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During this ECHO session discussions will be recorded so that people who cannot attend will be able to benefit at another time. Filming is regarded as ‘personal data’ under the General Data Protection Regulations (GDPR) under that law we need you to be aware that this Data will be stored with password protection on the internet.

This Data will be available for as long as your network continues to meet and will then be taken down from the internet and either stored securely at the Superhub or deleted.

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If you are NOT willing for your data to be used in this way, please LEAVE the session at this point.

www.hospiceuk.org
WELCOME TO CLINICAL ECHO September 2022
Evidence Update
Max Watson

Research Review
Kate Flemming

Growing our own Nurses Gill Horne and Claire Booth, Rowcroft Hospice

The Cost of Dying Crisis  Sam Royston, Marie Curie

Energy  Cost Implications  Matt Dore, APM

What are we doing? Ideas to share? Breakout room discussions

September 14, 2022
“Lived until she died…”

Chat Box
• Your Questions
• Resources
• Information /innovations
• Email clinical@hospiceuk.org

Please share resources, powerpoint, links etc with those who would benefit
The changes began slowly. Initially, we realised that she was less energetic year by year. This is the stage of dying when life expectancy is usually still measured in years.

After Prince Philip died she was noticeably more tired, her public appearances less frequent, her energy less reliable. Losing weight, walking with a stick: changing month by month, a stage that usually indicates life expectancy measured in months.

She began to make clear her wishes. Charles' wife to be Queen Consort. The 2nd in line, William, to move to Windsor. Her dresser & special friend joined the Royal household as her daily companion.

Strength fading, she had tasks to complete. She was able to join in some, but not all, of the long-awaited Jubilee celebrations. The country waited for a new Prime Minister to be appointed by her, with weeks to wait for that election. She hung on.

Many people do this, living longer than expected in order to see somebody special, celebrate a last important occasion, hear longed-for news. Something held her, something important to her own heart, waiting.

Once at her beloved Balmoral, the break with tradition in asking the outgoing and new Prime Ministers to attend her there was a sign that she was now too tired to travel. Some of us in palliative care recognised what was unfolding. Yet dying remained un-named.

Missions all accomplished, arrangements within the family in place, Constitutional duties complete, her energy was spent. Even as the family was gathering, it was clear that she was in the last stage of dying. She has demonstrated the phases of ordinary dying to us all. How dying is mainly living, after all. And how, in the end, we can all plan ahead, address the unfinished business in our lives, and die with symptoms well-managed, even in our own bed if circumstances permit.

Dying in plain sight, camouflaged by briefings about 'mobility issues' and medical advice to 'rest.' Because like anyone else, the Queen was entitled to die away from the public gaze.

What can we learn? That dying is inevitable, recognisable, describable, and that we can prepare for it. The Queen had clearly planned ahead. That at the edge of life, we can still enjoy love, and peace, and companions. RIP

Kathryn Mannix
National mourning

A selection of articles and online resources exploring the phenomenon of national mourning in response to the deaths of people who are well-known or national figures. National grieving in the face of disasters is considered out of scope here.

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National guidance


General reading


About royalty

Watson CW. (1997) Born a lady, became a princess, died a saint. The reaction to the death of Diana, Princess of Wales. *Anthropology Today* 13(6): 3-7 Excerpt


Search strategy

Databases
- Google Scholar: “national mourning” OR “national grieving” OR “public mourning”
- JSTOR: “national mourning” OR “national grieving”
- PsychINFO: “national mourning” OR “national grieving”

Hand-searches and other resources

Journals
What plans does your organisation have to mitigate issues that are arising and will get worse over the coming months because of the cost of living crisis and its impact on patients, families and staff?
Update
Statistics
10th September, 2022

Last Month 60,306 deaths (44,000)
18 million cases (14 million)
Patients who have had a positive test for coronavirus in the last 14 days and are in hospital on the reporting date. Line shows weekly average. Data: data.gov.uk, updated 1 September, 2022
Weekly deaths with Covid

8 Sept 2022
Deaths: 430
7-day avg: 61

Each day shows deaths reported since the previous day.
This data shows how many people have received at least one dose of a vaccine. People who are fully vaccinated may have received more than one dose.
Vaccine
Canada Authorizes Its First Omicron-Adapted Vaccine for Adults

By Ismail Shenil
September 02, 2022

(Reuters) — Canada on Thursday authorized Moderna Inc's bivalent COVID-19 shots for adults, adding the first Omicron-adapted vaccine to its arsenal just as falling temperatures are poised to force people indoors where the risk of infection is higher.

COVID vaccines were originally developed to target the coronavirus strain first detected in China in 2019. Several new variants have since been detected, with Omicron considered one of the most contagious.

Moderna's so-called bivalent vaccine targets the original 2019 virus and the BA.1 version of Omicron, which caused a sudden, exponential rise of infections in Canada last winter.

"As winter comes and as people get pushed back indoors, there is a real risk of another serious wave of COVID," Prime Minister Justin Trudeau told reporters in Winnipeg, Manitoba.

"If we are able to hit that 80-90% of Canadians up to date on their vaccinations, we'll have a much better winter with much less need for the kinds of restrictions and rules that were so problematic for everyone over the past years," he said.

Health authorities in Europe and North America have also recommended bivalent vaccines, which are also made by Pfizer Inc and BioNTech.

Regulator Health Canada said in a statement that Moderna's bivalent Spikevax booster was safe and effective, while also generating a "good immune response" against the Omicron BA.4 and BA.5 sub-variants.

Canada has secured 12 million doses of the new vaccine booster, and Moderna will start delivering them from Friday.
It took a year for covid-19 vaccines to be tested and approved for use in children. As countries now reach out to the youngest age group, David Cox reports on the evidence for their effectiveness and deployment.

David Cox freelance journalist

On 18 June 2022, regulators in the US voted to authorise the Pfizer-BioNTech and Moderna’s covid-19 vaccines for children under the age of 5, meaning that the jabs will now be available to an estimated 20 million babies and toddlers.1 The decision sees the vaccines offered to children under the age of 5 in 15 countries, including Australia, Canada, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Norway, Portugal, and Sweden.2

"The top line efficacy results from interim analyses are impressive," says Hamid Merchant, a researcher in the department of pharmacy at the University of Huddersfield. "Although the vaccines are likely to be approved by the Medicines and Healthcare Products Regulatory Agency, they'll probably be deemed non-essential for healthy children under 5."

