Scottish hospices: Clinical innovation in response to COVID-19 pandemic

Summary of feedback gathered from Scottish hospices end of June-August 2020

1. Summary

Hospices across Scotland have rapidly adapted their services to meet evolving care needs in response to COVID-19. There has been a particular emphasis on:

- Significant shift to new ways of working, focusing on virtual support
- Introduction of new community-based models, in response to increased complexity of care needs in the community
- Providing support to and collaborating with other services and settings, including care homes, community services and acute care
- Working in close partnership across NHS, local authorities and health and social care partnerships, and participating in local and national planning

For the majority of changes introduced, it is too soon to assess what the impact has been. However there is some initial positive feedback, especially from staff in other settings who have received support, and from patients and families. The introduction and expansion of virtual services has been positive in allowing hospices to reach more people and freeing up staff time. However this has come with challenges, especially around supporting staff to work remotely and ensuring that patients and families are able to access the support they need.

To sustain beneficial changes long-term there needs to be a focus on:

- Service redesign to support new ways of working
- Additional/more efficient use of resources
- Strong partnership working
- Good infrastructure
- Support for staff, volunteers, patients and families to use virtual services
- A culture of safety, challenge and learning

Particular challenges faced have been:

- Challenges around remote working
- Ensuring patients and families are able to access the support they need
- Coping with staff absence
- The speed of change and maintaining the essence of hospice care in challenging times

2. What beneficial innovations/changes have been introduced?

What beneficial innovations/changes have occurred in your specialty and within patient pathways?	Please describe the impact of these innovations/ changes. How did you measure the benefit?
New community models	
• **Rapid Response service** established which allows urgent home assessment and intervention to support unstable patients on same day as referral (***Marie Curie Hospice Edinburgh***)	
• **Community Hub**: Many hospices developed a Community Hub where patients/families and health and social care professionals could get advice and support 24 hours per day and had specific slots where they could dial in to MDT support. This was used by the service leads and allowed the earlier identification of hot spots in the community (***PPWH***)	• Still to conduct a formal evaluation of these services, however anecdotally it has promoted better partnership working where we are seen as partners and not just a helpful addition to services and has prompted equipment sharing, support to care homes and general case discussion
• **A Community Hub** was created through our Marie Curie Hospice Glasgow service, which has further expanded external relationships with primary care. Virtual daily briefings were held from our hospice with Marie Curie Fast Track, Glasgow Royal Infirmary HPCT, District Nursing and Care Home liaison staff. The collaborative approach was highly successful and ensured person-centred care continued to lead decision making ***(Marie Curie Hospice Glasgow)***	• As a result of the positive impact of the Community Hub on patients, their families and staff, it will become a permanent feature of our Glasgow Hospice services as new levels of normality start to emerge
• **Out of hours oxygen delivery service** to support people with Covid-19 to have more effective symptom management in the community whether that be in their own home or in a care home. This service was rapidly developed to support our community and agreed by our regulator ***(PPWH)***	• This service has only been required on 3 occasions to date however, very positive feedback from the care homes who accessed the service, supporting the symptom management of their residents and preventing hospital admission. This is a service delivered by NHS/HSCP staff across the rest of Scotland and although the hospice responded rapidly to an identified need the goal would be that OOH HSCP services would pick this up
• **Community Hospice service** developed - a multi-professional team involving CNS's, medical team, band 4 associate roles and AHP (physio and OT).This is now in place and a new community hospice team lead will be in place from September 2020 ***(St Columba's Hospice Care)***	

