RIPEL: Rapid intervention for Palliative and End of Life Care
Update for Oxfordshire Health Overview and Scrutiny Committee meeting on 8th June 2023

1. Introduction

This paper gives an update on end of life care in Oxfordshire, particularly the RIPEL project, hosted by Oxford University Hospitals NHS Foundations Trust.

Over 500,000 people die a year in the UK, at least three quarters of which can be anticipated. With an ageing population, the number of deaths is predicted to rise significantly over the next two decades and the need for specialist palliative care is expected to grow by over 40%. By 2030, nationally at least 140,000 more people will need to be in receipt of palliative care services.

We know that the majority of the public want to be cared for at home and die at home. However public health data has shown that Oxfordshire is an outlier for the metric 'proportion of people who had 3 or more non-elective admissions during the last 90 days of life' at 9% compared to the English average of 7.5%. A local audit within OUH suggested that 57% of admissions occurring in the last 72hours of life would have been preventable with better crisis management and advance care planning.

Palliative and End of Life Care provision, via Integrated Care Boards (ICBs), has become a mandatory requirement since Health and Care Act reforms in 2022. Commissioning guidelines now also acknowledge the value of incorporating Social Investment.

2. Vision

Driven by critical gaps in the provision and coordination of community-based services for adults at the end of life and aligning with ICS and OUH strategic objectives, starting in April 2022 and mobilised within 2 years, we will have improved the network across Oxfordshire and South Northamptonshire to provide enhanced palliative care and support for adults with advanced life limiting illness. This will be in

conjunction with existing services provided by primary care, community services, secondary care, and specialist palliative care teams.

The overarching aim is for more people to have personalised care, including being cared for in their own homes at the end of life, provided that is their preference, and avoid unplanned bed days in the last 12 months of life.

RIPEL is funded for 3 years through a partnership with Sobell House Hospice, Macmillan Cancer Support (with Social Finance as a partner) and OUH. In this time the services will be developed and scrutinised. Efforts are underway to secure continued funding for services that have demonstrated their effectiveness and positive outcomes.

3. Rationale for project

OUH is the largest specialist palliative and end of life care (PEoLC) provider in Oxfordshire, caring for over 3,000 patients and their families annually. We host two hospices, Sobell House and Katharine House.

The need for care at home was evidenced by:

- **Patient preference.** Data suggests many people would prefer to die at home (ONS 2015), yet less than 50% do (Nuffield Trust 2021). The Ambitions for Palliative and End of Life Care: A national framework for local action (2021) highlighted the need for patients to receive the right type of care, in the right place at the right time and by the right people to reflect patient's needs and preferences.
- **Increasing demand.** Estimates suggest that the number of people needing PEoLC in England will rise by 55% over the next ten years (London Economics 2021). Innovation and shifting resources to care at home is a supported way to tackle this (RSM Stevens Lecture 2023)
- **NHS pressures.** The NHS Long Term Plan and the 2021/22 Priorities and Operational Planning Guidance set out three key priorities that RIPEL directly supports: reducing non-elective length of stay; avoiding unnecessary emergency admissions; and facilitating rapid discharge from hospital especially at the very end of life.
- **Personalised care.** The NHS Long Term Plan includes a commitment to personalised PEoLC.
- **Service gaps.** The Oxfordshire Palliative Care Network mapping identified gaps and lack of coordination in the provision of care packages enabling people to die at home; rapid response; provision for patients not eligible for fast track but needing short-term support; confusing and complicated pathways; lack of coordination and integration of existing services.

People are most likely to need access to healthcare in their last year of life, with numerous professionals involved at this time. RIPEL looks to seamlessly integrate specialist palliative care at our acute hospital with ongoing community care, ensuring responsiveness and patient safety, enabling choices, enhancing patient experience and care, and reducing non-elective bed days.

4. Design

Objectives:

- To enable care at home in the last days of life (or at times of crisis in the last 12 months of life) through provision of hands-on care and support with specialist level oversight [Home Hospice]
- To enhance palliative care at home through rapid intervention for crisis assessment, management and support [RIPEL Community Rapid Response and Enhanced Palliative Care Hub]
- To facilitate early supported discharge from hospital where this is the preference of patients and their families. [RIPEL Hospital Rapid response]

The RIPEL service focuses especially on the needs of two cohorts of patients:

- People who are likely to die within the next 2 weeks and who need more intensive hands-on care at home (home or usual place of care)
- Patients likely in last year of life who experience a crisis in the community, or resulting in hospital admission, and whose needs cannot be met sufficiently quickly or fully by the core specialist palliative care services, Urgent Community Response or other existing services.

