QUALITY ACCOUNT
2021 - 22

What is a Quality Account?

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

Introduction – Key Messages: Trinity Hospice and Palliative Care Services

- Trinity Hospice and Palliative Care Services is a local registered charity providing compassionate care on the journey towards the end of life for the people of the Fylde Coast.
- We work alongside others to care for people in their own homes, in care homes, in nursing homes and hospital. We always ensure people feel they are cared for as an individual, rather than as 'just another patient'.
- We work hard to ensure everyone who dies on the Fylde Coast gets the best care possible in the months, weeks or days before they die.
- We work collaboratively in partnership with other local key organisations and care providers to strategically plan and support the delivery of best possible palliative and end of life care for our local population.
- We encourage everyone in our local community to talk honestly and openly about death and dying.
- Through our inpatient unit, community, hospital, and Hospice at Home services, we touch the lives of around 8,000 people every year, supporting them physically, emotionally, and spiritually.
- Family, carers, and close friends have needs too; we are here for them with support and advice at every stage of illness and after bereavement.
- Working or volunteering for the hospice is rewarding and fulfilling and we share our knowledge to help others deliver excellent end of life care too.
- It costs over £9 million every year to run Trinity's services - over £6 million of that must come from voluntary donations and all our care is given free of charge.
- Trinity relies on the trust and goodwill of the local community and would never undermine that by using inappropriate fundraising tactics. Our approach is to inspire people to give, rather than make them feel in any way compelled.
- We are about living life to the full and living well to the very end.

Key Messages: Brian House Children's Hospice

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

- Children and their families are at the very centre of what we do.
- Brian House is not a sad place but a place full of happiness and hope.

- We support both children and young adults, from babies up to 24 years.
- We cover Blackpool, Fylde and Wyre – a children's hospice for local people.
- Brian House is the only children's hospice on the Fylde Coast.
- We provide a fun and engaged setting, full of warmth for families.
- We understand the breadth of highly complex medical conditions.
- We provide support to a parent, siblings and loved ones through tough times.
- Much-needed respite is provided for parents, so they can get a good night's rest.
- A child's final days in Brian House are memorable and special.
- Brian House requires £1.3 million to keep its doors open, most of which isn't funded.
- The services available at Brian House are provided to families free of charge.

Part One

Statement of Quality from our Chief Executive:

The past two years have felt a blur to many of us. They have also demonstrated only too harshly how care, dignity, and peace of mind can all be undermined when our health and social care systems are stretched beyond breaking point. Almost everywhere, colleagues have bravely battled on trying to keep the quality of their care at the standard they wish to offer.

Here at Trinity, we have broadly managed to do so, despite considerable impact from Covid with staff sickness at times up to 20% of the workforce. It was a testament to the passion and commitment of our teams that our services kept going and indeed grew, for example, in the hospital.

The last two years have also brought into focus another challenge for the hospice movement – to what extent should we flex our care, especially in In-Patient Units, to accommodate the increasing number of end of life patients languishing and dying poorly in hospitals amidst terrible 'winter pressures' – pressures that now last at least six months of the year. This question is not about 'undermining hospice standards'. Standards that reflect our charitable purpose and brand and are critical to ongoing public support. But it is a question that encourages all of us to think about the CQC Outstanding elements of 'Responsive' and 'Well-led' alongside the equally important 'Safe' and 'Caring'. It is clear that in future Quality Accounts, this discourse will continue and be demonstrated through new initiatives which focus on the quality of care necessary to determine a 'good death'.

Looking back over the past 12 months, for example:

- Focused on Covid security and infection control.
- Developed improved access through an A&E project.
- Several partnership and integration projects to improve patient care across the Fylde Coast health & social care system.
- Developing the use of intravenous (IV) therapy on the Adult In-Patient Unit (IPU).
- Several training and development programmes for Trinity Clinicians.
- Take part in a MySupport package linked to improving carers' lives and experiences.
- Programmes to provide wider access to Brian House services.

Looking forward:

- We will undertake further work on workforce planning.
- Introduce a new competency framework for children's hospice staff.
- Further consider the implications of new Liberty Protection Safeguards legislation.
- Plan to return to seven-day services in Brian House.
- Introduce improvements to bereavement services.
- Design and implement a pilot Single Point of Access Co-ordination System.
- Improve referral rates for patients with end stage liver disease.
- Further developed virtual clinics and consultations.
- Launch a 'dementia lounge'.
- Develop an improved Spiritual Assessment Tool.

Overall, these Quality Accounts demonstrate that Trinity and Brian House continue to focus strongly on quality improvement. Our commitment remains to give everyone on the Fylde Coast the opportunity to access good palliative and end of life care. With your ongoing help, we can achieve this vision.