And it’s not just Pfizer and Moderna. There are limited efficacy data available for the other three covid-19 vaccines currently approved for use in children under 5 in the UK—those produced by Chinese companies Sinopharm and Sinovac, and the SARS-CoV-2 vaccine from Cuba. Earlier this year, a study in Portugal found that a single dose of a vaccine in 69 650 3-5-year-olds in Chile, found that it was just 38% effective at preventing symptomatic infection.

Of course, how researchers and public health officials perceive the risk-benefit ratio of rolling out vaccines to children will depend on the impact covid-19 has had on that country. Sweden has had just a handful of fatalities in those aged under 18,3 and vaccines are still not available to children aged 5-11 years. But in Brazil the virus has killed an average of two children under the age of 5 each day—2000 or 1000 per month, compared with 294 per 100 000 for 75 to 85 year olds.

Moreover, in the wake of omicron and its subsequent subvariants, most under 5s are thought to have now been exposed to the SARS-CoV-2 virus, perhaps even before they were born.4 Most of these kids were infected between 9 and 15 months old, when the protective effect of maternal antibodies has waned.5 Whether they are likely to be approved by the Medicines and Healthcare Products Regulatory Agency, they’ll probably be deemed non-essential for healthy children under 5.

One of the benefits of vaccinating younger age groups is to reduce the impact of covid-19 in the severity of multiple infections.6 Sceptical parents

Even if vaccines are made available to children, it remains to be seen whether parents will be convinced. The Kaiser Family Foundation has already noted that vaccination rates among under 5s in the US have peaked and are now dropping. Just weeks after they became available.

Data looking at the proportion of 5-11 year olds in the US who have received covid-19 vaccines since they became available in this age group have already provided indications that many parents are not converted.7

For just 57% of 5-11 year-olds in the US have had at least one dose of a covid-19 vaccine since they were approved in November 2021.9 For just 37% of 5-11 year-olds in the UK have been vaccinated and received a single dose.

In one survey conducted in March, 46% of parents of UK primary school children said that they would not have their children vaccinated. And if this is the case, Covid vaccines are likely to be taken up by a few high risk children in order to protect their family members.

"We can’t know for sure if a new variant will have a significant impact on children’s health, says Ian Lipkin. But in the US, children under 5-11 years had received one dose, and 30% being double vaccinated.11"

This followed a disastrous gransones engagement approach with vaccination campaigns, such as the Vaccine Champions Podcast and Building Confidence in Covid-19 Vaccines sessions on preventing the importance of childhood immunisation to communities across the country.

"There are benefits in vaccinating children under 5—both direct and indirect," says Marie Vachon, a consultant paediatrician at the Royal Children’s Hospital in Melbourne, who was involved in both initiatives. "We know children at a low risk of severe disease, but it does occur, and while vaccines have shown to impact on transmission, there is still some evidence."

Ladhani notes that the major public health risk which comes with making vaccines available to under 5s is not so much safety—studies show that basic side effects—but what we call "opportunity costs." With nearly four million children in this age group, he predicts that vaccinating all of them against covid-19 would drive down transmission rates in other diseases, though healthcare measures becoming diluted.

"To give one opportunity, you have to take away from somewhere else," Ladhani says. "That’s unfortunately our healthcare system is already struggling, and because there’s not enough transmission. A lot of the disease control is dependent on the community, and the community needs these vaccines to have a meaningful impact on disease.\\n\\nNasal vaccines: a game-changer?

Ladhani feels it might be easier to see the benefits of vaccinating the youngest age group if the available vaccines were to protect against infection more robustly, limiting community transmission in the process. It would be to see vaccines that are delivered nasally, which would be much more effective at preventing infection in children between 6 months and 4 years old—this figure was, however, based on a sample of 10 children.

The main concern is protecting these children and avoiding interrupting scholarly activities, says Pilar Vera, a researcher at the Instituto de Ciências Biomédicas II in São Paulo. "We can’t know for sure if a new variant will have a significant impact on children’s health, says Ian Lipkin. But in the US, children under 5-11 years had received one dose, and 30% being double vaccinated.11"

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Prevention of covid-19 and other acute respiratory infections with cod liver oil supplementation, a low dose vitamin D supplement: quadruple blinded, randomised placebo controlled trial

Sonja H Brunsvoll,1 Anders B Nygaard,2 Merete Ellingjord-Dale,3 Petter Holland,1 Mette Stausland Istre,1 Karl Trygve Kalleberg,2 Camilla I Saraas,1 Kirsten B Holven,4,5 Stine M Ulven,6 Anette Hjartåker,1 Trond Haider,5 Fritjof Lund-Johansen,7 John Arne Dahl,4 Haakon E Meyer,6,8 Arne Saraas1

ABSTRACT

OBJECTIVE

To determine if daily supplementation with cod liver oil, a low dose vitamin D supplement, in winter, prevents SARS-CoV-2 infection, serious covid-19, or other acute respiratory infections in adults in Norway.

DESIGN

Quadruple blinded, randomised placebo controlled trial.

SETTING

Norway, 10 November 2020 to 2 June 2021.

PARTICIPANTS

34 601 adults (aged 18-75 years), not taking daily vitamin D supplements.

INTERVENTION

5 mL/day of cod liver oil (10 µg of vitamin D, n=17 278) or placebo (n=17 323) for up to six months.

MAIN OUTCOME MEASURES

Four co-primary endpoints were predefined: the first was a positive SARS-CoV-2 test result determined by reverse transcriptase-quantitative polymerase chain reaction and the second was serious covid-19, defined as self-reported dyspnoea, admission to hospital, or death. Other acute respiratory infections were indicated by the third and fourth co-primary endpoints: a negative SARS-CoV-2 test result and self-reported symptoms. Side effects related to the supplementation were self-reported. The fallback method was used to handle multiple comparisons.

