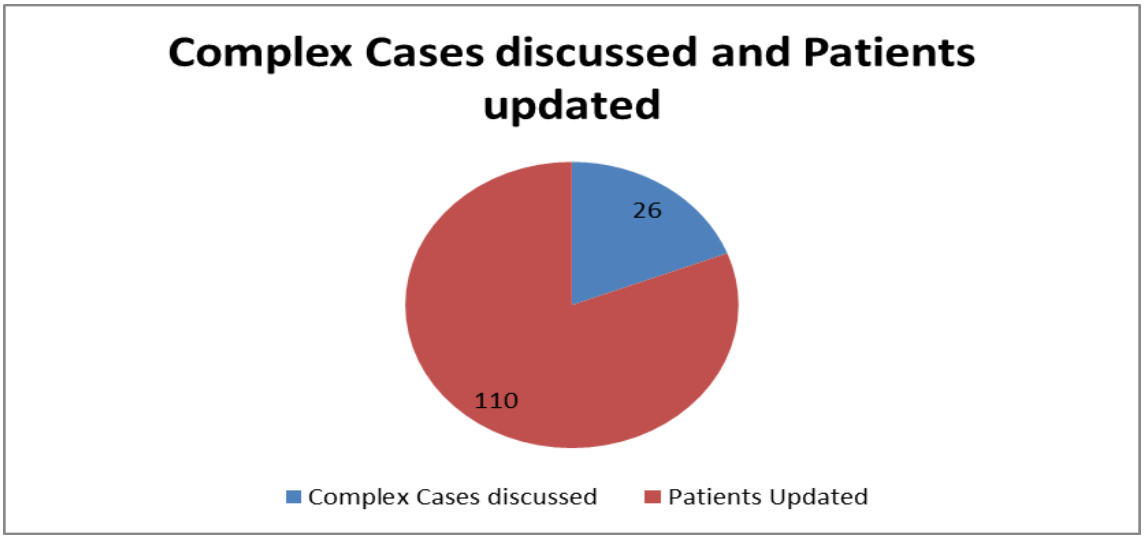
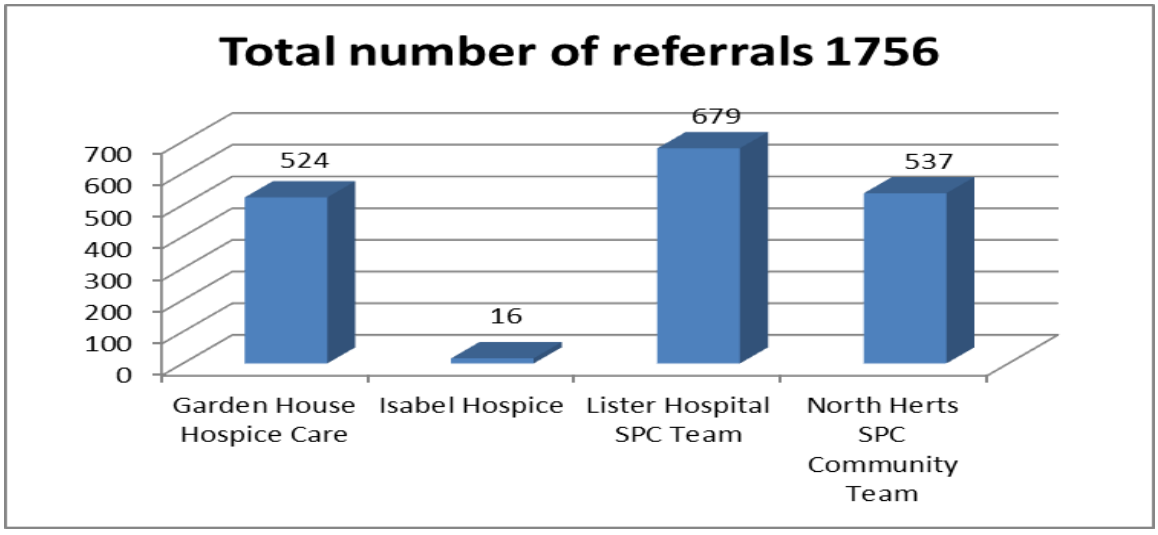
New referrals and patient updates:
At each meeting a list of new referrals to each service has been reviewed. Brief updates were given for some patients within this group, either secondary to discussions of the patient in previous weeks, or because it was helpful to share a short summary of the case with N Herts palliative care professionals attending the meeting. Over the past year, a record of these short discussions has been entered on the weekly report.

