Trinity Hospice
Compassion and care

QUALITY ACCOUNT 2022 - 23

What is a Quality Account?

A Quality Account is an annual report about the quality of services provided by a healthcare organisation. Quality Accounts aim to increase public accountability and drive improvements. Our Quality Accounts look back on how well we have done in the past year in achieving our goals and look forward to the year ahead, defining what our priorities for quality improvements will be and how we expect to achieve and monitor them. The report covers Trinity Hospice and Brian House Children's Hospice.

Introduction – Key Messages: Trinity Hospice and Palliative Care Services

- Trinity Hospice and Palliative Care Services is a Fylde Coast registered charity providing compassionate care on the journey towards the end of life for the people of the Fylde Coast.
- We work alongside others to care for people in their own homes, in care homes, in nursing homes and hospital settings. We always ensure people feel they are cared for as an individual, rather than as 'just another patient' and to focus on what matters most to them.
- We work hard to ensure everyone with a life limiting and palliative condition on the Fylde Coast is cared for and supported to live as well as possible.
- We work collaboratively and in partnership with other local organisations and care providers to strategically plan and support the delivery of best possible palliative and end of life care for our local population.
- We encourage everyone in our local community to talk honestly and openly about death and dying, and plan to ensure those who love and care for us understand our wishes and preferences and what matters most to us in the time we have remaining and after we die.
- Through our Inpatient Units, Community, Hospital, Living Well, Hospice at Home, Lymphoedema and Bereavement and Psychological services, we touch the lives of around 8,000 people every year, supporting them physically, emotionally, and spiritually.
- Family, carers, and close friends have needs too; we are here for them with support and advice at every stage of illness and through bereavement.
- Working or volunteering for the hospice is rewarding and fulfilling and we share our knowledge to help others deliver excellent end of life care too.
- A large part of our role is in supporting Palliative and End of Life Care training and education, We continuously host training placements for nursing and medical students, junior doctors in training, and a host of other health and social care professionals, such as paramedic, social workers and care home staff, who come to spend time with us on learning placements.
- We are a key stakeholder and a central contributor to the strategic planning of Palliative and End of Life Care services for the Fylde Coast.
- It costs over £11 million every year to run Trinity's services including Brian House Children's Hospice - over £7 million of that must come from voluntary donations and all our care is provided free of charge.
- Trinity relies on the trust and goodwill of the local community and would never undermine that by using inappropriate fundraising tactics. Our approach is to inspire people to give, rather than make them feel in any way compelled.
- We are about *living well* to the very end of our lives.

Key Messages: Brian House Children's Hospice

Brian House as the only children's hospice on the Fylde Coast supports babies, children and young people from birth up until they are nineteen who live in Blackpool, Fylde and Wyre.

Because some lives are too short – every child or young person with a terminal, life-limiting or life-threatening condition, and their families deserve exceptional all-round care, to enjoy the time they have got and, with help, live life to the full – making the most of every day.

- Children and their families are at the very centre of what we do. Our staff are passionate and dedicated with a focus on making the most of every moment the children spend in our care.
- Brian House is a place where very special memories are made.
- Brian House staff in-reach into hospitals and other care settings to support families during very challenging times.
- Brian House staff work collaboratively with the Macmillan Team supporting children with cancer diagnosis throughout their treatment helping them negotiate some of the many hurdles. Brian House staff are also there to support the family and the siblings at these very challenging times.
- Brian House staff work collaboratively with the neonatal team, hosting clinics in their child friendly sensory room ensuring families are supported from the birth of their baby throughout the child's life.
- Brian House has a cinema room, sensory room, soft play area, adapted playground and these are available for families to book free of charge allowing them to spend time as a family, in a safe environment where all the family's needs can be catered for.
- Brian House works as part of the Lancashire and South Cumbria network ensuring continued learning and development to support the increasing medical complexities and developing technology needs of the children we care for.
- We provide support to a parent, siblings and loved ones through tough times.
- Much-needed respite is provided for parents, so they can get a good night's rest, have a short break or spend time with other family members.
- We care for children at the very end of their lives and provide an arm around the whole family at this time whilst ensuring the holistic needs of the child and family are met.
- Brian House offers all these services free of charge to families.
- Brian House requires £1.3 million to keep its doors open, most of which isn't funded.

Part One

Statement of Quality From Our Chief Executive:

Last year, I wrote about the many challenges facing the health and social care system within the UK and the abject threat to ongoing quality for patients, families and those close to them. This threat now risks moving to an existential crisis for care in the UK. And we, as a hospice, cannot 'be an island entire of itself'. Rather, we continue to have a central role to play both in providing and advocating for high quality and importantly, consistent palliative and end of life care.

As an independent charitable hospice, we are perhaps less constrained and freer to speak up to defend the exceptional hard work we have witnessed in our partners as they strive to maintain quality under unrelenting pressure and limiting resources. We also have a duty to speak 'truth to power' in raising a warning that the quality and consistency of care for patients, including those towards end of life, is increasingly at risk in a system firefighting for its survival. The lack of forward planning from successive governments that has led to the dearth of doctors, nurses and other allied health and social care professionals now even affects Trinity and Brian House – our historically attractive workplace where staff *'have time to care'* holds little water if there are too few candidates available in the first place. 2022 saw us on occasion battling to keep services such as Hospice at Home and Brian House always fully staffed due to this issue. And, whilst we maintained services and continue to recruit, our ability to always provide the full service and to further grow services becomes more challenging by the year. This is compounded by reducing central government funding for our children's hospice and no increase in funding for 2023-24 for Trinity at a time when we have ongoing cost of living pressures and need to remain competitive against NHS pay rises.

Yet despite these pressures, our staff and volunteers here at Trinity have worked tirelessly to maintain exception levels of care. Additionally, where patients come under the Trinity palliative care pathway working with our partners in an increasingly integrated fashion, their chances of getting 'consistently' good and timely levels of support increase enormously. Their likelihood of being lost in the system or not found in the first place dramatically reduced.

Looking back over the past 12 months, we have for example:

- Undertaken further work on workforce planning.
- Introduced a new competency framework for children's hospice staff.
- Introduced improvements to bereavements services, including complementary therapy.
- Improved referral rates for patients with end stage liver disease.
- Developed virtual clinics, consultations and nurse-led clinics.
- Launched a Virtual Ward.
- Successfully launched our Dementia Lounge.
- Developed an improved Spiritual Care Model of Assessment.
- Strengthened our integrated and collaborative working with our key Fylde Coast partner services.
- Increased uptake of staff Flu and Covid19 vaccinations.
- Successfully awarded with match-funding for a two-year ACP Frailty Nurse post.
- Launched our Living Well Service.
- Expanded our specialist Lymphoedema service/team.
- Seen our volunteers return to Trinity.

- Expansion of our retail shops.
- Maintained our IiP Gold accreditation.

Looking forward to 2023-24, we plan to:

- Develop a strategic plan to formulate a Single Point of Access pilot across two neighbourhood care teams.
- See our conference facilities being utilised externally again.
- Expand on our Quality Improvement projects.
- Return to seven-day services in Brian House.
- Develop our facilities through our Hospice 2030 project.
- Optimise the use of EMIS electronic patient clinical records.
- Continue with the Upskillling project.
- Embed Virtual Ward into Trinity Hospice pathways.
- Develop and agree a Trinity Hospice Education Strategy.
- Review our clinical workforce models to ensure that we are prepared to care.
- Develop a governance accountability framework in line with the new CQC standards framework.

Our work, both over the past year and looking forward to 2023-24, strives to continue this journey to ensure everyone on the Fylde Coast, whether supported directly or not by Trinity, has good and consistent palliative and end of life care. I hope you will join us in this mission – one that is, given the current backdrop, more important than ever…

Thank you for your ongoing support.

Best wishes

David Houston - Chief Executive

Statement of Assurance from the Board of Trustees

The Board of Trustees has ultimate accountability for the quality of care provided within Trinity Hospice, which includes Brian House Children's Hospice.

In addition to Board meetings, which take place every two months, a large number of sub-committees focus on each and every area of our hospice and specifically on our clinical governance, both in Trinity Hospice and in Brian House, and within the community.

In addition, trustees are, without invitation, attending a number of staff meetings held during the year so that, as trustees, we can have input and can listen to discussions and decisions made and our attendance means that we are known by a growing number of staff clinical, medical and administrative. The trustees have also attended Schwartz Rounds.

We have recommenced trustee visits this year, four in total, which allows members of the Board to see first-hand the operation of our clinical and administrative teams.

We regularly receive reports focusing on quality, including approving our Quality Strategy, and take particular interest in the feedback from patients and those close to them through our anonymous 'iWantGreatCare' surveys, and the employee questionnaire which is considered in our People committee.

Face to face Board meetings now take place every two months and has included one newly appointed trustee who himself brings a wealth of experience from another hospice role and we have benefitted from reports direct to trustees from our nursing, clinical and administrative staff and others of the roles they undertake within the hospice.

The Chair of the Clinical Governance Committee and I undertook a formal enquiry into the receipt of anonymous letters of complaint from clinical staff within our community teams. We submitted a lengthy report to the executive and the staff after due enquiry and I am delighted to report that all our recommendations were accepted and acted upon both by the clinical staff and the executive. The report was sent to the CQC who noted our report.

I commend the medical and clinical teams who have continued to work so hard to maintain our service during the pandemic, supported as ever by our administrative and fundraising teams.

We were extremely pleased to maintain an 'Overall Outstanding' rating from the Care Quality Commission. This comes on top of high clinical audit ratings from those who oversee health provision on the Fylde Coast.

Looking forward, Trinity is keen to build on that Overall Outstanding rating, securing the CQC inspection areas in which it excelled – 'care' and 'well-led' and further improving those areas recognised as good – 'safe', 'responsive' and 'effective'. These goals are set out in our current Business Plan and reflect a key value, that of promoting 'excellence'.

We are now very much a 'hospice without walls' with a significant proportion of our work out in the community through Hospice at Home and our community teams.

The trustees strive in their role to assist our medical clinical fundraising and administrative staff to maintain those findings, by ensuring that the Board itself and the hospice generally is well led.

Nigel Law - Chairman

Part Two

Looking Forward: Our Improvements for 2023/24

These Quality Accounts link to our Quality Strategy and are supported and approved by our Board of Trustees. The following areas have been identified for development/improvement in 2023/24 by the Clinical Quality Improvement Group, under the following headings: Patient Safety, Clinical Effectiveness and Patient Experience. They have also been included in each department's Business Plans and Objectives.

The last few years have been the most challenging years the hospice has faced. The pandemic experience and recovery phase has seen our services transform in response to patients' and their families' needs in the context of immense pressures and changes within our own and wider health and social care service.

We are ever mindful of a need to strategically plan to develop our staff and services to be able to respond to the projected increasing palliative and end of life care needs of our aging population and those of the children and young people of the Fylde Coast living with life limiting conditions. This last year we have successfully recruited several new staff to our senior clinical leadership team, continued to expand and develop the skill mix within our clinical teams, re-instated our Clinical Educator role, and commenced a programme of professional development including leadership and management training for many of our senior staff.

Our staff need to be supported and prepared to deliver the future palliative and end of life care needs of our patients and families. We are seeing an ever-increasing prevalence of frailty and dementia. People are living longer, many with multiple and complex long-term conditions, physical and mental health disabilities, the impacts from previous cancer treatments, loneliness, and social isolation. The experience of death and dying is changing for us all with complex health, social and spiritual care need challenges to address in our society and local communities.

This last year has seen us further strengthen our integrated and collaborative working with our key Fylde Coast partner services across health, social and spiritual care and with other community voluntary sector service providers.