We built on national experiences to integrate our palliative and end of life care and Home Hospice services. Whilst hospices, Hospice at Home, community palliative care, hospital palliative care, and palliative care hub teams exist in pockets nationally, we believe we are the first service (or certainly one of the first) to bring all these aspects together, co-ordinated and supported by our palliative medicine multi-disciplinary team. This is further supported by close links to countywide organisations to try to ensure seamless provision and co-ordination of care.

We are currently live with a Home Hospice service and Hospital Rapid Response for inpatients. We will be going live soon with an expansion of the Palliative Care Hub and enhanced Community Response.

The social investment model requires repayments based on achievement of our primary outcome. Invigorated by this, we closely scrutinise our activity, improving operational oversight and ensuring early action on trends or issues. Further to this

there is flexibility to change the service model, being focused on getting the best outcomes for people.

While we deliver specialist PEoLC, we work within a network of other PEoLC providers across the county. Optimal patient experience and safety requires working with external partners to ensure patients can reach us in the most efficient way, whether previously known to our services or not. Enhancing co-ordination across PEOLC further reduces stress for healthcare colleagues as they can get the right care to the right patient in a timely manner.

A patient may document their preferences in an advance care plan. Whether or not this is in place, choices are explored with patients and teams are now able to make these happen, and faster.

RIPEL aligns 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. All patients within the RIPEL service are admitted to our virtual ward, ensuring daily review, support to teams, and rapid escalation through the MDT as needed. As per virtual ward eligibility criteria, each of these patients would have needed to be in hospital instead of in their own home, if we were not able to provide this service.

As this cohort with intensive needs is reviewed together at the virtual board round, we can manoeuvre between services efficiently. For example, patients that are rapidly discharged by Hospital Rapid Response may move straight to our Home Hospice Care Team with oversight from Community Rapid Response, all of whom are familiar with the patient from the daily board rounds, enhancing patient experience and safety.

Patient reported outcomes and palliative care assessment tools have been developed so that they are integrated into our electronic patient record and we are developing our patient portal so that patients or their carers can submit responses remotely. This enhances the accessibility of a patient's record, ensuring the most current data is easily viewed.

We measure success through qualitative feedback plus quantitative analyses around enabling the choice to be at home to die equitably across our patch and reductions in hospital length of stay in the last year of life. 29 KPIs are collected across the whole of RIPEL so we can scrutinise each element independently, as well as the programme as a whole.

5. Outcomes

Since launching in April 2022, RIPEL has saved 6786 non-elective bed days for the 645 patients we have cared for (Home Hospice and Hospital Rapid Response). This

is exceeding expectations. These are days our patients can now spend at home, if this is their choice, rather than in hospital.

The average length of stay with RIPEL Home Hospice is 10.9 days. Each of which would otherwise have been in hospital. Ongoing care provision is sought as soon as patients enter our service as, to remain reactive to the needs for bridging care. We propose care in the service to be for up to 14days.

Patients cared for by RIPEL have spent on average 16 fewer precious days in their last year of life in hospital.