Thank you for your support.

David Houston - Chief Executive

Statement of Assurance from the Board of Trustees

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

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

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

We are also to commence trustee visits during the forthcoming year, which allows us to see first-hand the operation of our clinical and administrative teams and to interact with patients and their loved ones.

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

The pandemic put a stop to many face-to-face meetings and so, as in many other organisations, a number of meetings have now been attended through Zoom. This has included some of our Board meetings and we have benefitted from reports direct to trustees from our nursing staff of the progress they and their colleagues have made in these difficult times.

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

We were extremely pleased to maintain an 'Overall Outstanding' rating from the Care Quality Commission. This came on top of high clinical audit ratings from Blackpool and Fylde & Wyre Clinical Commissioning Groups (CCGs) who oversee health provision on the Fylde Coast.

Looking forward, Trinity is keen to build on that Overall Outstanding rating, securing the CQC inspection areas in which it excelled – 'care' and 'well-led' and further improving those areas

recognised as good – ‘safe’, ‘responsive’ and ‘effective’. These goals are set out in our current Business Plan and reflect a key value, that of promoting ‘excellence’.

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

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

Nigel Law
Chairman

Part Two

Looking Forward: Our Improvements for 2022/23

These Quality Accounts link to our Quality Strategy and are supported and approved by our Board of Trustees. The following areas have been identified for development/improvement in 2022/23 by the Clinical Quality Improvement Group, under the following headings: Patient Safety, Clinical Effectiveness and Patient Experience. They have also been included in each department's Business Plans and Objectives.

The last couple of years have been two of the most challenging years the hospice has faced. The pandemic has seen some initiatives transform in response to emerging patients' needs and demands on services for all our hospice services, our patients and families and the wider health economy. Some of the initiatives that we planned before Covid have been superseded but not forgotten; hence they had been rolled forward as we see the hospice move towards a "new normal".

Working increasingly collaboratively in partnership with key Fylde Coast health and social care provider services, there have been several emergent priorities identified during the 2021-22 period in response to identified needs and it is envisaged that this proactive approach to improvement will continue alongside the identified improvements for 2022/23.

Patient Safety - Safe Staffing

Our Aim Was

The pandemic brought challenges with workforce planning that had the potential to challenge patient care and prevent the In-Patient Unit (IPU) being responsive to the needs of the wider health economy. To ensure that we were able to safely staff the IPU we undertook a workforce planning audit, which utilised an evidenced based validated tool, supported by St Annes Hospice, Manchester and Professor Keith Hurst in 2017.

What Do We Want To Achieve?

The tool identified a formula that supported safe staffing numbers and skill mix, but we wanted to build upon this to consider the nursing dependency and acuity of patients utilising an In-Patient Unit bed so that we could safely continue to admit patients whilst considering the needs of current patients and the affect this has on the number of nursing hours available. The aim is to provide a review of all patients' nursing needs twice daily, and then translate this into a score that demonstrates the available capacity. This will then be used daily to enable all departments internally alongside external partners to understand the pressures and our capacity.

How Will Progress Be Monitored and Reported?

- Implementing daily reports.
- Monitoring effects on quality and job satisfaction for staff.
- Undertaking a survey with external partners.
- Reporting to the Board.

Patient Safety - Competency Framework for Children's Hospice Staff

How Was This Identified As A Priority?

The clinical needs of some of the children who attend Brian House is increasing with differing complexities including children or babies who require invasive ventilation, children with complex cardiac conditions, children requiring peritoneal dialysis, patients requiring long term IV therapy, parenteral feeds, complex seizures, complex neurological conditions, complex neuromuscular conditions, children with a variety of cancer diagnosis, children requiring complex airway management.

In order to safely manage all of these conditions a robust competency framework is required to ensure staff have the appropriate up-to-date skills and competencies to safely and effectively address the care needs of each individual child.

What Do We Want To Achieve?

To ensure we equip our nurses and support workers with a wide range of skills and competencies to support the increasingly complex and end of life care needs that the children on our caseload are presenting with.

To be able to support the care needs of all the children on our case load with the assurance that all staff have the appropriate skills, competencies, and confidence.

- To work in an integrated way with our partner organisations in a system wide approach in the sharing of good practice, educational and training days, competency frameworks and competency booklets.
- To introduce "Training Thursdays" which will include unplanned emergency scenario training.
- To introduce champion roles to develop experts in each clinical competency.
- Establish rotational posts to a regional children's hospice with honorary contracts to support standardised competency training.
- Embed rotational posts to the local hospital children's service to develop links with the Practice Development Sisters and enhance acute clinical skills.