We are committed to supporting our colleagues and ensuring our services provide the care and support our patients and local communities need. Over the next year we will be continuing to develop initiatives to enable this including the provision of palliative and end of life care "virtual wards", the launch of a palliative and end of life care "single point of access" co-ordination service pilot project and the expansion of our Living Well Service.

Looking further ahead our Board is supporting investment in our *"Hospice 2030"* project with the aim of developing our facilities to enable us to deliver all our current and future services in the most effective and collaborative way possible. A feasibility study is currently underway and we hope that spades may be in the ground in the Spring of 2024.

Trinity continues to play a central role in the strategic planning for palliative and end of life care across the Fylde Coast. There have been several emergent priorities identified during the 2022-23 period in response to identified needs and it is envisaged that this proactive approach to

improvement will continue aligned with the priorities identified in the 2023-2028 Fylde Coast Integrated Strategy for Palliative and End of Life Care. These include:

- The development of a new palliative care virtual ward service.
- The piloting of two Single Point of Access Coordination Services in two Primary Care Networks – one in Fylde & Wyre, the other in Blackpool Place.
- A step forward in integrated education and training provision and the use of support frameworks for both the last year and last 1000 days such as Advance Care Plans, the EARLY Identification Tool and the like.
- A drive to transformation in the use and effectiveness of Electronic Palliative Care Records to promote timely, integrated and responsive services.
- A more flexible and responsive workforce with 24/7 access to specialist palliative care support and full 7 day/week admissions.
- The better use of data dashboards to enable more efficient and effective targeting of resources to improve palliative care outcomes.
- The development of enhanced support for carers, the general public's confidence in death and dying and that of the community as a whole as part of a compassionate communities framework.

Clinical Effectiveness – In-Patient Unit Staffing Establishment Review

Our aim is:

To improve our clinical effectiveness by maintaining enough suitably qualified, competent, skilled, and experienced skill mix, whilst at the same time allowing protected time for continued professional development and upskilling.

What do we want to achieve?

By exploring options to digitalise current paper-based systems in place for rotas and annual leave we hope to develop a systemic approach that will determine the number of staff and range of skills needed to safely staff the inpatient unit to support 18 open beds.

Through this work we will move from the current staffing model based on a scoring system to a clinical and evidence-based model that incorporates time for induction, onboarding, study leave, annual sickness, mandatory and developmental training for all IPU staff. Alongside this, we will introduce an electronic rostering system that will create efficiencies in time and cost, this system will also create a more equitable and proactive view of staffing the unit over 24 hours/7 days per week by considering skill mix, supervisory roles and management.

How will progress be monitored and reported?

- Staffing reports and organisational view for the management team.
- Monitoring trends of clinical incidents.
- Monitoring staff absence and sickness.
- Monitoring compliance with mandatory training.
- Data from "I want great care" surveys.
- Reporting to the Board of Trustees.

- Performance against KPI's (number of patients cared for, referrals and admissions).

Patient Experience – Care of the Dying and the Deceased

Our aim is:

To give personalised compassionate care that does not end when the person has died but continues with care after death, including supporting friends and families into bereavement. We recognise that each person is a unique individual therefore their death a uniquely individual experience affected by the illness the person has experienced and their personal preferences reflecting the social, cultural, spiritual, and religious aspects of the person's life. We aim to implement effective and practical measures to improve compliance with infection prevention and control alongside continued privacy and dignity for all of our patients and families cared for through the inpatient unit and bereavement suite.

What do we want to achieve?

We will continue to use resourceful ways to meet the information, emotional and practical needs of the dying and the immediately bereaved by supporting staff to work in a cross-organisational way and encouraging experience of other services.

We also will work alongside Facilities, Infection Prevention & Control, and external service partners such as the Acute Trust and local funeral directors to look at structural/logistical options for an improved bereavement suite and viewing/reflection area for families.

We recognise that competence to care for the deceased and support of their carers and families must be included in staff induction and ongoing training at all levels and grades within the inpatient unit.

We aim to implement an updated and resource enriched policy and risk assessment for the inpatient unit bereavement suite that is holistic and provides staff with the support they need including confirmation of death, care after death, communication, bereavement support and responsibilities of staff.

How will progress be monitored and reported?

- Monitoring of capacity levels in the bereavement suite.
- Monitoring of feedback from staff, patients, relatives and carers.
- Uptake of staff training/visits to external services.
- Reporting to the Board of Trustees.
- Reports of audits undertaken by Infection, Prevention & Control.

Patient Safety – Holistic Assessment - End of Life Care Template in Patient Electronic Records

Our aim is:

To record the individualised care delivered to the dying person in the last days and hours of their lives and support their families, carers and those close to them, ensuring a consistent approach to care and excellent documentation.

What do we want to achieve?

The introduction and evolution of the Individual Plan of Care and Support for the Dying Person in the last Days and Hours of Life utilising digital systems and multi-disciplinary working across medical and nursing teams on the inpatient unit.

We also will be improving the quality and governance around documentation of patient records to include a more holistic, personalised, and proactive approach rather than a prescriptive and responsive pathway approach to individuals who are within their last few days and hours.

We want to upskill and develop staff to contribute to the creation of meaningful and patient-centred care plans that incorporates people's priorities. Those priorities include acknowledging and documenting the person's particular unique needs and wishes, communications with those who are important to them around the time of dying and any decisions that are a result of those conversations and the needs of the families and others identified at such time resulting in an individualised plan of care that includes nutrition and hydration needs, symptom management, psychological, social and spiritual support, coordinated and delivered with compassion.

How will progress be monitored and reported?

- Monitoring of data through the clinical system.
- Feedback from families and carers.
- Reporting to the Board of Trustees.
- Feedback from staff.
- Electronic record reviews.

Clinical Effectiveness – Optimise the Use of Our EMIS Electronic Patient Clinical Record

How was this identified as a priority?

Our EMIS electronic patient clinical record supports the documentation of all our assessments, care, prescribing and care planning, underpinning safe and effective care for our patients. Optimal use of EMIS is essential for effective communication and continuity of care and underpins good clinical governance processes. It is eight years since EMIS was first introduced to Trinity during which time there have been upgrades and developments to the EMIS software which could significantly improve clinical productivity and efficiencies, our clinical administration and integrated working processes.

What do we want to achieve?

- Recruit an external EMIS development lead for 12 months to support this work and other digital transformation needs with support from colleagues in the Community and Primary Care Electronic Patient Record Team at Blackpool Teaching Hospitals NHS Trust
- Re-establish Trinity departmental "EMIS Champions"
- Establish an EMIS development project group to inform and steer the project to ensure EMIS optimisation including:
    - Implement and upgrade to our current version of EMIS.
    - Development of clinical templates so these are role specific and fit for purpose.
    - Development of Trinity electronic referral forms and referral processes.
    - Streamline processes and minimise duplication.
    - Optimise mail-merge and clinical administration processes.
    - Optimise use of EMIS appointments and bed management functionality.
    - Ensure consistent and up to date SNOWMED clinical coding.
    - Ensure developments are aligned to local GP and Community EMIS functions to support integrated working.
    - Support safe clinical data sharing for effective co-ordination and continuity of patient care.
    - Support clinical governance and audit processes.
    - Virtual consultations.
    - Electronic appointment reminders.
    - Consider options for In-Patient Unit electronic prescribing and medicines administration.
    - Staff training and evaluation.

How will progress be monitored and reported?

- Through regular monthly meeting of the EMIS Development Steering Group.
- Development and review of project action plan.
- Reported through Clinical Quality Improvement Group and reported to Clinical Governance Committee and Board.
- Feedback from staff and training evaluations.

Patient Safety/Clinical Effectiveness – Increasing the Uptake of Staff Flu and Covid-19 Vaccination

How was this identified as a priority?

Trinity Hospice has a responsibility as an employer to help protect staff, the people using our services, and to ensure the overall safe running of our organisation.

Free vaccinations are made available to Trinity staff, via Blackpool Teaching Hospital Occupational Health Service; however, access to a vaccination isn't always easy due to shift patterns and constraints of available vaccination clinics. In addition, NHS England acknowledge a general reluctance amongst healthcare staff to have further vaccinations after recent years campaigns and multiple booster shots of Covid and Flu as recommended for healthcare staff by the Joint Committee for Vaccinations (JCVI).

At the start of Autumn 2022 rates of uptake of both flu and covid vaccinations amongst staff was concerning; uptakes of flu 36%, Covid 42%, led to concern about staff absence at a time of high winter pressures. Frontline workers who are in direct contact with people who receive care and support services should be encouraged to get be immunised against seasonal respiratory infections (Covid-19 and flu) that can cause significant morbidity and mortality, outbreaks and affect staff sickness and absence rates.

A campaign to encourage flu and covid vaccinations was launched in November 22, to encourage vaccination resulting in a final uptake of Flu 63% and Covid 57%.

What do we want to achieve?

Repeat staff vaccination campaign to encourage the uptake of flu and Covid-19 vaccinations for Autumn 23/24 with the ambition to increase uptake for both vaccinations to above 65%.

Capture all refusals, and missing data and use a 'declination' form where staff sign and give a reason for non-vaccination. This can improve uptake as it makes refusal a conscious decision. It can also provide useful information to inform planning for future seasons and understanding why staff have reluctance for vaccinations.

Other important actions we want to achieve include:

- Identify a Vaccine Champion in each department to support their teams and encourage uptake.
- IPC Lead to promote confidence in vaccination via meetings, bulletins and offer of one to one supportive conversations.
- Consider use of incentives to staff to support uptake of vaccinations.
- Clear strategic responsibility for leading with responsibility for running the flu vaccination campaign.
- Continue to work in partnership with Occupational Health services at Blackpool Teaching Hospitals NHS Trust to provide onsite vaccination clinics.
- Plan to commence the vaccination campaign early so that all staff members are aware of the process and can access the vaccines as soon as possible after it becomes available.
- Ensure staff can make informed choices about vaccination, use resources such as posters, leaflets, and digital tools.
- Review the 23/24 vaccination campaign, discuss and record successes, challenges and learning points for next year.

How will progress be monitored and reported?

- Weekly review of data by HR Lead, Infection Control Lead, Clinical and Medical Directors.
- Review the uptake by individual department and share with department leads to promote vaccination and signpost to resources as necessary.
- Report results via quality governance forums, clinical groups and Trinity's Infection Prevention and Control meeting.
- Discussion a weekly safety huddle of prevalence rates of circulating flu and covid, and vaccine uptake.

Clinical Effectiveness – Single Point of Access (SPoA)

How was this identified as a priority?

This priority was originally identified during 2022/23 but due to the complexities and challenges which the Covid pandemic presented the project had to be paused.

Co-ordinated care is challenging in modern health and social care but is so important if someone is suffering from a palliative condition or is coming to the end of their life. This was identified a key area of development during the height of the pandemic, where lack of information and co-ordinated approaches to care became evident.

Developing a "one contact number" approach that enables callers to seek appropriate help was considered across the health economy with our partners, it was noted on several occasions that carers and patients could have up to seven telephone numbers to navigate to access the care required. The Integrated Care System (ICS) and Fylde Coast Integrated Care Partnership (ICP) wished to explore the concept further with local end of life partners and this exploration was supported by the Fylde Coast End of Life Steering Group.

What do we want to achieve?

- Develop a strategic plan to formulate a single point of access pilot (SPOA).
- Work in partnership with other health, social care and supporting services and commence a project group.
- Develop a referral process, criteria and process.
- Produce a Standard Operating Procedure and algorithms to ensure all palliative care emergencies are dealt with without delay.
- Provide communication to the wider teams about the pilot's aim and ambitions.
- To explore opportunities for integration of Electronic Palliative Care Coordination Record (EPaCCS) to enable patient information and advanced care plans to be shared across health and social care professionals.
- A single contact number for all patients cared for in the community and who are on the supportive palliative care register and have a life limiting condition.
- Pilot the concept of a SPOA with 2 Neighbourhood Care Teams from across Blackpool and Fylde and Wyre.
- Develop outcome measures and key performance indicators.