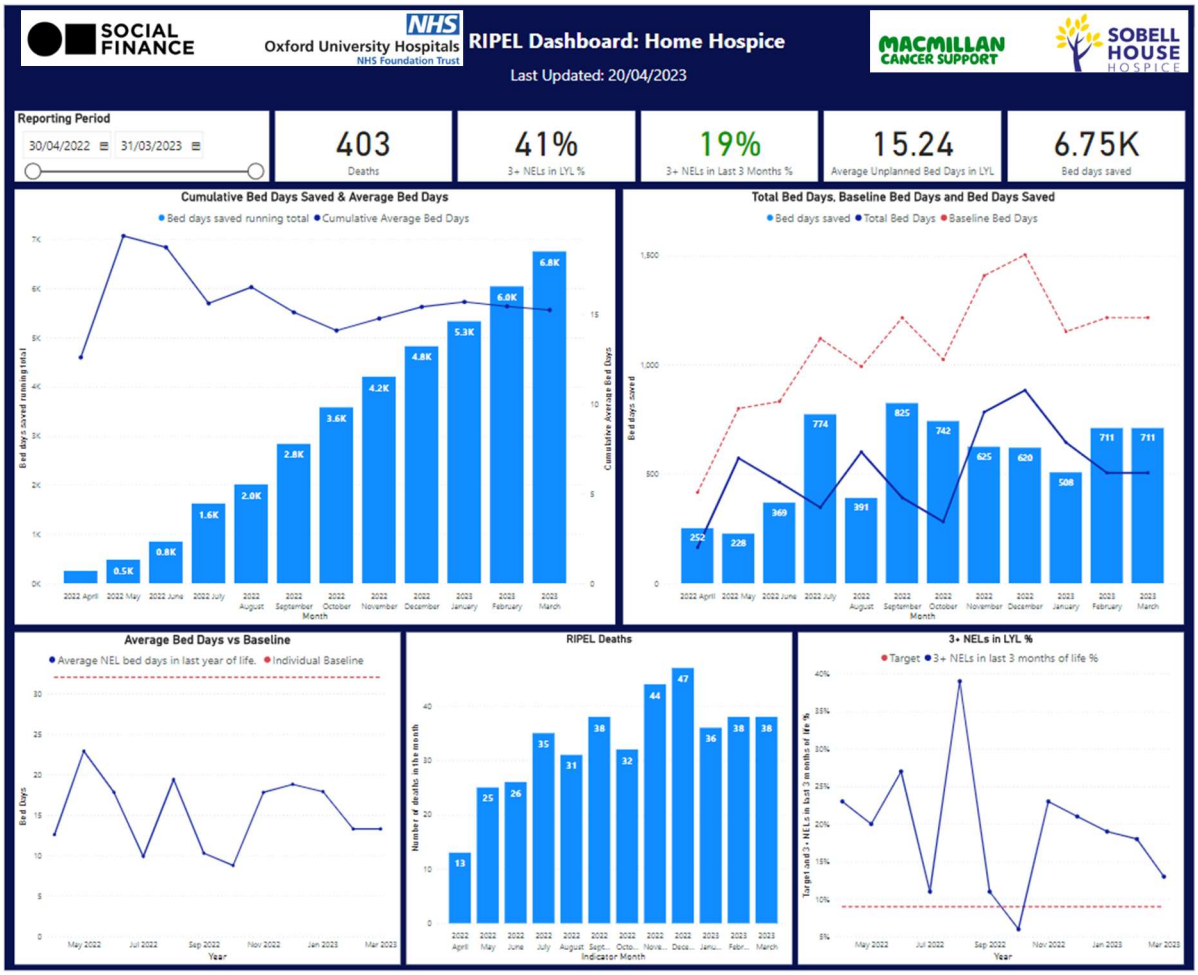

Figure 1 RIPEL Dashboard example slide

6. Feedback

The key to RIPEL is enabling patient choice, particularly in the last year of life when it is recognised that there is only one chance to get it right.

The most negative feedback we have received is around how hard it can be to have to move from our service to alternative care agencies. From this we have learnt to be

explicit around expectations when a person is first enrolled so that any transition required is smooth. Though we would love to keep caring for persons who no longer need our experienced palliative and end of life carers, we must ensure we can remain reactive to the urgent needs of new patients who require us, for them to be able to stay at home.

Healthcare staff appreciate being able to supply the care a patient needs in a timely manner. The Home Hospice has been able to fill the gap that was previously present for patients wanting to go home but needing rapid access to experienced care. This is demonstrated in day in the life stories and case studies.

A feedback postcard, with SAE, is placed in each patient pack when enrolled to the service, as we actively seek the views of our users and their loved ones.

We have daily huddles within our teams where any concerns, feedback or learning can be shared and this escalated across the service as necessary.

Feedback we have received from loved ones has been very positive, such as Myles, whose wife Liz died at home in 2022: *" …Home Hospice certainly fulfilled Liz's wish to be able to be in her own home at the end of her life."*

"My first experience of Sobell House was when the team cared for my gran and I was struck by how much the nurses cared. It wasn't just a job, they did everything they could to make her last days as comfortable as possible. Some years later, I'm now lucky enough to be a part of the Home Hospice Care team and they are such an amazing bunch of people, I really cannot say enough good things about them. I love being a part of the team and making small, positive differences every day to the patients we care for. It's a privilege to be in someone's home helping them live their final moments of life in comfort and in the place they want to be."

