Statement of Purpose

Trinity Hospice and Palliative Care Services including Brian House Children's Hospice.

'Compassionate Care on the Journey Towards the End of Life'.

(Independent Hospice)

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Company Number

Charity No.511009

July 2016.

Reviewed May 2022

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1. STATEMENT OF PURPOSE TRINITY HOSPICE & PALLIATIVE CARE SERVICES INCLUDING BRIAN HOUSE

Trinity is committed to providing accessible, high quality Specialist Palliative Care for everyone affected by an advanced, progressive life limiting illness.

We provide a co-ordinated system of Specialist Palliative Care for all residents of the Blackpool, Fylde & Wyre area through our family of services (as listed below).

Specialist Palliative Care encompasses meeting the physical, psychological, emotional, spiritual, and social needs of patients. Our care is inclusive and unconditional, non-judgemental, and provided free of charge to all at the point of delivery to all who need us irrespective of cultural, racial, religious, social, ethnic background or gender orientation.

Trinity Hospice & Palliative Care Services is registered with the Care Quality Commission, as required by the Health and Social Care Act 2008. The registered activities are as follows:

- **Treatment of disease, disorder, or injury.**

Trinity Mission Statement:

We will strive to ensure the people of Blackpool, Fylde and Wyre have compassionate care on the journey towards the end of life.

Today this mission translates into a vision and strategy which endeavours to ensure 'everyone on the Fylde Coast has access to consistent good quality palliative and end of life care'. To achieve this vision, Trinity works collaboratively as a palliative care hub with all key partners on the Fylde Coast. Having led on the establishment of a Fylde Coast Palliative and End of Life Steering Group in 2012, all partners now jointly develop a shared Fylde Coast End of Life Strategy. They collectively align their own organisational goals and resources to achieve the agreed priorities. We are currently facilitating the development of the third five-year strategy with all key partners aligned with the national ambitions for palliative and end of life care.

Additionally, Trinity has active seats on the Fylde Coast Place Based Partnership Board, the Fylde Coast Community Integration Collaborative, the Fylde Coast's Clinical Senate and is involved in wider integration projects including virtual wards, two-hour rapid response, daily system situational report (SITREP) meetings and Fylde Coast weekly and monthly tactical command groups. In all cases, Trinity endeavours to ensure it is working collaboratively to achieve safe and highly responsive services in partnership with our health and social care partners. Trinity also endeavours to play an important part in the local system's 'shared leadership', for example, in the development of a Fylde Coast Palliative Care Single Point of Access Project.

This partnership approach recognises the opportunities which can be grasped from reducing unnecessary duplication, improving skills amongst partners, levering even more care in a tight budget landscape, reducing the potential for patients to be missed from the palliative and end of life pathway or fall between the cracks through disjointed services and poor communications. In that regard, all partners are committed to transforming care using further innovation including digitally enabled care. Trinity and partners already benefit from access to shared patient records, the use of virtual technology and plans are in place for significant further enhancements in the coming two years.

We reviewed our values in partnership with our staff, volunteers and management team in 2017 as detailed below. The Board of Trustees' Governance Committee has made some further enhancements in 2022 following the recent updated publication of the 'Good Governance Guide':

Caring:

- Provide care with skill and compassion that is person and family centred.
- Truly listen to what matters to those in receipt of our care 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 independence.
- Provide a “hospice without walls” for continuity of care through integrated services across our IPU, community, hospital, and bereavement services and with our local partner providers in health and social care.
- Ensure the highest levels of infection prevention and control across all our services.
- Support the wellbeing and development of colleagues and volunteers at all times.
- Share our knowledge and expertise with others involved in the care of people with progressive life limiting illnesses.
- Promote a culture that values self-care and self-compassion throughout our organisation.

Adaptable:

- Respond positively, appropriately, and flexibly to challenges.
- Constantly strive to ensure all we do is of high quality and compliant (safe and risk assessed) in accordance with changing regulations.
- Respond to changing patient and demographic needs and projections.
- Develop a workforce to be adaptable and responsive to the changing needs of our local communities and partners.
- Work across sectors (voluntary, public, and private) to maximise our collective impact.
- Develop effective external collaborations based on mutual respect and trust reflection a philosophy of “co-creation”.
- Continue to promote and utilise digitally enabled care, training, and collaboration with external partners to grow services and enable continuation of service provision through joint working.

Responsible:

- Communicate information and expectations so that staff members and volunteers know what is required of them.
- Demonstrate a ‘can do’ attitude and being accountable for our individual actions.
- Investigate adverse comments and complaints carefully and honestly, to ensure learning, and continuous improvement, developing roles within the service to reduce gaps and adhere to the ‘you said, we did’.
- Listen to our service users, staff, and volunteers to inform service improvements for best possible experience of care.
- Promote duty of candour and the role of our Freedom to Speak Up Guardian.
- 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, flexibility of services and responsiveness. Giving patients the option of how and by whom they are contacted, bringing in the virtual concept.

Excellence:

- Constantly develop and apply our professional expertise in palliative care. Share knowledge with community and hospital colleagues to enhance the care of our services provide.
- Develop and sustain great leadership throughout the organisation.
- 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 competent individuals who share Trinity’s values.
- 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 ethical audit and research.
- Develop a workforce with the competences and skill set required to deliver the anticipated future palliative and end of life care needs of our local population.

Socially Engaged:

- Work in partnership with our community to achieve high quality care at the end of life, for all who need it.
- Ensure equal opportunities for all who engage with the hospice and provide a platform for their views and needs to be heard by the organisation.
- Strive for Board, staff and volunteer diversity that reflects the community the hospice serves.
- 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.
- Actively engage with partners to ensure no one is excluded from accessing our services.

Trinity Philosophy:

"Light and Help and Human Kindness".

Trinity Hospice and Palliative Care Services consist of the following family of services:

1. Clinical Nurse Specialist Team Hospital
2. Clinical Nurse Specialist Team Community
3. Adult Inpatient Unit
4. Living Well Service
5. Hospice at Home Team
6. Brian House Children's Hospice
7. Lymphoedema Service
8. Admiral Nursing Service
9. Linden Centre – Bereavement, information, and counselling support,
10. Complementary Therapy
11. Psychology Services
12. Learning Education and Research Centre
13. Physiotherapy and Rehabilitation Services
14. Chaplaincy and Spiritual Care Services

Trinity Management Team Executive

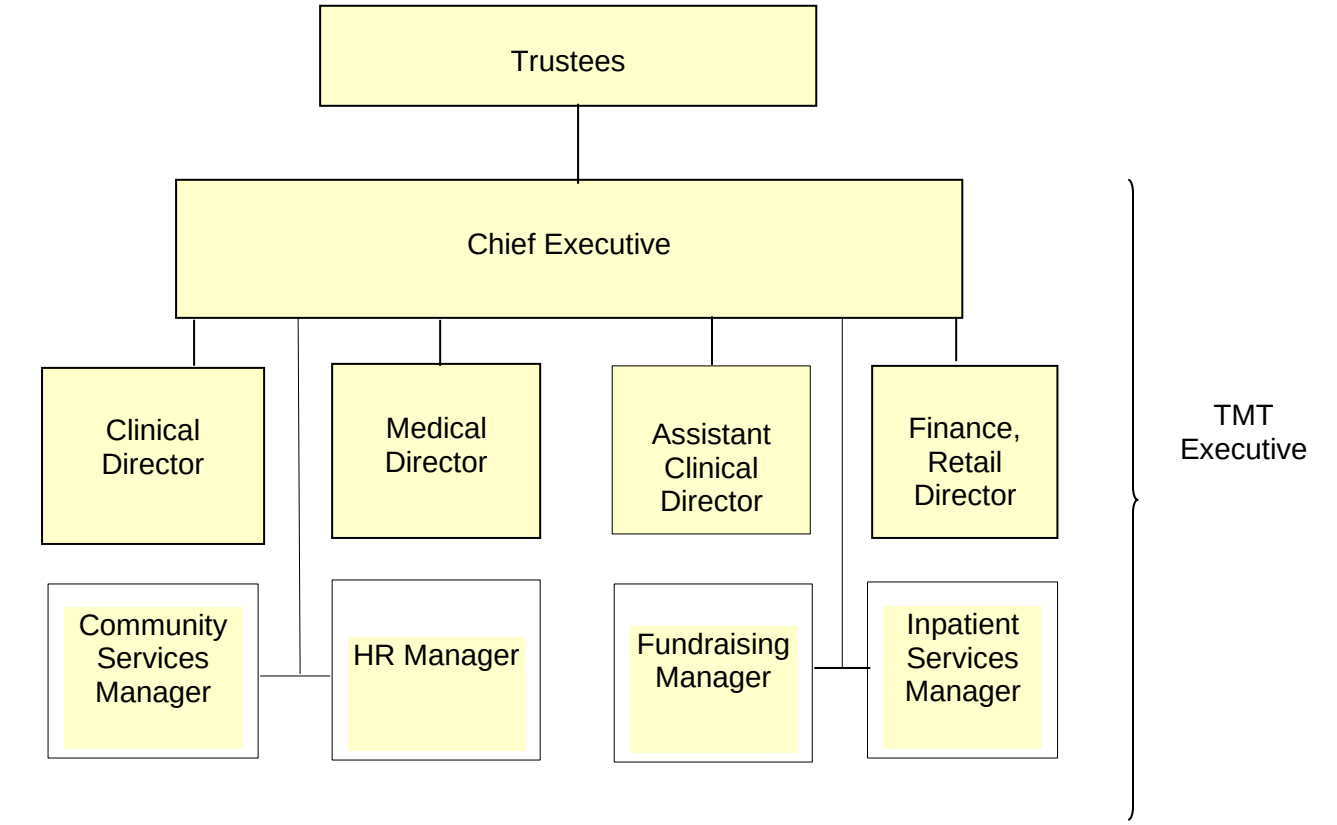
Chief Executive	David Houston
Medical Director	Gillian Au
Clinical Director	*Vacant*
Registered Manager	Gillian Au
Assistant Clinical Director	Lisa Barlow
Interim Finance Director	Martin Clapperton
Community Services Manager	Sarah Roberts
HR Manager	David Warburton
Fundraising Manager	Linzi Warburton
Ward Manager	Cathy Whittaker

The Board of Trustees provides governance and strategic leadership to the hospice and ensures resources are used wisely. Board Committees comprise of the Clinical Governance, Children's Committee, Audit Committee, Trinity Trading Ltd, Remuneration/HR and Investment Committee.