How Will Progress Be Monitored and Reported?

- Feedback from training days and rotational posts.
- Audit of clinical competencies.
- Review the children we are accepting.
- Benchmarking with other children's hospices.

Patient Safety – Implementation of Liberty Protection Safeguards legislation.

How Was This Identified As A Priority?

The UK government passed an amendment to the Mental Capacity Act (MCA) in May 2019 legislating a change from the existing Deprivation of Liberties Safeguards to new "Liberty

Protection Safeguards" (LPS). Adherence to the MCA is fundamental to the safeguarding of all patients who come under the care of Trinity Hospice and Brian House and we are legally bound to ensure the effective implementation of the new LPS into our organisation. The original date for publication of the National Code of Practice has been delayed a number of times due to Covid and there is currently no revised date for implementation, however we envisage this would be expected in 2022/23.

What Do We Want To Achieve?

LPS is part of MCA which is part of Human Rights Law. Implementation of the new LPS should be an opportunity to enhance awareness and application of the MCA with the aim of ensuring the happiness and autonomy of those very people who lack capacity to make important decisions about their personal care and welfare and are so vulnerable to having their freedoms curtailed. We will follow the national Code of Practice when published, develop our policy and implement staff training and procedures to reflect the new Liberty Protection Safeguards placing the patient's voice and experience at the centre of information gathering and decision making.

How Will Progress Be Monitored and Reported?

We will re-establish the LPS Implementation Task and Finish Group involving safeguarding leads from each area of our services including our Consultant Paediatrician, Admiral Nurse and Social Worker. We will work in collaboration with our local authorities and Clinical Commissioning Groups (CCGs) as our responsible bodies under the new legislation when the Code of Practice is published to develop our new policy, procedures, and a training programme.

We have included the implementation of LPS as a standing agenda item on our regular Safeguarding, Clinical Governance and Education & Training Group meetings to ensure progress is maintained, monitored, and reported throughout the year.

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

How Was This Identified As A Priority?

Brian House is operating seven days and four nights per week which limits the care that can be offered to the children. End of life children need to be provided with a service that operates over seven nights ensuring confidence that Brian House staff can care for the needs of the children on a consistent basis in the child and family's preferred place of death.

Families require support at the weekend with some of the more complex needs children allowing them to have some rest time and time to spend with other children knowing the child with complex care needs is being cared for in a safe environment.

The work force was limited in flexibility which limited our ability to offer the right service at the right time in the right way to families.

- Unable to operate over seven nights.
- Not fully meeting the holistic needs of the families.
- Unable to offer sufficient respite to families.

What Do We Want To Achieve?

- To operate over seven nights, 52 weeks of the year.
- To be able to offer services appropriate to the whole family's needs.
- To have a broad skill set to support the children and families in a holistic way.
- To be responsive to the needs of the families particularly the most vulnerable and those who are approaching end of life.
- To offer care in the place that meets the needs of the family, either at home or in the hospice.
- To develop a flexible workforce ensuring effective use of staffing time and the skill set of the team meets the needs of all our patients.
- To ensure we can always support the patient and their family in their preferred place of death.
- To offer families a minimum of three x 4-night (or shorter stays amounting to 12 nights if preferred) short respite breaks per year evenly spaced throughout the year.
- To offer cancellations out to families ensuring effective use of the services further supporting those families who may be struggling.

How Will Progress Be Monitored and Reported?

- Audit of nights offered.
- Key Performance Indicators (KPI's).
- IWantGreatCare feedback.
- Audit of services on offer.

Clinical Effectiveness – Bereavement Service Development

How Was This Identified As A Priority?

- Complaints relating to waiting times.
- Unable to offer timely and flexible patient counselling.
- Bereaved clients needing support immediately post bereavement unable to access due to the recommended eight-week delay post bereavement to allow for the normal grief process.
- Bereaved clients still requiring support after eight weeks of counselling – some clients on the books for months. Not really wanting face to face counselling but not wanting to feel abandoned.
- Some clients voicing their preference to attend a group rather than face to face counselling.
- Carers finding it difficult to access counselling due to their caring commitments.

What Do We Want To Achieve?

- A more flexible and responsive service that more effectively meets the needs of bereaved clients, carers and patients.
- Reduced waiting lists.
- Patient support to be the priority for face-to-face counselling but with other opportunities if preferred.
- Targeted therapy groups to better support carers/bereaved clients with feelings of isolation.
- Informal groups facilitated by volunteers to support the development of social networking.
- Walking groups to support patients/clients in ways that may meet their needs more effectively.
- Flexible working in the evenings to support patients and clients who have work/caring commitments.