How will progress be monitored and reported?

- Reporting to the Board of Trustees.
- Monitoring of Key Performance Indicators and outcome measures.
- Service user feedback including patients, carers, health, and social care professionals.
- Monthly review with operational partners via the project group.

Clinical Effectiveness – Nurse-Led Clinics

How was this identified as a priority?

Timely assessment and management of patients with palliative care needs and life limiting diagnoses, including long term conditions, has been shown to improve symptom burden, both physical and psychological needs and general quality of life.

All patients with cancer and non-malignant life limiting conditions should have access to a clinic setting (either at Trinity or in the community) to support them to live well and promote their independence in what matters most to them.

We have already provided an opportunity to patients who are cared for by the Community Palliative Care Team a choice of where they receive a holistic assessment, either within their own home or by attending a clinic setting. Nurse led clinics have been implemented twice a week within Trinity's Living Well Service and there has been a good uptake in patients who choose to attend a clinic and access Living Well Services.

However, we have identified an opportunity to expand the Nurse Led Clinics to include a greater cohort of patients who can be cared for by a greater range and skill mix of staff and also provide patients the opportunity to access Living Well Services.

What do we want to achieve?

- Optimise patient and carer choice for those patients well enough to visit the clinic.
- Reduce travel and location constraints for the community team when patients can come to clinic, saving time that could be used to provide patients with quicker access to a healthcare professional.
- Give patients the opportunity to see and benefit from the services of other members of our multi-disciplinary team and Living Well services.
- Reduce the need for home visits, which may interfere with patients' lifestyles.
- Providing an initial consultation and holistic assessment of patients with specialist palliative care needs.
- Invite potential referrers and stakeholders to visit the clinic and gain insight into its operation and purpose.
- Improve working with other care providers and specialist nurses, implementing joint clinics and education.
- Provide an opportunity to upskill Associate Clinical Nurse Specialist and Health Care assistant roles to support advanced care planning and an introduction to Trinity Hospice and Living Well Services.
- Develop key performance indicators and outcome measures.

How Will Progress Be Monitored and Reported?

- Reporting to the Board of Trustees.
- Monitoring of Key Performance Indicators and outcome measures.
- Service user feedback including patients, carers, health, and social care professionals.
- Audit of Advanced Care Planning and DNACPR discussion decisions recorded.

Clinical Effectiveness – Virtual Clinics and Consultations

How was the priority identified?

A recognition of need for further development of virtual clinics and consultations to support community and care home colleagues and patients and improve the effectiveness and responsiveness of our care.

Trinity is now set up to use 'Attend Anywhere' as a platform for virtual connections. This has already and successfully been used by Trinity's Community Team within Blackpool Teaching Hospitals and internally within our Clinical Psychology team.

The service is initially going to run in conjunction with Virtual Wards and we are looking at options to ensure patients have access to electronic devices.

There are still some patients that like using virtual technology but promotion and uptake of this has not been as good as it could have due to capacity and a restructure of the community team.

What do we want to achieve?

- To increase to number of virtual clinics to reach a more diverse range of patients and carers.
- To increase the opportunities for education and support for more community and care home staff.
- To re-establish virtual clinics within Clifton Hospital.
- To provide more opportunities to increase access to our services.
- To optimise the use of technology and support patients, carers and other health and social care professionals to become conversant with the technology.
- Send out monthly communication updates to Health and Social Care providers to promote the virtual clinic and provide instruction on how to access.
- Establish as part of Single Point of Access project.
- Development of key performance indicators and outcome measures.

How will progress be monitored and reported?

- Reporting to the Board of Trustees.
- Monitoring of Key Performance Indicators and outcome measures.
- Service user feedback including patients, carers, health, and social care professionals.
- Audit of Advanced Care Planning and DNACPR discussion decisions recorded.

Clinical Effectiveness- End of Life/Palliative Care Virtual Ward

How was this identified as a priority?

The NHS is under significant strain and there is a need to be able to care for more patients safely in their preferred place of care including their own home, therefore relieving the demand on NHS and Hospice inpatient beds.

A virtual ward is a safe and efficient alternative to NHS bedded care that is enabled by technology. Virtual wards, including Hospital at Home, are already supporting patients who would otherwise be

in hospital to receive the acute care, monitoring and treatment they need in their own home or place of residence. Palliative and end of life care services have a responsibility to support our patients to be cared for in their own home initially or to go home quicker, whether that be from hospital or hospice beds.

The long-term plan and the changing commissioning architecture gives us the opportunity to use collective resources within an ICS to develop a service which supports people to remain independent, safe and in their own homes for as long as possible. Giving patients and their relatives a choice of where they receive care which is supported by a wraparound service is important.

What do we want to achieve?

Palliative and End of Life Care virtual wards	
WHAT	To allow a safe alternative to hospital or hospice for patients who require palliative or end of life care through community-based acute health care delivery.
WHERE	In the patient's own home or usual place of residence, supported by the existing palliative and end of life services providing specialist advice and guidance.
WHO	Adults with palliative and end of life care needs who are in or reaching a crisis that requires acute level care
WHEN	As an alternative to admission to hospital or hospice or early discharge from hospital or hospice
WHY	Improved patient experience and outcomes. Multi-disciplinary decision-making for patients. Improved patient flow by reducing admissions and length of stay. Advanced Care Planning opportunities A system approach placing the patient at the centre
HOW	Enhanced monitoring with early recognition of deterioration or instability of condition and response with appropriate clinical input

How will progress be monitored and reported?

- Daily MDT at Trinity including senior clinician (Consultant, speciality doctor or Advanced Practitioner), community team members and Fylde Coast Medical Services.
- Triage including Inclusion/exclusion criteria to ensure the right patients receive the care provided (most unwell, carer burden, complex symptoms).
- Service user feedback including patients, carers, health, and social care professionals.

- Weekly attendance at Virtual Ward/crisis response meeting led by ICB and attended by other VW leads for updates.
- Completion of a daily activity spreadsheet submitted to the ICB.
- Monitoring of key performance indicators and outcome measures.
- Reporting to the Board of Trustees.
- Weekly review meeting with oversight from Trinity's leadership team.

Clinical Effectiveness and Patient Experience – Living Well with Frailty

How was the priority identified?

Working in collaboration with our community and hospital based NHS partners in the frailty service, we identified a gap in patient care which has resulted in unnecessary hospital admission for those frail patients nearing the end of their lives.

This has been linked to a Hospice UK grant-funded initiative 'Extending Frailty Care Programme' which we were successfully awarded with a match-funding from our NHS partners to provide a two-year pilot Advanced Clinical Practitioner frailty post.

What do we want to achieve?

- Employment of a suitably qualified and experienced Advanced Clinical Practitioner to lead the initiative.
- Improved awareness in the community of frailty as a health condition, particularly in care and nursing homes.
- Provision of frailty specific education and training plan.
- Joint working across hospice, community, hospital, and care home settings to improve end of life care for people with frailty.
- Reduction of inappropriate hospital admissions.
- Increase/improvement in provision of advance care planning for those with frailty.
- Increase in knowledge and education amongst health and social care professionals.
- The development of key performance indicators and outcome measurements.

How will progress be monitored and reported?

- Hospice UK have commissioned the external evaluators 'Whole Systems Partnership' to oversee the project for all their grantees within the extending frailty care programme.
- Submission of three monthly progress reports.
- Site visits from Hospice UK to evaluate progress.
- Regular attendance at Project ECHO meetings.
- Monitoring of key performance indicators and outcome measures.

Clinical Effectiveness, Patient Experience – Development of an Online Referral Form for Living Well Service Pathways

How was the priority identified?

With the development of the Living Well Service and associated pathways, the current referral forms were no longer thought to be fit for purpose. The current referral forms do not capture all the relevant information required to effectively assess and triage patient care needs consistently.

What do we want to achieve?

- To ensure a more standardised approach to referrals allowing referrers to be able to articulate information about the service they are referring into by using the Australia-modified Karnofsky Performance Scale (AKPS). The AKPS is a tool to enable the measurement of the patient's overall performance status or ability to perform their activities of daily living.
- To capture all the relevant information relating to the patient allowing Trinity's Living Well Services to be able to work in a more efficient way and offer a timelier service to meet the patient's needs.
- To ensure the safety of patients and our staff by capturing safeguarding information or any other important information relating to disability, social or access concerns.
- To make the referral process easier for referrers and available electronically.
- To encourage more interaction with the Trinity website as technology improves.

How will progress be monitored and reported?

- Audit on the appropriateness and content of referrals.
- The number of referrals.
- Service user feedback including patients, carers, health, and social care professionals.

Clinical Effectiveness, Patient Experience and Patient Safety – IPU Health Care Assistant (HCA) Training in Rehabilitation

How was the priority identified?

Trinity's IPU patients have previously benefitted from provision of HCA rehabilitation training provided by their more qualified HCA Level 3 colleagues, resulting in improved patient care through timely contact, addressing support needs, increase enablement and a reduction in the incidence of falls. Loss of this training during the pandemic and staff changes over time has removed most of this support which has been evident in reduced patient contact and increased wait times outside the core rehabilitation team.

What do we want to achieve?

- Interdisciplinary working.
- Provide timely contact for new patients to support mobility and walking aid assessment and provision.
- Understanding and adoption of the rehabilitative palliative care approach throughout the IPU including consideration for appropriate referral to the rehab team.

- Additional trained support on the IPU to work collaboratively when patients require assistance of 2 or more staff.
- Integration of IPU patients with LWS activities and services to access within their stay wherever appropriate and desired by them.
- Patient-centred, goal-oriented rehabilitative input throughout the teams.

How will progress be monitored and reported?

- Monitoring of Key Performance Indicators and outcome measures.
- Audit.
- Service user feedback including patients, carers, health, and social care professionals.

Clinical Effectiveness, Patient Experience and Patient Safety – Living Well Service (LWS) Team In-Patient Unit (IPU) Ward Round

How was the priority identified?

IPU rehabilitation provision and oversight will be via in-reach from the Living Well Service team as an aspect of their work, so time management is important in the provision of quality care. The team has recently expanded to include an Occupational Therapist and a Family Support Worker, the ideal time to implement a team-wide approach and the inclusion of new, multidimensional ways of working, assessments and outcome measures.

What do we want to achieve?

- Streamlined working with a dedicated, structured time to meet with and discuss patients on the IPU.
- Ensure rehabilitation team clinical oversight of in-patients from a person-centred, goal-led focus.
- Champion and facilitate rehabilitation, empowerment, reduction of isolation including participation in Living Well Service activities and events where able and staying on the IPU.
- Interdisciplinary working.
- Facilitating improved pathways of care for patients on referral between wider services.

How will progress be monitored and reported?

- Monitoring of Key Performance Indicators and outcome measures.
- Patient goal attainment monitoring.
- Audit.
- Service user feedback including patients, carers, health, and social care professionals.

Clinical Effectiveness and Patient Experience – Complementary Therapy Introduction of Carer and Bereaved Groups

How was the priority identified?

- Complementary Therapy has traditionally been delivered in a one to one format by our Complementary Therapy Co-Ordinator or one of her volunteers. This consisted of six individual appointments each for patients, their carers and bereaved.
- The team has been more limited in number and clinic space since the pandemic and other service expansions and concerns were raised by the team regarding capacity with waiting times beginning to lengthen beyond agreed targets.
- A caseload review revealed expansion to the extent that it had become too large to manage effectively with a higher proportion of carers to patients, prioritisation and service review became necessary.