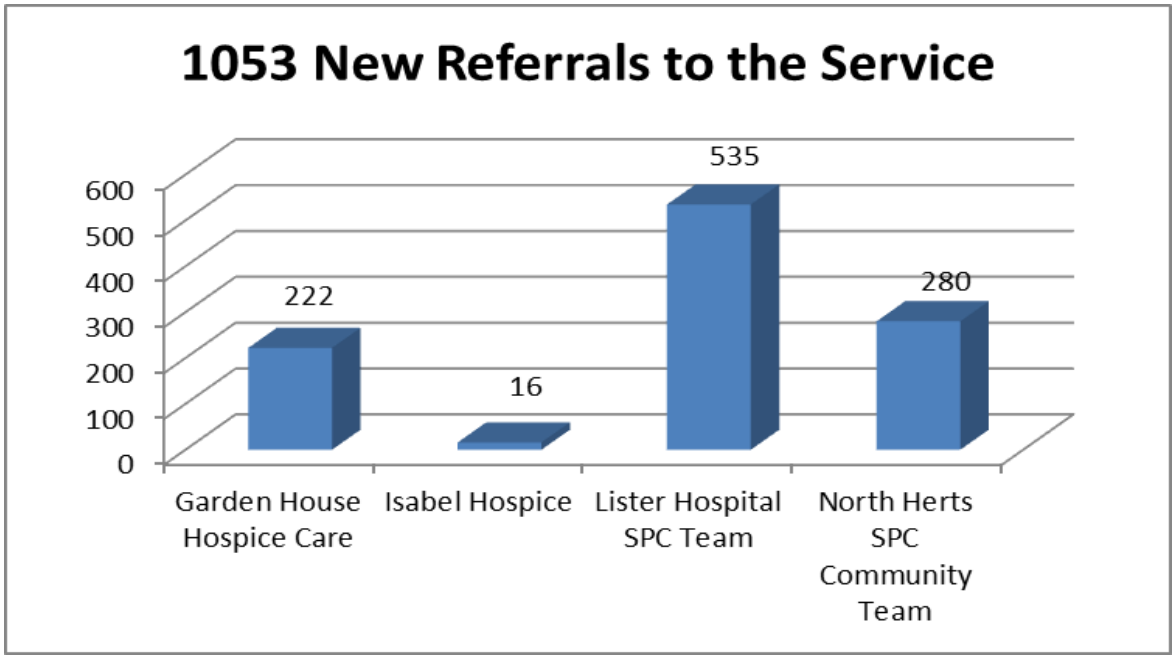
Complex case discussions:
Patients with complex needs have been discussed within the SMDT, usually by the keyworker, and a complex case proforma has been completed summarising the discussion and a forward action management plan. The proforma is shared with the GP within 24 hours of the meeting.
Moving forward for 2021-22 we will bring the complex case back to the following weeks meeting to confirm the management plan has been action. Any further updates will be added and a separate proforma will be emailed to the GP.