RESULTS

Supplementation with cod liver oil was not associated with a reduced risk of any of the co-primary endpoints. Participants took the supplement (cod liver oil or placebo) for a median of 164 days, and 227 (1.31%) other acute respiratory infections were reported in the cod liver oil group and 228 (1.32%) participants in the placebo group had a positive SARS-CoV-2 test result (relative risk 1.00, multiple comparison adjusted confidence interval 0.82 to 1.22). Serious covid-19 was identified in 121 (0.70%) participants in the cod liver oil group and in 101 (0.58%) participants in the placebo group (1.20, 0.87 to 1.65). 8546 (49.46%) and 8565 (49.44%) participants in the cod liver oil and placebo groups, respectively, had a negative SARS-CoV-2 test results ((1.00, 0.97 to 1.04). 3964 (22.94%) and 3834 (21.37%) participants in the cod liver oil and placebo groups, respectively, reported 1 acute respiratory infections (1.04, 0.97 to 1.11). Only low grade side effects were reported in the cod liver oil and placebo groups.

CONCLUSION

Supplementation with cod liver oil in the winter did not reduce the incidence of SARS-CoV-2 infection, serious covid-19, or other acute respiratory infections compared with placebo.

TRIAL REGISTRATION

ClinicalTrials.gov NCT04609423.

Introduction

Vitamin D has received much attention during the covid-19 pandemic for its potential role in preventing and treating covid-19. Preclinical studies have reported a role for vitamin D metabolites in the immune responses to respiratory viruses, although the mechanisms are not fully understood. Low levels of 25-hydroxyvitamin D3 (25(OH)D3) have been associated with an increased risk of acute respiratory infections. A recent meta-analysis, examining 46 randomised controlled trials, concluded that vitamin D supplementation (400-1000 UI/day or 10-25 µg/ day) decreased the risk of acute respiratory infections compared with placebo. Serious covid-19 has been associated with increased inflammation with uncontrolled activation of immune cells and excessive release of proinflammatory cytokines.

What is already known on this topic

Vitamin D has been suggested as having a role in the prevention of covid-19, but most studies have been observational. A recent meta-analysis of 46 randomised controlled trials showed that vitamin D supplementation decreased the risk of acute respiratory infections compared with placebo, but the effect was small.

What this study adds

Of 34 601 unselected adult participants, no difference in the incidence of SARS-CoV-2 infection, serious covid-19, or acute respiratory infections was found for those randomised to daily supplements of low dose vitamin D (cod liver oil) or placebo (corn oil) during the winter. The cod liver oil and placebo group had similar side effects, and only low grade side effects were reported.
COVID Spin

• It may be worth remembering how August 2022 feels, because a politician or a commentator may tell you in a year or two that the NHS and energy crises were figments of our imaginations, that the public or experts panicked and foisted disastrous policies on politicians. That’s exactly the narrative gathering momentum around covid-19, and it is a narrative that dishonestly disregards the unprecedented pressures on staff, services, and patients https://www.spectator.co.uk/article/the-lockdown-files-rishi-sunak-on-what-we-werent-told

• How the Virus SpreadsUK

• Care Homes

• Children and Schools how the UK failed children - UK an outlier
COVID UK SCHOOLS FAILURE?

- Pandemic policy on children and schools reflected UK based scientific narratives that did not align with global scientific consensus

- Government relied on evidence that downplayed the seriousness of covid-19 in children, underestimated the benefits of precautionary measures, and overestimated the harms of vaccination

- Return to school in September 2020 with minimal emphasis on masking and air quality, and inadequate support for isolation may have accelerated community transmission

- The public inquiry should explore why the UK was an international outlier in its approach to protecting children and making schools and communities safer

https://www.bmj.com/content/378/bmj-2022-071234
WORKFORCE
Doctors considering quitting health service over pay, says BMA

It said the inability to introduce the pay award due to the absence of an assembly and executive had further affected members, with 89% of respondents saying the inability to apply the increase "had decreased or significantly decreased their morale".

A spokesperson said staffing and the lack of doctors were among the key issues affecting the health service in Northern Ireland and the proposed pay increase was unlikely to help.

"When asked about their intentions as to the likelihood of them continuing to work in Northern Ireland, junior doctors said they were now more likely to leave because of the low pay award," said the BMA. "This was more than other branches of practice, with 72% of junior doctor respondents either 'more likely to leave' or 'much more likely to leave'. "However, over 55.71% of consultants, 53.26% of SAS (speciality) doctors and 52.57% of GPs also said the inability to make the award made them more likely or much more likely to leave the health service."

According to the BMA, more than 50% of respondents indicated they would be willing to take some form of industrial action.

In a BMA survey of more than 1,000 doctors, 85% of respondents said the proposed uplift of 4.5% was too low. The representative body said discontent was very high among junior doctors with 93% of them saying it was too low.
New malaria vaccine is world-changing, say scientists

By James Gallagher
Health and science correspondent

6 hours ago

A malaria vaccine with "world-changing" potential has been developed by scientists at the University of Oxford. The team expect it to be rolled out next year - trials showed up to 80% protection against the disease. Crucially, say the scientists, their vaccine is cheap and they already have a deal to manufacture more than 100 million doses a year.
Last year, the World Health Organization gave the historic go-ahead for the first vaccine - developed by pharmaceutical giant GSK - to be used in Africa.

However, the Oxford team claim their approach is more effective and can be manufactured on a far greater scale. Trial results from 409 children in Nanoro, Burkina Faso, have been published in the *Lancet Infectious Diseases*. It shows three initial doses followed by a booster a year later gives up to 80% protection. Oxford and GSK

Both target the first stage of the parasite's lifecycle by intercepting it before it gets to the liver and establishes a foothold in the body.

The vaccines are built using a combination of proteins from the malaria parasite and the hepatitis B virus, but Oxford's version has a higher proportion of malaria proteins.
Now a team in the University of Manchester, working with Joy, has developed a simple skin-swab test which they claim is 95% accurate under laboratory conditions when it comes to telling whether people have Parkinson's. The researchers analysed sebum - the oily substance on skin - which was collected by using a cotton swab on patients' backs. Using mass spectrometry, they compared 79 people with Parkinson's with a healthy control group of 71 people.
The research found more than 4,000 unique compounds in the samples, of which 500 were different between people with Parkinson's and the control group. "At the moment we have developed it in a research lab and we are now working with colleagues in hospital analytical labs to transfer our test to them so that it can work within an NHS environment," she said. "We are hoping within two years to be able to start to test people in the Manchester area."
The biological basis for how air pollution causes cancer has remained unclear. Unlike smoking or sun exposure, which directly cause DNA mutations linked to lung and skin cancer, air pollution does not cause cancer by triggering such genetic changes. Instead, those with non-smoking lung cancer tend to carry mutations that are also seen in healthy lung tissue – small errors that we accumulate in our DNA throughout life and which normally remain innocuous.