Trinity Management Team Executive is led by the Chief Executive, Medical Director, Clinical Director, Finance and Retail Director – see Structure Chart.

The hospice employs in the region of 250 staff and is supported by approx. 800 volunteers. A Staff and Volunteer Consultative Group provide two-way communication between the Chief Executive, Directors and them.

MANAGEMENT STRUCTURE



Trinity Management Team

- Chief Executive
- Finance & Retail Director
- Medical Director
- Clinical Director
- Assistant Clinical Director
- Community Services Manager
- Inpatient Services Manager
- Brian House ACP
- Facilities Manager
- HR Manager
- Retail Operations Manager
- Finance Manager
- Assistant Finance Manager
- Head of Fundraising
- Hospital Team Leads
- Inpatient Sisters
- Community Services Team Leader
- Practice Development Sister
- Press & Communications Manager
- Catering Manager
- Maintenance & Housekeeping Manager
- Quality & Governance Lead

Staff Consultative Group

Health & Safety Committee

Volunteer Consultative Group

2. REFERRALS TO TRINITY HOSPICE AND PALLIATIVE CARE SERVICES

Patients who have a diagnosis of progressive, life threatening or life limiting illness for whom the emphasis of care is around quality of life rather than life prolonging, will be admitted for symptom assessment and management, emotional support, assessment of future needs or terminal care.

All patients who are referred into the adult specialist palliative care services based at Trinity will be discussed at various multi-disciplinary teams meeting which include:

- Inpatient admissions meeting - daily at 8.30am.
- Weekly inpatient unit MDT.
- Community and Hospital Referrals meetings - daily at 8am.
- Bi-weekly lymphoedema MDT.
- Twice weekly inpatient ward rounds.
- Weekly bereavement/psychology service referrals/triage meeting.

A weekly wider multidisciplinary team meeting is held to discuss patients and families of concern to the service and the outcomes of that discussion used to influence care. All deaths are discussed at this meeting as needed to identify any learning or to plan care for bereaved relatives and carers. The meeting has an educational objective through case discussions and shared learning.

The weekly Multi-Disciplinary Team representation consists of:

- Palliative Care Consultants.
- Two core members of the Clinical Nurse Specialist Team (one community/one hospital) and further representation by Community teams to discuss complex patients.
- Inpatient medical and ACP staff.
- Inpatient nursing staff.
- Counselling/Psychologist (as required).
- Research Nurse.
- Social Worker.
- Allied Health Professional.
- Spiritual Care Support/Chaplain.
- Admiral Nurse (when required).
- Students on placement.
- Medical or Clinical Director.
- Invited guests.

3. SPECIALIST PALLIATIVE CARE TEAM – HOSPITAL BASED

The Palliative Care Team will NOT take over the clinical management of any patient referred but will work as a specialist resource in liaison with the patient and their current health and social care team within Blackpool Teaching Hospital and Acute Trust.

The team is made up of palliative care consultants, speciality doctor, trainee advanced practitioners, clinical nurse specialists, associate nurse specialists and clinical assistants.

The team works seven days a week, 7.30am – 5.30pm, including Bank Holidays.

Referral Process:

- Verbal request and written documentation on EMIS electronic patient record from other Trinity services.
- In the hospital setting when a referral comes from a junior doctor, they, as the referrer, must ensure consent from the doctor in charge of the patient's care. Referrals are made by ward staff using the hospital Nexus IT system.

- In the case of patients with haematological malignancies, consent must be obtained from the consultant haematologist.

The Role of the Team is to Provide:

- Assessment, symptom management advice and advanced care planning for patients with complex palliative care needs, their families and carers whilst the patient is in hospital.
- Non-medical prescribers on the team can prescribe from their formulary as part of a holistic plan of care.
- Provide reactive support as part of 24 hour/7 days a week response to patients referred.
- Respond to calls to the emergency department about patients at end of life to ensure a quick turn around and potential admission avoidance where appropriate.
- Reasons for inappropriate admission are reviewed and signposting to the correct health care professionals to support in their preferred place of care.
- Support and provide guidance for colleagues who are providing generalist palliative care to patients in hospital.
- Collaborative team working within the End of Life and Bereavement teams within community, in-patient unit and withing the acute trust to ensure patients receive a seamless service.
- To provide teaching and learning for all health care professionals working within the Acute Trust.
- To participate in various specialist MDTs to support the identification of patients who have a life limiting illness and may benefit from palliative or end of life care support.
- To contribute to research into palliative care as opportunity allows.
- Out of hours specialist advice can be obtained via the 24/7 advice line which, in daytime hours is part of the community service provision.

Discharge Criteria:

- Patient is discharged from hospital and does not need specialist palliative care input – refer to district nurses.
- Symptoms settle whilst in hospital and staff on wards are managing the patient's needs.

4. SPECIALIST PALLIATIVE CARE TEAM - COMMUNITY

The palliative care team will NOT take over the clinical management of any patient referred but will work as a specialist resource in liaison with the patient and their current health and social care team within Blackpool, Fylde & Wyre CCG.

The team works over seven days to provide, alongside the Hospice at Home night service, 24 hour palliative care nursing cover. The day service runs from 7.30am – 9pm.

The team consists of a part time consultant, speciality doctor, trainee advanced practitioners, clinical nurse specialists, associate nurse specialists, trainee nurse associate and health care assistants. An Admiral Nurse and Physiotherapist ACP works alongside the team.

Referral Criteria and Process:

- An advanced progressive life limiting illness where the decision has been made that the pursuit of quality of life takes precedence over length of life.
- Complex problems that cannot be adequately addressed by the patient's current health care team.
- The patient has reasonable understanding of their illness and where has capacity and accepts referral to the Specialist Palliative Care Service.
- Referrals are expected to cover issues such as symptom management, emotional, psychological and spiritual support for the patient and where needed for their families and close carers.

The Role of the Team is to Provide:

- Support for the existing health care team to ensure the patient's symptom management needs are met. This includes psychological, social, cultural, spiritual and physical needs.

- Assessment, symptom management advice and advanced care planning for patients with complex palliative care needs, their families and carers in the patient's preferred place of care.
- Prescribing of new medications and anticipatory end of life medication of known patients as appropriate.
- Input into EMIS and updating the Electronic Palliative Care patient record (EPaCCS) to inform other health care professions of "What matters most to the patient", ie PPD, DNACPR, advanced care planning, ceilings of treatment decisions.
- Teaching and learning for all health care professionals working within the Blackpool, Fylde and Wyre community including care and nursing homes, Clifton Hospital and The Harbour mental health in-patient unit.
- Support care needs in the last 72 hours of life.
- Community bereavement support.
- To contribute to research into palliative care as opportunity allows.
- Specialist palliative care input and support to each of the nine Fylde Coast Primary Care Networks.
- Advice and guidance over the 24hour Fylde Coast specialist palliative care advice line.

Principles Of Triage Process

- Take handover from Hospice at Home and prioritise urgent cases.
- Review phone calls from previous night.
- Review urgency. Prioritise and allocate all new referrals into the service.
- Available for urgent advice through the day.
- Signpost incoming calls to the most appropriate clinician.
- Medical team and trainee advanced practitioners to work alongside associate nurses to support the management of complex cases and as support learning and professional development.

Nurse Led Clinic

The community service operates a nurse led clinic for those patients able to come into a clinic environment or alternatively via the use of remote consultations. The clinic is facilitated by the trainee advanced practitioners working in partnership with all consultants and Medical Director and have access to specialist support from complimentary services and all the future resources of the Living Well Service.

The team also operates remote clinics working in partnership with GPs, consultants, care homes and local community hospitals to facilitate a "virtual ward round" to support care and facilitate management plans for patients.

Role Of Trinity: Associate Clinical Nurse Specialist

- To support the Trinity Specialist Palliative Care Team to achieve the outcomes of assessment and care planning for patients with complex palliative care needs, their families and carers whether the patient is in hospital, in their own home or in a care home in Blackpool, Fylde and Wyre.
- To support and provide guidance for colleagues who are providing generalist palliative care to patients in hospital, in their own home or in a care home in Blackpool, Fylde and Wyre.
- To provide opportunities for teaching and learning for health and social care professionals across Blackpool, Fylde and Wyre.
- To contribute to research into palliative care as opportunity allows.
- Out of hours specialist advice calls can be obtained from the sister in charge of the inpatient unit when the community team at unavailable.