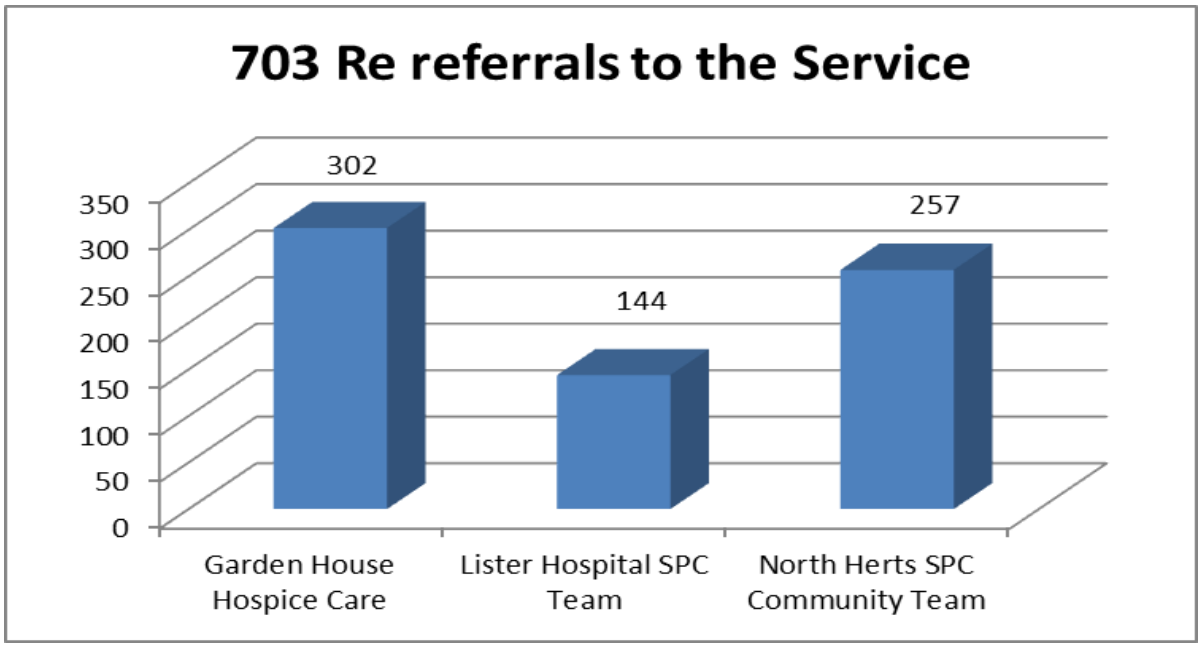


The charts below are from data received in 2021-2022 for new referrals to the SPC services in East & North Herts.

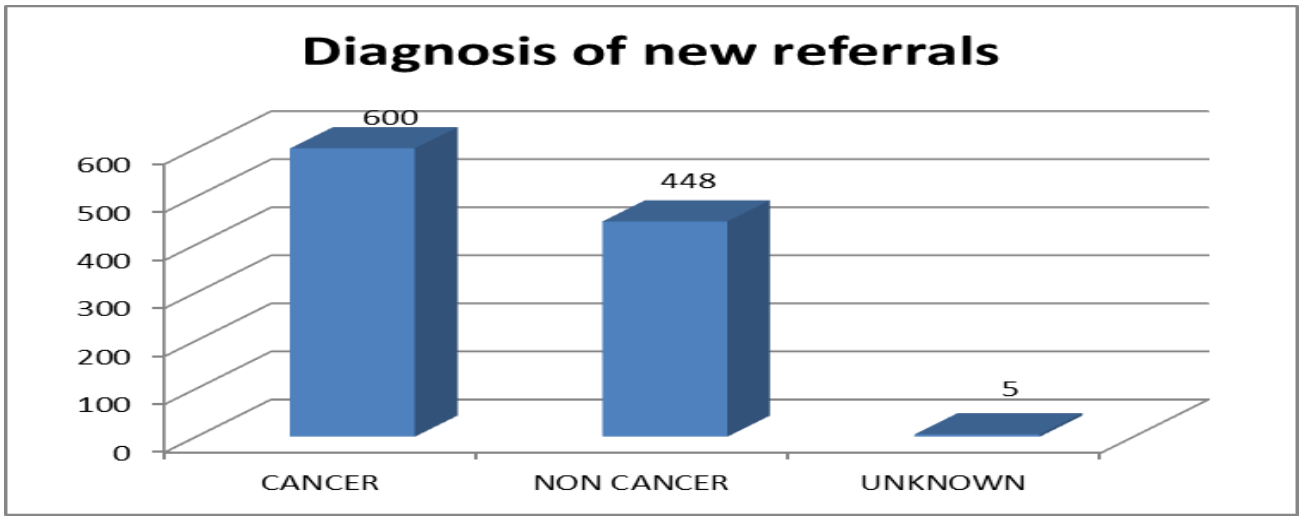
The data collection criteria were changed from 1st November 2021. The data from all referrals added to a caseload are now sent to the coordinator. Prior to 1st November all data was from patients who had a face 2 face assessment. The pandemic has change the way in which the teams work and more patients are reviewed by telephone.