• **Hospice at home team** introduced in June 2020, following support from a practice development team and governance team. Team consists of registered nurse coordinators and band 3 nursing assistants *(**St Columba's Hospice Care**)*	
• **'Hospice at Home' model** of care was quickly mobilised to enable more patients to receive treatment and die at home where possible (hospice admission was final resort due to visiting restrictions). This was also to enable as many patients as possible to be with their families • **Community CNS team** continued to provide face-to-face visits along with virtual or telephone follow-up for stable patients • **Maximising Clinical Portal access:** After we were granted access to the Clinical Portal at the end of March, there was a significant amount of work done going through our outpatient and community caseloads and contacting patients to discuss their wishes for future care ***(Marie Curie Hospice Glasgow)***	
• **Increased data sharing and multidisciplinary discussion** of patients to cope with the increase in complex care delivered at home, while patients were not in hospice or hospital in usual numbers ***(St Andrew's Hospice)***	
• **Hospice Hearty Meals** pilot - two course meals provided to patients who are isolated and have very limited support from family or friends, focusing in particular on patients who don't have the ability to prepare nutritious meals themselves where this has a potential impact on their overall health and wellbeing ***(St Andrew's Hospice)***	• Evaluated feedback from a patient experience survey. Patients reported a positive impact on symptoms such as fatigue
• **Outreach service:** Immediate conversion of the Edwina Bradley Day Hospice to an Outreach Service including a Blood Transfusion Service and Interventional Cancer Pain Team Service - The facilitation of refilling an intrathecal device remotely by the Interventional Cancer Pain Team and Hospice staff - The development of a cross-matching process in circumstances where sampling cannot be undertaken or retrieved in the community or within a Care Home setting - The creation of a Pre-Transfusion Information Leaflet to support retrieval within Care Home/Community – Guide for professionals - Transport – Hospice Ambulance or Patient Transport supporting transport to and from the Hospice **(*St Margaret of Scotland Hospice)***	
Virtual services	
• Patient and Family Support Team/CNS teams working from home and utilising **virtual consultations** where possible. CNS teams able to screen and triage remotely for home visits, where appropriate. • **Day Therapy Unit** virtual activities programme **(*Marie Curie Hospice Edinburgh*)**	• Review by Research Lead of acceptability of virtual ways of patient consultation. Feedback collected by DTU service on new, virtual ways of working from patients. Definitely a sense that staff are able to work more efficiently e.g. significant savings on travel expenses, time and resources to attend meetings and

	similar. This also benefits staff as limits number of long days/journeys
• **Outpatient and Day Services** all converted to virtual service. Staff quickly developed and became comfortable with developing virtual groups with both pre-recorded and, more recently, live content, including Tai Chi, hand massage, fatigue management and management of breathlessness • **Video and phone consultations** supporting patients at home. All meetings with partners from outwith the hospice building have been held via Microsoft Teams • **Newsletter for outpatients** to update them on new developments, share encouragement and provide activity sheets/links to resources to help prevent boredom and isolation • **Digital Champions** introduced with a lead role in ensuring all staff and clients have appropriate knowledge and access to allow them to engage in the services ***(St Andrew's Hospice)***	• Virtual Outpatient and day service sessions are accessible by a much wider audience and are particularly useful to those who physically would not have been able to attend Outpatient groups previously. • Information videos: through patient feedback via survey and social media interaction it has been highlighted that patients have found the online videos useful at helping managing their conditions and symptoms. The Tai Chi videos have offered access to exercise for those patients who are at home and unable to engage in any other activity due to shielding. The new Wellbeing section on our Website where they are hosted has had over 700 hits since it commenced at the beginning of April • Support calls - Patient and Carer feedback has shown that these calls have offered invaluable support to people, some have described them as a lifeline throughout the lockdown, and they have offered carers and patients a listening ear and access to advice and information to support their needs • Less travelling time has allowed interaction with more patients and families in the community. On the negative side, fewer family members of hospice patients have had face to face discussions with medical staff.
• **Community and Outpatient department** moved rapidly to using virtual technology to provide consultation which were not assessed as needing face to face contact. More people can be assessed and potentially seen, although not examined, using this facility than face to face consultations *(**PPWH**)*	• Yet to formally evaluate, however going forward a good way to reduce patient travel time and effort, infection risk and unnecessary staff travelling time. Frees up time and resources to allow the right people to be seen at the right time by the right service. Absolutely a way to support patient choice.
• Developed a **virtual living well hub** focusing on the key elements which had been the cornerstones of our recently started face to face hub. This closed face book page has been available to our day service, outpatients and community case load and supported by the	• Still formally evaluating but a definite difference in reducing social isolation, keeping people mentally and

multidisciplinary team. A newsletter was also sent to people who chose or were unable to engage in Facebook highlighting the themes on the Facebook page *(**PPWH**)*	physically active and promoting intergenerational peer support for patients and their carers
• Transfer of **Day Therapy** to online and telephone support. Using Zoom for group therapy sessions (***Highland Hospice****)*	• Taking referrals from wider geographical area. Surprisingly successful and looks likely to be an ongoing model of delivery
• The **Family and Bereavement Support Team** have been working remotely and have created website resources, provided **telephone and video support** for counselling and have plans to provide future virtual groups and virtual school support. The impact of the restricted visiting of children remain a focus for the team moving forward • **Funding** has also been secured to provide education to the counselling team on carrying out remote consultations and appropriate devices *(**St Columba's Hospice Care**)*	

