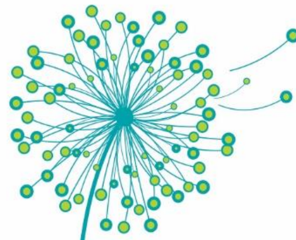


QUALITY ACCOUNT
2023 - 24

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 Palliative Care Services including 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 Unit, Community, Hospital, Living Well, Hospice at Home, Lymphoedema and Bereavement & 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 paramedics, 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 is the only children's hospice on the Fylde Coast and 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 outreach into the community setting and 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 parents, 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 £1.4 million to keep its doors open, most of which isn't funded.

Part One

Statement of Quality from Our Chief Executive:

What does 'quality' mean to you?

If you do a search on the internet, you may find the following phrase "how good something is compared to other similar things". For hospices that find themselves working in an increasingly overstretched health & social care landscape, it could feel like we can 'rest on our laurels' with our 'relative' quality assured. But there is not one single hospice in the UK that would buy into this mindset. Why?

All who come to work in hospice and palliative care cannot accept the status quo or that nothing can be done to improve the lives and deaths of those travelling the path to the end of life, even in such challenging times. This mindset drives our staff and volunteers to always try to go the extra mile, to make the time to listen to the individual needs of all who we care for, and to advocate for all who live on the Fylde Coast for 'consistent' and 'timely' access to good quality palliative and end of life care.

It's increasingly tough though as hospice statutory funding continues fall in real terms and remains at around only 27% of our overall operating costs. Despite this, we continue to strive to improve our services and the quality of our care and working with our supporters and partners, we continue to do so.

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

- Developed a strategic plan to formulate a Single Point of Access pilot across two neighbourhood care teams.
- Seen our conference facilities being utilised externally again.
- Expanded on our Quality Improvement projects.
- Started to develop our facilities through our Hospice 2030 project.
- Optimised the use of EMIS electronic patient clinical records.
- Continued with the upskilling project.
- Embedded Virtual Ward into Trinity Hospice pathways.
- Developed and agreed a Trinity Hospice Education Strategy.
- Reviewed our clinical workforce models to ensure that we are prepared to care.
- Developed a governance accountability framework in line with the new CQC standards framework

Looking forward to 2024-25, we plan to:

- Improving Engagement and Involving Patients, Families and Staff Following a Patient Safety Incident In Line With the Principles of NHS England's Patient Safety Investigation Response Framework (PSIRF)
- Optimising the Use of Our EMIS Electronic Patient Clinical Record
- Enable a Brian House Seven-Day Service Through Community Outreach
- Implementing Safer Ways of Working Through Supporting Staff
- To Provide a Career Pathway and Training Opportunities For Staff That Encourages Retention and Recruitment

- To Expand the Provision of Specialist Palliative and End of Life Care (PEoLC) Training to Staff at Trinity and Partner Organisations to Include the Wider Community and Social Care Teams
- Specialist Palliative Care Support for the Withdrawal of Ventilation at End of Life Within the Medical Enhanced Care Unit (MECU) at Blackpool Teaching Hospital.
- Develop a Nurse Led Advanced Care Planning (ACP) Outpatient Clinic
- Review our clinical workforce models to ensure that we are prepared to care.
- Reduce Waiting Time for Patients Referred into the Service Accessing Counselling/Wellbeing Support
- Improve the Environment in the Bereavement Suite on IPU for Care of the Deceased
- Integrate Community Palliative Care Team Into Palliative Care Networks
- Develop a Twilight Hospice at Home
- Support our teams to be educated to enable them to undertake a specialist role in line with NMC and CQC Guidelines

I hope this gives you confidence that we remain committed to continuing to strive forward with our focus on delivery high quality palliative care for all who we support. We cannot do this without your ongoing support.

Thank you

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, many 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 but on notice, 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, administrative, facilities and retail. The trustees have also attended Schwartz Rounds.

Trustee visits to parts of the hospice have continued which allows members of the board to see first-hand the operation of our clinical, administrative, facilities and retail teams. The written reports are remitted to senior management for comment before reference to the board which we consider strengthens the report that is finally approved by the board.

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.

Board meetings take place every two months and has included three newly appointed trustees who bring a wealth of experience from NHS administration and Civil Service administration and HR practices. We, the trustees, have benefitted from oral reports direct to trustees at board meetings from our clinical, medical, administrative, facilities and retail teams and others of the roles they undertake within the hospice.

I commend the medical and clinical teams who have continued to work so hard to maintain our services, supported as ever by our administrative, fundraising, retail and facilities teams. In particular we commend our CEO, David Houston, for the way he has led the staff and our new Finance Director, Andrea Lumb, who led the change of our investment providers. The clinical team is well led by David Kay, our Director of Clinical Services, who has ensured that his team is now fully staffed enabling him to develop in the future the role of Deputy CEO.

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 a hospice that enables our patients to live well to the end of life and for our children to live their lives to the full.

The trustees strive in their role to assist our medical, clinical, fundraising, administrative, facilities and retail 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 2024/25

These Quality Accounts contribute to our Quality Strategy and are supported and approved by our Board of Trustees. The following areas have been identified for development/improvement in 2024/25 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 and contribute to the Fylde Coasts Dying Well Strategy 2024-2029.

As we have emerged from the Covid 19 pandemic, and entered the recovery phase, Trinity Hospice has continued to face challenges as our services have transformed in response to patients' and their families' needs. This is also in the context of immense pressures and changes within our own and wider health and social care system across the Fylde Coast.

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 who has developed a three-year education strategy.

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.

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 which will, in line with the new five-year strategy, improve patient safety, improve effectiveness and improve patient experience.

Trinity Hospice continues to play a central role in the strategic planning for palliative and end of life care across the Fylde Coast. This year has seen the launch of the Fylde Coast's Dying Well Strategy 2024 – 2029. The five-year strategy will provide the blueprint for an integrated and collaborative working approach with our key Fylde Coast partner services across health, social and spiritual care and with other community voluntary sector service providers.

Clinical Effectiveness, Patient Safety and Patient Experience – Improving Engagement and Involving Patients, Families and Staff Following a Patient Safety Incident In Line With the Principles of NHS England's Patient Safety Investigation Response Framework (PSIRF)

Our aim is:

Increase engagement with those affected by clinical incidents, including patients, families, and staff, ensuring they are treated with compassion and can be part of any investigation in order to promote systematic, compassionate, and proportionate responses to patient safety incidents, anchored in the principles of openness, fair accountability, learning and continuous improvement, with the aim of learning how to reduce risk and associated harm.

What do we want to achieve?

Review and amend the systems we already have in place to ensure an effective process of engagement and involvement with those affected by patient safety incidents. This should include those affected including staff, the person or patient (the individual) to whom the incident occurred, their family and close relations. This is firstly to ensure immediate needs are met in respect of our duty of care and secondly to improve our understanding of what happened and potentially how to prevent a similar incident in future. To achieve this, we need to embed the foundations of effective and compassionate engagement including leadership, training and competencies, support systems, ensuring inclusivity, information resources, clarify the process for seeking and acting on feedback, process for managing dissatisfaction.

How will progress be monitored and reported?

- Develop training and evaluate if staff have received the appropriate knowledge to understand how to involve those affected by patient safety incidents.

- Identify engagement leads to support staff and individuals involved in patient safety incidents.

- Evaluate current and develop new information resources to ensure they signpost and adequately describe the engagement principles to those affected by a patient safety incident including what to expect from the process.

- Evaluate through feedback that managers and staff demonstrate their commitment to compassionate engagement with anyone involved in an incident.

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?

- The Digital Transformation Lead, with support from colleagues in the Community and Primary Care Electronic Patient Record Team at Blackpool Teaching Hospitals NHS Trust. will lead on the optimisation and update of EMIS and other digital transformation needs.

- Embed the re-establishment of Trinity departmental “EMIS Champions”.

- Achieve the following aims:
    - 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 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.
    - Staff training and evaluation.

How will progress be monitored and reported?

- Development and review of project action plan.

- Provide EMIS development progress reports at the Clinical Quality Improvement Group Meetings and report to Clinical Governance Committee and Board.

- Feedback from staff and training evaluations.

- Proven efficiency savings and improved management information.

Clinical Effectiveness – Enabling a Seven-Day Service Through Community Outreach

Our aim is:

Brian House provides a service to our local community in supporting children and their families in complex care and management for children with life-long limiting illnesses. We therefore envisage expansion of our service provision and activity both in Brian House and community by increasing the core staffing resource through enhancing and expanding the care teams specialist skills and knowledge.

How was the priority identified?

Through effective communication and collaboration between staff, and users of the service provided. It Is recognised the current staffing structure does not permit Brian House to be operational seven days a week.

Through the establishment of a Community Senior Staff Nurse post within the community to support children and families in their own homes, community, and hospital settings.

What do we want to achieve?

- Brian House aims to achieve an increase in our service provision through a workforce review to enable a seven-day service, providing an integrated and flexible workforce to meet the needs of our service users. This will enable us to increase the specialism of roles and responsibilities within our workforce.

- To integrate with children's community services and social care to promote collaborative working between parties.

- To continue to improve access and quality over time, drawing on best practice and current guidance.

How will progress be monitored and reported?

- Review of workforce plan to identify gaps, pressure points, and provide solutions to achieve strategic objectives.
- KPI figures and analysis of performance.
- Regular progress reports to the Board.
- Recruitment and retention figures.
- Completion of Audits.
- Patient and family feedback.

Patient Experience – Engagement Through Different Ways of Working

Our aim is:

Brian House aims to create a culture of positivity and drive. We aim to support our children and families within the community ensuring they have a positive experience from the service they engage with. We aim to develop the way we engage and support families with the community and identify increase mechanisms to gather feedback. Feedback shall be sourced from a variety of areas including social media.

How was the priority identified?