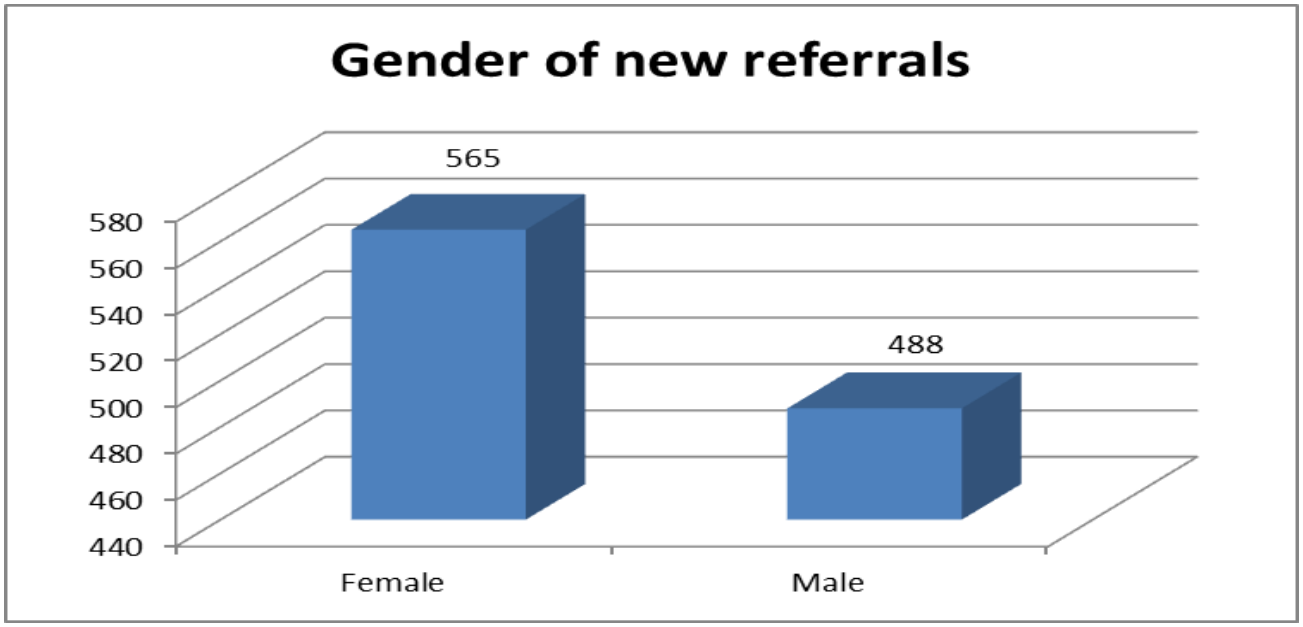


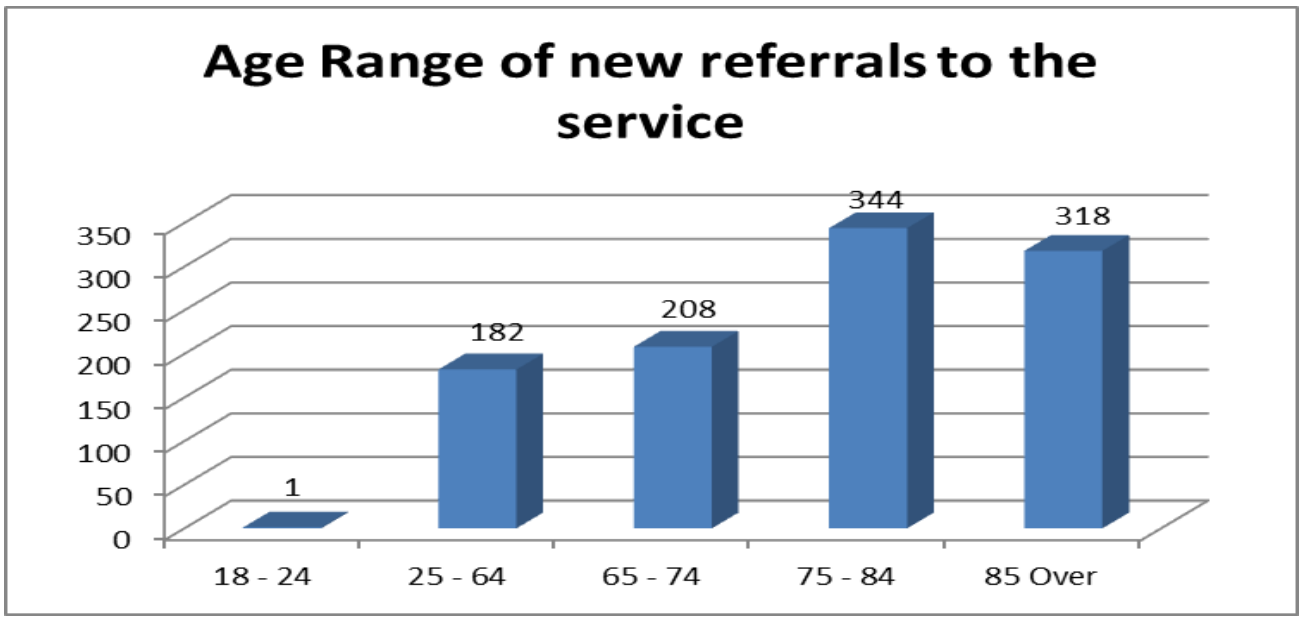

1053 New Referrals to the Service
600
500
400
300
200
100
0
222
16
535
280
Garden House Hospice Care
Isabel Hospice
Lister Hospital SPC Team
North Herts SPC Community Team