Referral Criteria to Trinity Specialist Palliative Care Team

Referral to Trinity Specialist Palliative Care Team is for patients who have the following:

- An advanced progressive life limiting illness where the decision has been made that the pursuit of quality of life takes precedence over length of life.
- Complex problems that cannot be adequately addressed by the patient's current health care team.

- The patient has a reasonable understanding of their illness and, where has capacity, accepts referred to the Specialist Palliative Care Service.
- Referrals are expected to cover issues such as symptom management, emotional, psychological and spiritual support for the patient and where needed for their families and close carers.

How A Referral Is Made

A referral is made via the Trinity Hospice and Palliative Care Services referral form, which can be accessed via our website, a consultant or GP letter or, in the case of urgent referrals, a phone call:

trinity.referrals@nhs.net

External referrals can be accepted from the patient's General Practitioner, Hospital Consultant, Tumour Site Specific Clinical Nurse Specialist, Community Clinical Nurse Managers, Community Matrons and district nurses. Internal referrals are made via the EMIS system from all internal departments.

In the case of patients with haematological malignancies, conversations will be held with the haematology team if the referral hasn't come from them.

The referral form has been reviewed to ensure only essential information is requested. Consent from the patient ensures the team can access their medical records via EMIS.

The minimum information a referral must contain is:

- Patient's name, address, telephone number, date of birth and name of GP and consultant involved in their care.
- Patient's diagnosis.
- Next of kin/carer details.
- Patient consent.
- Evidence of palliative disease.
- Evidence of patient insight and acceptance of the referral.
- Reason for referral.
- Relevant EPaCCS, advanced care planning discussions and ceilings of treatment.
- Referrer details.
- Patients preferred method of contact.

A referral to the Community Specialist Palliative Care Team is a referral to the whole specialist palliative care service and the team will direct the referral to other parts of the service as they deem appropriate either from the referral received or as a result of their assessment.

It will be expected that any patient referred to the service from the community will be known to the district nurses and be included on the GP practice supportive and palliative care register and have an EPaCCS record in place.

Response Times

The Community Team will endeavour to contact new referrals i.e. the patient and/or carer within one working day for End of Life Care, two working days for symptom management, three working days for emotional/psychological support. A first contact service is available for "on the day" needs of patients.

Discussions during the morning multi-disciplinary meeting will determine response time, prioritising the most complex and urgent referrals.

At the first contact, all patients will be given the contact telephone number for the team.

Outcomes Of A Referral

- Acceptance of the patient for ongoing support by the team until their complex needs are addressed. This includes prescribing appropriate medications where required and implementing/updating SPAR booklets.
- Assessment for admission to the In-Patient Unit.
- One off assessment visit with advice alongside the current health care team as to how to manage the situation.
- One off assessment of the patient and signposting to the appropriate health care service.
- Referral to Living Well Service if felt more appropriate.
- Any updates to EPaCCS will be communicated back to the patients GP.

Discharge Criteria:

- Complex holistic needs and problems have resolved or are stable.
- Complex symptoms are controlled (but may continue to have basic symptom needs that can be managed by the patient's own healthcare team).
- Medication is stable.
- Patient declines service input.
- Patient moves out of area – refer onto other services.
- Discussion with current caring team to ensure awareness of discharge from Trinity community service via phone, email, or handover at palliative care support meetings.
- Clarification of discharge with patient and family (where appropriate) with the emphasis that the door is always open for them to contact us in the future (01253 952566).

ALL PATIENTS PREVIOUSLY KNOWN TO THE SERVICE WILL BE ACCEPTED BACK ONTO THE CASELOAD TO ENSURE THEY RECEIVE THE APPROPRIATE SUPPORT.

Disputes About Referrals

A one-off assessment will be made by a team member with the referrer and a decision made based on that assessment.

The Community Palliative Care Team reserve the right not to accept a patient who they do not think meets the eligibility criteria or where they do not feel the patient has consented freely to that referral, either through lack of insight or due to undue coercion from a third party.

5. ADMIRAL NURSING SERVICE

Trinity Hospice works in partnership with Dementia UK to facilitate an Admiral Nurse. The role of the Admiral Nurse is to support those caring for someone with dementia. The Admiral Nurse works within the Admiral Nurse Competency Framework, which ensures that the nurse meets the following six competencies:

1. Providing Person-Centred Care.
2. Using Therapeutic Skills.
3. Building Triadic Relationships.
4. Sharing Knowledge.
5. Promoting Best Practice.
6. Using Critical Reflective Practice.

The Admiral Nurse will offer high intensive support or maintenance support depending on complexities in care. The Admiral Nurse will assess the physical/mental health of the person with dementia and their family carer, their care-giving skills and carer coping strategies and undertake a full risk assessment. Using a carer assessment tool, the Admiral Nurse would evaluate carer resilience/stress/coping strategies in order to assist with promoting carer wellbeing. The Admiral Nurse will liaise with other care professionals within the Blackpool, Fylde and Wyre footprint, to provide a cohesive and seamless transition between services, keeping the service user at the heart of all we do. Forging links between Blackpool, Fylde and

Wyre Dementia Nurse and dementia champions, liaising with Lancashire and South Cumbria teams within older adults mental health services, both in the community and at The Harbour and liaising with our charitable services across the Fylde Coast. The Admiral Nurse will hold a small caseload of 20 palliative care clients/carers. Referrals are made via a referral form and currently accepted from within Trinity family of services. The Admiral Nurse provides education, training, signposting and information to the Dementia Lounge, our Trinity colleagues, community colleagues, carers, social prescribers, thus sharing dementia care, knowledge, providing a proactive service to supporting our communities. We are re-commencing the Dementia Action Alliance to create a dementia-friendlier community for all.

6. HOSPICE AT HOME SERVICE

The Hospice at Home Team are based at the hospice and are co-located with the district nursing night service. They work in two teams covering North and South of the Fylde Coast. The teams will consist of a Registered Nurse and a Health Care Assistant and will operate seven nights per week from 9pm until 8am. They will work closely with the overnight district nursing team and out of hour's medical providers – Fylde Coast Medical Services (FCMS). **The Hospice at Home Team will aim to:**

- Provide additional support for the patient and families caring for patients in the last year of life.
- Prompt management of symptoms.
- Provide support, emotional and psychological care to patients and families and carers.
- Prevent avoidable hospital admissions.
- Support fast track discharges.
- Reduce crisis.
- Nursing to patients in their specified preferred place of care and death at home or in care homes.
- Provide additional personal care.
- Referral on to other services as appropriate ie Marie Curie.
- Access to chaplaincy/spiritual and religious care.

Referral Criteria

- Patients 18 years and above.
- Patient has consented to referral.
- Have an advanced, progressive life limiting illness where reversible causes have been considered.
- Patients whose Preferred Place of Care is home, family and carers in support of this and where possible advance care plans are in place to support this including an EPaCCS record.
- DNACPR should be actively explored for patients referred to the Hospice at Home service, particularly those referred for symptom control at end of life whose PPC/PPD is home.
- Patient's GP is aware of the referral.

Exclusion

- Patients with no life limiting illness (except in the case of frail elderly in end stages of life).

Considerations

- Patients who have had chemotherapy and/or radiotherapy in the last 14 days (patients will be triaged by the out of hours GP and if appropriate referred to Hospice at Home. Patients fast tracked home to die, despite having treatments in the last 14 days, can access the service without delay.
- Patients who have been assessed as a risk to staff will be assessed on an individual basis.

How is a Referral Made?

All referrals to Hospice at Home will be via Fylde Coast Medical Services using the dedicated health care professional line. The service proforma will be completed by FCMS. The team join a dial in handover at 9.30pm and 7.30am with the Fylde Coast District Nursing Team to ensure continuity and smooth transition between days and nights.

Assessment will be undertaken at the patient's home and appropriate intervention planned and implemented. The care will be reviewed according to the patients and carers changing needs. The

Hospice at Home team will liaise with the District Nursing Services throughout the shift to review the workload and to be able to be responsive to patient's needs.

Patients requiring support and intervention overnight by the Hospice at Home team will be handed back to the District Nursing team the following day, any changes to clinical condition or intervention that has taken place will be documented on EMIS and EPaCCS information updated. Where complex specialist palliative care needs are apparent the patients will be referred by the Hospice at Home team to Trinity Clinical Nurse Specialist First Contact Team for prompt assessment and medical review as appropriate.

Discharge

Patients will be discharged from the Hospice at Home Service if:

- The patient no longer requires the service.
- A referral to other services may be more appropriate (Marie Curie); this will be discussed with the current care team who will action those referrals.

When their loved one dies, initial bereavement information and support will be provided and a referral will be made to specialist bereavement services with consent if indicated.