What do we want to achieve?

- Alternative approach to caseload management, implementing new carer and bereaved group sessions avoiding the otherwise inevitable decision to reduce service provision.
- Ensure continuation of timely patient input.
- Provide an additional layer of input by way of training carers to deliver complementary therapy to their loved ones when it is needed the most.
- Lasting input to patients, carers and bereaved through a well thought out, structured programme of education, activities and therapies without losing the personalised touch.

How will progress be monitored and reported?

- All attendees complete a feedback form for monitoring and to inform future refinements and changes.
- "I Want Great Care" patient and carer feedback.
- Ongoing monitoring of caseload management and capacity.

Patient Experience – Dementia Carers' Support "Dementia Lounge"

How was the priority identified?

Living with and caring for someone with dementia can feel a lonely, isolated place for many people. The ethos of the lounge is to support those living well with dementia and their carers to prevent social isolation, so they feel less alone in their caring roles, build peer support and to share information, knowledge, education, and best practice.

What do we want to achieve?

- With the partnership of staff skills, carer expertise, and lived experience of those living with dementia, we aim to create a safe space to engage in an informal and relaxed environment. We want to empower carers to feel supported and well informed and leave the lounge feeling uplifted and connected.

- Work in partnership with Dementia UK sharing a commitment to focus on 'Living well with Dementia'. We are aiming to raise awareness through proactive information sharing across the Fylde Coast, thus making our groups and communities accessible for all.
- To provide activities to promote inclusion, engagement, and enjoyment.
- Support a team of volunteers to provide meaningful activities, and encourage a safe space for conversations.
- To work in partnership with community organisations and health and social care professional.
- To encourage and support the lounge to become self-sustaining directed by the service users and volunteers in the longer term establishing similar, smaller groups in local communities across the Fylde Coast facilitated by carers, for carers, in a safe supported space.
- To plan for future developments, for example, dementia café's, dementia restaurants, dementia shopping hour, dementia gardens/gardening enabling Compassionate Dementia Friendlier Communities.

How will progress be monitored and reported?

- Evaluation forms will be undertaken with carers and professional attendees.
- Numbers attending the Dementia Lounge sessions will be monitored.
- Progress and outcomes will be reported through our departmental business meetings, Clinical Quality Improvement Group and Clinical Governance Committee.
- Through Admiral nurse steering groups with team manager and Dementia UK.

Clinical Effectiveness – Access to Virtual Counselling and Wellbeing Support

How was the priority identified?

As the referrals for support increased it became apparent that there was a need to offer a more flexible and responsive service to meet the needs of all clients who access our service.

We had noted the increasing number of clients who were accessing telephone counselling as they were unable to attend the centre for different reasons some of which were medical.

We had monitored the number of missed or rearranged appointments due to lack of time for carers to drive to, and from the Linden Centre, to attend face to face appointments, leaving the person they are caring for without support. It was also recognised that several patients were house bound and unable to access the appointments in the Linden centre.

It was noted that carers found it difficult to maintain regular appointments for counselling due to their time and caring commitments and the wellbeing worker had alerted us to the amount of home visits that she was making.

What do we want to achieve?

- Our aim is to ensure our services remain as effective and responsive as possible.
- To increase the capacity for our wellbeing worker by reducing the number of home visits.
- To maintain provision and access to counselling appointments and provide an offer for those patients who may be disadvantaged.

- We aim to optimise choice for carers and patients and for those bereaved who are housebound.
- We wanted to offer an alternative option in addition to face to face and telephone counselling.

How will progress be monitored and reported?

- Monitor progress of virtual working through clinical supervision.
- I Want Great Care Feedback from service users.
- Key Performance Indicators.
- Audit of services on offer and uptake of virtual counselling support.
- Monitoring a hoped-for reduction in waiting times.
- Regular updates through our Clinical Quality and Improvement group reporting into our Clinical Governance committee.

Clinical Effectiveness – Children's Counselling Training

How was the priority identified?

The external Clinical Supervisor who supports the Linden Centres counselling staff identified that some counsellors would benefit from some additional child counselling training due to increasing numbers of referrals for children's counselling with more complexities.

What do we want to achieve?

- To empower counsellors to deliver effective children's counselling by providing upskilling skills and knowledge using up to date guidance and techniques.
- To establish children's counselling groups for children of a similar age, experience, and/or sibling groups.

How will progress be monitored and reported?

- Delivery of children's counselling training to all counselling staff.
- Review staff feedback after the training to see if this has improved their skills, knowledge, and confidence.
- Feedback from service users and parents.

Clinical Effectiveness – Streamline Linden Centre Administration Processes Aligned with Trinity

How was the priority identified?

Team members working in the Linden Centre have identified that the current administrative systems and processes are inefficient, have a significant reliance on paper based systems and are time consuming.

The referral system is very Inefficient with a duplication of electronic and manual referral processes.

What do we want to achieve?

- A streamlined approach to recording client's data in accordance with Trinity's wider electronic patient record system and Clinical Governance processes.
- A more time efficient administrative service within the Linden Centre.
- To prevent duplication of processes.

How will progress be monitored and reported?

- Ongoing audit of the counselling service and established Trinity clinical governance monitoring processes.
- Reported through team meetings, line management supervision up to the Trinity Clinical Governance Committee.
- Review the new process and systems and gain staff feedback.

Clinical Effectiveness – Improvement of Brian House patient Care Plans

How was the priority identified?

Following a record keeping audit, it was noted that the children's care plans could be better formatted to provide a structured holistic framework that addresses the clinical, emotional, and spiritual needs of the child and family for both routine rapid discharges and end of life care. The new plan will incorporate the twelve standard nursing daily activities of living.

What do we want to achieve?

- We want to achieve our mission that all the most vulnerable children on our caseload have an Advanced Care Plan in place.
- To develop and document a completely holistic understanding of the child and family need.
- To be able to provide expert paediatric palliative care advice to parents and external professionals by working in partnership with education learning groups, the National Head of Care meeting, The Lancashire and South Cumbria Education Project being hosted at Derian House along with encouraging staff to undertake appropriate research.
- Use the skills, experiences, and specialist interests of the team to develop the most holistic child and family care plan.
- Develop a more streamlined care plan for respite stays and advanced care planning incorporating all care interventions into the one care plan.
- Increase our interaction with the National Heads of Care meetings, to develop benchmarking opportunities between other national children's hospices with the target to work towards a standardised plan of care across the children's hospice network.
- Strengthen our involvement in the Paediatric Palliative Care Zonal group to finalise the development of a standardised rapid discharge plan.

How will progress be monitored and reported?

- Training days and feedback from staff.
- Audit.
- Feedback from parents, families and healthcare professionals.

- Benchmarking with external professional teams and networking with national children's hospices.

Patient Experience – Establish Consultant/ACP-Led Clinics

How was the priority identified?

The complexity of the health and social needs of children who access Brian House is increasing and there is an opportunity for care to be provided in a community setting rather than increasing demand on acute services.

What do we want to achieve?

- To implement a paediatric consultant/ACP-led clinic within Brian House.
- For parents to have more responsive service in an environment that is closer to home and easier to access.
- Children to access consultant palliative care advice and support outside of the acute hospital settings.
- Children to see the same consultant, reducing the need for the family to have to repeat providing the child's history to different health care professionals.
- To avoid unnecessary hospital admissions for all vulnerable children.
- Reduce risks of hospital required infections for children with life threatening and complex needs.
- To strengthen relationships with parents and families.
- Provide a more focused education for families on the values of advanced care planning and support with developing their child's care and advanced decision making.

How will progress be monitored and reported?

- "I Want Great Care" feedback.
- KPI figures and analysis of performance.
- Clinical improvement Audits.

Patient Safety – A Structured Monthly Educational Programme for All Brian House Clinical Staff and Volunteers

How was the priority identified?

As the complexity of the health and social care needs of patients who access Brian House increases it is important that the staff are prepared to be able to care. There is a need for continuous upskilling of clinical nursing teams and enhancing learning opportunities benefiting our goal of providing excellence in care to all our children and families that we support across the Fylde Coast.

What do we want to achieve?

- Encompass all internal learning into a focused learning opportunity to upskill our staff using the knowledge and experiences from our senior team members.
- To link into more learning delivered by Trinity Hospice organisation.
- To network with all other children's hospices sharing competency skill teachings and learning sessions.
- To work collaboratively with the Lancashire and South Cumbria Education (L&SC) Project participating in the education programme, attending group and individual learning sessions.
- Up skill our champion leads to become "train the trainers" utilising the L&SC education project, in their subject fields.
- Have a robust training programme board with all relevant and up to date information and upcoming sessions.
- Utilise the professional medical knowledge and skills from our designated Paediatric Consultant who leads the paediatric service at the local acute hospital. Nurses to be able to work alongside her to develop their learning.
- Exercise the professional learning of skills and knowledge from our trainee paediatric Advanced Nursing Practitioner. Bridging the gap between all medical teams, external agencies', other organisations, and all sides of the experienced nursing team.
- Identify opportunities for skill sharing, enhancing teaching approaches, providing vision for leadership developments through focused education within the hospice environment.

How will progress be monitored and reported?

- Feedback from training days.
- Undertaking audit.
- Staff training records.
- Feedback from patients, parents and families.
- Benchmarking with external professional teams and networking with national children's hospices.
- Reporting through quarterly Trinity Training and Education group meetings and up to Children's and Clinical Governance Committees.

Clinical Effectiveness and Patient Experience – Specialist Palliative Care Support for the Withdrawal of Respiratory Support at End of Life Within the Medical Enhanced Care Unit (MECU) at Blackpool Teaching Hospital

How was the priority identified?

The MECU is a ward that offers a higher level of monitoring and respiratory intervention than is typically available in routine ward settings. MECU patients are those who require additional monitoring and/or intervention but do not presently require intensive care.

The Hospital-based Palliative Care Team has been actively involved in supporting the care of several patients where respiratory support was being withdrawn. Since MECU opened we have supported 36 patients, 83% of whom we supported at end of life and were able to provide

additional support for their clinical teams, and families. Just over half of these patients were unknown to palliative care services prior to their referral.

A range of respiratory interventions including non-invasive ventilation (NIV), continuous positive airway pressure (CPAP), and high-flow nasal oxygen therapy (NHFO) are commonly administered to critically ill patients; however, there are times when a medical clinician deems a particular treatment futile, and the patient, family, and/or carers consent to withdraw that treatment.

When a decision has been made to withdraw these treatments, there is currently an absence of national guidance to facilitate their withdrawal in a way that maximises patient comfort and dignity. It has been left to local centres to implement their own guidance and this has become a priority for Blackpool Teaching Hospitals.

What do we want to achieve?

- To support the respiratory team to implement and ratify guidelines for the withdrawal of ventilation that are already in draft form and adapted by the Leeds Royal Infirmary.
- To support education on these guidelines with the nursing staff on the unit and within our hospital palliative care team.
- To see the guidelines are being followed.
- To look at the patient group offered this treatment and if it prolongs suffering or improves outcomes.
- To look at the length of time often on the ventilation before deemed futile.
- Earlier referrals to palliative care to support advanced care planning and preferred place of death if deemed the withdrawal is for end-of life.
- To provide support for families/caregivers throughout the removal of respiratory support.

How will progress be monitored and reported?

- A proforma has been developed to capture the key data.
- The post data will be collected 3 months after the release of the guidelines.
- Results will be reported through team meetings, Clinical Quality Improvement Group and to Clinical Governance Committee.