“Clearly these patients are getting cancer without having mutations, so there’s got to be something else going on,” said Swanton, who is also Cancer Research UK’s chief clinician. “Air pollution is associated with lung cancer but people have largely ignored it because the mechanisms behind it were unclear.”

The latest work unveils this mechanism through a series of meticulous experiments showing that cells carrying dormant mutations can turn cancerous when exposed to PM2.5 particles. The pollutant is the equivalent of the ignition spark on a gas hob.
Efficacy and safety of subcutaneous clonidine for refractory symptoms in palliative medicine: a retrospective study

Paul Howard 1,2, John Curtin1,2

ABSTRACT
Objectives To investigate the efficacy and safety of subcutaneous clonidine for refractory symptoms in the palliative setting.
Methods A retrospective chart review of the use of clonidine since it was introduced in our locality 2½ years ago. All clinical notes, medication administration records and infusion monitoring documentation were examined to ascertain therapeutic aim, efficacy and tolerability.
Results Subcutaneous clonidine was administered to 113 patients. Recipients were generally frail (median Karnofsky Score 20%) and in the last weeks of life (median survival 6 days). The most common indications were opioid poorly responsive pain (59%), agitation refractory to antipsychotics and/or benzodiazepines (18%) or both (35). Symptoms appeared to improve in the majority (85/113, 75%). Some (36, 32%) required no further medication changes once clonidine was commenced. Clonidine appeared well tolerated although blood pressure was not monitored in the majority, in line with our practice to discontinue such observations in those who are nursed in bed and receiving symptom-focused care.
Conclusions Subcutaneous administration of clonidine appears to be a promising alternative option for refractory symptoms in the last weeks of life. We suggest some possible next steps for further research.

INTRODUCTION
Opioid poorly responsive pain (OPRP) can be difficult to treat in the last weeks of life if the oral route is lost because many conventional treatments (eg, amitriptyline, pregabalin, duloxetine) have no parenteral equivalent. Further, both pain and analgesics can exacerbate agitation.

We report our experience of using subcutaneous clonidine to alleviate such symptoms. Our first patient experienced extreme distress on moving or micturating due to multiple fungating inguinal and vulval tumours. Once the oral route was lost, the pain was refractory to subcutaneous infusions of oxycodone, ketamine, methadone and lidocaine, with subcutaneous ketamine twice daily. Sedation with dexmedetomidine was offered but she wished to remain alert. Aware that dexmedetomidine, a native α2 adrenergic agonist, can be difficult to treat in the last weeks of life if the oral route is lost because many conventional treatments (eg, amitriptyline, pregabalin, duloxetine) have no parenteral equivalent. Further, neither pain nor sedation control was possible, and agitation persisted.

Three further patients had similar clinical presentations: in each case, the oral route was lost due to fungating wounds, malignant bowel obstruction, or an inguinal hernia. In each case, clonidine was reported to alleviate refractory pain (59%), agitation (35%), and sedation (32%). The antipsychotic risperidone was also required in two cases. All patients who received clonidine had a good quality of death.

We suggest some possible next steps for further research:

WHAT THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE AND/OR POLICY
Subcutaneous clonidine may have a role for symptoms refractory to usual measures.
Further research is proposed to clarify its place.

WHAT IS ALREADY KNOWN ON THIS TOPIC
In the palliative setting, subcutaneous clonidine might be effective for opioid poorly responsive pain and agitation refractory to benzodiazepines and/or antipsychotics.

WHAT THIS STUDY ADDS
In the palliative setting, subcutaneous clonidine might be effective for opioid poorly responsive pain and agitation refractory to benzodiazepines and/or antipsychotics.

Further research is proposed to clarify its place.
Efficacy and safety of subcutaneous clonidine for refractory symptoms in palliative medicine: a retrospective study

Paul Howard 1,2, John Curtin 1,2

- Retrospective chart review of the use of subcutaneous clonidine in a single palliative care centre
- Patients initiated on clonidine in inpatient hospice, hospital and community palliative care service were recorded on an audit form.
- After receiving treatment with clonidine, clinical notes and medication administration records were retrospectively reviewed
What they did

One of three categories

‘Fully effective’ if neither new medications nor titration of prior medications were required

‘Partially effective’ if new medications and/or titration of prior medications were required but the clonidine was effective enough to be continued,

‘Ineffective’ if clonidine was discontinued due to lack of effect and/or intolerance.

If no conclusion was reached, for example, because of rapid deterioration or because clonidine was given together with another medication, response was recorded as ‘uncertain’
What they found

113 patients received subcutaneous clonidine:

- Underlying malignancy (79/113, 70%),
- Frail (median Karnofsky Performance Score 20%)
- In the last weeks of life (100/113, 88%, ≤1 month from starting clonidine to dying; median 6 days).

The most common indications were:

- Opioid Poorly Responsive Pain (OPRP) (59/113, 52%)
- Agitation refractory to benzodiazepines and/or antipsychotics (18/113, 16%)
- Both pain and agitation (27/113, 24%)
Practice changed over time

Initially, commenced subcutaneous infusions which were titrated over time.

Subsequently, found a response (or lack of) was generally evident within an hour of 75–150 μg subcutaneous boluses.

Went on to assess response and dose requirements from initial subcutaneous boluses, and subsequently added clonididine to subcutaneous infusions only where it appeared helpful.
Clonidine was reported to be helpful in 85/113 (75%) patients by either the patients themselves, the family or the clinicians caring for them.

Some (36/113, 32%) required no further medication changes.

The remainder (49/113, 43%) required further medications but clonidine was reported to reduce symptom intensity to a helpful extent.
Conclusion

Open-label retrospective methodology precludes the drawing of firm conclusions about efficacy, administration of clonidine was frequently followed by a reduction of symptoms refractory to other treatments already tried.