• Set up the **UK's first virtual children's hospice service** which allowed us to deliver holistic palliative care to families throughout lockdown – particularly those shielding who did not wish to accept external care into the home. The virtual hospice offers families nursing, medical and pharmacy advice by phone and video; bereavement support; money and benefits advice; and practical advice around coronavirus. The service also offers a storytelling service for children at home; letter writing for children and parents; activity packs and art clubs; and virtual Clowndoctor visits, with more activities being planned *(**CHAS**)*	• Reached huge numbers of families. In May, CHAS's Virtual Hospice delivered:
	  • Over 75 hours of palliative care services delivered through Zoom
	  • 337 participants in online palliative care sessions
	  • 17 different services
	  • 145 minutes of consulting on Near Me
	  • Two funeral services delivered by video link
	  • CHAS Remembering Day held virtually with over 150 people attending
	• 100% of families responded positively to each episode of care, and 100% of families reported improved quality of life following calls from CHAS

• **A virtual ward** was established at our Marie Curie Hospice Glasgow which enabled support for up to five patients with more complex needs being cared for at home. This worked well and included daily input from medical and community clinical nursing teams, Marie Curie Fast Track Service and District Nurses to ensure patients and their families received the support they needed. This innovation will help explore and inform future models of care (***Marie Curie Hospice Glasgow****)*	
• **Outpatient activity:** Marie Curie Hospice Glasgow usually has a busy programme of outpatient activity which had to be suspended. We have followed up with these patients via video consultation (NHS Near Me), telephone consultation and home visits. New outpatients are reviewed by video consultation or home visit (***Marie Curie Hospice Glasgow****)*	

• Introduction of **remote patient**: family connectivity to allow all patients opportunity to continue to see and converse with family members and say goodnight ***(St Margaret of Scotland Hospice)***	
• **Attend Anywhere Consultations** - Virtual new referral assessment consultations – all new referrals for Specialist Palliative Care support and advice are assessed virtually by a Senior Medic and Senior Nurse Manager - Outpatient Clinic Appointments – virtual and telephone - Virtual ongoing assessment or update sessions - Virtual support sessions with GP and DN's – joint sessions in the patient's home when required - Virtual and telephone emotional/isolation reduction calls to patients known to Edwina Bradley Day Hospice - Virtual and emotional/isolation reduction calls to patients known to the Community Specialist Palliative Care Team • **Virtual emotional/bereavement support** - telephone call or zoom ***(St Margaret of Scotland Hospice)***	
Staffing changes/reprioritisation	
• **Speciality doctor** assigned to work with community teams and available to do urgent visits to home or care homes (***Marie Curie Hospice Edinburgh***)	
• **Specialty doctor** was redeployed to work with the Lanarkshire hospital@home team supporting Care of Elderly consultants with palliative cases • **Medical sessional input** was more than doubled in both acute and community specialist palliative care teams. This was possible due to a marked fall in hospice inpatients • **Sub-teams** - Within the NHS community specialist palliative care team the CNSs were regrouped into sub-teams to allow for cross cover in times of staff absence (***St Andrew's Hospice***)	• Feedback from colleagues in teams in other settings is hugely appreciative of the increase in palliative medicine review of patients and support and training of staff. More patients have had access to palliative medicine in other settings and fewer within the hospice inpatient unit
• **7 day working** of the hospital based specialist palliative care teams to support generalist colleagues (***PPWH***)	• Hospital team evaluating this, however the 7 day visiting service introduced in hospital where the teams also support the hospice out of hours service, had an impact on the complexity of the OOH medical rota
• **Staffing resource was redistributed** with complementary therapists, day therapies, research and education team taking on clinical roles in IPU. AHP roles were integrated with nursing team so MDT care delivery in place. IPU Band 2 staff took up roles in the new Hospice at Home Team (commenced June 2020) • **Clinical Governance Team** were initially located to support on a part time basis and has been increased to full team to support safety, training, change and development	• The changes of roles, either on a temporary or permanent basis, has facilitated a more flexible approach and a wider understanding between the teams