7. ADULT IN-PATIENT UNIT - 18 BEDS

A daily admissions meeting is held Monday to Friday to prioritise referrals for admission using the Responding to Urgency in Palliative Care Triage Tool (RUN-PC), however referrals for urgent admissions are accepted seven days a week. Patients who are put forward for admission should:

- Have a diagnosis of a progressive, life threatening or life limiting illness for whom the emphasis of care is around quality of life rather than life prolonging, can be admitted for symptom assessment and management, emotional, psychological and spiritual support as needed and assessment of future needs or terminal care.

Admission for symptom management such as Intravenous Therapies and Paracentesis are also available to avoid hospital admission or prolonged lengths of stay.

Referrals are welcomed from our community and hospital teams, hospital discharge team and from GPs and consultants via the direct referral form on our website.

Referrals are assessed at 8.30am every morning and triaged according to urgency and complexity of needs.

The service aims to be as responsive as possible according to prioritisation and aims to admit seven days a week on the same day or as soon as a bed becomes available.

Facilities:

- In-Patient Unit is bright and airy and has been refurbished with a dementia friendly interior to support patients and family members with Dementia.
- Infection Prevention and Control is of high importance on IPU. All patients are screened for Covid-19 on admission and barrier nursed accordingly. All staff and visitors are required to wear a face covering on the In-Patient Unit. If a patient is Covid-19 positive, visitors will be asked to wear full PPE and nursing staff will provide guidance on this.
- Our nurse call system is silent, to provide a peaceful atmosphere. A variety of nurse call buttons are available for this system to meet the needs patients with greater disability. All staff members on duty carry a pager to inform of any calls.
- Patients will be accommodated in single (four with en-suite facilities), three or two bedded rooms dependent on need and availability and accommodated for single sex gender.

- For those patients in three and two-bedded rooms, well-fitting cubicle curtains ensure privacy can be maintained.
- Three bedded rooms have an en-suite shower room. All bathrooms and toilets have engaged signs and are lockable.
- Patients with specific needs are assessed on an individual basis with relevant equipment hired in these circumstances.
- Wardrobes with patient's own safe, bedside cabinets and televisions are available at each bed space with no monetary cost. Headphones are used to prevent disturbance to other patients.
- All patients' rooms look out onto extensive gardens and have patio doors for easy access outdoors.
- A smoking shelter is located in the garden for patients and visitors who wish to smoke.
- An internal Courtyard area with comfortable chairs is available where relatives may obtain drinks and snacks. A child friendly corner is available and a table tennis and pool table are available as diversional therapies for patients, if able, and visitors. This also overlooks a garden area.
- The Chapel is available to patients and visitors as a safe quiet space.
- Wireless internet is available for patients and visitor use throughout the unit.
- iPads are available to our patients to facilitate virtual connectedness with their families and loves ones and remote consultations as needed.
- Two relatives' rooms are available for overnight use and may be used by patient's families for private conversations during the day. Comfortable chairs are available for family members if they would prefer to stay by the patient's bedside.
- A cold room for our patient's to rest in peace following death.
- A viewing room for bereaved families to spend time with their loved ones following death.
- Our garden is available for use for both patients and families with a large screen TV, with Sky.
- The surroundings are pleasant and tasteful with the emphasis on comfort.
- The hospice building and grounds are otherwise a 'No Smoking' area.

Multi-Disciplinary Team Meetings

Continuous nursing and medical review of patients, assessments, and communications with families to inform care planning, advance care planning and ceilings of treatment, documented and updated with the team at handovers and daily huddles to support communication between medical and nursing teams and following the consultant ward round.

A weekly MDT and twice weekly ward rounds are held to review the care and plan discharge for patients on the in-patient unit attended by the medical and nursing teams, discharge co-ordinator, physiotherapist, social worker, pharmacist and spiritual care team. Discussion will take place regarding whether the objectives have been met for each in-patient.

- Where the objectives have been met, plans for future care will be made and the input required from all professionals identified.
- Where objectives have not been met, the reasons will be discussed and proposed future treatment will be discussed, planned and implemented.
- Discharges will be supported by our discharge coordinator, pharmacist, social worker and physiotherapy team as needed.
- All of our patient records are available for our GP and community colleagues in the EMIS shared record, and a discharge summary letter is sent to GP on the day of discharge with updated EPaCCS information and referral to our community team if indicated for continuity of care.

Fylde Coast Wide MDT

Representative from across the palliative care service meet, this includes the local teaching hospital (Blackpool Teaching Hospitals) and representatives from all relevant Trinity services on a Wednesday at 3pm. The team includes clinicians, social worker, psychologist, chaplain, Admiral Nurse and physiotherapist and any visiting students or invited guests.

The MDT discusses:

- Patients and families of concern across all services.
- All discharges from the previous week will be discussed and any relevant information given to the appropriate professionals present to ensure co-ordination and continuity of care.
- Potential patients for admission.
- All deaths during the previous week will be discussed and audited in order to ensure best practice continues in achieving good symptom management in the terminal stages of the disease. Any relatives/carers requiring more than the routine bereavement follow up and support will be identified, and the appropriate professionals made aware.
- Updates from the strategic clinical network.
- Updates from Research.
- Learning and reflective practice shared across all services.

In-Patient Unit Admission's Meetings

These are held at 08:30 on weekday mornings and attended by the Specialist Palliative Care Doctor, trainee GP's, trainee ACP's, Ward Manager, Chaplain and senior nurse from the unit.

- Those patients requiring admission have been identified on EMIS via In-Patient Unit admission template and will then be reviewed and scored using the Responding to Urgency of Need in Palliative Care (RUN-PC) Triage Tool to aid prioritisation of referrals for admission.
- A brief update will be given on all in-patients including the nursing establishment.
- The team will have the opportunity to discuss any issues relating to patient care with their colleagues.

Criteria For Admission

Patients who have a diagnosis of a progressive, life threatening or life limiting illness for whom the emphasis of care is around quality of life rather than life prolonging, will be admitted for symptom assessment and management, emotional, psychological and spiritual support, assessment of future needs or end of life care.

Admission will be for an initial period of assessment or for end-of-life care.

Priority for admission will be established at the multi-professional meeting held each weekday morning utilising a validated tool to inform prioritisation according to needs. Those patients deemed to be in greatest need will be prioritised for same day or soonest possible admission including over weekends. For those where beds are not available on that day, a plan will be made to ensure best possible palliative care support in their current or alternative place of care until a bed becomes available.

Potential weekend admissions will be discussed with the nurse in charge, via the nurse in charge mobile, and first on-call member of the medical team over the weekend.

Staffing

There will be a minimum of nine staff on duty between 07:30 and 16:00 hours each day at least three Staff Nurses and at least one Sister or Senior Staff Nurse. The remaining staff will be NVQ3 or Healthcare Assistants.

There will be six staff on duty between 16:00 and 20:45 hours each day, at least two Staff Nurses, one of whom will be a Sister or Senior Staff Nurse.

There will be a minimum of five nurses on duty between 20:45 and 07:45 hours each day, at least two Staff Nurses, one of whom will be a Sister or Senior Staff Nurse.

There will be at least two qualified members of staff on each shift with specialist palliative care experience and training.

The above staffing levels are based on 18 beds being occupied; if above 18 occupied then extra staff will be required.

A Ward Aide is available Monday-Friday 08:00 – 16:00 to support with administrative duties.

A Discharge Co-Ordinator is also available to lead on planning discharges of patients. They also hold the post of Senior Staff Nurse to be able to support the In-Patient Unit if the needs for discharge are reduced. A physio assistant is available Monday - Thursday to provide rehabilitation support and a small number of the NVQ3 post have received training in basic assessment of patients' mobility, to limit delay in physio support.

Nurse Associates and Trainee Nurse Associates are developing within the team, to compliment the skill mix within the team

Volunteers available for support. Volunteer Ward Aide's work to support in administrative tasks, usually in the morning.

Volunteer's also work shifts throughout the day to provide refreshments for patients and their relatives.

8. PHYSIOTHERAPY

Physiotherapy will be available for those under the Living Well Service and inpatient unit. This is provided by a suitably qualified physiotherapist with support from a rehabilitation assistant. Referrals will be made internally via EMIS for triage by a member of the team. In addition, the physiotherapist can undertake limited occupational therapy (OT) cross-prescribing for basic equipment where appropriate and within scope of practice; otherwise, referral will be made into the community OT team. The community OT service will only see out patients when they are already at home. They are unable to support discharges

9. OCCUPATIONAL THERAPY

Referrals will be made directly to the Community Occupational Therapist.

10. COMPLEMENTARY THERAPY SERVICE

The role of the Complementary Therapy Service is:

- To help develop patients coping strategies through the use of therapeutic techniques.
- To support carers caring for patients approaching end of life with relaxation therapies to help them with the stress both physically and emotionally.
- Providing treatments for patients approaching the end of life with complex needs that require specialised clinically trained therapist.
- Work alongside other Trinity services to provide non-medical support to patient/carers.
- Enhancing the holistic approach to Trinity's multi-disciplinary care planning.
- Weekly sessions are available to staff to support wellbeing.
- Weekly Pilates and Yoga classes are available to staff to support wellbeing.

The following therapies – massage, aromatherapy, Reiki, Touch therapy, reflexology, Bach flower remedies and relaxation/guided visualisation may be used during treatment. All of these therapies can help by relaxing you, by reducing tension, stress and anxiety and allowing much needed "time out''. Additional benefits from the treatments can be:

- Short term pain relief.
- An increased sense of well-being.
- Reduction in nausea.
- Relaxation to help encourage sleep.