Through staff and patient engagement/feedback in developing the service via social media.

Families have demonstrated interest in attending peer support groups, expressing that attending current stay and play sessions have enabled them to meet other parents who have offered support and who understood the daily challenges, as they too have children with complex needs.

What do we want to achieve?

Family and patient engagement with social media to raise awareness of the service and increase the credibility of Brian House.

Collaboration with the marketing team to promote digital technology.

The adoption of new and established technologies alike, and data-driven care delivery.

Create innovative partnerships with local non-health organisations and community assets.

New technologies are embraced.

Facilitate opportunities for families to access peer support sessions.

Provide experience for patients and families through social engagement within our community.

Development of different ways of seeking feedback, which allows us to understand what is working well, what needs improving, how we could do things better, or differently and what families want more of.

How will progress be monitored and reported?

- Audits.
- Patient feedback and family feedback.
- Analyse data and usage.
- Evaluation and analysis of support groups.

Patient Safety – Implementing Safer Ways of Working Through Supporting Staff

Our aim is:

Review and update the current clinical information system to support and evidence safe and effective care.

To transcribe safely and competently and review the current Standard Operating Procedure and policy.

To create a safe environment for staff to flourish within a reflective environment through dedicated support from restorative clinical supervision.

To continue to develop upon building a service delivery with the right skill, right place, and time, through utilisation of continuing professional development and learning.

How was priority identified?

- Collation of key performance data.
- Through audits of reconciliation and transcribing.
- Staff engagement and satisfaction.
- Through fostering a learning and development culture.

What do we want to achieve?

Technology that enables joined up care and information sharing and supports safe care and support.

Staff suitably trained and competent in transcribing medication.

Support the emotional needs of staff, providing ‘thinking space’ which reduces stress and burnout and improves staff retention.

Staff to become experts in their field of practice to be able to provide a high-quality standard of care to patients and families within Brian House and the community setting.

How will we monitor progress?

- Clinical audits.
- Staff, patient and family engagement.
- Feedback from staff following engagement in reflective clinical supervision.
- Staff retention figures.

Patient Safety - To Provide a Career Pathway and Training Opportunities For Staff That Encourages Retention and Recruitment

Our aim is:

To address retention issues, support staff and encourage further recruitment of skilled staff, to ensure sustained growth and success by providing a clear career pathway and learning and development opportunities.

In the current climate competition for skilled staff is intense. To attract the right candidates and keep them, we want to be able to offer opportunities for learning and development and career progression.

How was the priority identified:

The need was identified from informal discussions with staff, asking their opinion on what would make them be more likely to stay with Trinity in their careers. From feedback from course attendees and from training needs analysis questionnaires – full results not yet available for this.

We also researched the availability of learning opportunities with the local universities and looked at how much external training had been sources over the last three years.

This has been identified as a priority within the Ambitions for Palliative and End of Life Care document (May 2021) and subsequently within the Lancashire and South Cumbria Strategy and the Fylde Coast Integrated Palliative End of Life Care Strategy (2023). In addition, it is a theme within the aims of the Lancashire and South Cumbria Hospices Together Collaborative.

What do we want to achieve?

A well-defined career pathway and a full comprehensive training programme that meets the needs of staff will equip our clinical team to be "fit for the future". By investing in training, we can equip staff with the skills and knowledge they need to succeed in their roles and recognise their full potential.

Training programmes offered should be tailored to the specific needs of the roles and to the individual. This may include online virtual, face to face, practical skills, leadership and mentoring and will embrace modern technologies and methodologies.

We want Trinity to be known as an employer dedicated to fostering a culture of learning and continuous improvement in a positive and supportive environment.

How will progress be monitored and reported?

- Monitoring compliance with mandatory training and taking measures to improve specific areas when concerns identified by the learning and research co-ordinator.
- Feedback from all course evaluations will be reviewed by the facilitators and the clinical educator and acted upon where appropriate.
- Reporting to the Board of Trustees.
- Performance against KPI's (number of staff attending training courses both internal and external, mandatory training percentages, number of training courses offered).
- Annual Training Needs Analysis to be undertaken and results analysed to feed into future years provision.
- Analysis of individual learning styles to be undertaken and results analysed to inform future delivery and provision.

Clinical Effectiveness - To Expand the Provision of Specialist Palliative and End of Life Care (PEoLC) Training to Staff at Trinity and Partner Organisations to Include the Wider Community and Social Care Teams

Our aim is:

To establish Trinity Hospice as a centre of excellence for the provision of PEoLC training in the local area and within the communities we serve.

How was the priority identified:

Historically, Trinity had the reputation already; however over the last years since the Covid pandemic, this has not been a priority area. It was always the intention of the Board to regain the status as a centre for excellence in PEoLC.

By working collaboratively with the Trust, we have been able to continue to offer training sessions and are now in a position to begin to expand this further to include the wider community.

This has been identified as a priority within the Ambitions for Palliative and End of Life Care document (May 2021) and subsequently within the Lancashire and South Cumbria Strategy and the Fylde Coast Integrated PEoLC Strategy (2023).

What do we want to achieve?

In this rapidly evolving area of healthcare, we want to be able to serve as a beacon of knowledge and expertise to our partner organisations and to the community. We will do this by fostering collaboration between our community partners, other hospices in the region, our university partners and our healthcare partners at the local Trust.

There is a requirement to provide holistic individualised care that addresses the spiritual, emotional and physical needs of the patients. This is not only for staff at Trinity but also for others who may have input into the patient's life story. Carers, family members, friends, community groups all, at some time or another, may be called upon to draw on their knowledge of PEoLC.

We want people to feel confident and competent to provide the care needed on whatever level that may be.

By having in place, a training programme that is accessible and informed by the latest research and innovation, we can help to inform and equip people with the tools and knowledge to provide exceptional care. The training programme will be tailored to the specific needs of the population we serve and our staff.

How will progress be monitored and reported?

- Feedback from all course evaluations will be reviewed by the facilitators and the clinical educator and acted upon where appropriate.

- Reporting to the Board of Trustees.

- Performance against KPI's (number of training courses delivered from Trinity).

- Statistical data to be collated on PEoLC training sessions and courses delivered to staff and also to partner organisation and the general public eg "Last Days Matter".

- Reports from the Fylde Coast Dying Well Education stream and the Compassionate Communities stream.

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

How was the priority identified?

The Medical Enhanced Care Unit (MECU) was established at Blackpool Teaching Hospital (BTH) in January 2023 for patients who require more monitoring or interventions than usual on a general ward but do not require admission to Critical Care.

Many of these patients receive oxygen therapy, non-invasive ventilation (NIV), continuous positive airway pressure (CPAP), and high-flow nasal oxygen (NHFO) therapy. All these treatments are commonly administered to critically ill patients; however, there are times when a medical clinician

deems a particular treatment futile and withdrawal of that treatment is agreed upon with the patient's, family, and/or caregivers.

Currently, BTH lacks ratified withdrawal guidelines; as a result, withdrawal is frequently suboptimal and distressing for all involved.

Our hospital-based Palliative Care Team has received 36 referrals from the MECU since the unit's opening and of those 36 patients, 83% died, 56% received NHFO, and 26% received NIV. Individuals who had EPaCCS in place before being admitted: No = 56%, previous palliative care input: No = 56%, and hospital = 90% were the places of death.

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 look at the patient group offered this treatment and determine if it prolongs suffering or improves outcomes.

To look at the length of time on 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.

How will progress be monitored and reported?

- A proforma has been developed to capture the following data for the month of May:
    - Diagnosis.
    - Ventilation method, duration, withdrawal, date of withdrawal, length of time on the ventilation.
    - Discussion documented and dated re discussion with patient/family.
    - Symptom management prior to withdrawal, did CSCI commence and when.
    - Mediations throughout the withdrawal (PRN meds).
    - Consent.
    - Previous palliative care support, previous advanced care planning discussions.
    - Previous hospital admissions and
    - If death occurred, the date of death.

- The TACP has discussed with key stakeholders, Lead ACP on MECU and Medical Team.

- The TACP has been invited to attend and discuss this project at the next respiratory meeting.

- The TACP will collect the data from May and use this as the pre data prior to the release of the guidelines.

- The post data will be collected three months post the release of the guidelines.

- Results will be reported through team meetings, Clinical Quality Improvement Group and to Clinical Governance Committee.

Clinical Effectiveness – Nurse Led Advanced Care Planning (ACP) Outpatient Clinic

How was this identified as a priority?

Patients in palliative care often need to make important decisions about their future care.

Advanced care planning enables healthcare professionals to conduct structured, meaningful conversations with patients about their wishes and preferences regarding treatment goals, preferences, and location of care.

Many of our patients are referred to our service when actively dying or too unwell to have significant advanced care planning decisions. As part of our MECU and A&E projects, it was identified that many of these patients have never previously had any previous ACP discussions, electronic palliative care co-ordination system, EPaCCs have not been completed and DNAR orders have not been discussed leading to increased distress for patients and families and unnecessary admissions to hospital.

What do we want to achieve?

Increase the probability that patients with life-limiting illnesses can die in their preferred place, such as their home.

Positively impact quality of life and end-of-life care by ensuring preferences and wishes are discussed, documented, and shared with other health care professionals.

Improve confidence of other health care professionals in delivering advance care planning through joint working and collaboration.

Improves the experience of families by reducing stress, anxiety, and depression after a loved one’s death.

More effective and efficient use of resources in delivering person-centred care in preferred locations.

How will the progress be monitored and supported?

- Update GP via letter post appointment with advance care planning discussions and decisions enabling Epaccs to be completed.
- Post evaluation questionnaire to determine benefit of appointment, bereavement support offered.
- Signpost to other health care professionals if needed for ongoing support.
- Discuss with site specific clinical nurse specialists/oncologists/treating consultant to determine their knowledge and confidence in delivering advance care planning discussions.