• Immediately prior to the pandemic, the hospice recruited a Band 7 AHP lead practitioner and Band 6 OT for the short stay unit. They have both since joined our hospice team *(**St Columba's Hospice Care**)*	
• **Redeployed both hospice and hospital-based staff** to provide care in families' homes. Prioritised supporting the NHS and local authorities to continue care for families at home by diverting resource to CHAS at Home to support health and social care packages • Focus has been on **crisis, emergency, step down and end of life care** *(**CHAS**)*	• Reached the most vulnerable families through outreach visits by the family support team and by supporting local authority social work teams to reach families • Provided hospice care for children who would otherwise have remained in hospital • Our income maximisation service has yielded significant gains for families – over £37,000 in April and May
• **Virtual 2nd on call consultant cover:** Begun prior to Covid but has enhanced service resilience during the pandemic. Consultant out of hours cover is provided by St Christopher's Hospice in London by use of zoom, Whats app and telephone support. Medical and multi-professional education beginning to be provided by SCH also ***(Ardgowan Hospice)***	• Will be written up
• **Speciality doctor:** Redeployed to undertake care home project described below ***(Ardgowan Hospice)***	
Inpatient provision	
• Our 2020 strategic plan was to decrease inpatient beds from 30 to 23 inpatient beds for complex symptom management including seven nurse lead beds for end-of-life care. This would also include short stay Monday to Friday beds for rehab symptom management review, Practical education, and respite support. As a result of Covid 19- we have reduced inpatient beds to 22 to ensure single occupancy in all rooms *(**St Columba's Hospice Care**)*	
• Reduced the number of available beds in each hospice (to 3 bed plus a rainbow room at each hospice) to comply with Scottish Government guidance around physical distancing *(**CHAS**)*	
Referrals/triage	
• Introduced a single point of access for all referrals and a newly created team of supportive care lead, community CNS, ward charge nurse and administration support was identified from existing resources. The team has reviewed the use of the newly implemented TrakCare system to meet the needs of the new team, working collaboratively with NHS Lothian. All referrals triaged and allocated to services based on person's needs *(**St Columba's Hospice Care**)*	

• Our kindness call service (to triage a family's need for help) has resulted in referrals for additional support *(**CHAS**)*	
• **Daily MDT referral and referral update meetings** to process new referrals to the Hospice – referrals to both the Specialist Palliative Care Centre and the Hospital Based Complex Clinical Care Unit. This included - Thinking creatively as a team to support professionals caring for patients whose preferred place of care and death was home – generic and complex situations - Advocating home visits/symptom review sessions from both GP's and District Nurses when patients at home may not have received regular review and support with symptom assessment and management - Triaging referrals for patients who had experienced sudden deterioration at home or had experienced a fall but were not being directed towards the acute setting or where the clinical impression was the 'patient was approaching end of life' when the situation was reversible – advocating appropriate assessment, management and treatment plans. - Advocating continuation of essential services where required – X-ray, medical or surgical review, oncological support, scanning and/or radiotherapy ***(St Margaret of Scotland Hospice)***	
• Reshape of the **hospice 'In-Patient' referral process** - Assessment of reason for referral - Assessment and identification of place of care and death – home or care home - Assessment of professional/social care input and efficacy of input in place - Assessment of patient and family perception and understanding of the Hospice Visiting Policy Restrictions - Assessment of prevalence and incidence of COVID 19 within each care environment the patient was being referred from - home/care home/acute setting - Screen of symptom history: 7-day history of clinical observations; symptoms of COVID 19 – temperature, new cough, shortness of breath and later anosmia. - Screen of immediate and regular/irregular contacts for those living at home – family, friends, carers, and professionals - 2 x negative COVID 19 swabs. This was difficult to achieve due to lack of process supporting swabbing within primary care. The Hospice Team worked closely with NHSGGC Public Health to create new pathways for to establish a GP swabbing request process – this has been added to the Primary Care electronic system ***(St Margaret of Scotland Hospice)***	
• **24/7 admission process** for those living with complex and progressive symptoms or approaching end of life with no/minimal social and professional support. This includes	