Therapies recommended by the National Guidelines for the Use of Complementary Therapies in Supportive and Palliative Care 2003 (NGCTSPC) and the Guidelines for Complementary Therapy Provision in the

Lancashire and South Cumbria Cancer Network (May 2012) will be provided by qualified staff and volunteers for patients and carers.

Patients can only be referred to the Complementary Therapy services if already known to another aspect of Trinity Hospice and Palliative Services, with an internal referral being made. In-Patient referrals will be assessed within two working days from the date of receipt, whilst out-patient referrals will be assessed within three weeks from date of referral. The Complementary Therapy Co-ordinator will be supported by suitably qualified Complementary Therapy volunteers. Evidence of their personal development will be maintained by the Complementary Therapy Co-Ordinator. All therapies we offer are free of charge.

11. COUSELLING AND BEREAVEMENT SUPPORT SERVICES

The Linden Centre provides counselling services for all patients who are being cared for by the Trinity family of services. Referrals can be made by any Trinity/Brian House staff or by other professionals.

Referrals are discussed at a weekly MDT and accepted referrals added to the caseload. Patients are prioritised for counselling following an initial assessment which will identify their individual needs allowing them to be allocated to an appropriate counsellor. Sessions are tailored to the individual patient need, this may be in the form of one-to-one counselling, group sessions, or it may be the client would benefit from one of our therapy sessions as well as, or instead of, counselling related support. As patient needs change during the trajectory of their illness patients are able to re-refer to counselling as required.

Patients who are identified as having more complex psychological needs are discussed at the MDT with the Clinical Psychologist and can be referred into this service as appropriate.

The Linden Centre is working very closely with the emerging Living Well Service and referrals will ultimately come from a holistic assessment completed in a nurse led clinic ensuring the patient has opportunity to discuss all of their concerns allowing us to work collaboratively with the patient developing a tailored care plan supporting them to live the best life they can.

The Linden Centre also offers support for the carers of those who are referred to the Trinity family of services. They will be discussed at the weekly MDT and, following an assessment by a trained counsellor, will be offered a place at one of the carer groups or one to one counselling sessions as appropriate.

The Linden Centre also provides support for bereaved family members both adult and children, who can self-refer or may be referred by other professionals and are discussed at the weekly MDT.

Bereaved family members will be offered a place at one of the bereavement groups and this can be any time from the loss of the loved ones. There are three different levels of bereavement group:

- Drop-in bereavement support group where networking with others and social interaction is the aim of the group. These are volunteer led groups.
- A more focussed group where there is some facilitation from the counsellor to initiate conversations, but no set structure led by a counsellor.
- Therapeutic group with a set structure led by a counsellor.

For family members who are experiencing complex grief, they will be assessed by one of the trained counsellors and offered support at one of the therapeutic group sessions or one to one counselling as appropriate.

All counsellors receive supervision on a monthly basis, those supporting patients are supervised by the Clinical Psychologist who tailors the training and support needs from these sessions.

Those staff who are counselling bereaved family members receive monthly supervision from an external supervisor who meets quarterly with the Assistant Clinical Director, informing her of any support needs or recurring themes supporting training and development plans. Any concerns not able to be addressed in supervision will be escalated to the line manager.

12. CHAPLAINCY AND SPIRITUAL CARE

Day-to-day care is managed by our Spiritual Care Co-Ordinator in partnership with chaplains from Blackpool Teaching Hospitals NHS Foundation Trust. Assessments are made and individualised help and support is offered to patients and their families. This support is, increasingly, also being offered outside the walls of the hospice in response to referrals from the community CNS team.

The hospice maintains good relationships with local ministers and leaders of the principal faith communities in Blackpool and, where appropriate, they are contacted and welcomed in to support members of their congregations.

The hospice also has a large, dedicated space which is set aside for worship and quiet reflection. The Chapel has played host to a weekly Christian service and additional seasonal services and reflections as well as the occasional family celebration, wedding blessing and prayer service. The Chapel is also used for our annual 'Light Up a Life' and 'Butterfly' remembrance services.

Patient weddings may be arranged via the local Registrar and facilitated on site, while Holy Communion and other sacraments are offered at the patient's bedside as requested. In addition, the Spiritual Care Co-ordinator stocks reading material, alongside, religious, and non-religious items, which offer spiritual comfort and relief to those who need it.

The Chaplain plays a key role in supporting the wellbeing of staff and volunteers in helping to lead initiatives including Schwartz Rounds and the Staff Wellbeing Group, in addition to being available on a one-to-one basis for staff support.

The Chaplaincy team deliver a range of training modules to enable staff and trainee medical students to have a better understanding of the role of spiritual care.

13. SOCIAL WORK PROVISION

There is an in-house social worker based at the hospice providing support to both the in-patient team and the community-based services. Where a referred patient is already known to social services and has an open worker then the in-house social worker will forward the case to that worker and update on relevant details. Where the person is not already known to social services the in-house social worker will assign the case to themself if possible and action any work/assessments/commissioning required.

The in-house social worker can also provide support and advice to family's and carers of patients and can help them access relevant supports as required. The social work role is very much part of the wider integrated team and works in conjunction with nurses and therapists and other relevant professionals to help provide a seamless service to those accessing the hospice services.

In the absence of the in-house social worker staff can refer directly to the relevant local authority or practice hub.

If patients are already known to Social Services, contact should be made to them. Patients newly identified requiring a social worker, will be referred to our in-house social worker or the neighbourhood hub relevant to the patients GP practice and locality or in the case of Lancashire social service referred to the single point of access hub.

14. MEDICATIONS AND PHARMACY SERVICES

Patient's own current non controlled medications which are brought in with them will be used for their own use if in a satisfactory condition until the stock is exhausted when hospice stock will then be used. All controlled drugs will be returned to the family to take home or destroyed under the Management of Medicines Policy following permission from the patient.

All other drugs and dressings required will be obtained from the pharmacist holding the contract to supply the hospice.

Orders will be emailed through daily, Monday - Saturday with collection by hospice porter normally available on the same day.

The hospice commissions pharmacy services from a local community pharmacy of WELL Pharmacy Services. A pharmacist is always available (including out of hours) for advice and will visit the hospice twice weekly to review prescription sheets, maintain and support staff with safe stock levels, provide education, participate in policy development, attend the Medicines Management Committee and complete weekly controlled drug stock checks. On occasions the weekly checks are delegated to a registered pharmacy assistant or other suitably qualified pharmacist. The pharmacist reviews all prescriptions in both Trinity Hospice and Brian House Children's Hospice. The pharmacist participates in audit and analyses for emerging patterns and feedback as part of our governance arrangements.

15. MEALS & DIETARY REQUIREMENTS

A varied and nutritious diet will be provided for all patients appropriate to their needs. A choice of two main meals will be available at lunch and evening mealtime and a cooked breakfast will also be available.

Patients will be assisted to make their choices if necessary.

The hospice head chef will see any patients requiring information regarding general nutritional needs or special dietary requirements.

Patients requiring further advice on special diets or methods of feeding will be referred to the hospital dietician/speech and language assessment service directly by telephone. Initial screening may be undertaken by the nutrition and hydration link nurse for non-complex advice and swallowing assessments under our feeding at risk policy.

If patients have been assessed by Speech and Language Service as requiring a specific consistency of food. This has now been uniformed for safety by The International Dysphagia Diet Standardisation Initiative (IDDSI) and a safe level for food and drink advised. An assessment from is completed on admission and the kitchen staff are informed of the relevant level. A variety of foods are stocked and can be ordered in line with patients preferences.

Visitors may purchase meals when staying with very ill patients and snacks and drinks are readily available for purchase at all times.

The catering team engage with patients, families, and relatives on admission to build up a relationship with them from day one to hopefully cater for their needs and all requirements, where possible, making them feel nothing is too much trouble.

The team always continue to check in with the patients and make sure everything is OK. They advise and guide where they think it is required, coming up with suggestions and ideas, promoting healthy and nutritious meals where they can.

They are also committed to supporting families and relatives too, making sure they are felt as important as the patients.

16. OTHER ACTIVITIES

There will be a planned programme of social activities arranged in the Living Well Service and inpatients may freely attend these. There is provision in the family area known as The Courtyard to support a variety of age groups that are there to support as diversional therapies such as pool and table tennis.

17. CELEBRATIONS

Patients will be encouraged to celebrate all special occasions, birthdays, anniversaries etc, and catering for these can be arranged through the Catering Department. All events are captured as "going the extra mile" events and patients and families are asked to consent to telling their story about these events for use to promote hospice services to the wider public.

18. VISITING

Visitors are welcome during 11:00 – 20:00, visiting will always be accommodated outside of these hours by discussion. Visiting may be restricted at other times at the patient's request, or if they are causing problems to other patients in the hospice.

Visiting is unrestricted for families of patients who are at the very end of life and actively dying.

Visitors are required to wear a face covering on the In-Patient Unit for Infection Control. If a patient is barrier nursed, visitors will be required to wear PPE, nursing staff will advise on the process when vising.

Relatives, friends, and carers may make telephone contact with patients via the main hospice switchboard.

Relatives/carers are welcome to stay with very ill patients and accommodation can be provided at the bedside or in an overnight room with en-suite facilities.