Looking Back:

Improvement Priorities Identified in our Quality Accounts 2021-22 and Progress Made:

Clinical Effectiveness – Single Point of Access (SPoA)

Developed and carried forward into 23-24 with update detailed above.

Clinical Effectiveness – Advanced Clinical Practitioner led clinics

Developed and carried forward into 23-24 with update detailed above.

Clinical Effectiveness – Virtual Clinics and Consultations

Carried forward into 23-24 with update detailed above.

Patient Safety - Competency Framework for Children's Hospice Staff.

Our aim was:

- To be able to support the care needs of all the children who access Brian House and be able to provide assurance that all staff have the appropriate skills, competencies, and confidence.
- To work collaboratively with our partner organisations in a system wide approach in the sharing of good practice, educational and training days, competency frameworks and booklets.
- To introduce training days which including unplanned emergency scenario training.
- To introduce champion roles to develop expertise in each clinical competency.
- To establish rotational posts to a regional children's hospice with honorary contracts to support standardised competency training.
- To embed rotational posts to BTH further developing links with the Practice Development Sisters to enhance the staff's clinical skills.

What we did:

- We set up three dedicated training days with experts in different interventions delivering the sessions.
- We introduced competency workbooks allowing staff to work from novice to expert over a period.
- We developed champions in each complex clinical area and all the champions have additional knowledge and are assessed as competent to teach in the specific clinical intervention.
- We developed a competency framework that clearly defines competencies required for each different grade of staff.
- All existing staff have completed and had marked their competency workbooks.
- We have regular scenario sessions with feedback currently managed by the Paediatric Consultant.
- We have introduced a monthly twenty second training board.
- Our Advanced Clinical Practitioner worked on the children's admissions unit to increase her assessment and prescribing skills
- We offered a secondment post to a senior nurse to increase more specialist knowledge skills and confidence in an acute setting.
- All our staff now have honorary contracts allowing them to work at BTH to further develop their clinical skills.
- We developed a new induction plan with a buddy and a mentor for new starters to effectively monitor their progress and ensure they are fully supported in their new role.
- We trained all our HCA3's to be able to second check control drugs.
- We introduced scenario training led by our Advanced Clinical Practitioner, supported by our Paediatric Consultant.
- We had three dedicated training days for all staff to increase competencies inviting experts in a variety of clinical interventions.
- We upskilled our staff to be able to support children that require Level 3 ventilation.

Clinical Effectiveness – Expand Our Brian House Service Provision to Cover Seven Nights Per Week

Our aim was:

- To operate over seven nights, 52 weeks of the year.
- To be able to offer services appropriate to the whole family's needs.
- To have a broad skill set to support the children and families holistically
- To be responsive to the needs of the families particularly the most vulnerable and those who are approaching end of life.
- To offer care in the place that meets the needs of the family, either at home or in the hospice.
- To develop a flexible workforce ensuring effective use of staffing and the skill set of the team to meet the needs of all patients.
- To ensure we can always support the patient and their family in their preferred place of care and/or death.
- To offer families a minimum of three four night respite stays (or shorter stays amounting to 12 nights if preferred).
- To offer cancellations to families ensuring effective use of the services further supporting those families who are in crisis or having a particularly challenging time.

What we did:

- We supported all referrals for sudden deaths into our Butterfly Suite by offering a 24/7 day service.
- Supported end of life care by offering a 24/7 day service in the preferred place of death.
- Although we did not manage to increase our staffing consistently to manage 24/7 days throughout the year we did offer this service for a period of 2 months.
- We introduced a bulk texting system which we use for cancellations, and this is now embedded into the service.
- We have developed a new and fairer respite model ensuring all families are offered equal respite throughout the year.
- We have maximised our day care allowing us to provide additional support to the respite nights for our most vulnerable children and families.
- All our staff are now working flexibly across the service ensuring we can maximise our capacity and skill mix.
- We have offered a six-month secondment to the Children's Community Nursing Team for a senior nurse to increase clinical knowledge and familiarity with the families in their own home.
- We introduced a nurse on call system to support a one nurse, one HCA 3 model supported by a Senior Nurse on call.

Patient Experience - To Develop Groups to Support Siblings, Parents and Grandparents Incorporating an Allotment Project and Cinema Experience

Our aim was:

- To set up additional clinics and groups to provide additional support to children and their families.

What we did:

- Set up baby and toddler groups.
- Commenced sibling groups for younger and older siblings.
- Facilitated the neonatal outreach team to run clinics from Brian House as part of our collaborative work within the wider system and this has supported families become familiar with Brian House and subsequently increased neonatal referrals.
- Set up stay and play sessions where families can book out the cinema room, the soft play area, the sensory room, and the garden.
- Based on parent feedback we commenced themed family events during school holidays as an alternative to parent groups.
- Set up a calendar of events to email out to families in advance.
- Increased our volunteer complement to support our group work.
- Set up six monthly volunteer training days to offer support to our volunteers and ensure they have the skills required.
- We have linked in with Aiming High and have joint sessions both here and at the Aiming High facility to support families increase their network of support and offer our facilities to those who face more challenges accessing the standard public services.
- Worked in partnership with Rainbow Trust who support us accessing those hard-to-reach families and can transport families without vehicle access to Brian House.
- We have linked in with the LWS and offered our parents access to complementary therapy group sessions.
- We have commenced Advance Care Planning clinics supported by our Advanced Clinical Practitioner and the Paediatric Consultant.

Clinical Effectiveness – Bereavement Service Development

Our aim was:

- To reduce waiting lists for access to counselling.
- A develop a more flexible and responsive service to meet the needs of all clients who access our service.
- We wanted patient support to be our priority offering face to face counselling with an offer of a range of alternative support to support individual needs.

What we did:

- We reviewed the referral criteria for bereaved clients.

- The Linden Centre is now open two evenings per week to support clients who have work/caring commitments.
- A Wellbeing Worker is now part of the Linden Centre Team offering wellbeing support to those people who have recently been bereaved rather than waiting for one-to-one counselling.
- Bereavement therapy and support groups were offered for clients who prefer a group setting rather than one to one sessions.
- A weekly bereavement social group to encourage social networking is now in place.
- Worked to reduce the number of DNA's.
- Carers groups set up as an alternative to counselling support which offer time for them away from their caring roles and linking in with the Living Well Service in regards complimentary therapy group appointments.
- Worked in collaboration with the Clinical Psychologist at Trinity who is now based in the Linden Centre offering a more effective and efficient response to patient referrals into counselling and counselling support on the IPU.

Patient Safety – Implementation of Liberty Protection Safeguards (LPS) Legislation

Our aim was:

To follow the national Code of Practice when published, developing our policy and implementing staff training and procedures to reflect the new Liberty Protection Safeguards (LPS) ensuring the best interests and autonomy of people who lack capacity to make important decisions about their personal care and welfare and are so vulnerable to having their freedoms curtailed.

What we did:

We initially formed an LPS Implementation Task and Finish Group involving safeguarding leads from each area of our services including our Consultant Pediatrician, Admiral Nurse and social worker. However, the pandemic delayed the implementation of the Liberty Protection Safeguards date, initially moved initially to April 2022 and then further extended.

What was the outcome?

On 5 April 2023, the Department of Health and Social Care announced a further delay to the implementation of the Liberty Protection Safeguards. The government has set outs its plans for adult social care reform in its publication of the "Next steps to put People at the Heart of Care" to enable them to focus on these critical priorities, the government has taken the decision to delay the implementation of the Liberty Protection Safeguards beyond the life of this Parliament.

Clinical Effectiveness- Leadership Training

Our aim was:

To provide leadership and management skills training to middle managers across the hospice, to help facilitate and bring to life our values and ways of working and to provide some peer supportive time to help develop and practice the skills.

What we did:

This training was sourced and is being delivered in partnership with a respected organisation called North West CVS training organisation. "The Upskilling Project" is now embedded as part of Trinity's wider staff education and training program.

What was the outcome?

We have commenced the first of three cohorts of our middle managers from across all services on and accredited Leadership and Management skills training program which will continue through 2023.

Patient Safety - Safe Staffing

Our aim was:

A "Dependency Assessment Tool" was developed to consider the nursing dependency and acuity of patients utilising an In-Patient Unit bed so that we could safely continue to admit patients whilst considering the needs of current patients and the affect this has on the number of nursing hours available and this day-to-day IPU bed capacity.

What we did:

The Dependency Assessment Tool was trialled over several months, entailing a review of all patients' nursing needs twice daily which then translated into a score that informed the available capacity on a day-to-day basis. Over time it became clear that the application of the Tool was time consuming and inconsistent, misunderstood the teams and did not reflect the changes we have seen in our in-patient demographic, patient complexity and turnover and skill mix.

What was the outcome?

The trial of the tool was abandoned with the service reverting back to the previously established model pending the recruitment of our new Director of Clinical Services and the commissioning of a more robust staffing establishment benchmarking exercise in Spring 2023.

Clinical Effectiveness – To Produce an Updated In-Patient Unit Discharge Letter That is Fit for Purpose

Our aim was:

- To improve the quality of information handed over to healthcare professionals.
- To develop an electronic discharge summary template that captures all the relevant information needed for the healthcare professionals involved, including EPaCCS data.
- To design a discharge template that is simple to complete.

What we did:

- Two of our GPSTs led on this as their Quality Improvement Project and surveyed colleagues and GPs to produce a list of key information they would wish to see in a comprehensive discharge summary.

- A MS Word template has been developed with a view of incorporating this into the EMIS system and templates.

What was the outcome?

- The next step is to get the template functioning in the EMIS patient electronic record.
- The medical team will then receive training on using the template and start a three-month trial of its use and re-evaluate the tool (the medical team using it and the end users – our team and GPs).
- We want to keep the GPSTs involved in this (as their Quality Improvement Project part of their placement).

Clinical Effectiveness and Patient Experience - Improving Referral Rates to Palliative Care for Patients With End Stage Liver Disease (ESLD)

Our aim was:

- To improve referral rates to palliative care, much earlier in the ESLD trajectory.
- To improve symptom management, psychological and spiritual support.
- To improve healthcare professionals understanding of the role of a specialist palliative care nurse.
- To work collaboratively with all members of the multi-disciplinary team.
- To encourage Advanced Care Planning discussions earlier.
- For all health clinicians to become more comfortable with open and honest conversation.
- To provide support for the families/caregivers.
- To reduce the stigma associated with ESLD.
- To support a pathway for patients with end-stage liver disease from AE to ward which will include referral to palliative care if appropriate.

What we did:

- Attended twice weekly board rounds on the gastroenterology ward to support identification of patients who may be appropriate for palliative care input earlier within their disease trajectory.
- Worked to build relationships with the gastroenterology team.
- Worked alongside other members of the multi-disciplinary team.
- Completed a proforma for patients referred to our service with end-stage liver disease.
- Data collection/KPIs looking at numbers of referrals, symptoms, days from referral to death, previous palliative care input, previous advanced care planning discussions, EpaCCs in place, cause of liver disease.
- Worked with the Quality Improvement Team at Blackpool Teaching Hospital.
- Attended AQUA stirring group around end-stage liver disease meetings to support a new pathway.
- Increasing palliative presence on the gastroenterology ward.

What was the outcome?

- Preliminary results have been reviewed. Following attendance of the ward board round twice weekly for 2 months, received 33 referrals for patients with end-stage liver disease: a significant increase.
- The findings were presented to the AQUA steering group committee at Blackpool Teaching Hospitals: palliative care will be on the new pathway currently under construction.
- Invited to present at the gastroenterology medical team's monthly education session.
- Invited to present at the clinical nurse study day in May 2023 exploring the role of palliative care and end stage liver disease.

