Royal College of Physicians

Association for Palliative Medicine

JSC Palliative Medicine - COVID preparedness. Our learning from the initial peak of COVID-19 in acute Trusts is that palliative care is an essential front line service, supporting patients at risk of or dying and not suitable for escalation to ICU on COVID wards, including patients failing trials of CPAP. Therefore it is critical to maintain a core presence of medical, nursing and admin specialist palliative care staff.

Optimum palliative care service – 100%/ideal capacity and function	75% capacity and function	50% capacity and function	25% capacity and function
Multi-professional specialist trained workforce to include at least 1 WTE consultant in Palliative Medicine per 250 beds, CNSs, access to therapists and psychological support services	Therapists and counselors redeployed elsewhere so loss of rehabilitation and discharge planning functionality, level 3 and 4 psychological support	Therapists and counselors redeployed elsewhere so loss of rehabilitation and discharge planning functionality, level 3 and 4 psychological support	Therapists and counselors redeployed elsewhere so loss of rehabilitation and discharge planning functionality, level 3 and 4 psychological support
Face-to-face visiting seven days a week 9 to 5 with 4-hour response time for urgent symptom control referrals and access to guidelines and advice outside of this.	Face-to-face visiting five days a week for 9 to 5 with 4-hour response time for urgent symptom control referrals. Seven day service may be for reduced hours.	Reduced ability to visit patients. Potential for delay in urgent visits. Seven day service abandoned.	No routine face to face visiting. Telephone advice only with visiting only in exceptional circumstances. Seven day service abandoned
Outpatient review and hot clinic availability for urgent advice	Reduced availability for hot clinic advice	Limited availability to cover regular clinics. Urgent advice only	Regular clinics cancelled. Urgent advice only
Provision of expert palliative medicine telephone advice 24/7 from senior CNS or doctor.	Service maintained and may be supported by collaborating with neighbouring services to mitigate gaps from sickness	Service maintained and may be supported by collaborating with neighbouring services to mitigate gaps from sickness	Reduced service from out of hours advice with either long delays or more variable level of support or gaps in availability.

Specialist Palliative Care input to cancer and non-cancer MDTs	Attendance at MDTs reduced.	Attendance maintained to relevant part of MDT meetings (ie oncology part of list but not diagnostic/surgical for cancer MDTs)	Reduced availability, may not meet targets for number of cancer MDTs attended. Can advise only on patients flagged up by teams.
Palliative and end of life care education including education for staff being redeployed to ICU/NIV areas	Able to deliver most sessions	Able to support with educational resource but not deliver all sessions	Unable to support education
Supervision of trainees	Regular supervision meetings held less frequently. Reduced capacity to support training needs.	Only able to hold minimum number of meetings required with trainee. Reduced capacity to support training needs.	May be unable to fulfil educational requirements of trainee and risk losing training post.
Support to families including supporting virtual meetings and phone calls where necessary	Continue to be able to contact families for information and support including facilitating some video-calls	Able to support some families by phone, not able to support video-calls	Able to support a few families by phone only
Support for clinical decision making for individual treatment escalation plans and trust clinical decision groups	Able to attend most appropriate ward MDTs (eg ICU/NIV areas) to support individual decision making	Able to attend some but not all appropriate ward MDTS to support decision making, support available via telephone advice for individual patients.	Very limited capacity to support decision making
Support staff wellbeing on all areas of the hospital, including reflection sessions around particular events where appropriate	Informal support offered on visits to wards. Some input to Schwartz rounds	No input to facilitation of ward rounds. More limited informal support to staff as more limited ward presence	Very limited staff support of any sort
Provision of bereavement support for families/those close to patients	Most service maintained, including urgent follow up; potential for delay in follow up	Service reduced; delays in contacting families or following up those that are acutely distressed	Limited service