using Hospice transport to transport the patient from home or hospital to Hospice ***(St Margaret of Scotland Hospice)***	
Medication/pharmacy	
• **'Just in Case' medicines** - Hospice medical staff able to prescribe anticipatory medicines for first time to patients at home and able to store medication in the hospice which can be used by the medical staff for patients at home • **Palliative care pharmacy toolkit** - Pharmacist and consultant engaged in pan-Lothian palliative care pharmacy group to co-ordinate local delivery of National palliative care pharmacy toolkit (***Marie Curie Hospice Edinburgh****)*	
Infection control	
• **Clinical meeting rooms** restricted to the number of staff who could safely maintain 2 metre social distancing. • We introduced **temperature taking** for clinical staff arriving for duty, and later for non-clinical teams. Following review, these practices were discontinued following concerns around the difficulties to socially distance at the temperature stations. • **Leadership walk rounds** were increased (at least 3 times per week) and involved Domestic staff, ward managers, clinical governance team and deputy CEO. The ward leadership team will be implementing the Health Protection Scotland framework within their walk round observation to ensure compliance across in-patient services *(**St Columba's Hospice Care**)*	
• **Reshape of Infection Control measures and practices** – whole hospice team approach • **PPE**: Immediate links with NHS GGC procurement team and medical devices unit in relation to the supply of and assessment of appropriate PPE ***(St Margaret of Scotland Hospice)***	
Visiting policy	
• Introduction of **compassionate visiting policy** for patients approaching the end of life, this includes - COVID 19 Screening Process for all visitors - Support to don and doff PPE - The facilitation of family updates/meetings – utilising socially distant protection measures - Family visits within the Hospice Gardens - Emotional support for families as end of life approaches - 24/7 spiritual care for all patients by Hospice CEO, Sisters of Charity and staff ***(St Margaret of Scotland Hospice)***	

Support to and collaboration with other settings and services	
• **Community hospital**: Charge Nurse and medical input/advice to local Community Hospital COVID ward. Developed into 'education and support role' from Charge Nurse for care homes in the locality (***Marie Curie Hospice Edinburgh***)	
• **Care homes**: Engagement of Patient and Family Support Team and CNS teams to deliver a virtual supportive reflective practice session for catchment care homes on one to one basis and as an ECHO network – in progress (***Marie Curie Hospice Edinburgh***)	
• **Care homes:** virtual staff support sessions offered during crisis**,** facilitated by education, clinical and patient and family support team (ECHO) • CNS team involved in daily care home MDT meetings • 24 hour drug courier service implemented to support local care home staff ***(ACCORD Hospice)***	• Evaluated positively with a further education ECHO programme scheduled September 2020
• **Care homes**: Daily care home update and weekly Microsoft Teams meeting with HSCP colleagues to discuss community and, in particular, care home issues with the commissioning team and support partnership working. This has led to two examples of bespoke information and support being delivered to care homes. Initially care homes were reluctant to accept support and, listening to colleagues across Scotland and Scottish Care, there has been a similar experience of care homes throughout Scotland, potentially exacerbated by the level of criticism being levelled their way by the media (***PPWH***)	• The work with the wider commissioning teams has allowed a more collaborative approach and allowed us to respond to the support and education needs care homes identified. This information has helped us proactively contact homes with growing numbers of Covid-19 positive patients to offer support- the more information we have the more integrated we become. Potentially do not need such frequent meetings going forward. Support and education to care homes still to be formally evaluated by our education team however the initial input in one care home led to them requesting more formal palliative care education
• **Nursing Home Support:** All local nursing homes in Inverclyde approached and offered support. Staff trained in use of the SPICT tool to identify which of their residents have palliative care needs. Staff supported to develop ACPs for all residents. Consultations held via Attend Anywhere and staff training undertaken. Avoidance of admission to hospital facilitated ***(Ardgowan Hospice)***	• Will be evaluated by Dec 2020

• **Primary care:** Three separate COVID-19 knowledge ECHO networks rapidly established within 72 hours to support primary care in the Highland area: (i) out of hours GPs; (ii) rural GPs; and (iii) general GPs. Small number of ANPs also participated. 369 individuals participated in total. 1,738 instances of attendance ***(Highland Hospice)***	• Evaluation of ECHO carried out
	  • 89% participants reported that their daily practice had changed as a result of the ECHO
	  • 93% felt the programme met their needs and expectations
	  • 80% reported an increase in clinical knowledge, confidence and skills