It was well tolerated and appeared visually compatible with a range of other medications.
Tuesday 22 November – Thursday 24 November

Hospice UK National Conference

Get together Wednesday, 8-9am
‘Growing our own Nurses’

Dr Gill Horne, Programme Director – Care Services
gill.horne@rowcrofthospice.org.uk
Claire Booth, Head of People & OD:
claire.booth@rowcrofthospice.org.uk
Background

- National RN vacancies circa 50,000
- Aging workforce
- Applicants to our RN posts declined over the past 2-3 years
- Myths – hospice for experienced nurses only!
- Competing with local NHS – RN apprentices paid salary
- Plans to build 60-bedded nursing home - even more nurses needed!
Proposal

- To sponsor 4 existing student nurses (year 2 onwards)
- Host T-level college students (16-19yr olds)
- Advertise internally 2 nursing associates
- Investigate further RN apprentices *salary being key consideration
- Explore diploma route for health/social care college students & provide placements
Rowcroft’s offer

- A bursary of £4,250 per year for up to 2 years.

- Engagement with Rowcroft with access to our award-winning education programme, connections with clinical leads, and sharing of information.

- A permanent role with Rowcroft across one of our nursing teams in the new Nursing Home, Inpatient Unit, or Hospice at Home when qualified.

- A supportive and enriching environment to begin and nurture your career.
Recruitment Process

- Collaboration and support from Plymouth University
- Joint comms/marketing via social media
- Shortlisting
- Interviews - 2 components
- Module marks
- Personal tutor reference
Agreement - Principles

• Protect our investment
• Provide flexibility for future job offer
• Create a mutual obligation on both sides
• Agreement:
  • Intention to offer
  • Obligation to accept
  • Repayment of bursary on sliding scale
Impact

- 4 nurse students sponsored – each will do at least one placement with us
- 2 nursing associate apprentices appointed
- Media coverage papers/radio
- 2 student nurses requested bank work
- Private donor paid first year
- Board agreed to repeat next year
The cost of dying crisis.
Poverty at the end of life in the UK

Dr Sam Royston
Research and Policy Director, Marie Curie
Sam.Royston@mariecurie.org.uk
Key questions we have sought to address

Poverty and life expectancy are linked; but how many people actually die in poverty?

Mortality risk increases with age – how does this relate to poverty rates?

Do additional costs of terminal illness contribute to the risk of poverty? How can this be measured?

Are sub-groups within the population particularly at risk of dying in poverty?
Headline statistics: what is ‘poverty’?

Typically, a person is said in relative income poverty, if they live in a household with income below 60% of median household income.

Using the Social Metrics Commission definition

The SMC is an independent Commission and a non-partisan organisation dedicated to helping policy makers and the public understand and act to tackle poverty.

Two key features of the SMC approach:
1. All material resources are incorporated, not just incomes, including available liquid assets (savings, stocks and shares).

2. The measure takes account of inescapable costs, including childcare and the extra costs of disability, by deducting them from income.
Four categories of findings

- Headline statistics
- Geographical variation
- Understanding of sub-groups
- Pathways into poverty at end of life
Headline Statistics
We estimate that in 2019, more than 90,000 adults died in poverty in the UK.
Headline statistics: adult population

Among **working age people**, the risk being in poverty is more than a third higher for those who are in the last 12 months of life than for others in the same age group.

The overall risk for **pensioners** is lower, but being in the last year of life still increases their likelihood of being in poverty by 23%.
Geographical variation
## Geographical variation

<table>
<thead>
<tr>
<th>Region</th>
<th>In the last 12 months of life</th>
<th>Not in the last 12 months of life</th>
</tr>
</thead>
<tbody>
<tr>
<td>London</td>
<td>32%</td>
<td>25%</td>
</tr>
<tr>
<td>West Midlands</td>
<td>32%</td>
<td>24%</td>
</tr>
<tr>
<td>Yorkshire and The Humber</td>
<td>31%</td>
<td>23%</td>
</tr>
<tr>
<td>Scotland</td>
<td>30%</td>
<td>22%</td>
</tr>
<tr>
<td>East Midlands</td>
<td>29%</td>
<td>21%</td>
</tr>
<tr>
<td>South West</td>
<td>28%</td>
<td>19%</td>
</tr>
<tr>
<td>London</td>
<td>32%</td>
<td>25%</td>
</tr>
<tr>
<td>West Midlands</td>
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<td>24%</td>
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<td>29%</td>
<td>21%</td>
</tr>
<tr>
<td>South West</td>
<td>28%</td>
<td>19%</td>
</tr>
</tbody>
</table>

Estimated % in poverty

- **In the last 12 months of life**
- **Not in the last 12 months of life**
Geographical variation: Local Authorities

For both working age individuals and pensioners, the three local authorities with the highest rates of poverty among those who died are in London. Large, urban areas in the North and the Midlands, including Manchester and Birmingham, also feature in the top 20 highest rates of poverty at the end of life.
## Geographical variation: Local Authorities

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Region</th>
<th>Number died in poverty</th>
<th>% in poverty among those who died</th>
<th>% in poverty among those who did not die</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tower Hamlets</td>
<td>London</td>
<td>102</td>
<td>44.0%</td>
<td>33.7%</td>
</tr>
<tr>
<td>Newham</td>
<td>London</td>
<td>163</td>
<td>43.5%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Hackney</td>
<td>London</td>
<td>128</td>
<td>42.0%</td>
<td>32.1%</td>
</tr>
<tr>
<td>Manchester</td>
<td>North West</td>
<td>314</td>
<td>41.5%</td>
<td>31.9%</td>
</tr>
<tr>
<td>Birmingham</td>
<td>West Midlands</td>
<td>645</td>
<td>41.5%</td>
<td>31.6%</td>
</tr>
<tr>
<td>Leicester</td>
<td>East Midlands</td>
<td>168</td>
<td>39.8%</td>
<td>30.4%</td>
</tr>
<tr>
<td>Slough</td>
<td>South East</td>
<td>70</td>
<td>39.3%</td>
<td>29.7%</td>
</tr>
<tr>
<td>Southwark</td>
<td>London</td>
<td>142</td>
<td>39.2%</td>
<td>29.9%</td>
</tr>
<tr>
<td>Newcastle upon Tyne</td>
<td>North East</td>
<td>156</td>
<td>38.7%</td>
<td>29.2%</td>
</tr>
<tr>
<td>Brent</td>
<td>London</td>
<td>124</td>
<td>38.4%</td>
<td>29.2%</td>
</tr>
</tbody>
</table>
Understanding of Sub-Groups
Subgroups: sex