Clinical Effectiveness – IPU Staffing Establishment

How was the priority identified?

This priority remains an active and ongoing quality account for the next financial year. Utilising the information gathered so far, we are now creating a document that will set out the establishment needed to safely run a leading-edge Adult Inpatient Unit within Specialist End of Life Care.

What do we want to achieve

Consistent bed occupancy of 80% or more, safe staffing reports, reduction in staffing incidents, confident and competent workforce, flexible workforce over a 24 hour period across 365 days a year, improved staff resilience and morale, improved sickness levels, higher retention and recruitment rates, a more robust bank system, a staffing model that provides safe staffing and opportunity for development and training in which we can implement into an E-rostering system in the next 12-18 months.

How will progress be monitored and reported

- Staffing reports and organisational view for management.
- 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.
- Performance against KPI’s (number of patients cared for, referrals and admissions).

Patient Safety - Holistic Assessment (EoLC Template)

How was the priority identified?

We are continuing with the work ongoing for this quality account and aim to pilot an EoLC template “last days of life” template on IPU around June/July 2024.

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 but 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 persons needs and wishes, sensitive communication and those who are important to them at the time of dying and any decisions that are a result of those conversations, the needs of the families and others identified at such time, resulting in an individualised plan of care including food and drink, symptom management, psychological, social and spiritual support that is 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.
- Feedback from staff.
- Electronic record reviews.

Patient Safety - Improving Patient Safety and Managing Acuity, Complexity and Transfers of Care

How was the priority identified?

Following increase in clinical incidents due to patient need and staffing establishment.

What do we want to achieve?

Safety huddles will become embedded and part of the culture on IPU, acuity and complexity are documented/scored via a tool that supports staff to make clinical decisions based on dependency of patients, admissions and discharges are improved, MDT approach is improved due to more information on patients being admitted onto IPU for care or discharged into the care of our community teams, patient safety is increased in terms of pressure area care, timely and effective symptom management for patients. Introduce a handover process between hospital and IPU staff, using SBAR template to ensure a safe and timely handover from clinician to clinician prior to transfer. Improve understanding of the key principles of the Mental Capacity Act 2005 and best interest decisions and apply these in practice.

How will progress be monitored and reported?

- Monitor the number of incidents reported in relation to staffing/acuity.
- Feedback from staff (IPU and hospital).
- MCA audit pre and post training.
- Electronic record reviews.

Clinical Effectiveness – Reduce Waiting Time for Patients Referred into the Service Accessing Counselling/Wellbeing Support

How was the priority identified?

Previous service structures have separated client pathways and referral routes into the service upon professional training background and not based on need. As the counselling service in recent months has started to re-introduce patient working as part of their remit, alongside existing client work, meeting patient needs flexibly and timely has been a challenge, prompting the need to review the current structure.

What do we want to achieve?

We want to ensure that all clients (including patients) have access to a service responsive to their needs. Patients require additional flexibility in managing their appointments to fit around other health demands within their health context. We aim for the counselling team to mirror where possible the existing psychology service in being able to provide the additional flexibility across

organisational boundaries in the delivery of this aspect of the service. This will include virtual working, home visits and clinic based appointments, timely inpatient working with counsellors with a specialist interest in working with patients with dedicated hours in their working week to focus on this.

How will progress be monitored and reported?

Progress will be monitored through the additional waiting time KPI and monitored against existing pathways into the psychology service within the team. This will be reported within the usual KPI's.

Clinical Effectiveness – Access to a Range of Levels of Service Provision (Stepped Care) Across All Clients Referred into the Linden Centre

How was the priority identified?

Previous service structures have separated client pathways and referral routes into the service upon professional training background and not based on need. Patients previously were referred to the psychologist, bereaved (more than three months) and carer clients referred to counselling and bereaved clients (less than three months) were referred to our Wellbeing Worker. Utilising the range of skills within the service, it felt appropriate to consider that clients should be able to access a range of therapeutic skills dependent upon need based on triage and within a stepped care model.

What do we want to achieve?

All family members and patients should be able to access wellbeing or counselling support and signposted within the service depending upon need. Whilst family members currently will not be able to access psychology in direct support of these, clients will be given through supervision and reflective practice.

How will progress be monitored and reported?

Through KPI reporting by 'type' of inbound referrals and monitoring pathways.

Clinical Effectiveness – Community Bereavement Groups and Linden Centre Carers Groups

How was the priority identified?

Since recommencing bereavement support groups on site at Trinity, we have received increased interest from community groups wanting to support people from within their communities, with support from Trinity, in the delivery of their own bereavement support groups. Enabling a model of support within communities would potentially ease referral rates into the Linden Centre whilst outreaching support to communities across the Fylde Coast.

What do we want to achieve?

In model similar to the former 'Stepping Stones' the aim is to engage with community groups and enable them to deliver, through support from the Linden Centre, their own bereavement groups within their own localities. We would provide regular mentoring and training. We would work collaboratively with the Swan Team at BTH in the identification of groups and service delivery.

How will progress be monitored and reported?

Through identifying possible groups, monitoring number of established groups and agreed outcomes from individual groups (use of quantitative measures of outcome success and qualitative feedback).

Patient Safety & Clinical Effectiveness - Improvement of the Environment in the Bereavement Suite on IPU for Care of the Deceased

How was the priority identified?

For many years Trinity has a designated refrigerated room solely for the purpose of body storage in by the nature of operations and the room itself can sometimes lead to deceased patients being cared for, for up to several days.

Following an infection prevention and control inspection in Winter 2022, and subsequent multi-disciplinary risk assessment by the Infection Control Nurse, highlighted that the current IPU Cold Room provision at Trinity Hospice is inadequate in terms of fitness for purpose to maintain a safe, secure, dignified, and clean environment for our deceased patients. In addition, work undertaken by the IPU Operational Manager identified significant risks associated with capacity and operational movement issues in the Cold Room over a 24/7/365 period creating overcrowding exacerbated by delayed transfer to the care of undertakers.

What do we want to achieve?

Improve our facilities for care of the deceased to include:

- Improve the physical environment to improve fixtures, fittings and décor in the room.
- Ensure its easily cleaned and disinfected.
- New mattresses for beds.
- Improved viewing room space.
- Increased safety and security.
- Increased privacy and dignit.
- Improve capacity and operational issues.

How will progress be monitored and reported?

Progress and planning via the ***Project Start Up Group – IPU Cold Room*** chaired by Graham Ratcliffe.

Quarterly updates to CQIG and Trinity Infection Prevention and Control Committee.

Clinical Effectiveness - Integration of Community Palliative Care Team Into Palliative Care Networks

What do we want to achieve?

Palliative care can be challenging and the importance of exploring the effectiveness of the service we deliver is paramount to improving the collaboration between services. Collaboration of working between services is vital to provide and ensure a seamless service is provided across the Fylde Coast and everyone has fair access to services from diagnosis to end of life. We are aiming to continue to co-ordinate services, Living Well with the Community Palliative Care Team and Community NHS staff. This will develop effective communication between all services to support our wider community including those of hard-to-reach areas. Visibility of palliative care specialists within the community nursing teams will demonstrate we aim to lead the service to a higher level through development and transformation of the service we deliver.

Promoting the services offered at Trinity Hospice to all community NHS teams including community nurses, rapid response, enhanced primary care, IV team and Clifton Hospital. Integration of community specialist palliative care nurses embedded within the community NHS nursing teams as a point of expert clinical advice.

How was the priority identified?

- Identified through developments within Living Well.
- Through feedback from patients, relatives, staff, and external agencies.
- Through the Fylde Coast Palliative and End of Life Strategy.
- Through working alongside the Ambitions of Palliative Care.
- Need to provide sustainable services.

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 the at the clinical education group.

Patient Safety - Supporting Our Teams to be Educated to Enable Them to Undertake a Specialist Role in Line with NMC and CQC Guidelines

Safety is paramount to the service we deliver at Trinity. We aim to focus upon the social, psychological, spiritual and physical aspects of patient care within palliative and end of life care to provide a holistic approach to care. We aim to build a workforce fit for the future ensuring the aspects of CQC are embedded within the knowledge of the staff. We aim to develop and build a continued area of learning and development for staff to give them the opportunity to develop within the field of palliative specialist care. This will support both our patients and our staff putting them at the centre of what we do.

How was the priority identified?

Through work with Hospices Together and collaboration with regional hospices within South Lancashire and Cumbria.

Through identifying a reduction in the number of clinical nurse specialists in palliative care. Therefore, up skilling the current workforce is paramount to delivering specialist palliative care within the community.

What do we want to achieve?

We aim to upskill the current workforce through education and support in becoming specialists in the field of palliative care. Ensuring we have the right skill at the right place and time to support patients in their own homes and keep them safe.

Understanding around CQC domains of safety, governance and GDPR.

A workforce that is equipped to provide support to more patients and relatives in the community enabling them to remain in their preferred place of death.

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.
- CQC evidence.
- Collaboration with Trinity Clinical Educator.

Patient Experience - Twilight Hospice at Home

What do we want to achieve?

To ensure the patient's preferred place and care and death is identified early. To ensure we continue to embed advanced care planning within our roles giving patients the opportunity to discuss their wishes and needs. To increase capacity within the Virtual Ward and Community Palliative Care Team to create an environment within community where patients feel supported and cared for from diagnosis to death. This will enable more patients to live well within community enabling faster discharges from hospital to community to enable patients to be cared for in their preferred place of care and death. To develop a twilight service utilising the current workforce which will integrate Trinity and Community NHS services in supporting the patients at home in an evening. Create more flexible working options for staff.

How was the priority identified?

- Regional hospices links discussions.
- Data analysis on data virtual ward.
- Office of National Statistics on place of deaths.
- Due to a gap in service from the hours of 18:00 till 21:00 hours where there is a reduction in community nurses and specialist clinical oversight from the palliative care team.

What do we want to achieve?