	• 77% said that the ECHO had influenced their relationship with colleagues in primary and secondary care
• **24/7 Specialist palliative care support advice service:** Management of increased number of calls from GPs supporting patients in complex situations whose PPC was home, both in hours and out of hours • **Support of community-based colleagues** with both symptom/medical management planning and the development of emotional resilience by signposting to Scottish Symptom Management Guidelines; COVID 19 symptom management guidelines; Health and Social Care Partnership Wellbeing Service; NHSGGC Core Brief publications ***(St Margaret of Scotland Hospice)***	
• Implementation of the **Hospice Ambulance and Patient Transport Service** supporting transfer of patients from the acute setting or home to the Hospice – both to the Specialist Palliative Care Centre or the Hospice Based Complex Clinical Care Unit ***(St Margaret of Scotland Hospice)***	• Liaison with the Scottish Ambulance Service and Paramedic End of Life Coordinators to take this forward into the future
• **Collaboration:** Responsiveness of external agencies and others to requests for help, knowledge and advice was excellent. Responsiveness to the needs of other and supporting environments that we would have had less interaction with before e.g. Psychiatric Geriatric Ward ***(Marie Curie Hospice Glasgow)***	• Evidence of greater partnership working and eagerness to collaborate to problem solve and share experiences
Education	
• **Medical student teaching**: Medical team collaboration with St Columba's and Edinburgh University Medical School to deliver medical student teaching online for 5th and 6th year students (***Marie Curie Hospice Edinburgh***)	
• **ANPs**: Needs-led educational support to advanced nurse practitioners supporting care homes on a weekly basis (***PPWH***)	• Identified ongoing need for ANP education and support, as support evaluated well
• Delivery of **Last Aid training** via Zoom. We were initially sceptical if this would work but we have now delivered 5 training sessions. Future sessions planned which are fully booked. This will continue in this format for the foreseeable (***Highland Hospice***)	
• A **comprehensive education plan** was developed by the Clinical Governance Team and Practice Development Team and was mandatory for all clinical staff. Staff had previously completed the SIPCEP modules so the education plan was built on this knowledge ***(St Columba's Hospice Care)***	

• **ECHO project** has been accelerated to include care homes and also in house mandatory training e.g. medicine management programme for all Glasgow Hospice RNs being piloted in August • Supportive reflective sessions held for housekeeping and ancillary workers • Statutory and **mandatory training** has been reviewed and will now consist of physical distancing, virtual and online delivery during 2020 ***(ACCORD Hospice)***	• Pilot will be evaluated and results disseminated to all participating hospices • Anecdotal evidence suggested staff felt a worthwhile exercise and very much appreciated time out.
• We have provided education through **webinars for HSCP colleagues** in care homes and primary care through NES and University of Glasgow ***(Marie Curie Hospice Glasgow)***	
• Reshape of **Hospice Induction and Mandatory Training Programme** - Learn-Pro electronic learning theoretical sessions; socially distant sessions face to face • In-hospice **education sessions for all hospice staff**: infection control sessions, donning and doffing of PPE, National Infection Prevention and Control Manual – SICPs Audit Programme, waste management streams • Remote support of students undertaking the End of Life Care: The Principles module (Accredited by GCU) • Creation of online palliative care module - Supportive Care at End of Life (Accredited by GCU for implementation September 2020) ***(St Margaret of Scotland Hospice)***	
Support for staff	
• **Hospice staff support:** A range of interventions have been developed for our own staff, these have included virtual yoga and mindfulness sessions, social events on zoom. All staff were offered the opportunity to join a workshop to learn how to use self-hypnosis to enhance their resilience. ***(Ardgowan Hospice)***	• Staff feedback has been very positive
• **External Staff Support:** Extension of emotional support to staff/carers working within the catchment. Family Support Team extended to increase capacity. Staff trained to be able to train staff to use self-hypnosis to support themselves, individually or as staff groups. Staff likely to have had traumatic experiences of deaths related to Covid 19 targeted and hospice Family Support staff have received additional training on working with trauma ***(Ardgowan Hospice)***	• Services only recently launched – will be evaluated as a requirement for the Lottery who have funded this
• **Increase staff support:** daily inspirational/spiritual reflections following each patient handover or meeting • Weekly update by Hospice CEO to support staff and their families to cope practically, emotionally and spiritually with the ever-changing lifestyle considerations and restrictions relating to covid-19	