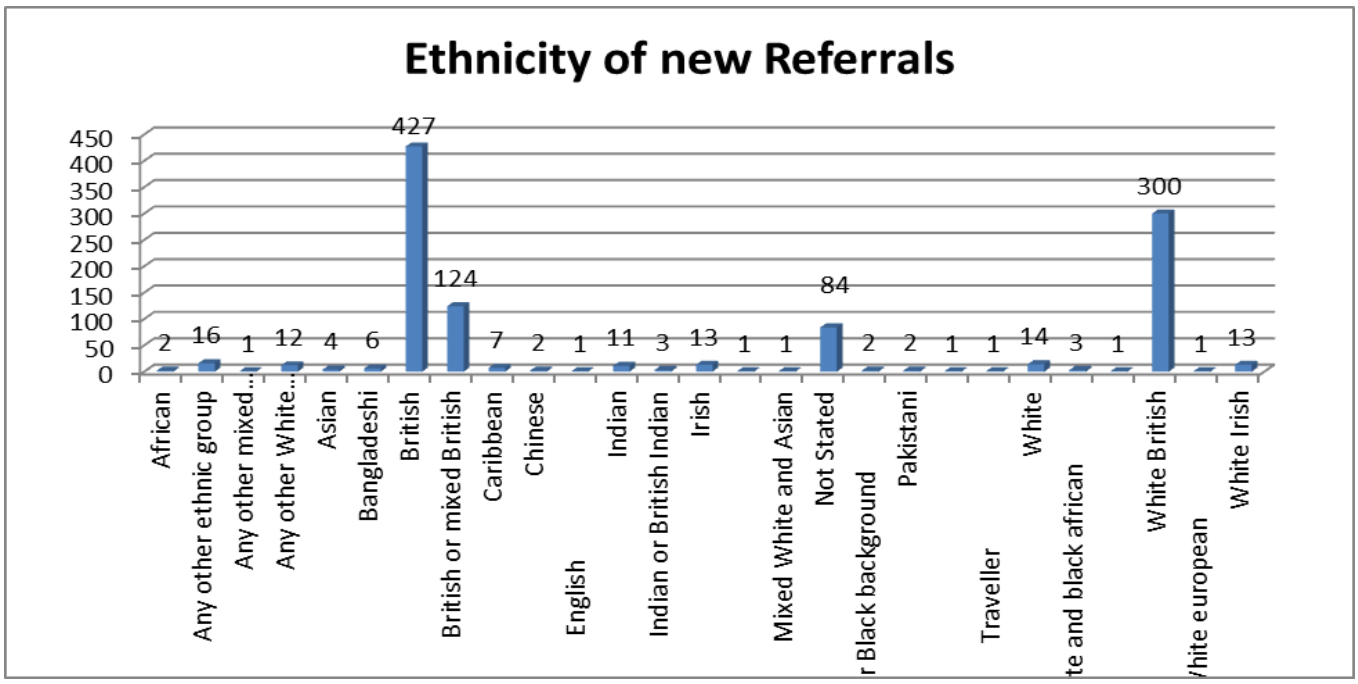

703 Re referrals to the Service
350
300
250
200
150
100
50
0
302
144
257
Garden House Hospice Care
Lister Hospital SPC Team
North Herts SPC Community Team