- Reduce hospitals admissions in the last six months of life and increase the number of patients dying in their preferred place of care and death.

- Integrated co-ordinated ways of working.

- Responsiveness of the palliative specialist palliative care team.

- Extended specialist palliative care service within the community in-between the hours of 18:00 to 21:00 hours which is not currently provided in existing services.

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.

Patient Experience - Single Point of Access (SPoA)

How was the priority identified?

Trinity has been working with external partners to undertake a pilot alongside two GP surgeries in Blackpool South. This current development has been paused whilst discussions remain ongoing with BTH Trust and ICB partners.

Discussion with Lancashire and South Cumbria hospices has led to further thinking around an 'in-house' Trinity SPoA to encourage the services to work together and have a greater understanding of our service provision.

SPOA is aligned with the desire to have a 24/7 advice line supported by senior clinicians within the service.

Fylde Coast Palliative and End of Life Care Strategy 2024-29 priorities.

Feedback from patients, relatives, and staff.

What do we want to achieve?

A single contact number for all patients 'Out of hospital' who are on the supportive palliative care register and have a life limiting condition.

Join up Trinity services embedding the 'Living well' ethos.

Patients only have one number to phone for **ALL** services within Trinity.

Robust triage at source would enable the patients/relatives/health care professionals reach the right person at the right time.

Single process across Trinity to prevent mistakes/reduce duplication.

Access to Trinity to ensure that each person gets fair access to good end of life and palliative care in a co-ordinated way, which is aligned with the sustainability and access workstream developed from the Fylde Coast Dying Well Group.

People on the Fylde Coast get good and coordinated end of life and palliative care regardless of who they are, where they live or the circumstances of their lives.

How will progress be monitored and reported?

- Key performance indicators and outcome measures.
- Reporting to the Board of Trustees.
- Service user feedback including patients, carers, health, and social care professionals.
- Report to Clinical Quality Improvement Group.
- Fylde Coast Dying Well Steering Group.

LOOKING BACK:

Improvement Priorities Identified in Our Quality Accounts 2023-24 and Progress Made:

Clinical Effectiveness – Single Point of Access (SPoA)
Developed and carried forward into 2024-25 with update detailed above.

Clinical Effectiveness - Staffing Establishment
Developed and carried forward into 24-25 with detailed update above.

Patient Safety - Holistic Assessment (EoLC template)
Developed and carried forward into 24-25 with detailed update 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.

Review of Service 2023-2024

During 2023/24, 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 2023/24 represents circa 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.

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

Our aim was:

Make improvement to EMIS to provide effective communication and continuity of care and improve clinical productivity and efficiencies to our clinical administration and integrated working processes which underpin good clinical governance. processes.

What we did:

We recruited an external Electronic Patient Records Development Lead for 12 months (WTE) who started in post in January 2024. They are working collaboratively with colleagues in the Community and Primary Care Electronic Patient Record Team at Blackpool Teaching Hospitals NHS Trust to progress the digital transformation needs of clinical staff across Trinity Hospice and Brian House Children's Hospice.

What was the outcome?

The initial work has concentrated on the mapping of how EMIS is currently used across clinical services to identify where efficiencies and improvements can be made.

We have produced a high level roadmap and are developing a project plan to be monitored at Clinical Quality Improvement Group meetings.

There has been an initial focus on the development of new services such as Single Point of Access, Virtual Ward and Living Well alongside the mapping of existing services to ensure clinical templates are up to date and fit for the future needs of the organisation.

We have started engagement with EMIS with regards to new functionality that Trinity can utilise to support clinical staff in supporting patients and also improve management information that supports patient outcomes, such as bed management and automated appointment reminders and dynamic templates.

Work has started on the development of current reporting mechanisms to provide additional data to support Key Performance Indicator setting for 2024-25.

Work is ongoing on developing Standard Operating Procedures across all clinical settings to facilitate improvement and efficiency in existing processes and better support induction and training of new staff to promote standardisation.

We are looking at electronic referral and the referral processes not only internally but with external partners across the health economy to provide efficient access to care.

We have started identifying EMIS champions and EMIS administrators who can support new and existing staff into the future.

Work on this will continue throughout 2024-25.

Clinical Effectiveness – Accident & Emergency (A&E) Project 2023

How was this identified as a priority?

Emergency admissions to hospital increase in the last year of life and can be avoided. With over 1.6 million admissions in 2016 the UK costing £2.5 billion. These figures are higher in areas of social deprivation. Emergency Department (ED) attendance data can be used as a quality indicator for care at the end of life and early palliative care involvement during a hospital admission can reduce length of stay.

It was identified by the Hospital Palliative Care Team, through their current work in the Acute Medical Unit (AMU) and ED, that many patients with a palliative diagnosis were attending the departments and being admitted unnecessarily. It was felt that more could be done at first point of access in the ED to try and prevent admissions or put plans in place to reduce the amount of time

they spent in hospital. The learning needs of the staff within the ED regarding caring for patients with a palliative diagnosis was also identified.

What did we want to achieve?

- To improve the experience for patients in the ED department with a palliative diagnosis.
- Reduce unnecessary hospital admissions and GP contacts.
- Reduce overall length of stay through early specialist input at the ‘front door’.
- Increase the numbers seen achieving their preferred place of care and death and to ensure we utilise the EPaCCS.
- We wanted to improve staff knowledge of palliative and end of life care and the tools we use to support our practice.

What we did:

Data was collated monthly and reported to the project group. The total number of patients seen in A&E 2022/2024 was 344 with 48 admissions avoided. Acute bed days saved 170. The number of patients at end of life seen in this setting reflects the current pressure on local health care systems. The number of patients attending A&E without a completed EPaCCS record or a DNACPR in place is high.

We provided - and continue to provide daily - in reach to the ED, proactively seeking patients suitable for our support. A dedicated bleep was used that was specific to ED and AMU. This was allocated to the senior team member for the day. Posters with the Palliative Care Team contact details were created and circulated.

We liaised with IT and the Quality Improvement Department at BTH regarding creating a Palliative Care in ED digital dashboard so ‘live’ data can be seen more easily, trends identified promptly, and action sought to address any issues.

A survey was developed and circulated to staff in the department to determine learning needs - 93% of staff surveyed agreed on the need for ED in-reach.

100% of staff felt they would benefit from further education.

Several training sessions were delivered to nursing and medical staffing the department with positive feedback.
A box with syringe driver equipment was placed in ED. 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. Grab bags with personal care essentials were made up to support needs of patients who were experiencing long waits in the department.

This project was highlighted as a good practice example by NHS Benchmarking and was winner of the Special Recognition award winners at Blackpool Teaching Hospitals NHS Trust Quality Awards 2023.

The team were also shortlisted for a Nursing Times award “Palliative Care at the Front Door“. A poster was presented at Hospice UK 2022. Global Research and Future Innovations in Best Care for the Dying Person Conference 2022 (highly commended)

Clinical Effectiveness and Patient Experience - Improving Referral Rates to Palliative Care for Those Patients with Decompensated Liver Disease 2023

How was the priority identified?

Mortality rates for liver disease have increased by 400% since 1970, with figures highest in areas of social deprivation. In 2021, Blackpool had the highest premature death rates in Decomposed Liver Disease (DLD), (52.4 to 66.2) per 100,00 population aged under 75) in the country. Current costs to the NHS for liver disease are estimated to exceed £17 billion annually and COVID-19 pandemic exacerbated the burden of liver disease, with deaths increasing between 2019 and 2020 by over 20%. Hospital admissions due to liver disease are rising year-on-year with a large majority of patients admitted with complications of liver cirrhosis. Liver disease is continuing to rise and is now the second most common cause of premature deaths in the UK.

DLD patients experience severe physical and psychological symptoms that negatively affect their quality of life (QOL), along with many kinds of unmet demands. A prognosis of two years or so is similar to that of many malignancies. Though it is acknowledged that Palliative Care Support (PCS) is underutilised in this cohort, early PCS has a good influence on reaching patient-centred realistic objectives, managing aggressive symptoms, and minimising repeat admissions in the final six months of life. Death can come suddenly and unexpectedly.

One trainee Advance Practitioner's quality improvement project involved addressing local inequities within the DLD community as part of their Advance Practitioner Master's Degree. When the first data was gathered for 2021, it was shown that 36 of the 1,399 referrals made to the Hospital Palliative Care Team were patients with liver disease. The purpose of this initiative was to increase health professionals' understanding of the role that PCS can play in supporting patients with DLD on a BTH gastroenterology unit.

What did we want to achieve?

- To improve patient experience and improve symptom burden at EoL.
- To improve health care professionals understanding of the role of a specialist palliative care nurse. To encourage earlier referrals, as currently we tend to receive a referral when the patient has only short weeks to days to live.
- To improve education around end-of-life care and what can be offered to the staff on Ward 12 (Gastroenterology).
- To increase referral rates for patients with DLD.
- Improve communication/collaboration with other health professionals, patients, and carers.

What we did:

- Our hospital team based tACP attended the weekly liver disease board round, to support the building of relationships and provide the opportunity to highlight patients that may be suitable for our palliative care assessment and support earlier.

- Data was collected over a 12-month period January - December 2023.

- An Excel spreadsheet and proforma was created to gather the data.

- Increased referrals to the service. In 2023 we received 49 referrals for patients with DLD compared with 38 in 2022.

- A pre and post education questionnaire was developed and analysed. Educational sessions for the nursing and medical staff on Ward 12 were delivered with positive feedback.

- Invited to be a member of the Aqua Steering Group for Decompensated Liver Disease to share learning and good practice.

- Supported the development of a DLD pathway to be initiated at the front door (AE) which includes consideration for a referral to PC if appropriate.

- Invited to take part in a research project on the ‘Experiences of care in advanced liver disease’.

Clinical Effectiveness - Staffing Establishment

Our aim was:

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 we did:

Worked with HR to improve the way we manage short and long-term absence.