• Implementation of a risk assessment to identify key 'at risk' staffing groups • Safe recruitment - telephone conference call initial interview / Zoom face to face 2nd interview ***(St Margaret of Scotland Hospice)***	
Volunteers and communities	
• **Bereavement volunteers** providing 1 to 1 advice via Marie Curie Information &Support Service (***Marie Curie Hospice Edinburgh***)	
• **Recruitment of volunteers** to support Highland Home Carers - largest care at home provider in Highlands. 60 volunteers recruited and trained *(**Highland Hospice**)*	• This is being written up by HIS as a case study. In the end the need for volunteers wasn't as great as first thought, but it is a good demonstration of the ability to rapidly respond
• With the predicted increase in demand, **additional volunteer counsellors** have been recruited • **Hospice Friends coordinator** identified from current staffing model. This post will be supported by a team of volunteers in each locality. • **Compassionate community lead** also identified whose role will be to integrate with local community groups. With COVID-19 the development of compassionate communities and hospice friends will need to be explored and developed within the ever-changing restrictions of social distancing. The plan is to create a community of practice across Scottish hospices and virtual communities *(**St Columba's Hospice Care**)*	
• Joint project in place with Renfrewshire HSCP and St Vincent's Hospice to provide a **reactive bereavement service** for those affected by Covid 19. Includes additional volunteer recruitment and training ***(ACCORD Hospice)***	
• **Extension of bereavement support:** The Family Support Service has extended its services to people who live within the catchment area who have been bereaved by Covid or whose bereavement has been complexified by Covid e.g. the family weren't able to be in attendance at the death or to attend the funeral. This includes 1:1 emotional support, initially virtually, but face-to-face as restrictions are lifted. Groupwork planned service for adults and children and young people Memorial opportunities being arranged for Absent Friends week ***(Ardgowan Hospice)***	• Services only recently launched. Will be evaluated as a requirement for the Lottery who have funded this
• **Compassionate Communities:** Compassionate Inverclyde (CI) part of Ardgowan Hospice is one of a number of organisations in Inverclyde which came together for a period to respond to Covid. CI had to halt some of its services e.g. No One Dies Alone (NODA) but	• Numbers of beneficiaries have been collated

worked with the other local organisations adapting normal services e.g. Back Home [from hospital] Boxes have been changed to Social Isolation Boxes, companions have been redeployed to collect and deliver prescriptions or groceries for people who are shielded and have been telephoning socially isolated individuals. Coordinated by HSCP and local CVS. CI has taken the lead in applying for funds to show appreciation to community home carers on behalf of all organisations and HSCP ***(Ardgowan Hospice)***	
Collaboration, planning and guidelines	
• **Local planning -** Engagement in integrated pan-Lothian community covid group for planning and service delivery • **Local guidelines** - Pharmacist and consultant involved in development of three local guidelines for Unscheduled Care, General Practitioners and for Community nursing staff to enable pan-Lothian implementation of the National Covid dying guideline and supporting use of a community drug administration chart including practice change to train community nursing staff and care home nursing staff to use drug dose ranges • **Clinical leadership of National covid guidelines -** *Guideline for symptom control for rapid high distress dying from Covid19*; *Guideline for alternatives to standard pall care drugs (for anticipated drug shortage and staff shortage*; *Guideline for ethical and moral framework for visiting restrictions during covid-19* (***Marie Curie Hospice Edinburgh***)	
• **Guidelines:** Very rapidly worked collaboratively to develop guidelines: *End of Life Care Guidance when a Person is Imminently Dying from COVID-19 Lung Disease* and *Alternatives to Regular Medication Normally Given via a Syringe Pump When this is Not Available* (***PPWH***)	• Likely to be a formal national evaluation of the guidance however it is apparent from conversations and practice that our generalist colleagues are aware of these guidelines and have appreciated the support to their symptom control and rapid development
• **Guidelines**: We have contributed to the revision of guidelines locally and nationally ***(Marie Curie Hospice Glasgow)***	
• Hospice contribution to the development of national COVID 19 Symptom Management Guidelines and local protocol development • **Virtual meeting attendance**: SNAPC meetings; national meetings relative to COVID 19 supporting national response ***(St Margaret of Scotland Hospice)***	

3. What is needed to sustain the change?

Service redesign to support new ways of working

- Develop funding streams/service level agreements to support service development
- Incorporate the most successful changes into recovery plans and future service model e.g. virtual hospice services being incorporated into every role and relaunched as an integrated part of the service
- Target effective ways to change using quality improvement techniques (e.g. small tests of change; 5 whys) to ensure that we are effectively changing what needs to change