Women are slightly more likely to be in poverty at the end of life than men. For pensioners, the additional risk of poverty in the last 12 months of life is higher for women than for men.
Inequalities in poverty rates by ethnicity persist at the end of life. **More than 40%** of working-age people in minority ethnic groups are estimated to be in poverty in the last 12 months of life.
Subgroups: diagnosis

For people in the last 12 months of life at working age, the risk of being in poverty is 10 percentage points higher for those with conditions other than cancer, at 31%, compared with 21% of those with cancer.
Pathways into poverty
Typical poverty sequence in the last 5 years of life

<table>
<thead>
<tr>
<th>POVERTY TRAJECTORY</th>
<th>YEARS PRECEDING DEATH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5 years</td>
</tr>
<tr>
<td>Never in poverty</td>
<td></td>
</tr>
<tr>
<td>Mostly in poverty</td>
<td></td>
</tr>
<tr>
<td>Moving into poverty at the end of life</td>
<td></td>
</tr>
<tr>
<td>Moving in and out of poverty at the end of life</td>
<td></td>
</tr>
</tbody>
</table>
Risk of being in a particular poverty trajectory group by family type

Among family types, families with children are most vulnerable to being in poverty – two-thirds are in poverty at least once during the last five years of life.

They are also the group most likely to be in ‘moving into poverty’ group.

Moving in and out of poverty
Moving into poverty
Risk of being in a particular poverty trajectory group by tenure

Those in private or social rented housing are also more at risk of being or moving into poverty, with those in social housing at highest risk of being in the ‘moving into poverty’ trajectory group.

<table>
<thead>
<tr>
<th>Tenure</th>
<th>Moving in and out of poverty</th>
<th>Moving into poverty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owned outright</td>
<td>8%</td>
<td>79%</td>
</tr>
<tr>
<td>Owned with mortgage</td>
<td>6%</td>
<td>64%</td>
</tr>
<tr>
<td>Private rented</td>
<td>28%</td>
<td>50%</td>
</tr>
<tr>
<td>Social rented</td>
<td>22%</td>
<td>46%</td>
</tr>
</tbody>
</table>

Owned outright: 8% (79%)  Owned with mortgage: 6% (64%)  Private rented: 28% (50%)  Social rented: 22% (46%)
Predicted probability of moving into poverty at the end of life, by years until death

The risk of moving into poverty increases as the number of years until death decreases, with a particularly steep increase in the last three years of life.
Key messages
Key messages

• Poverty at the end of life is an extensive and wide-reaching issue that affects people at all ages and in all areas of the UK. People are more likely to face poverty at the end of life than at other life stages.

• People of working age are more likely to be in poverty than pensioners overall, but the findings show that this difference becomes even more pronounced for people at the end of life.

• The high risk of poverty at the end of life amongst those who die in working age, is likely to be both the result of people in poverty dying younger on average than those of higher incomes, AND the result of people being pushed into poverty as a direct result of becoming terminally ill.

• People in certain subgroups of the population who are approaching the end of life can face a high risk of poverty, at a time when they feel vulnerable and least able to deal with financial or material hardship.
How is Marie Curie responding?
Policy recommendations

• The UK Government must implement changes to the Special Rules for Terminal Illness affecting PIP, DLA and Attendance Allowance quickly and keep the impact of these changes under review.

• The UK Department for Work & Pensions and Northern Ireland Department for Communities must ensure that those with a terminal illness are eligible for Winter Fuel Payments even if they are under 65 years old. The Scottish Government must also ensure this is the case for Winter Heating Assistance from November 2022.

• Local authorities in England must use their leadership role on Health & Wellbeing Boards and Integrated Care Systems to ensure these bodies audit their compliance with NICE’s NG6 recommendations.

• Terminally ill people of working age must be entitled to claim the State Pension.
This is already a challenge Marie Curie deals with day-to-day – we are reviewing how we can address this in our own practice

- Marie Curie is already dealing with the consequences of poverty at the end of life. 65% of Marie Curie community nurses believed that they had supported patients in the last year who were struggling to make ends meet financially.

- Amongst this group, community nurses were seeing people struggling with the costs of fuel, food, housing and social activities.

- In 2021 8% of calls to the Marie Curie helpline (1281) were about financial issues, without any advertising that we provide support in this space.

“One family I went to had the bare minimum. They were in a farm cottage with little or no heating as the lady could not cut the logs for the fire. They had no family and relied on one neighbour to give them food for 4 months as they had no money to pay for the food or repairs in their small cottage. The house was so cold and damp. They had the bare minimum in the fridge. When I made the lady a cup of tea, she shared with me that, due to her husband’s illness, they had used all their savings.”

— Marie Curie Nurse
What do we want to achieve through improving money advice for people living with terminal illness?

More people who are terminally ill, and their carers and loved ones, and people who have faced bereavement receive the benefits they are entitled to receive.

More people are able to get the support they need with other money advice issues – eg housing and debt.

More people are able to access up to date information on money advice issues.

Social policy is improved by ensuring problems are identified early, and the voices of people affected by money problems at the end of life are heard.

The consistency of money advice, information and support to people affected by dying death and bereavement is improved across the UK – including across devolved nations and in localities.

Less people face poverty at the end of life.
On 20th September 7:30 pm the APM bookclub and Rachel Clarke are interviewing Raynor Winn

Please Register

https://apmeducationhub.org/events/book-club/
By the end of 2022 the estimated costs in the UK will rise to 35.5p/kWh for electricity. (The average cost was 18.9p/kWh in 2021)

- Yurday E. Average Cost of Electricity per kWh in the UK 2022. - 12th Sept

![Historical Variable Energy Prices in the UK](chart.png)

Source: www.gov.uk. Note: the Department for Business, Energy & Industrial Strategy changed their calculation of bills from being based on fixed consumption levels of 3,800 kWh per year for standard electricity to 3,600 kWh per year. The data from 2010 to 2016 reflects 3,800 kWh per year consumption and from 2017 onwards reflects 3,600 kWh per year. The figure for 2022 is an estimate based on the average price cap unit rate for a customer with typical usage, paying by direct debit, through September 2022 and estimates of an 82% rise in October.
Worried about a few thing
- Split into 2 broad groups....

Energy costs for ‘us’ the palliative care community

1) Rising fuel costs going to see community patients
2) Hospice energy and heating costs
3) Energy poverty for our workforce

But also our patients...
Rapid Response:
Are people choosing between their oxygen concentrators and heating?