Worked and continue to work with Establishment Genie who are reviewing our staffing and staffing model. In this work, we have provided Establishment Genie with our current in-post hours and planned budget for the next financial year. Using this we will assess what we are able to provide in terms of cover across the seven day period and where our short-falls are in view to improve this with flexible working. Establishment Genie are benchmarking us against 43 other hospices nationally and looking at how we compare in terms of shift-lengths, flexibility, and care hours per staff member per patient. The aim of this review is to consider what is needed to improve our staffing, be realistic about what capacity we currently have to staff an 18 bed-model and to ensure we are allowing time for training, absence and leave.

We drove forward with the recruitment and offers of bank posts to over eight members of staff (five have been recruited and three were recently offered bank positions following interviews for substantive posts). We also worked with Brian House and identified a further three members of Brian House staff that were willing to join our IPU Bank Team.

We incorporated cross-service working in terms of utilising HCA NVQ3s from the Trinity Hospital Team to support our new starters in their development and competencies. This received positive feedback and we plan to continue this work into this year to ensure our HCAs and HCA3s are prepared to care and understand the ways of working at Trinity

We reviewed and changed the shift request process to ensure fairness and flexibility across the 24 hour service.

We have removed the fixed rotational calendar that was in place over 12 months to allow more flexibility in the current rota system; this means now staff should be placed on the rota to meet the needs of the service in a better and more responsive way.

We identified that there is going to be changes made on the IPU and that engagement is really important, we therefore have commenced a project that incorporates all work we are doing that may involve change.

We have supported three staff to undertake developmental roles, this includes two HCAs to become HCA3s and one Nursing Associate to commence on the Registered Nurse Degree Apprenticeship.

What was the outcome?

We had originally planned to undertake the Establishment Genie work and E-rostering work in tandem but on reflection and after having reviewed and attended demonstrations of different E-rostering solutions over the last 12 months, it was felt more beneficial to consider implementing an electronic rota once the staffing model is identified and embedded

The HCA training and development we have implemented on the unit means that, even with difficulties of recruitment that is faced across healthcare and nursing, we are growing our own staff and providing routes of progression and upskilling

The changes to shift requests meant that we could monitor and ensure staff were utilising shift requests in the best way whilst also meeting the needs of the service.

Introduction of a better bank system has meant that substantive positions are not over-burdened by additional shifts, hopefully leading to less burn out and better morale of the team.

Work with Establishment Genie is still ongoing and we will continue this as a quality account into 2024/25.

Patient Experience – Care of the Dying and Deceased

Our aim was:

To improve our Cold Room facility and prepare options for the future of the care of the deceased.

What we did:

Risk Register: The highlighted risk was added to the organisation's Clinical Risk Register to highlight the risks identified and mitigate them.

Engagement Events: During 2023, the Infection, Prevention & Control Lead and the IPU Operational Manager held a series of staff engagement events to listen and engage staff with the aim to better understand current challenges and practices that surround the Cold Room and caring for the deceased. These events were well attended and provided insightful and important information that has been used within this paper.

Cleaning and Disinfection: A schedule and frequency of cleaning and disinfection measures has been implemented. Housekeeping services clean and disinfect the room daily (access permitting), this includes floors and horizontal surfaces, bed frames and mattress if beds are not occupied. Additionally, a schedule of deep cleaning is in place with additional floor and wall washing.

Visits to other hospices/Mortuaries: Visited BTH Mortuary area, visited St Catherines and St Mary's Hospices and reviewed other provision.

Monitoring of temperatures: daily temperature monitoring takes place.

Privacy and Dignity: Implemented covering of all patients, to align Trinity with up-to-date guidance from Hospice UK, Care of the Deceased – 4th Edition.

Improved co-ordination and prioritisation of timely transfers: Utilisation of ward admin and nursing staff to identify patients to be moved in a proactive way rather than waiting to hear from families.

Engaged with local funeral directors: Regarding possible equipment (more narrow trolleys), potential for contracts and SLAs and for advice on what to when breaching capacity.

Reviewed current security conditions of our deceased in relation to the Fuller Inquiry.
Collected data (30 deaths) on common causes for delays/breached capacity in the cold room.

What was the outcome:

Align Trinity practice and policy with best practice and up to date guidance, CQC requirements.

Address capacity issues when room capacity is breached.

Ensure we comply with ME requirements and can accommodate the demand for space.

Ensure the risks of infection from handling the deceased are mitigated.

Safe preparation of the deceased for transfer to the mortuary or the funeral director's.

Ensuring that the privacy, dignity, and respect of the deceased is maintained at all times.

Ensuring that the health and safety of everyone who comes into contact with the deceased is protected (staff, students, porters, undertakers).

Agree a plan to work towards.

Moved this quality account to Donna Taylor, Lead for Infection Prevention & Control.

Patient Safety – Holistic Assessment (EoLC Template)

Our aim was:

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 we did:

We met as group and looked at the current care plan that is on our clinical system. We identified that the existing template is comprehensive but there were some issues with functionality on EMIS. Following this we sought the advice of the EMIS Lead for the organisation and worked on a plan of a fit for purpose document/template that could meet the digital needs of the EoL Care Plan. We then created the name "Last Days of Life" template and agreed on a project plan to start the work to begin in June/July with staff training and a pilot of the template once it has been amended to suit the needs of the users.

What was the outcome?

- Identified the need to pilot.
- Creation of a task and finish group for the EoLC template.
- Plan to implement by June/July 2024.
- Continue this as a quality account into 2024/25.

Clinical Effectiveness – Single Point of Access (SPoA)

Our aim was:

The Lancashire and South Cumbria Integrated Care System's (ICS) strategy recognises that good palliative and end of life care improves patient outcomes and significantly reduces unnecessary hospital admissions. Healthier Fylde Coast Integrated Care Partnership (ICP) and its Clinical Senate have also highlighted this importance given our aging population with a focus, for example, on 'the last 1000 days' and supported through the six ambitions outlined within the Fylde Coast end of life strategy.

Due to fragmented services, patients and carers are often confused at time of crisis. Our aim is to identify where time is wasted, make efficiencies and share examples of successes for learning and service improvement; equity of access across the geography and for each part of the patients circle of support. Patients may have several contact numbers and details at present. This could result in not being signposted at times in the most efficient way, impacting on patient/family/carer experience.
The aim was to create a single point of access with one contact number, a clinical triage service, person-centred interventions and effective use of the EPaCCS system. to improve patient experience and co-ordination of care within palliative care. The model will support all 'out of hospital' patients at the end of their lives and their families and carers to improve palliative and end of life care patient outcomes across the Fylde Coast.

What we did:

Engage with palliative care networks (PCN) to scope interest in being involved in project.

Strategic plan was formulated with a Single Point of Access pilot (SPOA) within two community neighbourhood teams in the South PCN supported by the Trinity Project Manager.

Partnership with other health, social care and supporting services and commenced a project group. This included both internal and external colleagues- FCMS, Gp surgeries, district nurses, Trinity community team.

Referral process, criteria and pathways completed for the two GP surgeries and Fylde Coast Medical Services within the pilot scheme.

Produced a Standard Operating Procedure and algorithms within FCMS to ensure all palliative care emergencies are dealt with without delay.

Effective Communication between NHS pilot teams and Trinity teams about the pilot's aim and ambitions.

Development of outcome measures and key performance indicators.

Developed a pathway that incorporated all the partners ways of working to enable calls to be received safe and effectively.

What was outcome?

SPA within the two GP surgeries now paused and under review with BTH and ICB colleagues.

Discussion regarding a new pilot working group and project plan designed for SPoA within Trinity services rather than community for all referrals into Trinity for palliative and end of life care. This would still require collaboration with other services to ensure a streamlined approach when referring into and out of all Trinity services.

Amendment of a Standard Operating Procedure and algorithms to ensure all palliative care emergencies are dealt with without delay.

Ongoing discussions within the development will provide communication to the wider teams about the pilot's aim and ambitions.

Development of outcome measures and key performance indicators.

Clinical Effectiveness –Nurse-Led Clinics

Our aim was:

All patients with cancer and non-malignant life-limiting conditions to 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.

Promote the ethos of 'Living well' and understanding 'What matters' to patients and their loved ones.

Develop a service where staff work across different services to give greater access to health care professionals, create learning opportunities and understanding of roles.

Patients are given the choice of whether they want to come to Trinity or seen at home.

What we did:

Commencement of twice weekly clinics within the community palliative care team.

Teams working collaboratively to undertake a one stop shop clinic setting embedding living well within community.

Project support for the development of clinics within living well to develop a service around 'what matters to me' for the patient utilising occupational therapist, physiotherapist, and community palliative care specialists.

What was the outcome:

- Face to face contact in a clinic setting reducing the need for home visits enabling patients the opportunity to live well.

- Some sporadic cancelling of clinics due to staff pressures but this has been resolved and is now part of the day-to-day management of patient care.

- Collaboration of services within Trinity working around the needs of the patient, improving the workforce.

- Upskilling of Associate Clinical Nurse Specialist and Health Care Assistant roles to support advanced care planning and an introduction to Living Well.

- Key performance indicators identified to measure the quality of the service.

- Plan to create a 'one stop shop' whereby any healthcare professional can assess a patient and signpost to the most appropriate person to support them.

- Planning for 'away day' to discuss ways of working across community and 'living well clinics' including nurses, physiotherapist, occupational therapist, frailty ACP, complementary therapy and living well support worker.

Clinical Effectiveness – Virtual Clinics and Consultations

Our aim was:

To develop the virtual clinics to enable consultations to support community and care home colleagues and patients and improve the effectiveness and responsiveness of our care.

What we did:

Development of nurse-led virtual clinics within the community palliative care team.

What was the outcome?

When used, nurse led virtual clinics have given the patients an opportunity to utilise technology to support their palliative needs, however, the platform being utilised is currently under review.

