

REPORT OF: THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (HOSC):

Palliative/End of Life Care in Oxfordshire:

**REPORT BY: HEALTH SCRUTINY OFFICER, OXFORDSHIRE COUNTY
COUNCIL, DR OMID NOURI**

INTRODUCTION AND OVERVIEW

1. At its meeting on 06 June 2024, the Oxfordshire Joint Health and Overview Scrutiny Committee (HOSC) received a report providing an update on palliative care in Oxfordshire.
2. The Committee felt it crucial to receive an update on the developments around the RIPEL project as well as the state of palliative care services more broadly. The Committee also sought to assess the degree to which system partners were working collaboratively to deliver and improve palliative care.
3. This item was scrutinised by HOSC given that it has a constitutional remit over all aspects of health as a whole; and this includes the nature of palliative or end of life care services being provided to patients, including in their own homes and localities. When commissioning this report on palliative care, some of the insights that the Committee sought to receive were as follows:
 - The geographical spread of palliative care services, and how these operate Countywide.
 - The resources, support, or budgets being allocated for palliative care services by the ICB.
 - The degree to which the RIPEL project has proven effective since the previous year, and whether sustainable sources of funding have been secured for its continuation.
 - The status and the future of palliative care to be delivered in Wantage (in light of the NHS's expressed commitments to providing palliative care services in the context of the public engagement exercise around the future of Wantage Community Hospital).

SUMMARY

4. The Committee would like to express thanks to Dr Victoria Bradley (Consultant in and Clinical Lead for Palliative Medicine Oxford University Hospitals NHS Foundation Trust); Kerri Packwood (Programme Manager for RIPEL at Oxford University Hospitals NHS Foundation Trust); Karen Fuller (Director of Adult Social Care); and Dan Leveson (BOB ICB Place Director for Oxfordshire); for

attending this meeting item on 06 June 2024 and for answering questions from the Committee.

5. The Clinical Lead for and Consultant in Palliative Medicine provided an update on the project's progress and achievements, and highlighted the significant improvements made in patient and family experiences due to the specialist services introduced over the past two years. These improvements were attributed to funding from Macmillan and the Sobell House Hospice charity, which had enabled much-needed advancements in palliative care. Despite challenging financial circumstances, the service had managed to save more resources within the system than it spent. She emphasised the profound impact of enabling patients to die at home, in accordance with their wishes, rather than in less preferred environments.
6. The Committee asked about the involvement of the community and stakeholders, and how deeply coproduction was embedded in the service design. The Clinical Lead acknowledged that while the service had always prided itself on being close to the community, there had been limited formal coproduction in the initial setup due to the speed required to implement changes. Moving forward, there was a strong emphasis on involving patients, families, and bereaved relatives in a more structured manner. This approach aimed to ensure that future service developments were closely aligned with the needs and preferences of those directly affected.
7. The Committee raised a question about the underutilisation of palliative care services by ethnic minority groups. The Clinical Lead explained that an Equality Diversity Inclusion Officer, funded by charity partners, was actively working to identify key groups and engage with them to understand and address barriers to service access. This included outreach efforts to culturally specific communities, such as the mosque in Banbury, to discuss culturally competent end-of-life care.
8. The Committee enquired about the justification for not extending the palliative care hub hours beyond the standard 9 AM to 5 PM. The Clinical Lead explained that while recognising that health crises occur outside regular working hours, pilot projects had shown minimal demand for extended hours. Embedding a specialist nurse within the Oxford Health single point of access from 5 PM to 8 PM resulted in very few additional calls, indicating that resources could be more effectively allocated elsewhere.
9. The Committee asked whether there was any additional support to pilot dedicated palliative transport services, and how confident the Trust was that they could access the resources for this. The Clinical Lead highlighted the significant distress caused by long waits for ambulance services, particularly for patients needing urgent transfers to hospices or their homes. To alleviate this, a pilot scheme funded by Sobell House was proposed to provide dedicated transportation options, aiming to improve patient and family experiences and assess the feasibility of long-term implementation.

10. The Committee asked about the relationship between palliative care services and care homes, and how contact was initiated. The Clinical Lead explained that the service maintained close ties with care homes, offering support through various means, including direct referrals and training for care home staff. The goal was to ensure that both patients and their families were aware of the available palliative care options and how to access them.
11. The Committee asked how confident the Trust were in securing ongoing and sustainable financial support for RIPEL from June 2025 onwards. It was responded that despite the project's demonstrated cost-effectiveness, securing continuous funding remained a challenge. Discussions with the ICB and other partners were ongoing to develop a sustainable business case for the project's continuation.
12. The Committee enquired how the Trust would increase support for carers and whether any specific areas of improvement had been identified. The Clinical Lead outlined ongoing research to better understand the needs of unpaid carers and the various support tools available. The aim was to ensure that carers were aware of the professional and community resources at their disposal, acknowledging the invaluable role they play in patient care.
13. The Committee asked about the status of the HOSC recommendations for improving palliative care services in Wantage, particularly regarding the provision of crisis palliative care beds. The Program Lead explained that the focus was on ensuring that community beds were generalist-led but specialist-supported, as demonstrated by the model implemented at Wallingford. Discussions were ongoing to determine the best approach for meeting the needs of the Wantage community.

KEY POINTS OF OBSERVATION & RECOMMENDATIONS

14. Below are 3 key points/themes of observation that the Committee has in relation to palliative care in Oxfordshire. These 3 key points of observation relate to some of the themes of discussion during the meeting on 06 June, and have also been used to shape the recommendations made by the Committee. Beneath each observation point is a specific recommendation being made by the Committee.

