Annex F

Summary of Discussion from the Meeting held on 6th August 2012

1. Acknowledged early on that patients and close relatives would be at their most vulnerable if they were in a situation when they had to decide whether or not to allow for CPR to be performed.

2. In reference to **Annex G** (NHS leaflet – 'What happens if my heart stops') it was felt that the publicity and availability of the leaflet had a very high value and it could prompt discussions between patients and GPs around a very sensitive subject.

3. The representatives from the Out of Hours Service (OOH) run by Harrogate and District Foundation Trust raised concerns that much of the evidence received to date around the OOH had been anecdotal. They raised concerns that these comments were taken out of context in relation to the way the service was operated.

    i. The OOH Service saw approximately 130, 000 patients a year and provided a range of different services for a range of different people. Much of the time everything ran very smoothly, however when dealing with this many patients occasionally the service would not get everything right.

    ii. Clarity was given by the Clinical Director of Unscheduled Care that the OOH Service didn't play any part in putting DNACPR orders in place, this was the responsibility of the 'In-hours' Service as they worked with patients on a regular basis and had access to medical records and a greater understanding of a patient's medical history. It was also highlighted both within **Annex H** and at this meeting that if the 'in-hours' clinicians had not completed the process correctly then the information around a patient's end of life care would not be available to the OOH service.

    iii. There were difficulties around the different IT systems in place, not all of which were compatible with each other. As highlighted in point 2 of **Annex H** the OOH service used the Adastra IT platform which currently does not allow the OOH clinicians to

view a patient's GP or hospital records. At some sites (including York Primary Care Centre) we can view a patient's hospital record, however this is not available when the clinician is out in one of the mobile units.

iv. The OOH call handling service (operated by Yorkshire Ambulance Service) can sometimes trigger an ambulance response; especially if a patient or their carer/relative telephones in distress.

v. DNACPR does not mean do not treat. It is sometimes appropriate to admit a patient to hospital, even if they are nearing the end of their life and have a DNACPR order in place.

vi. The OOH Service is provided by Harrogate and District Foundation Trust but the District Nurses are provided by York Teaching Hospital NHS Foundation Trust and this can lead to gaps in service and conflicting priorities. The two organisations had slightly different agendas and were slightly less joined up than when one organisation had responsibility for both.

vii. The District Nursing service in York has faced staffing difficulties recently which has resulted in a lack of support for palliative patients during the night.

viii. We need to work closely with care homes to develop treatment pathways that give staff the confidence/support to continue to look after patients if they deteriorate.

ix. The OOH does have budgetary constraints and is under resourced. It has faced budget cuts for at least the last four years yet the activity increases year on year. We are uncertain of the impact that NHS 111 will have on the OOH Service but fear that it may increase their workload even more with no extra resource allocation

4. Various questions were asked around access to medical records and whether there were any ongoing projects to improve continuity and information sharing between key health partners. The Director of Partnerships and Innovation at Harrogate and District Foundation Trust said that some parts of were now standardised but interfaces between different IT systems still presented difficulties. There was an ongoing national project around this but there were no indicative timescales for completion.

5. In North Yorkshire there was no active work happening around this issue; however the NHS were committed to working in partnership and trying to improve systems across the region.

6. Further discussion took place around the new NHS 111 Service and how the OOH Service would work with this and what some of the challenges might be. There was apprehension around how the NHS 111 Service's software would identify if a patient needed to receive telephone triage, see a GP or be admitted to hospital. There were concerns that the percentage of telephone triage would reduce and the OOH Service would be expected to see more patients face to face without having any extra resources to manage this and any further capacity to respond. As far as the OOH Service were aware there were no plans to increase the number of clinicians. There were currently very few OOH clinicians to cover a large geographical area covering York and North Yorkshire. For example, there was only one OOH doctor for the York and Selby area.

7. Referring to the figures in **Annex H** discussion was had around the low number of DNACPR forms that appeared to be in place for those with expected deaths. It was felt that more robust policies needed to be in place to ensure that the OOH service were aware of DNACPR orders that were in place. The Medical Director at York Hospital highlighted the importance of sharing information as much as possible and said that most GPs could access hospital records for a patient and vice-versa; however this did not currently stretch to the OOH service. There was also a need to be mindful of only

sharing information about a patient with those who needed it and there were regulations around this that had to be adhered to.

8. It was difficult to store DNACPR forms electronically as they were essentially ‘live’ documents that required review at frequent intervals. The form also needed to travel with the patient and not be kept by the GP or the hospital.

9. Further discussion ensued around ‘how we can do something together with the public around the delicate subject of End of Life Care’ and how awareness could be raised around this sensitive issue as a whole.

10. A representative from York Carer’s Forum felt that community meetings could provide a chance for discussion and input into the successful use of the DNACPR form and believed that people would welcome the opportunity to have an input into this debate.

11. A representative from the Independent Care Group felt that whilst we had come a long way in improving communication and information sharing stronger connections needed to be made between GPs, OOH Service, Yorkshire Ambulance Service and Care Homes.

12. The representative from the Independent Care Group also spoke about how some patients with neurological problems in care homes had an Advanced Decision in place. An Advanced Decision was a legally binding contract which allowed the patient to refuse treatment. In comparison to a DNACPR it could also be interpreted differently, for example if a patient had a DNACPR order in place there were circumstances where a medical practitioner might override this and resuscitate a patient, this could not happen if the patient had made an Advance Decision.

13. Discussion moved on to identify some possible areas where recommendations might be made namely;

- Better press and publicity around End of Life Care issues in general, leading to increased public awareness and willingness to have conversations around this subject.

- Improvements to information sharing between the different agencies involved

- Improvements to IT systems

- Partnership working between the Vale of York Clinical Commissioning Group and City of York Council (using the Neighbourhood Care Teams)

- Ensuring that reviews of existing DNACPR forms already in place are done in a systematic way

- Further work on Advanced Decisions and DNACPR orders and how these can be used side by side.