Dear Editor,

Are people choosing between their oxygen concentrators and heating?

What are the energy costs of the medical equipment we provide? This question is becoming more and more pertinent as we place this forgotten burden on our patients.

UK inflation is at the highest rate in 40 years and the cost of living crisis biting, there is a real crisis in terms of energy costs. This winter is going to be very hard for many.

As a palliative care physician it is worth noting at the end stages of life a lot of medical equipment is often used in people’s homes provided by ourselves in healthcare. The most basic things are: a hospital bed (one available type, up to 0.27 kWh) which allows you to position the patient; an air mattress (one available type, 3.0 kWh) which is constantly inflated to avoid pressure sores; and an oxygen concentrator (approx. 2.88 kWh) to vitally maintain comfortable breathing. This roughly adds up to 6.15 kWh. This additional cost is neglecting to factor in many other vital medical appliances such as nebulisers, hoists, cough assists, NIV, riser-recliner chairs and many more energy consuming medical appliances for a lot longer in many other groups of chronic patients.

By the end of 2022 the estimated costs in the UK will rise to 51p/kWh for electricity. (The average cost was 18.9p/kWh in 2021) [1] For many patients and particularly our end of life patients this is simply an impossible cost to bear.

This is neglecting to ever consider the obvious cost of the additional cost of energy they need to keep their oxygen concentrators and medical equipment. It is vital we are aware of this hidden cost.
<table>
<thead>
<tr>
<th>Product</th>
<th>Power Usage (W/hrs)</th>
<th>Power Consumption (kW/24hr)</th>
<th>Cost Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPAP</td>
<td>60-120w – 8hrs (90wx8/1000)</td>
<td>0.72 kw/24hr</td>
<td><a href="https://www.cpaptalk.com/viewtopic/t45078/CPAP-power-usage-and-cost-to-operate.html/view=print">https://www.cpaptalk.com/viewtopic/t45078/CPAP-power-usage-and-cost-to-operate.html/view=print</a></td>
</tr>
<tr>
<td>INNOV8 iQ Bed</td>
<td>Approx. 0.27 kW/24hr</td>
<td></td>
<td><a href="https://drivedevilbiss.co.uk/our-products/beds-transfer-trolleys/hospital-beds/innov8-iq-bed">https://drivedevilbiss.co.uk/our-products/beds-transfer-trolleys/hospital-beds/innov8-iq-bed</a></td>
</tr>
<tr>
<td>Air-o-flow mattress</td>
<td>Approx. 2.4 - 3.0 kW/24hr</td>
<td></td>
<td><a href="https://www.shelden-healthcare.co.uk/air-o-flow-mattress">https://www.shelden-healthcare.co.uk/air-o-flow-mattress</a></td>
</tr>
<tr>
<td>Equipment</td>
<td>Power Consumption</td>
<td>Energy Usage</td>
<td>Source</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------</td>
<td>-------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Riser Recliner Chair</td>
<td>14W on standby and 58W</td>
<td>0.8kw/24hr</td>
<td><a href="https://mobilityfurniturecompany.co.uk/blog/product-guides/do-electric-recliner-chairs-use-a-lot-of-electricity/">https://mobilityfurniturecompany.co.uk/blog/product-guides/do-electric-recliner-chairs-use-a-lot-of-electricity/</a></td>
</tr>
<tr>
<td>Cough assist</td>
<td>0.01 kw/24hr</td>
<td><a href="https://www.philips.co.uk/healthcare/product/HC1098159/cough-assist-e70-ventilation">https://www.philips.co.uk/healthcare/product/HC1098159/cough-assist-e70-ventilation</a></td>
<td></td>
</tr>
</tbody>
</table>
Impact of the rising cost of electricity on home mechanical ventilation patients

8 June 2022

BTS is aware that rising costs in electricity from the 1st April 2022 will impact particularly on those respiratory patients dependent on home mechanical ventilation, and in some cases will mean that they are unable to meet the costs of their electricity bills. These increases in costs have a disproportionate impact on patients who are dependent on electrical equipment to stay alive. Currently, there is no reimbursement or financial payments for electricity for ventilator dependent patients.

BTS has drawn these concerns to the attention of the National Clinical Director for Respiratory - the aim being that a route for financial reimbursement or support to
Suggested draft letter to CEO’s

Dear CEO of...

I am writing to ask for your support in escalating a concern affecting many of the individuals under the care of this organisation.

I am a lead clinician within the regional ventilation service for... We support a population of individuals who are dependent on the use of a ventilator to maintain their health and quality of life. A proportion of these individuals are dependent on the use of a ventilator for 16 hours or more a day, without this the risk of death or serious harm is a high possibility. Some of our patients use a ventilator for life support and cannot breathe without it for any duration. For all our patients the inability to use a ventilator is likely to increase mortality and co-morbidity as well as reduce quality of life.

The escalating cost of electricity directly impacts on our patients’ ability to use their ventilators as well as other medical technologies such as feeding pumps, air mattresses etc. We are hearing regular accounts from our ventilator users that electricity costs have doubled or higher. Many are now unable to afford to run their equipment or face crippling debt.

As a group of specialists working in this field, we have escalated our concerns to the NHSE CEO asking for a route for financial reimbursement or support to offset the cost of using medical equipment. We are uncertain that our escalation alone is enough to bring this change.

We are asking for the CEOs of the organisations that deliver complex home ventilation services to also raise this as a serious concern. Please can we ask you to raise a concern to the NHSE executive team and the NHSE CEO, asking for a route for financial assistance to offset the rising electricity costs for our vulnerable patient’s dependant on medical technology?

I have attached a draft that you may wish to amend to send

Thank you

Signed.... (add service lead names)
<table>
<thead>
<tr>
<th>Electric wheelchairs</th>
<th>Very variable depending upon motors approx. 3-6kw/24hr</th>
<th><a href="https://picaxeforum.co.uk/threads/how-much-current-does-a-typical-wheelchair-motor-draw.11535/">https://picaxeforum.co.uk/threads/how-much-current-does-a-typical-wheelchair-motor-draw.11535/</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Electric mobility scooter</td>
<td>3-6kw/24hr</td>
<td><a href="https://mobilitypluswheelchairs.co.uk/products/triumph-3-wheel-mobility-scooter?currency=GBP&amp;utm_medium=cpc&amp;utm_source=google&amp;utm_campaign=Google%20Shopping">https://mobilitypluswheelchairs.co.uk/products/triumph-3-wheel-mobility-scooter?currency=GBP&amp;utm_medium=cpc&amp;utm_source=google&amp;utm_campaign=Google%20Shopping</a></td>
</tr>
</tbody>
</table>

Home dialysis machines – Peritoneal or fistula
EXCLUSIVE: Families who need electricity to stay ALIVE put at risk by energy price rises

By Natasha Wyn
12:44, 1 Apr 2022

Soaring energy alive.