The following charts refer to the 1053 new referrals to the service in 2021/2022





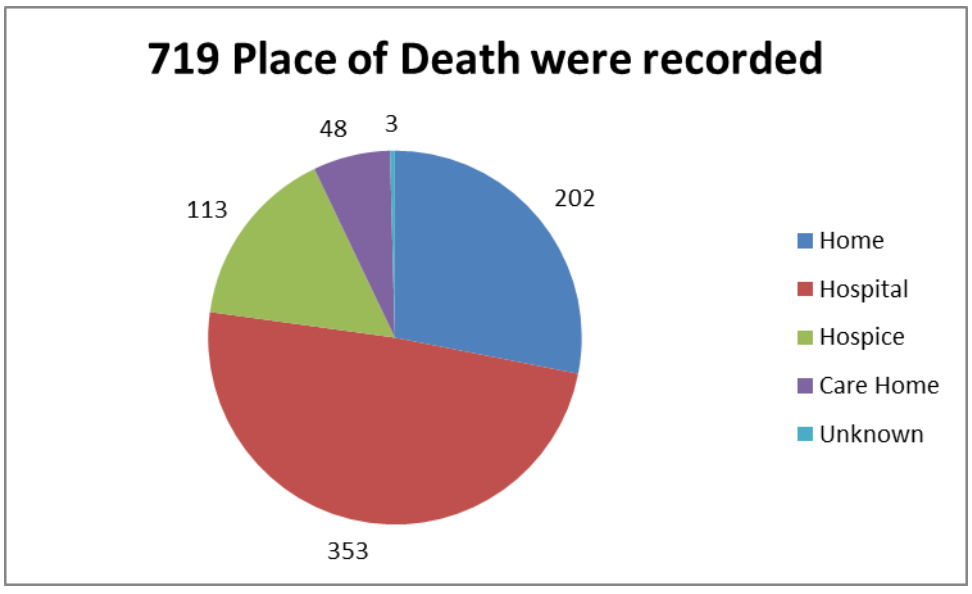




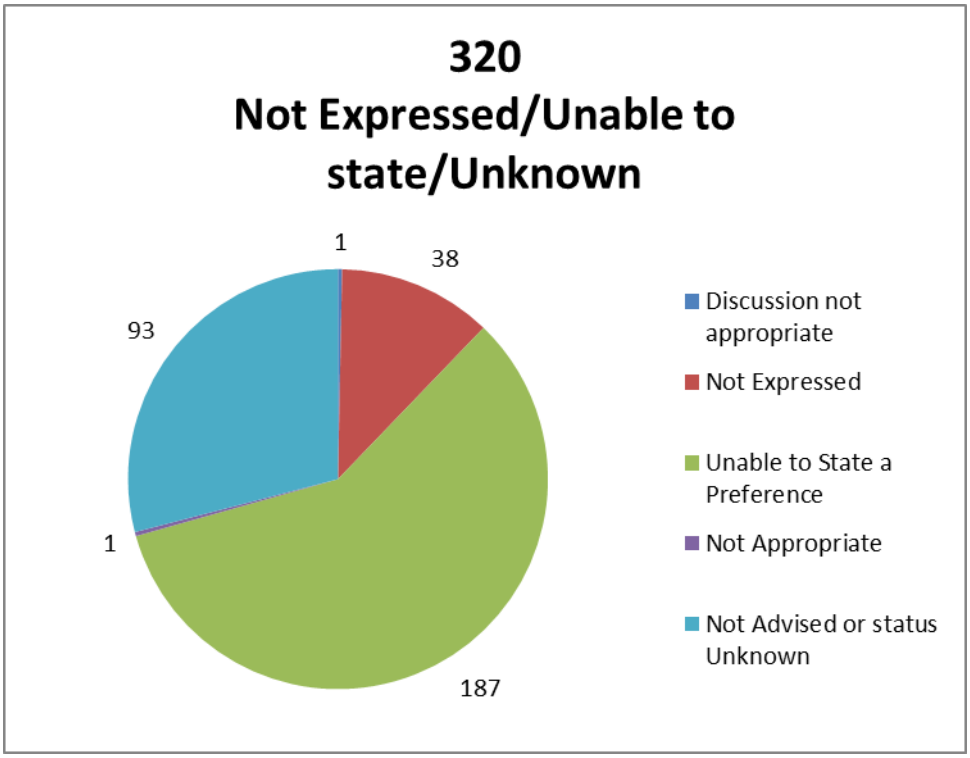
7. Preferred place of death

During 2021-22, the SMDT co-ordinator was informed of 719 patients known to the service who had died. Of the 719 patients, 399 (55.5%) stated a preferred place of death, of which 318 (80%) were fully met. Of the 719 patients, 320 (44.5%) either did not state a preference or were unable to state a preference.

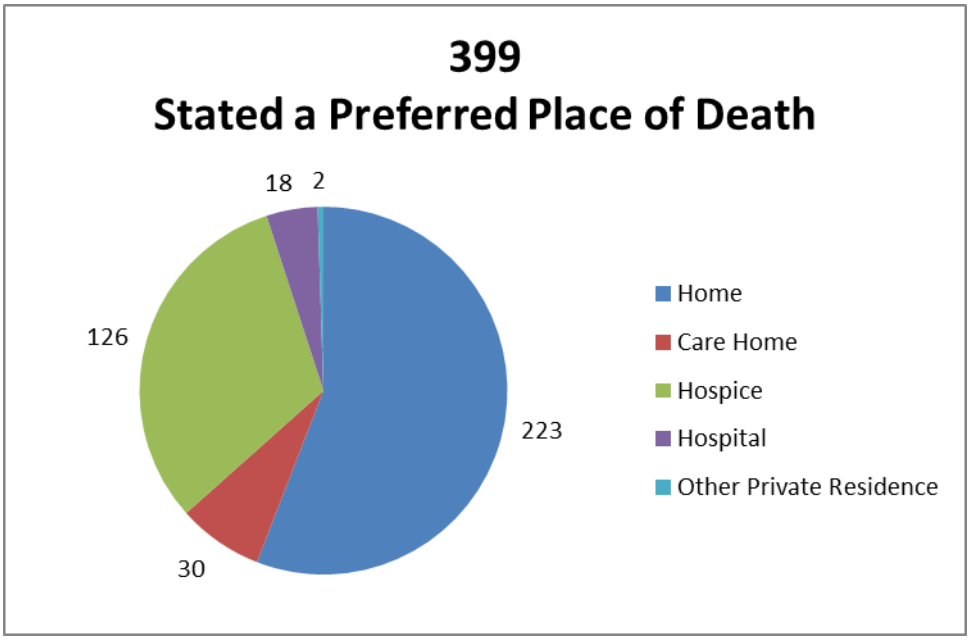
Potential factors resulting in patients not stating a preference or being unable to do so including: late identification of patients approaching the end of life and subsequent late referral to specialist palliative care services; poor uptake of advance care planning; a delay in the continuing healthcare application pathway.
The SMDT is actively working to overcome all of these issues through education, collaborative working and a range of other measures.