Additional/more efficient use of resources

- Some initiatives have been possible because other services, such as day services and face to face outpatient clinics, have not been running. Going forward, there will need to be additional resource or diversion/more efficient use of existing resource to support sustainability, as other services reopen or hospice admissions increase
    - E.g. more efficient use of using medical resource - developing different categories of hospice beds, or a 'hospice@home' service, or supporting colleagues within and outwith the specialist palliative care team with fewer sessions and personal contacts
    - E.g. additional input from hospice volunteer networks to provide the ongoing resource

Strong partnership working

- Continued connections with the HSCP care home commissioning teams
- Optimise on the positive way that palliative care as a specialty is being viewed by care homes
- Sustain and increase collaboration with community nursing colleagues
- Continued intercollegiate network of specialist palliative care clinicians to be able to respond to challenges effectively

Good infrastructure

- Integrated IT systems, WIFI, access to appropriate kit, suitable office space etc
- Educational resources and digital platforms, such as Zoom, via ECHO

Support for staff and volunteers around remote working

- Upskill staff's own knowledge of digital technology to provide remote services and support clients
- Develop new ways of supporting staff who are working remotely e.g. DSE-related, team communications etc
- Understand the time needed to prepare for and undertake virtual sessions based on the potential audience, as well as undertaking appropriate risk assessments
- Review roles and responsibilities within staff job descriptions to incorporate new ways of working
- Support leaders and managers to work in different ways to support and engage teams
- Introduce digital champions to support staff and clients
- Embrace the benefits that virtual support can provide
- Support for volunteers around new models of working

- More effective change management and education to better support technology/virtual services that were introduced quickly in a rapidly changing environment

Support for patients and families

- Continued support for patients and families to use video consultations and online resources with confidence
- Grants to support families without good IT access to access it, to make this a fair and equitable choice for people
- Promotion of public support for community-based and facing services

Culture of safety, challenge and learning

- Continued promotion of culture of safety and challenge. There needs to be open discussion and challenging of decisions and practice, so that staff are supported to raise concerns
- Need to celebrate and praise good practice and challenge practice that falls below acceptable levels
- Take the opportunity to reflect and learn from the unprecedented speed that hospices have had to change and adapt

4. What, if anything, hasn't worked so well?

Challenges with remote working

- Some staff have struggled with remote working.
    - The majority of staff are hands on tactile health care professionals and have found this method of working challenging both professionally and individually.
    - Challenges may be related to home conditions and family arrangements but also to emotional and mental health wellbeing. Can be difficult to separate work and home. This can counterbalance the benefits if not managed effectively.
    - Some staff have struggled with the IT and having the confidence in using new IT software. There is a built-in bias against these individuals.
- Introducing new technology (e.g. Attend Anywhere clinics) in a rapidly changing external environment means it may not be as well established as it potentially could be
- Impact on MDT working because of social distancing and the ability to have groups of people together. This can partly be resolved with zoom/teams but staff are missing face to face contact
- Introducing clients to new technology has been difficult at times. Explaining access over the phone and not being able to be there in person has made it very difficult for those patients whose previous knowledge of digital technology was scarce. Some clients have felt frustrated by this

Access and support available to patients and families

- Some patients find virtual consultation unhelpful and this may threaten the ability of clinicians to assess and support patients and families effectively
- Threat of exacerbating health inequalities where people lack resources or skills to support IT-based service provision
- Following guidance to prioritise virtual work may have been to the detriment of some families

- Many families did not want to have physical support and opted to shield
- Significant rise in the incidence of domestic abuse, which has increased the complexity of the support provided

Staff absence

- Teams are vulnerable to staff absence, especially medical staff spread over several different sites/teams
- Many staff have been furloughed

Speed of change

- Staff have had to adapt to deliver complex care and cope with a huge amount of change
- The speed of change has been relentless. Staff are tired and at risk of burnout. Whilst it is crucial to continue to consider COVID-19 in all planning and developments, the risk of "Covid fatigue" may adversely affect the focus and primary aim we want to achieve

Maintaining the essence of hospice care

- Delivering hospice care is hard in the context of COVID
- Challenging to maintain the essence and culture of hospice care, while wearing PPE and having restricted visiting
- How to maintain a community presence when the future of hospice shops is uncertain

Contact:

Helen Malo, Policy and Advocacy Manager Scotland, Hospice UK

h.malo@hospiceuk.org