Patient's pets may be brought to visit but should remain on a lead.

19. TRANSPORT OF PATIENTS

The local ambulance service or the patient's family will provide transport for admission, discharge and attendance at hospital outpatient appointments. Regulated private ambulance companies may occasionally be used if NHS ambulance is unavailable to support timely transfers.

Discharge Arrangements

Staff will make every effort to ensure that patients are discharged into a safe environment with adequate equipment and arrangements for support.

A discharge leaflet is available and given to patients and families on commencement of discharge planning, detailing the discharge process to families, including processes such as continuing health care and supported packages of social care. Our Discharge Co-ordinator and Social Worker will support with discussions around packages of care.

Home assessments, if necessary, will be carried out by our physiotherapy team and/or community Occupational Therapy service.

The patient will be given a week's supply of medication together with a copy of a detailed discharge prescription sheet and a discharge booklet that will include the most appropriate contact details to support on discharge. Discharge letter and discharge prescription sheets are securely emailed to the GP, District Nurses and Fylde Coast Medical Services (FCMS) on the day the patient goes home.

Patients who may benefit from attending the LWS after discharge will be identified at the weekly multi-disciplinary meeting and a referral form completed if they fulfil the LWS admission criteria.

Patients referred to the LWS will be discussed at the LWS MDT.

All patients are referred to the district nurse teams for ongoing support via an electronic referral form. This will be verbally discussed with the patient prior to discharge. The district nurse will be encouraged to visit the hospice to discuss patients with complex needs or alternatively a case conference can be arranged with hospice staff, allocated Social Worker, Trinity Community Nurses, allied health practitioners and patient and family present.

Hospital beds required for patients at home are ordered via an on-line system and e-mailed to the appropriate funding authority ie Fylde and Wyre NHS or Blackpool NHS for authorisation.

The patient will be referred to the appropriate member of the Trinity Clinical Nurse Specialist Team prior to discharge for continuing support at home.

20. LIVING WELL SERVICE

Ambition

The Trinity Living Well Service (LWS) is a new and developing collection of services and professionals currently operating in a limited capacity, at a pilot stage.

Its aim is to meet palliative patients earlier in their journey, which will provide care and guidance primarily from a rehabilitative and socially enabling standpoint.

It will be integral with other Trinity services, working alongside our NHS partners.

The LWS will aim to be the initial contact patients and their relatives and carers have with us. It will aim to provide a positive introduction to Trinity early in a patient's journey and facilitate moving between its variety of services as deemed appropriate for the individual.

In addition, support will be offered for their families and carers both during their journey and during bereavement.

Structure Of the Service

The LWS pilot is overseen by the Assistant Clinical Director and led by the Advanced Clinical Practice (ACP) Physiotherapist. This is complemented by a core MDT comprising:

- Trainee ACP – experienced palliative CNS background;
- Clinical psychologist;
- Counsellors
- Complementary Therapist
- Spiritual Care/Chaplain
- Admiral Nurse
- Bereavement Support HCA
- Volunteers.

Patients under the pilot service will be discussed at the team MDT and commence with an initial holistic assessment led by the ACP or trainee ACP. They will plan with the patient, setting goals and providing support from a menu of available options provided by the LWS MDT, volunteers and local community – the aim will be to make their experience bespoke, with as little input as required to achieve their agreed goals.

Planned groups/activities for development and dependent upon availability and Covid restrictions include:

- Psychological services;
- Complementary therapy;
- Chaplaincy and spiritual care;
- Admiral nursing;
- Bereavement support;
- Carer information and training;
- Family support such as housing, benefits, will making etc;
- Social work support;
- Physiotherapy/exercise/diet and nutrition;
- Breathlessness and fatigue management;
- Symptom management/advice;
- Transition to adult care from Brian House;
- Advance Care Planning;
- Arts and music creative therapies;
- Photography/film digital memory;
- Community access – allotments, gyms, parks, return to work etc.

Facilities

While based at Trinity Hospice, LWS will be a community provision.

A working group is currently in operation to assess and plan the redevelopment of buildings and structure to best meet the needs of the new LWS in the long term.

Interim planning is taking place to make the most of facilities and resources available; including planning to maintain service operation during any such works – contingency is being planned to relocate the services within the organisation to facilitate this.

Development of these services will also aim to support staff development and wellbeing such as through use of gym facilities, access to complementary therapy, education, training and post rotation.

Referral

This will be in line with Trinity's referral criteria but will aim to meet patients much earlier in their journey.

Referrals ultimately will be accepted from our health care partners across the Fylde Coast teams. When established, this will be via our Single Point of Access (SPoA) with trained staff triaging towards our service.

The interim service will accept referrals from Trinity services and via the Quality Improvement Project run by our trainee Advanced Practitioner which has linked with selected local partners in Primary Care and aims to commence in May 2022.

Discharge

Discharge planning will be built upon attainment of the goals identified within their holistic assessment and assessed need within the relevant services involved. The LWS aims walk alongside our patients through their journey; offering 'drop in' informal sessions and to be there at key points such as when change in condition occurs, which can initiate re-referral by professional colleagues or patient-initiated follow up where appropriate.

21. CLINICAL PSYCHOLOGY SERVICES

"Providing specialist psychological services across a range of settings for people significantly challenged by life-limiting illness".

The Clinical Psychology team offer evidence-based talking therapies that help patients cope with life-limiting illness and related challenges, such as impact on quality of life, mood, and family. They are part of several specialist teams within the Blackpool Teaching Hospitals Trust (including cancer, chronic pain, cardiac and cystic fibrosis) and have a dedicated Principal Clinical Psychologist hosted by Trinity Hospice providing a service five days per week. The Psychology service operates alongside the Linden Centre Therapy Services, and within the specialist multi-disciplinary palliative care team, offering a flexible service across organisational contexts including inpatient, outpatient, community, and hospital settings. The service is digitally enabled, offering virtual sessions and contact with patients, integrated into regular service delivery.

The service offers structured supervision/reflective practice to our nursing teams and provides level 2 training in psychological assessment and interventions in conjunction with the wider Psychology service within the Trust. The Trinity Psychologist provides consultancy, support, and formal supervision to the Linden Centre Counselling Service, offering quarterly inhouse training sessions and supports staff wellbeing across the organisation.

22. BRIAN HOUSE CHILDREN'S IN-PATIENT UNIT FIVE BEDS & FOUR DAY CARE PLACES

Brian House is a purpose-built children's unit and has been established to provide palliative, end of life care and respite care to children, young people and their families primarily residing in Blackpool, Fylde and Wyre communities.

Palliative Care

An active and total approach to care embracing physical, emotional, social, and spiritual elements. It focuses on quality of life for the child and support for the whole family and includes the relief of symptoms, provision of respite and care through death and bereavement.

End of Life Care

Refers only to the critical stage where life is imminently coming to an end and where the child is totally reliant upon the support of others towards a dignified death. Such a stage will incorporate the child being conscious or unconscious and where physical (and or mental) functioning is observably deteriorating.

Brian House has an SLA with a Paediatric Consultant from the local acute trust who provides specialist training in symptom management and supports the team with anticipatory prescribing ensuring patients receive the treatment they may require without delay.

The Paediatric Consultant will be informed of any referral for end-of-life care and confirm she is happy to accept the referral and will lead on the symptom management prescribing supported by the Brian House Non-Medical Prescribers and any other services involved.

Rapid referrals can be made for end-of-life care, an assessment will be arranged and completed as a priority and patients transferred once the consultant has confirmed she is happy to accept the referral and all the assessments have been completed with any medication/equipment required obtained.

The Paediatric Consultant supports the three NMPs with their continued development in prescribing end of life medication for children in the care of Brian House ensuring the most up to date evidence-based care is always provided.

Brian House has a Trainee Advanced Clinical Practitioner who works closely with the consultant providing the link between the child's nominated consultant and nursing team with shared learning delivered via team meetings, training days, scenario training and one to one support as required.

Brian House has the support of a chaplain who regularly attends the MDT meetings, group sessions and drop ins to get to know the families. The Chaplain is available to families at any time throughout their child's time at Brian House through to end-of-life care and bereavement support.

Daily MDTs are held for children who are receiving end of life care involving the senior nurse caring for the child, the parents, the NMP, either tACP or the Paediatric Consultant and any external staff who are involved in the care. This could include, for example, the MacMillan or community team ensuring parallel planning is always considered.

Butterfly Suite

The Butterfly Suite is available with a sensitively designed cold room with a deceased child can rest in peace for up to seven days, allowing the family time to stay close to their child using the purpose built two-bedroomed flat which accommodates up to two adults, two children and one baby. The self-contained flat allows the family to have quiet time if required.

The Butterfly Suite has a separate room for parents to sit in to be with their child as they wish.

The palliative care nurses and HCAs are available to support the family with memory making whilst their child is in the Butterfly Suite.

Respite Care

Children can be referred in for respite care by professionals or self-referral. These are discussed weekly at MDT and an assessment visit planned to determine whether the child meets the referral criteria:

- Life limited or life threatened.
- Have special medical or nursing needs.
- Have complex health needs.
- Require and could benefit from active health rehabilitation during a period of respite care.
- Is receiving a package of palliative care at home and it is thought, following a multi-disciplinary assessment, that they or their relatives would benefit from respite care.