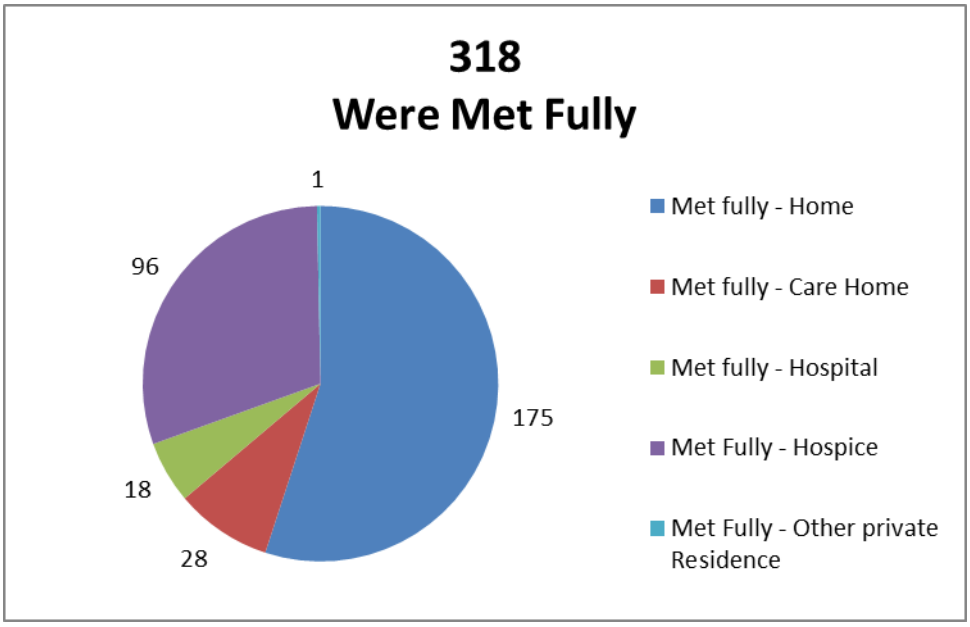
Of the 719 patients 320 (44.5%) were unable to state or express their preferred place of death, or it was unknown.



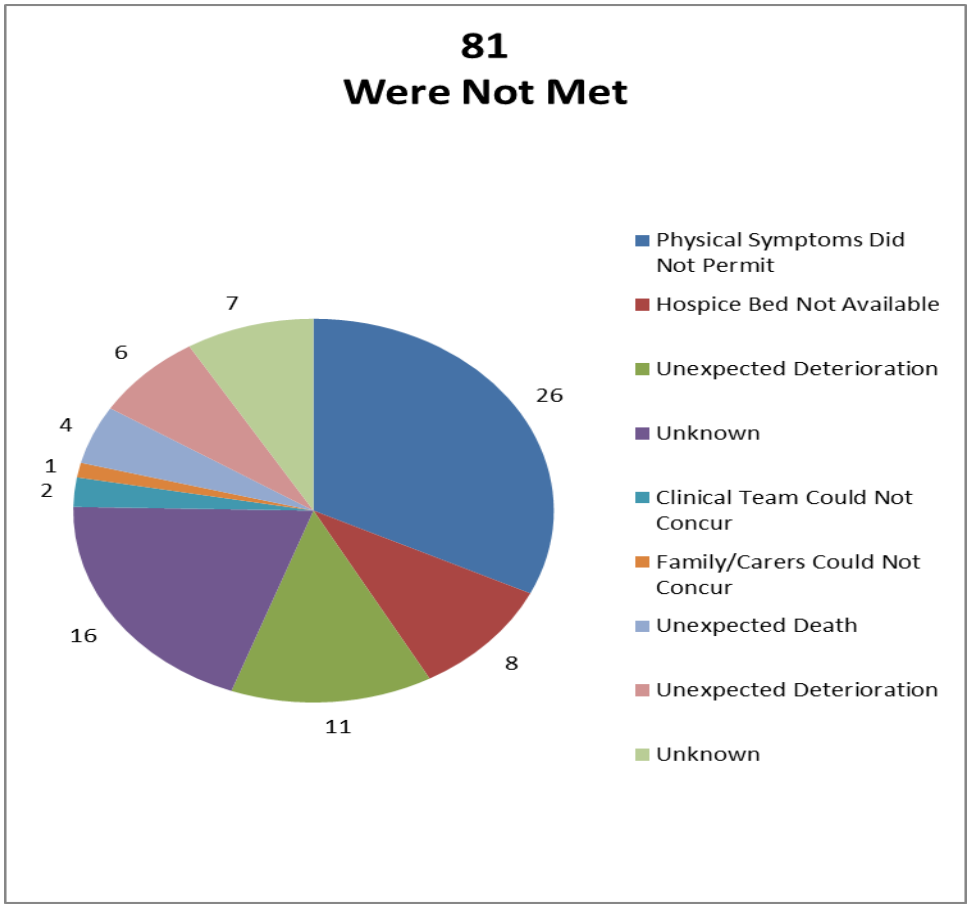
Of the 719 patients 399 (55.5%) stated a preferred place of death.