Clinical Effectiveness – Accident & Emergency (A&E) Project

How was this identified as a priority?

Through their work in the Acute Medical Unit (AMU) and Emergency Department (ED), the Hospital Palliative Care Team observed that many patients with a palliative diagnosis at end of life were attending the departments and being admitted unnecessarily. It was felt that more could be achieved at first point of access in the ED to try and prevent inappropriate admissions or put plans in place to reduce the amount of time they spent in hospital. Educational needs of the staff within the ED department regarding caring for patients with a palliative diagnosis at end of life was also identified.

Our aim was:

- The main aim was to try and improve the experience for patients in the ED department with a palliative diagnosis in addition to making the most efficient use of vital resources and ensure that patients are cared for in the right place and at the right time.
- We wanted to ensure that advance care planning decisions are acted upon especially in relation to a patient's preferred place of care or death, and to ensure we utilise the electronic palliative care coordination record (EPaCCS).
- We wanted to improve emergency staff knowledge of palliative and end of life care and the tools we use to support our practice.

What we did:

- A project group was commenced.
- We provided and continue to provide daily in reach to the ED department, proactively seeking patients suitable for our support, liaising with the nurse in charge of the department, reviewing patients and providing any appropriate care and collecting data as we go along.
- New posters with the Palliative Care Team contact details have been created. These have been circulated to all areas of ED to encourage referral to palliative care at an earlier stage.
- We have liaised with IT and the Quality Improvement Department at BTH regarding creating a Palliative Care in ED digital dashboard so that live data can be accessed easier, trends identified promptly, and action sought to address any issues.
- Our Advanced Clinical Practitioner has completed eLearning on the MAXIMS system which is the clinical system used in ED. Access to this system will allow us to see live data of who

is in the department to proactively identify patients who may be suitable for our support. This will be looked at each morning and lunchtime.

- A survey was developed and circulated to staff in the department to determine learning needs and the survey has been analysed and areas for training have been identified. Suitable dates for the team to deliver training will be arranged.
- A box with syringe driver equipment has been placed in the resuscitation area. This includes all the consumables that are needed to set up a syringe driver and some short reference guides detailing how to set up a syringe driver. This was created as ED do not routinely stock the equipment needed and time was being wasted having to go to different departments for equipment. Stock levels are going to be checked regularly by a member of the ED team.

- **What was the outcome?**

- Data was collated monthly and reported to the project group.
- The total number of patients seen by the team in A&E in 2022 (excluding December) was 130 and 21 admissions were avoided.
- 77 acute bed days were saved.
- The number of patients at end of life assessed in ED reflects the current pressure on local health care systems.
- The number of patients at end of life attending A&E without a completed EPaCCS record or a DNACPR in place is high.
- The project was discussed at NHS England benchmarking and a poster was presented at Hospice UK conference. The project was the winner of a quality improvement award at BVH.

Patient Experience – Dementia Carers' Support "Dementia Lounge"

Our aim was:

To engage people living with Dementia and their carers across the whole Trinity Hospice Footprint, offering a safe and supportive environment, with access to the Admiral nursing service. Living with and caring for someone with dementia can feel a lonely, isolated place for many people. The ethos of the lounge is to support those living well with dementia and their carers to prevent social isolation, so they feel less alone in their caring roles, build peer support, and share information, knowledge, education, and best practice.

What we did:

- Empowered carers to feel supported and well informed and leave the lounge feeling uplifted and connected. With the partnership of staff skills, carer expertise, and lived experience of those living with dementia, we created a safe space to engage in an informal and relaxed environment.
- Worked closely with Dementia UK sharing a commitment to focus on 'Living well with Dementia', and sharing up to date info and best practice, we raised awareness through proactive information sharing across the Fylde Coast, thus making our groups and communities accessible for all.

- Each month we provided an activity to promote inclusion, engagement, and enjoyment.
- We have grown a team of volunteers to support meaningful activities, and encourage a safe space for conversations.
- We worked closely in partnership with other valued community organisations and professionals to include Alzheimer's Society, the Carers Centre at Beaverbrook's House, UCLAN-Best Research in Dementia, Local Solicitors, Lancashire Fire and Rescue Services, N-Compass, memory assessment, The Harbour Hospital, local libraries, social prescribers, all welcomed to enhance the outcome for the Dementia Lounge attendees.
- The Dementia Lounge is growing considerably and becoming more self-sustaining and being directed by the service users and volunteers. One of our very active Dementia Lounge volunteers has opened her own very successful Dementia Café and more recently a singing for the brain.
- We encouraged our Dementia Lounge attendees to access our allotment at the HASSRA grounds, and we are now working with FTFC on planning dementia-friendlier activities. We continue in our aim to support the commitment for enabling Compassionate Dementia Friendlier Communities.
- We continue to engage with the plans for the Living Well Centre - to offer Admiral Nurse drop-in clinics, during and post Dementia Lounge

What was the outcome?

- Numbers attending the Dementia Lounge have increased considerably, with the review of participants showing a positive experience for attendees. We have listened to what the carers and people living with Dementia want, and they prefer to chat to one another and engage in activity rather than have professional talks. However, we do encourage professionals to attend but on a more informal basis, so they can engage one to one if the attendees want or need further information. Activities have included hand massage, pumpkin calving, Drumming for Dementia, sports quizzes, Valentine's Day card making and singing, we are having a visit from alpacas, we also share important dates within the calendars and promoted Nutrition and Hydration week recently.
- Volunteers to the Dementia Lounge have grown to now include a driver, our own PA, hand massage lady, and volunteers with lived experience and a keen interest in supporting people living with Dementia to engage meaningfully.
- From the success of the Lounge, we have made plans for Dementia Action week 2023, Blackpool Transport have kindly offered to support us with a heritage tram ride, so those living with Dementia and carers can enjoy new memories and reflect on times gone by.

Patient Experience - The Introduction of a Spiritual Assessment Tool to the Admissions Process for all Patients

Our aim was:

- To develop a new, user friendly spiritual care assessment tool to be implemented on the inpatient unit and eventually used across all hospice teams.
- Alongside this tool we aimed to develop a spiritual care assessment training/awareness session that would be attended by all clinical staff, then opened to all non-clinical and support staff.

- To ensure all patients admitted to IPU get a spiritual needs assessment using an approved assessment tool – removing the possibility of unconscious bias.
- Spiritual care training to be mandatory for all clinical staff and be accredited on Blue Stream Academy.

What we did:

- In collaboration with the Spiritual Care Lead we developed a new spiritual care model of assessment – "JUST ASK".
- We commenced training/awareness sessions – underpinning the importance placed on spiritual care by Trinity clinical staff following multiple staff surveys.
- Training sessions provided staff with an overview of spiritual care needs and how to identify spiritual pain/spiritual distress.
- We embedded the JUST ASK model on EMIS which launched as an EMIS template in March 2023.

Clinical Effectiveness – Lymphoedema Service Development

Our aim was:

To develop our specialist Lymphoedema service to ensure succession planned and identify efficiencies to be able to respond to increasing numbers and complexity of referrals.

What we did:

- Recruited two new nurses to the service to be trained up to ensure succession in anticipation of pending retirements of longstanding experienced specialist nurses.
- Introduced eight hours of dedicated clinical administration support to the service.
- Supporting the development of our HCA role to become a Trainee Nurse Associate (TNA).
- Reviewed and redesigned our referral forms to capture all the information needed to inform clinical triage and decision making and prioritisation of referrals for both cancer and non-cancer related lymphoedema.
- Reviewed and updated our Lymphoedema Management Pathway with our commissioners and communicated this out to our Fylde Coast GPs.
- Reviewed our service KPIs for 23-24 to reflect anticipated increased productivity from service review.
- Promoted awareness of the services.

What was the outcome?

- Released valuable senior clinical time through the addition of administrative support for direct patient care, leadership and training and educational activities to support the development of the junior members of the team.
- One new member of staff has completed her core training in Lymphoedema. Another is due to commence training during September 2023.
- The team's Trainee Nursing Associate is progressing well and about to complete the first year of her two-year training course.
- Two team members are undertaking leadership and management skills training.

- An audit of referrals and waiting times since the introduction of the new referral forms has shown positive encouraging result results, increased numbers of patients seen and a reduction in waiting times.
- The service has welcomed increasing numbers of students on learning placements.
- The team are introducing “Living Well with Lymphoedema” group sessions to promote self-care.
- There is now regular promotion of Lymphedema awareness through staff bulletins, training and externally through social media during National Lymphoedema Awareness week.

Review of Service 2022-2023

During 2022/23, Trinity Hospice provided the following services in conjunction with Blackpool and Fylde and Wyre NHS Clinical Commissioning Groups and latterly the Integrated Care Board in the provision of specialist palliative care services:

- An In-Patient Unit with 18 beds offering 24-hour care for the most complex patients and their families.
- A Community Nurse Specialist Team supporting patients and their primary care teams in the community over seven days.
- Hospice at Home overnight service, seven nights a week, supporting people in their own homes, care homes and nursing homes, working with out-of-hours medical services, district nursing teams and ambulance service.
- A Hospital Nurse Specialist Team supporting patients and colleagues within the hospital over seven days.
- We have continued the development of our new “Living Well Service” with an expanded skill mix.
- A specialist Lymphoedema service supporting patients, adults, and children, with both primary and secondary lymphoedema.
- Bereavement and counselling services run from the Linden Centre supporting adults and children, individually or in groups. We also run a Schools Link Service, helping schools to support children experiencing bereavement.
- Quarterly bereavement and annual bereavement events such as “Light Up A Life”.
- Specialist palliative and end of life care psychology services.
- Complementary therapy offering patients and carers a range of complementary therapies.
- Physiotherapy – supporting palliative rehabilitation, promoting independence, and improving quality of life and supporting discharge from the In-Patient Unit.
- Social worker helping patients to stay in their own homes and supporting discharge planning for the In-Patient Unit.
- Spiritual care and support by our Spiritual Co-Ordinator and chaplains.
- Admiral Nursing service in partnership role with Dementia UK, providing support and assessments for those caring for loved ones with a dementia diagnosis and education and training across the health care sector of the Fylde Coast.
- Education, training and research – a Learning and Research department that facilitates education internally and externally to the hospice. Co-ordinates educational events, supports opportunities for learners and palliative care research projects.
- Continuous training placements for Nursing and Medical Students and junior doctors.

- Learning placements for a host of other health and social care professionals.
- Brian House Children's Hospice supporting children and young people and their families with respite and end of life care (mainly funded by our charity's monies with a small emergency grant from the Department of Health).
- A 24/7 palliative care advice helpline manned by the community and In-Patient Unit staff.
- Volunteers – all aspects of the above services are supported by over 850 volunteers.

Trinity Hospice is an independent charity which provides all services free of charge. The income generated from the NHS in 2022/23 represents 35% of the overall costs of service delivery with the remaining income to fund our services coming from voluntary charitable donations, legacies, events, corporate and community fundraising, hospice shops and lottery.

CARE QUALITY COMMISSION – OUTSTANDING

The Care Quality Commission regulates Trinity Hospice for the following regulated activities:

- Treatment of disease, disorder or injury.

During this period, and since 2016, we have not had an inspection by the Care Quality Commission (CQC) but we do have quarterly engagement meetings with a CQC Engagement Officer and have maintained our outstanding rating with our current CQC risk rating unchanged. We receive data from CQC monthly regarding our rating and at present CQC have determined from a variety of sources that our current rating remains.

• **OVERALL RATING FOR THIS SERVICE**	**Outstanding**
• Is the service safe?	Good
• Is the service effective?	Good
• **Is the service caring?**	**Outstanding**
• Is the service responsive?	Good
• **Is the service well-led?**	**Outstanding**

What They Said:

Is the Service Safe?