Patient referrals may be made by:

- Paediatric Consultant;
- General Practitioner;
- Health Professionals;
- Family members, (providing that permission has been given by the child (if able) and parents/guardians)
- School nurses;
- Therapeutic centres;
- Neonatal services;
- Foetal Medicine;
- Specialist services, ie oncology, renal, cardiac;
- MacMillan Team.

All children are offered 14 nights respite which is pre-allocated on an annual basis allowing equitable access to the peak times.

Respite is spread evenly throughout the year allowing families planning time ensuring they can maximise the respite time. The respite is offered in blocks of up to four nights, but families can book more frequent shorter breaks if required.

All children will have access to the full range of Brian House facilities outside of these allocated visits.

The people making the assessment will be responsible for following internal procedures regarding access to services for children/young people and families. They will ensure that access is non-discriminatory, appropriate, and timely. They shall be able to assess the child and family needs and know when to refer to alternative health and/or social services.

Once a child has been accepted for admission, the child will be allocated respite pro rata and first visit arranged where a comprehensive person-centred care plan is completed, and the family is encouraged to stay for 24 hours with the child to support the child settling in.

If a child has not been accepted for admission, ie if they do not come within the criteria, then the referrer will be contacted by letter, stating the reason why, and letters will be forwarded to the social worker, GP and Paediatric Consultant. Re–referrals, should a child's condition change or deteriorate, will be accepted.

Children may not meet the criteria for respite care but may meet the requirements for tots/baby group. These will be young babies/children who score a green but are likely to deteriorate and will require respite in the future.

Community Services

We offer community support for children who are accepted on to the Brian House caseload. We can support children who are not attending school in their own home if they are too vulnerable to access the hospice. The support may be for a short respite break for parents to go to the shops, for a meal, siblings play at school, catch up with some housework etc, or even to support with bathing.

We also offer community support in the hospice; this includes:

- Baby Group.
- Tots Group.
- Siblings Group.
- Parents Group.
- Cinema nights.
- Stay and play using the facilities.
- Day care for those who are too vulnerable to attend school but can access the hospice.
- Day care for the pre-school aged children.

Planning

Weekly planning meetings review the needs of the children accessing the service for two weeks in advance ensuring staff skill mix is still appropriate and no other issues are identified prior to respite. If skill mix is found to be unacceptable, additional shifts are offered and if this isn't successful, respite is rescheduled as a last resort in collaboration with parents to minimise the disruption to families whilst maintaining safety.

MDT meetings are held to discuss children and young people in our care and staff attend MDT arranged for the children ensuring seamless care.

All staff are trained in safeguarding and the tACP is the lead for safeguarding within a Trinity Safeguarding Team.

Monthly meetings are scheduled with standing agenda items being Safeguarding, Health & Safety and risk. Reports are submitted by all senior nurses who have additional responsibilities in:

- IPC
- Safeguarding
- CDOP
- Child and parent involvement
- Feedback
- Service development
- Students
- Education and training
- Transition.

Young Adults

Referrals to Brian House are accepted until an adolescent's 16th birthday. Young people already admitted to Brian House for care before that age may access the service up until the age of 18 years.

Children aged 14 years and above will be supported during transition to adult services if required. The nurse with an additional role in transition will ensure she links into the transitional care for the child, attending MDTs where required.

Young adults will be admitted together wherever possible to support their social interactions.

Staffing

Brian House staffing structure consists of an Assistant Clinical Director, Paediatric Consultant, trainee Advanced Clinical Practitioner, Senior Nurses, Nursing Associates, HCSWs Level 3 and HCSWs who work as a team to support the needs of the children.

There will be a minimum of one nurse and one on call nurse on duty throughout the 24-hour period when Brian House is open. They will be supported by NAs or specially trained HCAs with competencies in the complex needs of the children.

Facilities

Patients will be accommodated in single bedrooms and have access to a rise and fall bath.

Other facilities include:

- Multi-sensory room.
- Sitting/play area.
- Kitchen/dining area.
- Quiet room.
- Creative Therapies Room.
- Bath/WC.
- Disabled WC.
- Teenage lounge/cinema room.
- Craft/play area.
- Garden incorporating a growing area for children and young people.
- Butterfly Suite.
- Access to a chapel/sacred space.
- A nurse call system is available in all areas.

The areas are available to all age groups of patients and are appropriately decorated and furnished.

Parent's accommodation including lounge, kitchen, bedrooms, and bathrooms are available for overnight use by families of very ill children or those attending Brian House for the first time.

Services

Specialist nursing interventions, pastoral care and play activities will be made available to all children registered with Brian House as appropriate and considering their age and developmental needs.

Special diets and enteral feeding will be catered for and a wide variety of age-appropriate meals will be available.

All care is family centred and carers/relatives are encouraged to have as much involvement and spend as much time as they wish with those attending Brian House for inpatient or day care.

Chaplaincy and spiritual care are also available

23. LYMPHOEDEMA SERVICE

The role of the Lymphoedema Service is to provide treatment for adults and children with lymphoedema arising from cancer or its treatment and non-cancer related causes. Primary lymphoedema patients and lipoedema patients are also able to access the service.

Location

The clinic is based at Trinity Hospice and Palliative Care Services. The clinic operates weekdays 08:30 to 16:45. If the staff are unavailable to take telephone calls, messages can be left on the answer phone for the team. The answerphone will be checked twice daily.

Staffing

The Lymphoedema Team consists of two Lymphoedema Sisters, two Staff Nurses and a Health Care Assistant practitioner. Children will be seen in clinic as they may need to access specialist equipment and treatment with a paediatric nurse from Brian House present as a chaperone. There is no out of hours or weekend service. Messages will be taken, or advice may be sought by telephoning Trinity Hospice and Palliative Care Services on 01253 358881 and speaking to the Sister in Charge.

Referrals

Referrals are accepted from the patients GP, Consultant or Clinical Nurse Specialist (Breast Care or Surgical Nurse Practitioner) on a specific service referral form. Direct referrals are accepted for those patients already under the care of Trinity Specialist Palliative Care Services. The service will accept referrals for clients within the Blackpool, Fylde and Wyre areas.

Referral Criteria

- Primary lymphoedema (hypo/hyper or aplasia of the lymphatic system).
- Secondary lymphoedema (cause may be cancer-related, infection, trauma or inflammation).
- Lipoedema.
- Oedema in the palliative setting.

Exclusion Criteria

- Patients being treated for a deep vein thrombosis until 8 - 12 weeks after commencing anti-coagulant treatment.
- Oedema due to cardiac failure/renal failure.
- Patients with a known ankle brachial pressure index (ABPI) of less than 0.8 as lymphoedema compression therapy is contra-indicated.
- Out of area referrals.

Referral System

- Referrals will be made on the Lymphoedema Service referral form. Referrals from other lymphoedema services will be accepted with the relevant documentation.
- The patient's GP or referring specialist if not the GP, will confirm the presence or absence of any relevant co-existing medical conditions before treatment commences. Referrals made by specialist nurses will be accepted. It is their responsibility to inform the relevant consultant that a referral has been made.
- Contact will be made to new referrals by letter within once the referral has been accepted.
- Appointments to be seen for first assessment will be within 18 weeks but priority is given to patients with palliative care needs and secondary lymphoedema.
- Hosiery will be issued from GP practice on FP10.

www.lymphoedema.org/bls/ is the British Lymphology website for professionals.

www.lymphoedema.org/lsn is the Lymphoedema Support Network website for patients/carers.

Multidisciplinary Meeting

The team have a multidisciplinary meeting twice a month to discuss complex patients and new referrals, this is supported by the Assistant Clinical Director and Clinical Director and Medical Director as appropriate.

Training

The Clinical Nurse Specialist should be educated to Diploma or Degree level. A specialist lymphoedema qualification is essential. All staff with have completed and be up to date with safeguarding training.

24. LEARNING AND RESEARCH CENTRE

There is an extensive and varied programme of in-service teaching available to clinical and non-clinical staff. The agenda is determined by training needs highlighted at staff appraisal, volunteer reviews as well as addressing issues raised on an ad hoc basis. We have a dedicated Learning and Research Lead and a research nurse.

We offer training to a large number of health and social care professionals and have good links with a number of local universities, providing post graduate training. We provide learning placements for medical, nursing and other students and specialist trainees. As a teaching hospice we welcome students and clinicians on placement.

Trinity is a research active hospice and works with local and national research networks, taking part in projects that attempt to benefit patients directly.

25. TRAINING AND PROFESSIONAL DEVELOPMENT

Mandatory Training for All Staff

Mandatory training appropriate to the needs of the service will be made available to all inpatient unit staff and will be monitored to ensure compliance. This will include online training modules in key topics available on the Blue Stream Academy online training system and staff will also be required to attend regular practical training provided by qualified trainers (both inhouse trainers and external trainers). This practical training includes skills such as Basic Life Support and Moving and Handling.

The target for mandatory training for the organisation is 90%, with this being monitored as part of the director's quarterly compliance and via the Education Group and clinical team meetings.

Registered Nurses

All registered nurses new to working on the adult inpatient unit will have a tailored induction programme created to meet their learning needs and provide the training and development needed for them to fulfil their role safety. They will complete a pre-agreed supernumerary period in which to focus on learning about medications management, clinical skills and key safety and security knowledge before they are included in the staffing numbers.