Of the 399 patients with a known PPD 318 (80%) met fully.



Of the 399 patients 81 (20%) where not met. The following chart shows the reasons why.



8. Clinical Governance - Accountability

The SMDT reports to the Herts & West Essex ICS Specialist Palliative Care Clinical Advisory Group. The SMDT Lead Clinician, Deputy and SMDT co-ordinator all sit on this group.

9. Annual General Meeting

The annual general meeting was held on 5th April 2022. The following topics were discussed: -

1. Review of Core Membership/Cover

CORE MEMBERSHIP/COVER		
Name	**Position**	**Cover**
Dr Sarah Bell (Chair)	Medical Director - Garden House Hospice Care	Dr Ros Marvin
Rachael Dinnage (Deputy Chair)	Palliative Care CNS - Lister Hospital	Kirsten Porter
Claire Hayward	HCT SPC Community CNS	Tracy Behr
Cathy Hunt	Team lead for H@H/CHC – Garden House Hospice Care	Linda Richmond
Dr Marie Joseph	Palliative Care Consultant - Lister Hospital	Dr Ros Marvin
Julie Watson	Palliative Care Co-ordinator - Lister Hospital	TBC

2. Work plan 2022-23

3. Annual Report 2021-22

4. House Keeping

- Meeting time
- Complex case proforma/Updates
- Weekly Report

5. Any Other Business

- Lister CNS Core Hours
- Learning Points
- Lister Admin Support

10. Network Training and Education

The SMDT agrees to work to the Herts and West Essex Education Leads Strategy. North Herts specialist palliative care providers work collaboratively to produce an education programme across the locality. This continues as virtual sessions as well as face to face sessions held within the Hospice environment and Care homes.

Training includes areas such as symptom management, medication prescribing and use, advance care planning, spirituality and communication skills. Some of the specific educational provision includes:

- In House Education programme at GHHC, open to all professionals within the locality – delivery supported by the Lister Education team
- Introduction to Palliative Care
- Priorities for Care of the Dying Person, HCT and Lister Hospital
- Eight Day Palliative Care Programme
- Sage & Thyme; Foundation Level Communication Skills
- Intermediate and Advanced Communication Skills
- Advance Care Planning
- Bereavement
- Dementia Care
- Resilience
- Frailty
- Palliative Care Specialist trainee (registrar) placement at GHHC on yearly rotation
- Placement for four GP trainees at GHHC on a 4 monthly rotation
- Placements for final year medical students from University of Cambridge School of Medicine at GHHC
- Shadowing of SPC Lister Hospital consultant ward rounds by University of Cambridge School of Medicine final year medical students and hospital palliative care case presentation seminars with final year students,
- Shadowing with the Lister Hospital SPC Team of Student Nurses, trainee medical staff (in addition to the Cambridge programme) including GP rotation, shadowing by other specialities
- Paramedic training and placements at GHHC and Lister Hospital
- Psychological Assessment Skills
- Medicine management for Registered nurses
- Annual updates for Health Care Assistants
- Advice line training
- Medical Gases training
- Verification of Adult Expected Death for Hospice and Community staff
- Care Home specific End of Life Care Education.