- The service was safe.
- Staffing levels were sufficient to meet people's needs and individuals we spoke with said there were enough staff to keep them safe. The management team had not always followed their recruitment systems but took immediate action to address this.
- Staff had a good awareness of safeguarding principles and who to report concerns to if people were at risk of harm or injury.
- We observed people receiving their medicines on time and when required. Staff were skilled and managed medicines carefully.

Is the Service Effective?

- The service was effective.

- People told us they felt staff were experienced and skilled. Staff files we saw showed they received a wide range of training.
- Care files contained nutritional risk assessments and control measures to minimise the risk of malnutrition.
- Staff receive training about Mental Capacity Act and Deprivation of Liberty Safeguards. People told us they were supported to make decisions.
- Staff worked with other healthcare services to monitor people's ongoing physical and mental health.

Is the Service Caring?

- The service was exceptionally caring.
- Without exception, people and their relatives spoke extremely highly of staff and their experiences of care. We found staff were passionate about providing a non-discriminatory service.
- We toured the service and found it was exceptionally tranquil, warm, happy and welcoming atmosphere throughout. People said this enabled them to feel exceptionally comfortable and relaxed.
- The Registered Manager worked with other healthcare services to provide relatives with dignified end of life care. Care planning was highly personalised and held details about the person's preferences and how they wished to be supported.

Was the Service Responsive?

- The service was responsive.
- Care planning was personalised and gave staff precise direction to care. People told us that staff were efficient at responding to them and their requirements.
- The provider maintained the environment to a very high standard to enhance people's wellbeing and stimulation. This included a range of activities, facilities and holistic therapies.
- We saw that the Registered Manager dealt with complaints competently.

Is the Service Well Led?

- The service was extremely well led.
- The Registered Manager acted with other agencies to develop best practice and foster excellent partnership relationships. They worked with the local hospital to influence and improve best practice and national policy making. We found this had a major impact upon people's care, safety and welfare.
- Staff, people and visitors said the service was organised and managed to an extremely high standard. They told us the Registered Manager was very active in supporting and understanding their requirements.
- The management team excelled at managing change in a coherent and cohesive approach. Staff said they felt fully involved in Trinity's ongoing development. They added the management team was extremely supportive and approachable.
- We found people were at the heart of Trinity's quality assurance programme. They fed back they would not hesitate to recommend the hospice to others. The Registered Manager had remarkable oversight of care provision, service quality and everybody's safety.

CQC has now changed its methodology for inspections and hospices come under the same directorate as NHS and Healthcare organisations. The Registered Manager meets with CQC on a quarterly basis completing a pre-meeting form to identify changes to practice and to support information gathering and intelligence data for the CQC Inspector. At the time of writing CQC are in a transition process so unsure as to when our next inspection will be.

Trinity's Values and Ways of Working

Trinity's values and ways of working are embedded throughout the organisation and staff are expected to act in accordance with them.

Trinity C.A.R.E.S

Caring

Provide care with skill and compassion that is person and family centred.

Truly listen in order to provide appropriate, warm hearted and honest support that meets physical, psychological and spiritual needs.

Place 'caring for patients and those important to them' at the heart of our actions.

Respect and value individual differences.

Support colleagues and volunteers at all times.

Share our knowledge and expertise with others involved in the care of people with progressive life-limiting illnesses.

Adaptable

Respond positively, appropriately and flexibly to challenges.

Constantly strive to ensure all we do is high quality and compliant (safe and risk assessed) in accordance with changing regulations.

Work across sectors (voluntary, public and private) to maximise our collective impact.

Develop effective external collaborations based on mutual respect and trust.

Responsible

Clearly communicate expectations so that staff members and volunteers know what is required of them.

Demonstrate a 'can do' attitude and be accountable for our individual actions.

Investigate adverse comments and complaints carefully and honestly, to ensure learning and continuous improvement.

Share compliments and celebrate successes to learn from good practice.

Ensure effective teaching and provide exceptional learning opportunities around end-of-life care.

Maximise our impact by effective team working.

Excellence

Constantly develop and apply our professional expertise in palliative care.

Encourage others to share ideas and learning.

Aspire to provide exceptional professional performance in all roles.

Promote learning and development for all those providing and needing our services.

Recruit capable and committed volunteers.

Strive for improvement every day as everyone makes a difference.

Continuously challenge assumptions and strive for cutting edge solutions.

Add new knowledge around end-of-life care through high quality audit and research.

Socially Engaged

Work in partnership with our community to achieve high quality care at the end of life, for all who need it.

Provide meaningful and satisfying employment and volunteering opportunities.

Fund our services through ethical and transparent fundraising.

Share Trinity's expertise to benefit the wider hospice and palliative care community as well as other care providers.

Speak up/advocate for vulnerable individuals or disadvantaged groups who need palliative care.

Endeavour to be environmentally and financially sustainable to benefit future generations.

Use available resources well, to maximise our shared compassionate cause.

Working Smarter

We have been working to develop smarter ways to deliver palliative care interventions and to support clinical colleagues to enhance their knowledge and skills in palliative care to improve outcomes for patients in their usual place of residence; this includes care and nursing home and local hospitals. We developed the use of remote technology with a number of care homes and with the local community hospital, undertaking virtual ward rounds with staff, in which patients are discussed and a management plan instigated; this is alongside training around palliative care and symptom management.

This coming year will see the further development and expansion of Virtual Wards which will enable a safe alternative to hospital or hospice for patients who require palliative or end of life care.

Staff Development

Trinity Hospice prides itself on supporting staff to undertake professional development. For nursing staff and allied health care professionals, this is an important part of demonstrating their fitness to practice. Revalidation supports nurses to capture their learning and, more importantly, how they have applied this to patient care.

Over the last three years we have supported a wide range of staff to develop their skills to improve the care they provide for patients and families. Clinical services celebrate this success and congratulate individuals and teams for their achievements. Staff development successes include:

- Developing the Advanced Clinical Practitioner role (ACP).
- Developing the Nurse Associate Programme.
- Commencing Management and Leadership upskilling across all clinical settings and teams.

Investors in People Gold

Trinity Hospice was first awarded Investor in People (IiP) Gold accreditation in 2016, having achieved Silver for the first time in 2015. Re-accreditation occurs every three years and in 2022 the hospice was delighted to retain its IiP Gold following a three-day assessment, which reflected extremely well on the contribution of everyone across the organisation. A Gold IiP accreditation is not easy to retain but everyone involved will be working hard towards the goal of once again retaining Trinity's Gold accreditation status.

Part Three: Review of Quality Performance

Trinity Hospice and Palliative Care Services

In-Patient Unit Service	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Total number of new admissions	291	288	287	304	351	390
Total number of admissions	333	320	325	340	374	414
% Bed occupancy	78%	74%	74%	67%	70%	84%
Number of patients discharged	80	85	107	104	86	110
Number of deceased patients	252	236	228	232	289	299

Clinical Nurse Specialist Team Community	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Total number of patients referred	1113	1402	1448	1429	1113	1564
% of patients with a non-malignant disease	20%	19%	16%	22%	18%	17%
% of patients who died outside hospital	94%	93%	95%	94%	98%	96%
% of patients that died in stated PPD	82%	84%	77%	85%	86%	80%

Clinical Nurse Specialist Hospital	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Total number of patients referred	1227	1348	1516	1467	1593	1932
% of patients with a non-malignant disease	43%	42%	38%	46%	47%	55%
Number of patients discharged	732	789	945	796	874	1033
Number of deaths in hospital	436	459	450	493	509	711

Lymphoedema Service	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Total number of new referrals	304	272	293	175	261	242
Average number of clinic appointments	15	7	9	8	10	12
Monthly case load number	-	260	252	247	257	242
% of non-attendance for booked appointments	-	8%	11%	2%	8%	6%

Hospice at Home	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Total number of patients referred	916	1159	1264	1301	1075	1157
Face to face contact	2152	1940	1921	2962	4279	3553
Telephone advice	5838	6861	3684	1571	1251	2835
% with non-malignant diagnosis	47%	43%	36%	43%	42%	45%

These above figures go some way to demonstrate how our patient services have seen a steady increase in referrals and patient contacts in all our core services and workforce reviews will be

required to ensure that we have a sustainable workforce to maintain quality and patient experience.

Our Participation in Clinical Audit

Clinical audit within the organisation continues to play an integral part in ensuring it constantly strives to improve and provide the highest standard of care by auditing our practice against agreed policies or standards. An action plan that may be required as a result of audit allows us to rectify or improve service provision. Re-audit then ensures any necessary changes have had an effect.

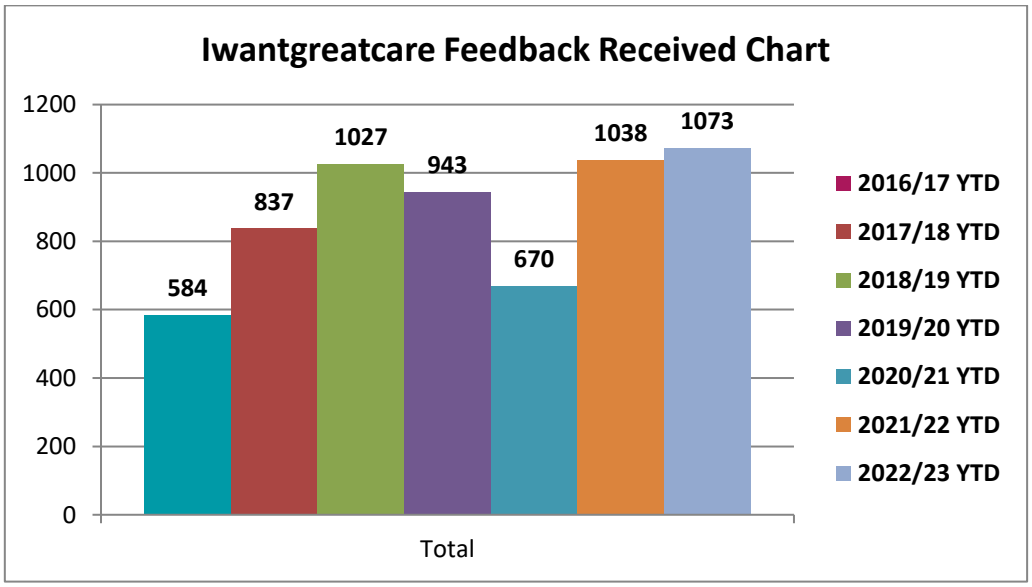
Improvement in practice must be embedded into all aspects of Trinity Hospice and Palliative Care Services but specifically patient safety, patient experience and effectiveness of care. In doing so we strive to comply with all aspects of clinical governance and meet the standards required by our regulatory body, the Care Quality Commission.

Membership of the Audit Group continues to comprise of a representative from each area of the clinical directorate, the medical directorate, and services. The group meets quarterly, and this is fed back into the Clinical Quality Improvement Group.

‘’Iwantgreatcare’’

What Do Patients Say About Us?

Each department undertakes evaluation of their service which entails seeking views, comments and suggestions of patients and their families and carers who use the service. Feedback is gathered using ‘Iwantgreatcare’, thank you cards, letters and comments and learning from complaints.