There hasn't been the uptake in this that was initially desired, so data is limited.

Next steps include input from our new data lead, Charlotte Mays, to ensure we are utilising the same systems to ensure there are less barriers to connections.

There is a review underway for laptop usage and whether connectivity issues are a risk to provision of this service.

Further insight into care home use of iPods proved that they were not using the equipment, some had lost it and or didn't know how to use it. This would be a huge undertaking and is currently being reviewed by the end-of-life community team (BTH).

Initial plans for a second pilot with Clifton Hospital are currently under discussion.

Clinical Effectiveness- End of Life/Palliative Care Virtual Ward

Our aim was:

To provide a safe environment for hospital or hospice patients to be cared for in their homes with the utilisation of effective technology and support from specialist practitioners within the field of palliative care.

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.

Support adults with palliative and end of life care needs who are in or reaching a crisis that requires acute level care.

To provide an alternative to admission to hospital or hospice or early discharge from hospital or hospice.

What we did:

Attendance on the Fylde Coast Virtual Ward programme group.

Effective daily collaboration with external services through MDT.

Provision for up to 10 beds to support patients at home.

Close working relationships with out of hours (FCMS) and Marie Curie partners.

Patients admitted to ward with a DNACPR in situ and a ceiling of treatment limiting care to the community unless comfort measures fail. Which supports the decision making of the patient remaining in their own home.

FCMS aware of our most vulnerable patients which supports clinical decision making in the event of urgent request for contact out of hours.

Domiciliary gap supported where able until care package is in place.

Daily review by the advanced clinical practitioner.

Assessment through use of Integrated Palliative Outcome easures document (IPOS) to ensure health care professionals understand what matters to the patient/relatives.

All Health Care Assistants were given training in simple complementary therapy techniques, managing breathing and rehabilitation and psychology level 2.

Higher level of support/oversight from the virtual ward for patients awaiting Trinity for admission and on discharge.

Support for carers which is often one of the main reasons a patient would be admitted to hospital.

Management of complex symptoms.

What was the outcome?

Commencement of a Virtual Ward at home for palliative patients who require ongoing specialist palliative support. This has created enhanced monitoring with early recognition of deterioration or instability of condition enabling an effective reactive response. Integration of virtual ward, community palliative care team and living well through collaborative working within the referral process.

From April 2023 when the Virtual wWrd (VW) went live until end of March 2024 the team have:

- Supported 243 patients.
- Bed utilisation was 1162 which is a cost saving in comparison if they had been admitted to hospital.
- Number of patients admitted to hospital was 2.
- Bed utilisation year to date is 56%.

At the Fylde Coast VW meeting we were recognised as having the highest level of usage of our beds in the area. This was in relation to paediatrics, frailty and respiratory virtual wards.

Our next steps are to expand the care offer to patients. In the initial plan we hoped to be able to offer a consistent 72 hours of care at the end of life and/or crisis.

Clinical Effectiveness – Care Planning for Children

Our aim was:

Care plans are an integral part of how we care for patients within our service at Brian House. They provide guidance and assurance to support the team in providing holistic care to the community we serve, ensuring their dignity and privacy is always maintained. We have therefore improved our care plans within Brian House to engage the children and families we serve.

What we did:

Within Brian House we have reviewed and redesigned our care plans to incorporate the twelve standard nursing daily activities of living, placing the children and families at the centre. The care plans have been devised and completed with families, valuing family's expertise by experience. Collaboration within the multidisciplinary teams has proved invaluable in co-ordination of care to enable effective care plans to plan and co-ordinate care. We have advocated for the child and family, ensuring the provision of appropriate information and support services to provide a seamless service.

Engagement with the Lancashire and South Cumbria Education Project has been undertaken to train and upskill staff in paediatric palliative care.

What was the outcome?

- All children have a holistic care plan which defines appropriate individual safe care and support, delivered during their stay at Brian House.

- Completion of palliative care modules has enabled staff to communicate confidently and effectively with children and their carers who are living with life limiting/life threatening conditions and those who have experienced bereavement.

- Families and professionals are provided with expert paediatric palliative care advice.

- Staff can assess, plan, and implement effective symptom management approaches for common symptoms encountered in children's palliative and end of life care.

- Increased proficiency in assessing and managing the effects of death on the child.

- Feedback from staff in relation to training being informative and beneficial to developing their skills and knowledge around the area of palliative care. This has ensured we have the correct skill, at the right time and place to manage patients and families care effectively.

- Further education on spirituality sections of the care plan was initiated, to support staff to better understand the spiritual needs of the children we care for.

- Rapid discharge planning policy has been implemented, enabling a secure transfer of care between services and effective parallel planning.

Patient Experience – Symptom Management For Children

Our aim was:

Due to the pressures sustained from the acute care sectors we aim to decrease the demand placed upon them. We are an area of continuous improvement which is driven through the dedication of highly trained staff to support these children and families not only in Brian House but in our community.

What we did:

Within Brian House symptom management from a consultant paediatrician and trainee Advanced Care Practitioner (tACP) is now provided on an individual basis, over the phone, and in person.

We have strengthened our involvement within the paediatric groups enabling a standardised rapid discharge plan. This includes the published guidance on the transfer of a child from acute hospital to Brian House within a timely and effective way, ensuring compassionate care for the family and child. Paediatric consultant consults with the child's specialist consultant, ensuring consistent and seamless communication.

The creation of a Community Senior Staff Nurse role within the team which provides care closer to home in a flexible and responsive manner. Included within this is the liaison and signposting to alternative agencies where families can gain support.

Attendance at national heads of care meetings has been undertaken, along with opportunities to visit other hospice, to discuss workforce planning and reforming service delivery.

What was the outcome?

- Families can access specialist palliative care advice and support outside the acute hospital setting.
- Delivery of flexible and responsive home-based care for children and young people.
- Increased community visits providing bespoke needs led support for complex care and social needs.

- Families received appropriate support outside of the hospice remit.
- Strengthened relationships with families.
- Excellent feedback from 'I want great care.'

Patient Safety – Staff Skills and Competencies, Brian House

Our aim was:

To upskill staff within their clinical competences and enhance learning opportunities, benefiting our goal of providing excellence in care to all our children and families that we support across the Fylde Coast.

What we did:

Staff have completed paediatric palliative care modules in compassionate communication, grief and bereavement, symptom management planning and advanced care planning.

Implemented bitesize education programmes such as medication of month and focussed sessions on medical calculations.

Specialist nurses from Alderhey Hospital facilitated ventilation and tracheostomy education sessions.

Stoma care and epilepsy management was delivered by BTH specialist nurses.

Care of the dying information session by a local funeral director.

Two senior staff completed train the trainer palliative care modules and will now become Brian House champions and deliver training across the acute trust.

What was the outcome?

- Staff have the right skills at the right place and right time, to be able to support the increasing medical complexities and developing technology needs of the children who access the service.

- Children who require Level 2 and 3 ventilation can now access the service for short stays and day care.

Clinical Effectiveness – Access to Virtual Counselling and Wellbeing Support

Our aim was:

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.

What we did:

- The psychologist continues to offer virtual and in person sessions with patients both in centre and at home. The virtual platform was downloaded onto all counselling and wellbeing team laptops enabling capability of virtual working with patients and families. We are awaiting the new EMIS lead to explore the text message function for sending appointments to clients before this can go live.

- We reduced the number of home visits necessary to be undertaken by the wellbeing worker. Our wellbeing worker offered regular clinics in centre and more group sessions were established during 2023 enabling more client contact for family members. Further groups were established in collaboration with the Living Well Service to achieve the same.

- Increased choice for carers and bereaved in attending 1-1 sessions or groups for both adults and children.

Outcome:

Increase in capacity and choice. Increase in clinic appointments.

Clinical Effectiveness – Children's Counselling Training

Our aim was:

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.

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.

What we did:

- A series of in house training sessions were developed by the psychologist alongside existing supervisory arrangements to support a learning environment within the Linden Centre for counselling and wellbeing staff.

- The former counselling co-ordinator provided 6 hours of in house children's therapy training with existing staff in 2023.

- Two children's bereavement groups were established, one for children of primary school age and one for secondary school age children.

What was the outcome?

Following delivery of the training, counsellors reported in supervision feeling more confident in working with children in 1-1 counselling sessions and in group settings. The successful groups which have been facilitated so far have received favourable feedback with good clinical outcomes on formal psychometric measures. With the success of the training, it is the intention to run the training again with new staff to ensure quality delivery of 1-1 and group children's bereavement work.

Clinical Effectiveness – Streamline Linden Centre Administration Processes Aligned with Trinity

Our aim was:

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.

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.

What we did:

The Linden Centre EMIS system was fully embedded within the wider Trinity EMIS system. The psychology and counselling inbound referral process was streamlined into one inbox and triage takes place weekly to ensure an efficient and timely process with appropriate signposting within the service. Work continues with the EMIS lead to map process further to prevent duplication and increase efficiency.

What was the outcome:

More efficient administration of the Linden Centre service. All referrals processed and viewable in one place by al administrative staff, clinical lead and counselling co-ordinator. All clinical records now stored in one place and viewable where necessary by the clinical teams involved in the client/patients care. Improved monitoring of service quality, waiting times and session progress.

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

Our aim was:

Our aim was to facilitate a staff vaccination campaign in Autum 2023/24 to encourage the uptake of flu and Covid-19 vaccinations. The ambition was to achieve over 65% uptake for both vaccinations (flu and Covid), building on the uptake achieved of Autumn 22/23. This was to protect staff and patients from vaccine preventable diseases.