Support for carers: The Committee is pleased that there is ongoing research to further understand the needs of unpaid carers and the various support tools that are available to them. It is vital that carers are well familiarised with the professional as well as the community resources available to them. Carers play a substantial contributing role in palliative care, and this should be acknowledged by the system. A key way in which the system can acknowledge the role of carers is through both making them well aware of what support there is available, and through increasing the actual support available to them. Carers are at the frontline of ensuring that palliative care patients are receiving the support that they require with their physical needs. Additionally, the system

should also acknowledge the powerful role that carers play in supporting the mental health and emotional wellbeing of patients. Often, palliative care patients can feel a sense of loneliness or potentially even abandonment. Having carers that are well supported and trained could help these patients feel reassured that they have not been forgotten and that their physical and mental needs are being catered for.

It is important to consider that carers may feel very adamant on providing the support that they do to patients, but that they may also lack the tools or skills to be able to do so. Having adequate support mechanisms in place can help to overcome this predicament and could boost the confidence and morale of carers, which can have a knock-on positive effect on the patients they care for.

The Committee therefore recommends that carers receive as much guidance as possible. This guidance can also take the form of specific training courses that could help inform carers as to how to best perform their duties as well as how to access any available support. It is also crucial that guidance for carers is available in as many languages as possible so as to cater for the ethnic diversity of carers.

Furthermore, the government's roadmap for adult social care data, as well as the NHS Long Term Plan, have both emphasised the importance of more data to help in identifying carers, as well as to understand the extent to which they are being supported effectively. By improving the recording and collection of data, the system could be in a better position to identify the unpaid carers who may be in the most need of support. This could also help to develop a stronger understanding of what the needs of these carers (and the needs of those they care for) may be, and could therefore enable the delivery of more targeted support.

Recommendation 1: *To ensure that carers receive the necessary guidance as well as support in being able to maximise the support they provide to palliative care patients.*

Sustainability of funding and resources: Upon scrutinising palliative care in an item in its June 2023 meeting, the Committee urged that sustainable sources of funding are secured for the continuation of the palliative care work provided in the context of the RIPEL project. One year on, and upon commissioning this year's palliative care report, the Committee was keen to understand how confident the system was in being able to secure ongoing and sustainable financial support for RIPEL from June 2025 onwards. Whilst the Committee is pleased with the proven cost-effectiveness of the project, it remains concerned regarding the challenges around securing continuous and sustainable funding for RIPEL. It is crucial that there is ongoing and in-depth collaboration between Oxford University Hospitals NHS Foundation Trust, the ICB and other key relevant partners to help develop a sustainable business case for the continuation of the project.

The imperative for sustainable funding and resource would also extend to palliative care services more broadly. The entire system should ideally work collaboratively to explore avenues for funding, as well as to help overcome challenges around workforce. The Committee appreciates that workforce shortages are not unique to Oxfordshire and that this constitutes a national challenge. However, demonstrable efforts should be made to ensure two things:

1. An identification of the level of workforce required to deliver palliative care services.
2. Clear steps to secure the required workforce and personnel required to provide palliative care services, including services in people's homes.

In NHS England's national framework for local action on palliative and end of life care, it is emphasised that whilst death cannot be defeated, systems should change the way we talk about dying, death and bereavement; and that there should be adequate preparation, planning, care, and support for those who are dying as well as for those who are close to them. If these objectives are to be met in Oxfordshire, then it is pivotal that the system identifies and secures the necessary resources to do so, and to ensure that such resources are as sustainable as possible.

Recommendation 2: *To secure sustainable sources of funding and resources for the RIPEL project, as well as Palliative Care Services more broadly.*

Improving transport services for palliative care patients: It is important that work is undertaken to improve transport services for palliative care patients. Such patients already experience tremendous physical, mental, and emotional difficulties, and it is therefore crucial that inconveniences caused by transportation are minimised inasmuch as possible. Long waits for transportation can cause significant distress for patients, particularly for patients who require urgent transfers to their homes or to hospices. The Committee urges that as much additional support as possible should be sought to pilot dedicated palliative transport services. The Committee is pleased to hear that a pilot scheme funded by Sobell House has been proposed to provide dedicated transportation options, with the aim of improving patient and family experiences. Nonetheless, assessments of the feasibility of a long-term implementation of such options should be made as urgently as possible.

Furthermore, as part of assessing and improving the quality of transport services in palliative care, the Committee urges that such services work closely with patients and their families to develop a robust feedback process. This can help transport services to review any potential areas of improvement. Additionally, transport services staff should receive as much training as possible in displaying empathy toward patients and their families, and in being able to physically handle patients in a manner that makes them feel as comfortable and as pain free as possible.

Recommendation 3: *To secure additional and sufficient resourcing and support for palliative transport services. It is recommended that transport services for palliative care patients are organised in a manner that avoids delay and distress for patients.*

Legal Implications

15. Health Scrutiny powers set out in the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide:
 - Power to scrutinise health bodies and authorities in the local area
 - Power to require members or officers of local health bodies to provide information and to attend health scrutiny meetings to answer questions
 - Duty of NHS to consult scrutiny on major service changes and provide feedback on consultations.
16. Under s. 22 (1) Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 'A local authority may make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised'.
17. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

Annex 1 – Scrutiny Response Pro Forma

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August 2024