- Stephen Choules, Home Hospice Care Team Assessor

7. Learning

RIPEL is the vanguard large-scale social investment project for our Trust and has paved the way for further such opportunities in other clinical disciplines. Our partnerships have offered us access to a wider breadth of expertise and experiences. Furthermore, we have been able to contribute to other programmes our partners are supporting, plus their lunch and learn programme.

Our steering and operations groups include representatives from across the hospital plus local healthcare partners and has Trust board oversight. Teams proactively present to colleagues across OUH, including discussions to gather feedback and ensure our service continues to meet the needs of our patients and staff.

We have given interviews to local radio and press, plus have had a clip on local television news. One of our home hospice assessors was invited to be part of a double-page spread in national press on International Women's Day.

RIPEL was presented by OUH Chief Finance Officer and Head of Financial Performance at a national HFMA webinar in October 2022, available to all finance directors in the NHS in the UK. Learning and ideas are shared to Macmillan's virtual Community of Interest which can support over 100 end of life care professionals throughout the UK. Futures NHS collaboration platform is utilised to share ideas and learning.

RIPEL was the key focus of Sobell House Hospice Charity's March campaign, sending mailings to new and existing supporters at around 45,000 households across Oxfordshire. This was part of a matched donation funding campaign and in total raised over £340,000 for the RIPEL programme.

Our teams are lined up to contribute to further national education sessions at OxCERPC on Outcome measures and to Project ECHO on Outcomes, Data and Dashboards.

We are one of the first home hospices in our county running as a virtual ward and contributing to national numbers for patients managed virtually. As such we have been asked to pilot workflows and contribute to the shaping of palliative care virtual wards across our ICS.

RIPEL shows the power of working together and the greater impact it can have.

8. Value

In the first year of operation (from 1 April 2022), 645 patients were seen and 6786 NEL beds were saved. Compared to inpatient treatment, £500,000 of costs have been avoided.

Further to this, many patients were able to fulfil their wish of dying at home. Though it is an aspect hard to quantify, this also contributes to the wellbeing of those that they loved. Whilst fulfilling national guidelines to respond to patient preference for place of death, we have enabled families to support these wishes, whilst they in addition are receiving support. Caring for a very ill relative can be isolating and frightening. The reassurance from the contact of staff involved in this project can improve that experience for families. We know that this can ease bereavement as it reduces feelings of guilt and number of questions that families have unanswered. A good bereavement outcome is likely to lead to less requirement on the health care economy in the future.

Through partnership working we have helped our teams to navigate the hospital and community care system much more efficiently. We have helped our teams do what

the patient needs by joining up organisations and filling gaps that previously had meant we, and our patients, were left waiting.

One Occupational Therapist said, *"Ultimately, the RIPEL project and especially the Home Hospice carers have helped us to spend more of our time thinking about patient care and less time worrying about resources in the community to support our patients at home. We have been able to help patients achieve what's important to them, which really is what we're here to do!"*

Through the joining up of care, our patients can be reassured that they can return to the comfort of home but still be actively supported through oversight of our MDT. The Home Hospice Care Team will visit up to four times a day as required, with virtual and in-person support from our community clinical team as needed.

"Having been given his diagnosis on 21 September, Collin was adamant that he wanted to be at home. The Home Hospice Care team swung into action and everything was provided to keep Collin comfortable and pain-free. We received hospital equipment and had the support from carers, nurses, doctors, and an occupational therapist. Everyone was so kind and caring and allowed Collin to leave us in the way that he wanted on 14 October 2022.Our grateful thanks to you all."
Pam, Matthew and Nicola

9. Next steps

Interrogation of data relating to those who died in hospital shows us that enhancing access to rapid transport and educating referrers about RIPEL could improve the service further.

We are working with system leaders and providers to further improve understanding of, and ultimately efficient access to, PEoLC.

We intend to interrogate our data further to investigate co-morbidities, indices of deprivation and equality, diversity and inclusion.

PCOM360 is a freely available tool, developed with Social Finance, that streamlines analysing and displaying Patient Centred Outcome Measures (PCOMs) in palliative care services. Our data set is growing in richness thanks to operational and digital developments. Once more matured, we aim to utilise this tool to help develop our services further.

RIPEL is scheduled to ramp up further over the next 12 months to widen its reach to support patients in their own home, avoiding unnecessary hospital admissions.