What we did:

We used a multifaced campaign strategy to encourage staff to be vaccinated. The campaign commenced in October 23 and ran until end of December 23. This included:

- Clear communications and posters, utilising or own staff.
- Commissioned six vaccination sessions from Blackpool Teaching Hospitals.
- Ensured staff know how to access vaccine sessions – times and dates regularly advertised.
- Signposted staff to alternate provision for accessing a vaccine in Blackpool.
- Ensured up to date resources on immunisation were available to staff.
- Immunisation page - Covid/Flu facts/Myth Buster on Trinity Intranet home page.
- Create 'opt out form'/declination form for staff to sign and give reason for non- vaccination

What was the outcome?

Percentage uptake at Trinity Hospice for patient facing staff for Autumn 23/24 was Covid 18%, Flu 28%. This was disappointing as it did not meet the ambitious target set for over 65 %, although when placed into context with other healthcare settings across the Northwest NHS Trusts, looking at BTH uptake at 23rd December 2024 was 18.3% (data source is Statistics » Vaccinations: COVID-19 (england.nhs.uk) for Healthcare Trusts in England), so similar to ours.

This lower than desirable uptake for Trinity Hospice should however needs to be placed in context to the wider picture of vaccination uptake across healthcare staff across England. Most uptake from acute Trusts in Northwest were similarly low, with highest uptake was 40% (Christie NHS Trust). Lowest was Northwest Ambulance Service 10.2.

Insight into why uptake may be lower than expected:

When supporting the vaccination sessions, and talking with staff and vaccinators, there emerged some possible explanations. These surfaced from conversations about vaccination and or declining vaccination, which may help us to better understand declines (this was especially significant when related to Covid vaccination):

- Trinity Hospice has no statutory reporting requirement to NHS England to capture uptake.

- Accept that vaccination is personal choice for each individual, and that they were exercising that choice.

- Acknowledge that it's likely that the perception of risk for individuals from acquiring Covid infection is low, and that Covid vaccination was unnecessary.

- There was considerable concern amongst staff about the perceived threat of experiencing severe side effects from Covid vaccination; despite information and 'myth busting' information being available.

- We may not have captured all uptake of staff vaccinations fully, (for staff who received vaccinations at other venues), but consider that amalgamating that missing data is unlikely to significantly boost uptake date.

- At one session, Covid vaccine was not available due to a central supply issue to the Occupational Health, some staff had attended on that specific available session to get Covid at that session, but were unable.

- Consider if clinical leadership at all levels for the programme was robust enough to support staff to make properly informed decisions about vaccination.

- Build insights into planning for vaccination campaign Autumn 2024/25.

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	2019/20	2020/21	2021/22	2022/23	2023/24
Total number of new admissions	287	304	351	390	351
Total number of admissions	325	340	374	414	362
% Bed occupancy	74%	67%	70%	84%	76%
Number of patients discharged	107	104	86	110	63
Number of deceased patients	228	232	289	299	304

Clinical Nurse Specialist Team Community	2019/20	2020/21	2021/22	2022/23	2023/24
Total number of patients referred	1448	1429	1113	1564	1748
% of patients with a non-malignant disease	16%	22%	18%	17%	20%
% of patients who died outside hospital	95%	94%	98%	96%	94%
% of patients that died in stated PPD	77%	85%	86%	80%	85%

Clinical Nurse Specialist Hospital	2019/20	2020/21	2021/22	2022/23	2023/24
Total number of patients referred	1516	1467	1593	1932	2058
% of patients with a non-malignant disease	38%	46%	47%	55%	60%
Number of patients discharged	945	796	874	1033	1143
Number of deaths in hospital	450	493	509	711	692

Lymphoedema Service	2019/20	2020/21	2021/22	2022/23	2023/24
Total number of new referrals	293	175	261	242	395
Average number of clinic appointments	9	8	10	12	10
Monthly case load number	252	247	257	242	244
% of non-attendance for booked appointments	11%	2%	8%	6%	8%

Hospice at Home	2019/20	2020/21	2021/22	2022/23	2023/24
Total number of patients referred	1264	1301	1075	1157	1158
Face to face contact	1921	2962	4279	3553	4234
Telephone advice	3684	1571	1251	2835	1417
% with non-malignant diagnosis	36%	43%	42%	45%	45%

The data demonstrates how our patient services have seen a steady increase in referrals and patient contacts within all our core services and clinical workforce reviews will be required to ensure that we have a sustainable workforce to maintain quality and patient experience for the future and in line with the Fylde Coast Five Year Dying Well Strategy.

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. Action plans as a result of audit allows us to rectify or improve service provision and safety. Re-audit then ensures any necessary changes have had an effect.

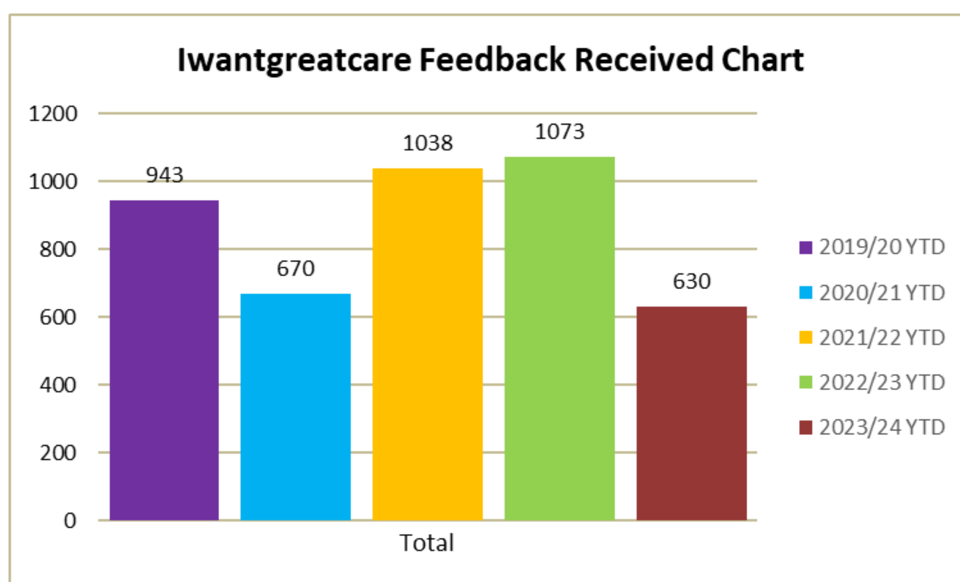
Improvement in practice is embedded into all aspects of Trinity Hospice and Palliative Care Services but specifically patient safety, patient experience and effectiveness of care. In doing so we strive to comply with all aspects of clinical governance and meet the standards required by our regulatory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

Membership of the Audit Group continues to comprise of a representative from each area of the clinical and medical directorates. The group meets quarterly chaired by the Clinical Audit Lead and this is fed back into the Clinical Quality Improvement Group and Clinical Governance

"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.



There has been a reduction in the overall amount of feedback we received in the last 12 months due to a change in the way we obtain feedback. We previously obtained patient feedback centrally with follow up calls completed by an impartial wellbeing worker. However, this was changed to the responsibility of individual clinical teams. This process is still being supported and expected to become embedded during 2024-25. Within Trinity Hospice there remains a focus on

family and patient engagement to ensuring we can get meaningful feedback to drive improvement in services.

''Iwantgreatcare''

Brian House – a total of 101 'iwantgreatcare' feedback forms completed during 2023-24.	
How likely are you to recommend our services?	**100%**
A selection of the comments received: • The staff do an amazing job and take great care of her. I have confidence and trust in them when looking after **** and they always keep me well informed about what they are doing with her. • Brian House staff take great care of ****. I love seeing the way they treat him. I think the staff are lovely. His time there allows me to spend quality time with his brother and sister. • **** and her twin sister **** came to Brian House last weekend for day-care. They really enjoyed themselves making fortune cookies and playing games with the staff. Nothing could have been done better. Mum felt guilty for picking the girls up early as they were having such a good time. • Our foster son came to Brian House for his first overnight stay last week. We stayed in the parents' room. The staff were great, kept me well informed as to what they were doing and were very welcoming and reassuring. We have no fears about his next overnight stay and will not need to stay again unless requested to. • **** came to Brian House for a three-night short stay last week. Unfortunately, he became ill within the first hour and was taken to hospital. Mum feels he received great hospital care because of the input from Brian House staff. • Our foster child really enjoyed her surprise stay at Brian House last week. She spoke to us whilst there and told us how much fun she was having. We know the staff there always take great care of her and this gives us time to have a rest from our caring duties.	

Community Clinical Nurse Specialist Team – a total of 232 'iwantgreatcare' feedback forms completed during 2023-24.	
How likely are you to recommend our services?	**99%**
A selection of the comments received: • The staff I have met up to the present date, have without exception been kind, caring and competent and fully professional in all their actions. • All the team cared for my husband with care and compassion. I could not have cared for him at home, where he wanted to be, without their help. They cared for me too. Nothing could have been done better unless the whole team moved in with us 24 hours a day! Thank you so much everyone. • Looked after my Dad very well. He felt a lot more happier and comfortable. • Exceptional – can't rate them highly enough. • **** in particular was supportive, informative, compassionate and thorough during our meetings in person and on the phone. Her help was invaluable and consistent. • After receiving life changing news, we felt alone in navigating the diagnosis, until Trinity came along. **** is caring and considerate and has sorted out so many things for us whilst being a friendly face, nothing is ever too much trouble.	

Hospice at Home – a total of 61 'iwantgreatcare' feedback forms completed during 2023-24.

How likely are you to recommend our services?	100%
A selection of the comments received: • Can't fault them – absolutely brilliant. • Fantastic – can't thank the nurses enough for what they did. • They always treated Dad as if he was their own and knew exactly what he and we needed. Thankyou is not a big enough word for what we feel about the whole service and services provided. You are a Godsend to all the family at a time of great emotion and need. Dad's final journey before he passed away was truly peaceful and filled with love from everyone involved in his care. • Nothing but praise for the Trinity team, they do a great job. • The Hospice team do a great job. Very satisfied with the care and service.	