All registered nurses will complete a medication competency framework in their initial months under supervision of a senior nurse to ensure they are competent with a variety of medication administration scenarios. The achievement of these competencies will be via a combination of observation by competent staff, supervision during medication administration until competent themselves, personal study to demonstrate knowledge (eg completion of medication calculations and a medication workbook) and attending specific training sessions to support safe medication administration (eg syringe pump training).

Newly registered nurses will complete a Preceptorship programme over the first year to ensure full support as they transition to the qualified practitioner. They will be allocated a Preceptor and support will be offered in line with NMC Principles of Preceptorship (2020). The Preceptorship programme may also be commenced for nurses that have been qualified for some time, but are new to palliative care, as it will support them to obtain the skills and knowledge needed to fulfil their new role.

The Preceptorship programme covers areas such as clinical skills, symptom management, patient admission and discharge, communication skills, care after death, infection prevention and advanced care planning.

Opportunities for additional training will be considered, for example staff may be supported to complete a relevant palliative care module at diploma level. Senior members of staff will be encouraged to be studying to Diploma/Degree level.

Registered nurses that fulfil the criteria will be required to complete the Symptom Control Portfolio in order to develop and demonstrate further knowledge as they continue to work within palliative care.

Healthcare Assistants

Healthcare Assistants at NVQ2 or NVQ3 level will be offered a tailored induction programme created to meet their learning needs and provide the training and development needed for them to fulfil their role safely. They will complete a pre-agreed supernumerary period in which to focus on learning about

medications management (if applicable – NVQ3 only), clinical skills and key safety and security knowledge before they are included in the staffing numbers.

As NVQ3 staff are involved in medication administration they will also complete a medication competency framework in their initial months under supervision of a senior nurse to ensure they are competent with a variety of medication administration scenarios. This package is similar to the registered nurse competency package described above but includes only those aspects relevant to NVQ3 staff.

All NVQ3 staff undertake additional roles on the inpatient unit which include catheterisation, injections and vital sign monitoring following appropriate training. They will be provided regular updates in these skills in order to ensure they are still competent.

It is encouraged that all health care staff working at NVQ2 or NVQ3 level who have not yet done so should undertake the Health Care Certificate within 12 weeks of commencing in post depending on individual circumstance.

Health Care Assistants will be offered relevant available training from an external provider to work towards NVQ Level 2 or 3 depending on their role. This can be as part of an in-service apprenticeship but those working from Level 2 up to Level 3 will need to apply for a post at NVQ Level 3 when one becomes available.

NVQ3 staff also complete a three-month rotation into the physiotherapy service to undertake new learning and skills development.

Staff will be supported in furthering their education in palliative care and other related topics as appropriate.

Community Palliative Care Team

Education, Training, Development and Collaborative Working

Mandatory training appropriate to the needs of the service will be made available to all staff in the Community Palliative Care Team and will be monitored to ensure compliance.

All new starters in the role of ACNS (Associate Clinical Nurse Specialist) will have an individual, tailored appropriately timed, phased induction programme to meet their learning and development needs to be a safe confident practitioner. This will be monitored by the allocated ‘Buddy’, Mentor and Team Leader/Manager at regular intervals.

All new starters will complete an individual ACNS Competence and Development Diary over the first year to ensure full support as they transition to an autonomous practitioner in the Community Palliative Care Team. The Competence and Development Diary gives the individual nurse the opportunity to record specific evidence to achieve the desired competencies to fulfil the role of ACNS, training sessions attended, reflective pieces and to identify learning needs and learning opportunities. This will be monitored and discussed at regular agreed intervals by the new starter and ‘Buddy’, mentor, and team leader manager. There is also a CNS (Clinical Nurse Specialist) Competence and Development Diary to follow for when an ACNS is developing into a CNS role.

ACNSs, as all registered nurses that fulfil the criteria, will be required to complete the Symptom Control Portfolio in order to develop and demonstrate further knowledge as they continue to work within palliative care.

Health Care Assistant induction is as Inpatient Unit Induction Programme with and an individual orientation plan to the Community Team.

All staff in the Community Palliative Care Team and all clinical staff within Trinity have the opportunity to attend regular teaching sessions held by Senior Clinicians at Trinity. (Specialist Palliative Care Learning and Development Pathway).

Bitesize sessions by Clinical Nurse Specialist for new starters to the Community Palliative Care Team are available on core dimensions of palliative care, oncology emergencies, communication and advanced care planning, these sessions will be ad hoc or as a structured timetable as needed to meet identified learning needs.

The CNS will complete a training/learning needs analysis annually to ensure individual training/learning needs are met and ongoing personal development attained.

Engagement and Collaborative Working with Our Colleagues in Blackpool, Fylde and Wyre

Each ACNS will take the lead regarding palliative care education/training with specific district nursing teams to ensure learning needs are identified and learning opportunities achieved.

Bitesize sessions on core dimensions of palliative care, oncology emergencies, communication and Advanced Care Planning are offered to support our local district nursing teams, particularly for their new starters.

A trial three-day District Nurse Palliative Care Link Nurse Programme has been created to show the benefits of experiential leaning in the palliative care setting. The launch of this programme, if successful, will provide the opportunity for all district nursing teams to have an identified district nurse as a palliative care link nurse who can participate in this three-day programme.

CNS/ACNS delivers symptom management sessions on the Community End of Life Rolling Programme and the District Nursing Preceptorship programme.

There is also a nominated CNS/ACNS and doctor to ensure appropriate support for the local open prison.

Advanced Clinical Practitioner Role (ACP)

In recent years we have invested in the development of Advanced Clinical Practitioner roles across our services, enhancing our skill sets, clinical leadership, responsiveness, and flexibility of our services, particularly valuable during the recent pandemic years. We now have one fully qualified Physiotherapy ACP who has been key to supporting the development of rehabilitative palliative care services across our IPU, community and Living Well services. We have one trainee ACP in our children's services, and five trainee ACPs working in rotation across our adult services, all supporting training, leadership, research, and quality improvement projects. Two of our soon to be qualified tACPs support the out of hours medical on-call rota for the In-Patient Unit.

Nurse Associates

The Nursing Associate (NA) is a new support role in England that bridges the gap between care assistants and registered nurses. The NA role was developed following the publication of The Shape of Caring Review, (Raising the Bar) in March 2015 by Health Education England (HEE). The NA delivers hands-on, person-centred care for patients and service users in a range of case settings. The NMC has developed and published robust standards of proficiency for NAs. These standards of proficiency provide a clear picture of what NAs know and can do when they join the register. Like nurses and other healthcare professionals, NAs may expand their scope of practice, within the regulatory framework, through further education and experience after they have qualified and joined the NA of the NMC register. All NAs benefit from two years of study in higher education and meet the NMC's standards of proficiency.

The NMC requires NA's programmes to be at Foundation Degree level (this is the equivalent to Level 5 in the England QAA Educational Framework). Trinity Hospice has one qualified Nursing Associate and three in training. We facilitate this programme in partnership with the University of Lancashire (UCLAN), the nurse associates have an initial scope of practice to work within which will extend as the role grows.

Training and Development

As for Registered Nurses, Nursing Associates will have a tailored induction programme created to meet their learning needs and provide the training and development needed for them to fulfil their role safely.

They will complete a pre-agreed supernumerary period in which to focus on learning about medications management, clinical skills and key safety and security knowledge before they are included in the staffing numbers.

On the In-Patient Unit, Nursing Associates will complete a medication competency framework and Preceptorship programme as per Registered Nurses, above, with some adjustments for the differences in their role.

Nursing Associates that fulfil the criteria will be required to complete the Symptom Control Portfolio in order to develop and demonstrate further knowledge as they continue to work within palliative care.

26. TRINITY – CARERS AND RELATIVES EXPERIENCE GROUP (CARES)

The CARES group is a bespoke programme to assist and enable informal carers to gain the practical and emotional skills required to care for a loved one at home. It's a six-week multi-disciplinary programme for carers referred from a variety of sources both internal and external. The programme is in its infancy at the time of writing. The programme is facilitated by the CNS service and works in collaboration with other "carers" organisations.

27. ENGAGING WITH SERVICE USERS

Patients, families and visitors are actively encouraged to make comments about service provision and facilities and user groups will be convened when appropriate for development or review of services. All services use "I Want Great Care" to obtain feedback from service users and this is co-ordinated via our Clinical Governance Framework. You said, we did is a theme across all services to ensure continuous improvement and service users experience.

Regular patient satisfaction audits are carried out in all parts of the service, which formulates part of the annual Qualitative and Quantitative Audit Report. This report is used to inform practice and continually raise standards. A copy of the annual report will be available on request.

28. COMPLAINTS

Trinity Hospice and Palliative Care Services are committed to the provision of high-quality care and continuous improvement. If we fail to meet expectations in any way, we hope that people will tell us. All adverse comments are welcome, and complaints are investigated and responded to in line with 'best practice'.

The Clinical Director or Assistant Clinical Direct are responsible for investigating and responding to formal complaints and a copy of the procedure is freely available to patients and relatives/carers on request.

Matters not satisfactorily resolved following investigation and discussions will be passed to the Chief Executive.