Brian House – a total of 128 'iwantgreatcare' feedback forms completed during this period.	
How likely are you to recommend our services?	**100%**

A selection of the comments received:

- **** stay at Brian House allowed him to play more independently in a safe environment, which he cannot do at home. The staff take great care of him. His stay at Brian House gives us a rest from our caring duties. Nothing could have been done better.
- **** stayed at Brian House for two nights last week. The staff took great care of him and changed how they look after him due to him recently being registered blind. They were very sympathetic to us parents saying they would assist us where possible. **** stay enabled mum to catch up with household jobs and get some sleep. Nothing could have been done better.
- When at Brian House **** gets to be independent in a safe environment. He loves his stay there. We have the opportunity to enjoy quality time with our other children.
- **** recently stayed at Brian House for the first time. I was allowed to stay with her and be involved in her care which was great as I was very apprehensive about her stay. The staff made us feel very welcome and took great care of both **** and me. S he was allowed to sit with other children when having their meals.
- **** struggles with anxiety and is a little apprehensive about going to Brian House but is always fine when there. Her respite stays encourage her to mix with other children which is helping to build her self-confidence. I value the time she spends there as it gives me the chance to have a full night's sleep.
- The Brian House service is a lifeline to me. There is nowhere else I could have *** to be looked after to her complete needs. The staff are very skilled and caring. I am also developing friendship by attending the tots groups with other children and their parents.

Community Clinical Nurse Specialist Team – a total of 399 'iwantgreatcare' feedback forms completed during this period.	
How likely are you to recommend our services?	**95%**

A selection of the comments received:

- Bearing in mind that this was not a visitor I ever thought to see. *** simplified my concerns, worries and anxieties. She answered my daughter's questions because this affects all the family.
- Excellent introduction. Good communication. Very professional.
- The visiting community CNS service work through in their assessment of my current and future needs and offered appropriate support and re-assurance.
- I was most impressed at the care and attention that I found from the team that came to see me. They really put my mind to rest in a lot of things that were worrying to me.
- I felt involved when discussing my treatment. Any queries I had wherever appropriate were answered.
- ****, her daughter and myself were treated with warmth, kindness and support. The information given was delivered clearly and at a pace we could take in at a very distressing time. We felt understood, supported and no longer felt alone in this life limited journey.
- Nurses demonstrated compassion and understanding. They explained their role and instilled confidence.
- My experience with the Admiral Nurse service was above and beyond expectation. The Admiral Nurses were professional, helpful and extremely caring. They are amazing.
- My experience has been above excellent. I was so nervous, apprehensive and worried about the visit. **** has really put me at ease, been a huge help with physical issues I'm

having with doctors/hospitals etc. Thank you for providing this much needed service, **** and **** have been amazing. Improvements: Excellent in every aspect.

Hospice at Home – a total of 245 'iwantgreatcare' feedback forms completed during this period.	
How likely are you to recommend our services?	**99%**
A selection of the comments received: • So amazing, care and support. Bereavement support, great support also. Thank you. • If it had not been for Trinity we would not have managed. • So supportive, came as quickly as could, as may times as we needed thank you. • So good as we live in isolated spot so nice to know they are able to come out. • Care home. Always good to know we can call them anytime. • Got all the support he needed	

In-Patient Unit – a total of 228 'iwantgreatcare' feedback forms completed during this period.	
How likely are you to recommend our services?	**98%**
A selection of the comments received: • The staff caring for my dad were kind, thoughtful and professional. Nothing was too much trouble. His death was peaceful and dignified I am forever grateful to everyone. Nothing could be improved upon. • Since arriving at Trinity *** has had the very best care. The staff are so kind and caring towards him, they take into account his wishes and nothing is too much trouble for them. Cannot thank them enough as this is so different to his previous care. • Excellent medical attention and care for my wife. Excellent support and consideration for me. I am vulnerable and the knowledge she is in very safe hands is a big help. • Great to get symptoms under control then back home thank you. • Dad hated the thought of coming and getting the help he needed. Within the first day he was won over by the care and attention and calls it 5* plus care and attention to detail is superb! • A fantastic place, my wife died just how she wanted to. So kind thank you and family could just be family. • Because the measure I have got from Trinity is nothing is a problem; medication, meals, support with my mobility and support with my care needs. Nothing is a problem with the caring staff. Improvements: I cannot think of anything that Trinity could have done better. • Couldn't ask for better care than what I got. Made to feel like an individual and not just a name or number. Everything has been outstanding. • Standard of care was second to none for the patient and her family. Total involvement, respect, warmth and dignity. Staff quickly identified anyone struggling emotionally and were ready with a hug and a listening ear. I don't think anything could have been done better. You are all marvellous. Thank you for your outstanding service.	

Linden Centre Counselling and Support – a total of 31 'iwantgreatcare' feedback forms completed during this period.	
How likely are you to recommend our services?	**100%**
A selection of the comments received: • Just what I needed and cleared my mind of a few points that were holding me back. Improvements: The service from start to finish was excellent. Just wish it could have been longer than six weeks. • I cannot express enough how grateful I am to ***. When I started my sessions I was so down and could not see any way forward. With her help and guidance I have started my obstacles and feel I now have a worth, she is amazing. • The counselling sessions with ****, who was brilliant, brought out hidden feelings and on completion made me better equipped to deal with loss. • Amazing support thorough my bereavement journey, so supportive and got me to join a group. • My answer is the results of a very positive experience with the counsellor, with whom I felt safe expressing some of my emotions. • He listened to what I wanted and not what everyone thinks I wanted. He was very understanding and encouraging to help me to as little or as long as I liked. Very professionally and compassionate. Thank you	

Lymphoedema – a total of 32 'iwantgreatcare' feedback forms completed during this period.	
How likely are you to recommend our services?	**100%**
A selection of the comments received: • **** and **** were informative, supportive, friendly and caring answered my questions and explained everything clearly. Excellent ladies and a credit to the service given. • I was very worried about going to the lymphoedema clinic. Staff I saw were brilliant. Reassuring and very kind outstanding. • I was extremely anxious when I arrived, and got very upset but **** and **** were lovely calmed me down, and talked me through everything. Improvements: Nothing at all, I came feeling very down and upset and left feeling positive and more informed on what is happening to me. I am a lot happier than when I arrived. • I have received excellent treatment and the staff have been very supportive and caring. • I have always relied on this service should I ever need it. Since 2007 I have always received fantastic care. Improvements: Nothing - my experience here is always good.	

Key Quality Indicators

Quality care is essential to patient care, to ensure patient safety and promoting a positive patient experience. The hospice promotes an open reporting system, recognising that patient safety is everybody's business. It supports and upholds the Duty of Candour and will continue to inform and involve patients and families in understanding any error or incident that has resulted in patient harm under hospice care.

Complaints

Trinity Hospice welcomes both positive and negative feedback from patients and families about their experience of our services. Negative feedback enables us to reflect and consider what we

could have done differently. It is only through valuable feedback that we can understand and improve the care we provide. All complaints received are dealt with as per policy and procedure. This includes an apology, investigation, an outcome, and actions put in place from lessons learnt. During this period, we received adverse/verbal comments and formal complaints.

Summary of Complaints/Adverse Comments Received

Brian House

Adverse Comments Received: A parent made adverse comments regarding the communication she had with a member of staff during a recent respite stay that made her feel like she was being challenged and not trusted.

What We Did: Following a face-to-face meeting with the Assistant Clinical Director there has been an update with staff regarding communication with this parent to ensure they feel supported and there are no more misunderstandings.

Community Team

Iwantgreatcare Adverse Comment: We received some adverse comments on an I want great care form.

What we did: We met with the relative and had a detailed discussion. They are now receiving counselling from our counselling services and we have explained that Virtual Ward has been started and we are moving towards single point of access which should prevent a breakdown in continuity of care between services. The relative was satisfied with the discussion.

What was said: We received a joint complaint with Blackpool Teaching Hospitals into care provided by the hospital and in respect of aspects of care provided by the Hospital Palliative Care Team and In-Patient Unit. The complaint relating to Trinity mainly involved breakdowns in communication and a lack of their understanding of the patient's condition and symptom control leading to distress to both the patient and their next of kin. It was a complex complaint that involved a patient who quickly deteriorated upon coming under our care.

What we did: We provided the family with a complete timeline of events and a full and complete answer to the questions they asked. We acknowledged several areas where we could have done better, all of these came down to communication between our teams and the family with better documentation of these conversations in the patient record, particularly by our nursing teams, including after death. This is something we are addressing with record keeping training. If important conversations must be had over the telephone, we need to be particularly careful to avoid ambiguous language.m Ideally these types of communications should be face to face or virtual if possible.

We offered the family the opportunity to meet in person to discuss things further if they wished.

In-Patient Unit

What Was Said: Complex case involving a discharge.

What We Did: MDT being arranged to agree a way forward. Complaint not upheld.

What was said: Phone call passed through from reception regarding historical concerns with aspects of care dating back to when her husband was on the In-Patient Unit in September 2022.

What was done: The Medical Director contacted the complainant the same day and has arranged for her to come in and raise her concerns in person. Both herself and her son attended a face-to-face meeting and expressed some of the historical issues they had faced prior to the patient coming to Trinity which had resulted in complex grief which they were struggling to get past. There were discussions regarding the discharge process from Trinity and communication around this. A letter was sent following the meeting offering the counselling services and memorial service.

Emailed Adverse Comment: An email was received regarding access in and out of the In-Patient Unit when no volunteer was available on reception and in respect of visiting hours and restrictions to visitor numbers and mask wearing.

What we did: The In-Patient Unit Manager had a conversation with the relative, apologised and explained the reasons for the visiting processes. They were satisfied following discussion.

Part Four

ICB Response to Trinity Hospice Quality Account 2022/23

Lancashire and South Cumbria Integrated Care Board (ICB) thanks the Hospice for producing this Quality Account which is reporting on 2022/23.

The restoration of services after the Covid-19 pandemic has been managed. As an extension to the comment by the Chairman of the Hospice Trustees, the ICB would also like to express our gratitude to the support provided by the Hospice to Blackpool, Fylde and Wyre residents during the Covid-19 pandemic. The partnership working by the Hospice and all partner organisations on the Fylde Coast was exemplary and has strengthened over the last year.

It is evident from the ongoing discussions the ICB has with the Hospice that a high quality of service has been maintained during 2022/23, despite challenging itself to further grow services, and the constrained funding available.

There is demonstratable evidence that most core patient services have seen an increase in referrals and patient contacts, and the management have identified that workforce reviews will be required to ensure that the Hospice has a sustainable workforce to maintain quality and patient experience.

It is reassuring to see Trinity's commitment to developing its workforce, including volunteers and this has resulted in the Hospice again retaining the 'Investors in people gold standard' this year, whilst continuing to strive to further improve where possible in the areas of:

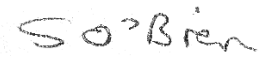
- Patient Safety
- Patient Experience
- Clinical effectiveness

So, with the strong management and quality governance in place and the continued investment in workforce, the Hospice is to be congratulated on:

- Maintaining the 'outstanding' rating from CQC and achieved high clinical audit ratings from those who oversee health provision on the Fylde Coast.
- Adopting a 'hospice without walls' ethos with a significant proportion of its work out in the community through Hospice at Home and community teams.
- Launching a Virtual Ward and developing virtual clinics, consultations and nurse-led clinics.
- Expanding the specialist Lymphoedema service/team.
- Making improvements to bereavements services, including complementary therapy.
- Successfully launching the Dementia Lounge.
- Developing an improved Spiritual Care Model of Assessment.
- Launching the Living Well Service.

The ICB recognises the challenges Trinity Hospice has faced over the last few years, and will continue to face for the foreseeable future, especially during the uncertain economic situation. Despite this they have achieved several of the priorities set out in 2022/23, whilst carrying over a number into 2023/24 and identifying more challenging and stretching goals, which the ICB endorses.

The ICB welcomes these plans and look forward to working with Trinity to achieve them in 2023/24.
Yours sincerely,



Professor Sarah O'Brien
Chief Nurse