In-Patient Unit – a total of 81 'iwantgreatcare' feedback forms completed during 2023-24.	
How likely are you to recommend our services?	**100%**
A selection of the comments received: • My sister and I have been wrapped in a warm soft blanket since we came here with Mum after a very traumatic period. You have kept Mum safe, comfortable and respect her dignity. You have provided us with more support than I have ever received including assisting with Dad's care home provision. I feel healthier and more repaired than before. The catering is excellent and everyone is so kind. • Everyone was brilliant. The chef offered my dad egg on toast, he initially declined. He helped encourage my dad to eat and it turned out to be my dad's last meal. He loved it. • From the moment we arrived we were made to feel as though we were the only family on the unit. Staff were not only excellent with my aunty but our family. Extremely understanding of our situation and allowing us to stay by her side the entire time. They have treated my aunty with absolute dignity and respect at all times even when she was very confused and agitated to being unconscious. • Outstanding care given to my dad when we needed it most. Each and every staff member - whether it was to care for our dad or offer a cup of tea, have exceptional, kind and incredibly compassionate. Everyone has been incredibly supportive and treated Dad with dignity, respect and such compassion. The facilities at Trinity are excellent and the cleanliness, food and rooms are exceptional we would like to offer our sincere thanks to the entire team who have made a really difficult time a little easier. • Not only was he given the greatest care possible, with dignity and respect, the whole family were also. As Dad's carer, I was praised for how well I had done with his care and they told me that now it was their turn to do the caring and for me to spend quality time with Dad 24/7, which I did. All questions were answered (and we had many) and nothing was too much trouble. My dad said it was like being in a first class all inclusive hotel with the care of angels! Thankyou is not a big enough word for what we feel about the whole service and services provided. • My mother's last request was to be cared for in the Trinity Hospice. The care she received in her last days could not have been better. At the time the unit was understaffed and could only accommodate six patients. We will be eternally grateful that she was able to have this last wish and for the care she received from all of the staff. A nurse I spoke to said it was a privilege to work there and she would not want to work anywhere else. I was very moved by what she said. The building and garden has a calm and peaceful feel about it. At first I thought it strange to have a games room but having spent a few days there I realised that having somewhere to have a little time out helped us to cope with the emotions felt during this sad time. Thank you all.	

Linden Centre Counselling and Support – a total of 59 ‘iwantgreatcare’ feedback forms completed during 2023-24.	
How likely are you to recommend our services?	**100%**

A selection of the comments received:

- **** was so welcoming at every session and made me feel relaxed and at ease from the moment the session started. I never felt judged or like she was not listening. The worksheet she gave me with techniques were all really helpful too. Counselling was not what I expected at first but I found it really beneficial in the end and looked forward to my sessions.
- I achieved the aim of understanding why I felt like I did and what the underlying causes might be. My counsellor was very skilled at breaking down what I was saying and reflecting it back to me. I had a very positive experience. The subject matter was extremely painful, but it was good to talk about it and feel better for it. **** has been lovely, very helpful, calm and respectful. She has helped me a lot and very grateful. Nothing was too much and always allowed me to express how I was feeling without being judged.
- **** has been lovely, very helpful, calm and respectful. She has helped me a lot and very grateful. Nothing was too much and always allowed me to express how I was feeling without being judged.
- Without the care and support of our counsellor I do not know where I would be today. She's been fantastic and cannot thank her enough.
- I found the counselling to be very helpful. I was able to express my emotions fully and received good advice, which was positive. I felt safe and felt I was listened to and it was non-judgemental, it has helped me to cope more through a very difficult time.
- She was so caring, understanding and empathetic and had helped me so much to move forward I am very grateful and thankful for this service thank you so much.

Lymphoedema – a total of 88 ‘iwantgreatcare’ feedback forms completed during 2023-24.	
How likely are you to recommend our services?	**100%**

A selection of the comments received:

- Very informative total understanding of advice given. Made to feel like my condition was going to be addressed. I felt very reassured and calm.
- The nurse I saw was excellent- very knowledgeable, informative and professional which led me to have great confidence in her.
- The sister **** was amazing. She was thorough, explaining everything in detail but in terms I completely understand. She was very empathetic when I had a meltdown and made my lymphoedoma clinic experience enjoyable.
- Everything was explained in detail and **** made sure I fully understood what my condition is. They were friendly and made me feel safe. I knew I could trust them straight away. They were honest about treatment options and I really felt they wanted the best for me.
- I did not know what to expect, but I am very happy with my treatment today with ****. She was so knowledgeable and explained everything in a way I could understand. She was very kind, caring and put my mind at ease in every way. Thank you.
- We were seen by Lymphoedema team very quickly after being referred by our GP and the Trinity service. They were very knowledgeable but made sure to explain things to us in a way that we could understand. As always with Trinity's services, nothing was too much trouble, and we could feel/tell that the staff genuinely cared about ensuring the best possible outcome for us.

Complementary Therapy – a total of 8 'iwantgreatcare' feedback forms completed during 2023-24.	
How likely are you to recommend our services?	**100%**
A selection of the comments received: • The support and service provided by Trinity is wonderful. All the staff are very nice, supportive, kind, lovely and caring. • **** was exceptional - provided excellent care and information. Always left completely relaxed and at ease.	

Patient Safety

Patient quality and safety is at the heart of everything Trinity Hospice does. 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 in line with the Patient Safety Investigation Response Framework which has been embedded into out processes in 2023-24.

Complaints or Adverse Comments

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.

What Was Said: Verbal adverse comments were made by next of kin who raised concerns on how they were made to feel when they attended the hospice overnight following the death of his mother.

What we did: The family met face-to-face with the Director of Clinical Services and the In-Patient Unit Manager to discuss how they felt and to raise any concerns they had. They were apologised to. I t was explained this would be fed back to staff to ensure lessons are learned from their experience. Following the meeting they did not want to make a formal complaint. The In-Patient Unit Manager has discussed this with staff to ensure they can reflect on the feedback and ensure other next of kin do not experience the same feelings of being rushed and are given appropriate time and support.

What Was Said: An adverse comment was received from a GP who wrote explaining that a patient was upset they had been discharged from the service following non-compliance with treatment.

What we did: A letter including a timeline was sent to the GP explaining that there had been discussion with the patient prior to discharge about the importance of wearing up to date garments, complying with skincare, movement and weight management. However during conversations with the patient it was evident that she was not completing these core elements of lymphoedema self-management and not complying with the advice offered and therefore she was discharged from our service following an explanation of the reasons. The patient's health and wellbeing worker has discussed the reasoning for discharge from the lymphoedema clinic and is supporting the patient with her weight management goals and skincare. Should compliance with

self-management improve the service confirmed they are happy to review the patient in clinic should she require any support in the future.

What Was Said: We received an email with feedback from a patient's brother regarding failings in their care at end of life prior to being known by Trinity Services but also on discharge from hospital to home whilst under the care of the Trinity Palliative Care Team and then the Community Team, Hospice at Home and District Nursing team. A lack of co-ordinated care and poor communication cited as main problem.

What We Did: This is being investigated as a joint complaint by Blackpool Teaching Hospitals and Trinity to identify shared learning and actions. A family joint engagement meeting is being offered.

Part Four

Lancashire and South Cumbria Integrated Care Board

Lancashire and South Cumbria Integrated Care Board (LSCICB) welcomes the opportunity to review and comment on the Trinity Hospice Quality Account 2023/24. The commentary provided in this letter relates to services commissioned by LSCICB as well as some general observations. We have a continued commitment to commissioning high quality services from the hospice and take seriously their responsibility to ensure that patients' needs are met by consistent and high standards of safe care, provision of effective services and that views and expectations of patients and the public are listened to and acted upon.

Firstly, we would like to commend the continued hard work and commitment Hospice staff continue to demonstrate whilst the NHS responds to ongoing recovery. This pays testament to the continued resilience shown by staff in light of what has and continues to be a very challenging operating environment. LSCICB are pleased about the recognition given throughout the account to the importance of staff well-being and support, as well as workforce retention. With the initiatives being undertaken by the hospice, this work will help to ensure that staff remain supported which will ultimately aid with the delivery of safe and effective care.

LSCICB are pleased with the progress made by Trinity Hospice against the quality priorities set out for 2023/24, this includes development of a strategic plan to formulate a Single Point of Access pilot, optimisation of the use of EMIS electronic patient clinical records, embedding of virtual wards into pathways and development of a governance accountability framework which aligns to the new CQC standards framework. All of these programmes work to improve the services, pathways and quality of care.

LSCICB notes the reference to participation in clinical audit and would welcome a more comprehensive update on audit compliance in future accounts.

LSCICB is encouraged to read that patient feedback remains consistently positive and note that there has been a change in the process of how feedback is obtained. We would appreciate an update regarding the impact of those changes, once embedded. The voice of patients and families is essential to ensuring that feedback drives improvement and we appreciate the insight provided into some of the complaints the hospice has received, including how these were responded to and any resulting actions taken to promote learning.

The Trinity Hospice Quality Account provides an open account of the achievements made in the past year, areas for improvement and describes the priorities for 2024/25 which include further improvements with engagement and involvement of patients, families and staff following implementation of the Patient Safety Incident Response Framework (PSIRF), enablement of a seven-day service at Brian House through community outreach, initiatives to retain and upskill staff and review of the clinical workforce model.

Additional information provided about the aims of these programmes, how they will be achieved and the monitoring approach have complimented our understanding of the delivery intention. LSCICB looks forward to seeing the outcomes of these programmes of work, which will promote improved services, experience, and outcomes for patients, with a continued focus on patient safety.

The Quality Account provides an open account of the achievements made in the past year and areas for improvement. This is an important contribution to public accountability in relation to quality and LSCICB appreciates the amount of work involved in producing this report.

Yours sincerely

Sarah O'Brien
LSCICB Chief Nursing Officer