Thousands of people, including ventilated patients living with serious medical conditions, are at risk of losing life-saving equipment as the cost of living crisis continues to rise,

Calls for new energy grant to help people with disability or serious medical condition pay fuel bills

Thousands of people have signed an online petition asking the UK Government for extra support for vulnerable people.

"It's impossible to pay": Disabled caller faces £6k energy bill to power medical equipment

2 April 2022, 17:51 | Updated: 2 April 2022, 17:52

It's impossible to pay. Disabled caller expects £6k annual energy bill to power medical equipment. Picture: LBC/Matty
I am critically dependent on medical equipment. What services are available?

Northern Ireland Electricity Networks (NIE Networks) offer a medical customer care information service to customers who are dependent on life supporting equipment.

If you use electrical equipment that is vital to your health, you may wish to register with NIE Networks to receive up-to-date information during a power cut or interruption to your supply.

You can register for this service on the [NIE Networks website](#) or by calling NIE Network’s customer helpline on 03457 643 643.

What is our Priority Services Register?

The ScottishPower PSR service will help many customers, including:

- Those in debt through the provision of help and advice. We can also ensure you are on our lowest cost provision of external sources of help
- The elderly
- The deaf
- Visually impaired
- The ill or disabled

**Electrical medical equipment and power cuts**

It’s important to know what to do if a power cut happens. And if you have electrical medical equipment, it’s even more important you’re prepared.
From: LG UK Homecare Admin <homecare.admin@boc.com>
Sent: 05 September 2022 12:22
To: LG UK BOC Medical <bocmedical-uk@boc.com>
Subject: RE: BOConline Enquiry Confirmation

Good Afternoon

Many thanks for your email enquiry.

Yes, we refund the cost of electricity to run the concentrator. A payment is made on a quarterly basis to a nominated bank account.

Pis contact 0800 136603 and give the patient's name and address to provide bank details.

With many thanks

BOC

Thank you for this,

Is this routinely offered to all people with oxygen concentrators? Where is this service advertised?

Our social work team was unaware this was available

with many kind regards,
Good afternoon

This refund is offered to all people with concentrators who are responsible for their energy supplier, i.e. in their own property. It would not be offered to patients in care homes, respite care or temporary holiday property.

When the concentrators are installed, patients are provided with a welcome pack and a form to return their bank details on.

Please see the following link for further information;

Electricity Rebates | BOC Home Oxygen Service

With many thanks
BOC
Our Home Oxygen Service
Find out more about the service we provide.

If you live in a rental property and are on oxygen it is important that you inform your landlord.

Stay up to date with NHS choices
Electricity Rebates

When an oxygen concentrator has been installed it will be serviced initially at 3 months and then every 6 months by a Patient Service Representative.

As part of the service, a meter reading from the concentrator will be taken. This meter reading records the number of hours your concentrator has been used.

We can then calculate the electricity that has been used to run your concentrator.

If you have any questions regarding your rebate please call our Patient Service Centre 0800 136 603.
Good Afternoon

The freedom of Information request can be processed, however I did offer incorrect information on a previous email that has now been verified.

Please be advised that we can offer refunds to NI Care homes for electricity used. However, for each permanent resident, we will need the correct payee details with BACS details to provide these refunds.

If you still wish to proceed with the freedom of information request then please let us know.

With many thanks and best wishes

BOC

BOC, The Forge, 43 Church Street West, Woking, Surrey, GU21 6HT
German landmarks switch off lights to conserve energy

Germany has been hit hard by Russian gas cuts. It's currently at phase two out of three in its emergency gas plan, with the final phase involving rationing. Local governments have already started to try and save as much energy as possible.

The Eiffel Tower’s extravagant lights are coming into question during Europe’s energy crisis—and will likely be shut off early

BY STEVE MOLLNAN
September 11, 2022, 10:23 PM GMT+1
Turning off computers and monitors rather than on standby

Water heaters for coffee and tea on constantly

Electric beds / equipment standby not in use

Charging hoists instead of plugging in

Wear warm scrubs!
What plans does your organisation have to mitigate issues that are arising and will get worse over the coming months because of the cost of living crisis and its impact on patients, families and staff?
THANK YOU
Care after Death
(Fourth Edition)
Guidance for staff responsible for care after death

Care after death 4th Edition
AMBITIONS FOR PALLIATIVE AND END OF LIFE CARE
Mapping Examples of Use in Practice

The foundations for the ambitions

- Personalised care planning
- Shared records
- Education and training
- 24/7 access
- Evidence and information
- Involving, supporting and caring for those important to the dying person
- Co-design
- Leadership

Ambitions Framework Mapping.pdf
This new Guidelines summary covers the assessment, treatment, and management of depression in people aged 18 years and over.
Evidence Update Max Watson

Research Review Kate Flemming

Growing our own Nurses Gill Horne and Claire Booth, Rowcroft Hospice

The Cost of Dying Crisis Sam Royston, Marie Curie

Energy Cost Implications Matt Dore, APM

What are we doing? Ideas to share?

Breakout room discussions

Chat Box
- Your Questions
- Resources
- Information/innovations
- Email clinical@hospiceuk.org

Please share resources, powerpoint, links etc. with those who would benefit
Lochnagar

The alder boughs hang heavy,
Red weighs the rowan-trees
That line the well-loved path which climbs
To Lochnagar from Dee

And knows at last the open hill,
Those ancient wind-honed heights
Where deer stand shy and sky-lined,
Then vanish from living sight.

Where grief is ice, and history
Is distant rolling skies,
Where weather chases weather
Across the lands she strived
To serve, and served supremely well,
Till the call came from afar;
Back to the country kept in her heart,
The Dee, and Lochnagar.

Scotland’s Makar Kathleen Jamie