How Will Progress Be Monitored and Reported?

- IWantGreatCare feedback.
- Key Performance Indicators.
- Audit of waiting lists.

Clinical Effectiveness – Single Point of Access (SPoA)

How Was This Identified As A Priority?

Co-ordinated care is challenging in modern health care but so important if someone is suffering from a palliative condition or is coming to the end of their life. This was identified a key area of development during the height of the pandemic, where lack of information and co-ordinated approaches to care was evident. Developing a “one number” approach that enables callers to seek appropriate help was considered across the health economy with our partners, it was noted on several occasions that carers and patients could have up to seven telephone numbers to navigate. The Integrated Care System (ICS) and Fylde Coast Integrated Care Partnership (ICP) wished to explore the concept further with local end of life partners and this exploration was supported by the Fylde Coast End of Life Steering Group.

What Do We Want To Achieve?

- Develop a strategic plan to formulate a single point of access pilot.
- Work in partnership with health, social care and supporting services.
- Develop referral process and criteria.
- Produce a Standard Operating Procedure and algorithms (Red/Amber/Green) to ensure all palliative care emergencies are dealt with without delay.
- Provide communication to the wider teams about the pilot’s aim and ambitions.
- To seek opportunities for integration of Electronic Palliative Care Coordination Record (EPaCCS).

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

How Will Progress Be Monitored and Reported?

- Develop links with project team including Thornton Practice, District Nurses, Marie Curie, Fylde Coast Medical Services (FCMS) out of hours primary care services, Blackpool Teaching Hospitals Foundation Trust and social services partners and commissioners.
- Develop monthly Key Performance Indicators supported by set outcome measures.
- Service user feedback.
- Monthly review with operational partners.
- Three-month service review and move to include wider Torentum Primary Care Network (PCN) if service outcomes achieved and service can support.
- Feedback to SPoA design team.

Clinical Effectiveness – Advanced Clinical Practitioner led clinics

How Was This Identified As A Priority?

Earlier palliative care input for patients with life limiting diagnoses with timely assessment and management has been shown to improve symptom burden, both physical and psychological needs and general quality of life.

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

ACP/Nurse Led Clinic Can:

- Provide a patient-centred approach to the management of illness and symptoms, preserves patient's good quality of life.
- Offer increased patient access and choice.
- Provide quicker access to medication.
- Provide vital psychological support.
- Enable patients and carers familiarity with the hospice reducing the anxiety often associated with the word "hospice" care.

What Do We Want To Achieve?

- Optimise patient and carer choice for those patients well enough to visit the clinic.
- Reduce travel and location constraints for the community team when patients can come to clinic, saving time that could be used to provide patients with quicker access to a healthcare professional.
- Give patients the opportunity to see and benefit from the services of other members of our MDT and Living Well services.
- Reduce the need for home visits, which may interfere with patients' lifestyles.

- Providing an initial consultation and holistic assessment of patients with specialist palliative care needs.
- Review and assess known patients at the request of other healthcare professionals within the hospice and other referrers catchment area.
- Invite potential referrers and colleagues from within our MDT to visit the clinic and gain insight into its operation and purpose.
- Improve working with other care providers and specialist nurses, implementing joint clinics and education.

How Will Progress Be Monitored and Reported?

- EMIS data analysed: Number of patients being referred, time of first assessment, source of referral (categories including other hospice departments and palliative care providers, PCT and other specialities), how long patients are seen for and referrals to other care providers.
- Audit of Advanced Care Planning and DNACPR discussion decisions recorded.
- Audit and evaluation questionnaires for patients.
- Through the Clinical Quality Improvement Group and Primary Care Gold Standard Framework (GSF) meetings.

Clinical Effectiveness - Leadership Training

How Was This Identified As A Priority?

Pre-pandemic we had several staff who moved into leadership roles across the organisation, our recent staff survey demonstrated that there is a gap in leadership skills and knowledge at the middle manager level.

What Do We Want To Achieve?

Our intention is to develop a bespoke course that provides the theory of leadership and bring the group of new leaders together on a regular basis to put the theory into practice, developing this in line with Trinity's ways of working.

How Will Progress Be Monitored and Reported?

- The course will be delivered.
- Improvements in leaders' capability.
- Continued success in the staff survey.

Clinical Effectiveness – To Produce An Updated Discharge Letter For The Inpatient Unit That Is Fit For Purpose

How Was This Identified As A Priority?

- Apart for some minor changes, the hospice In-Patient Unit (IPU) discharge letter has not been updated for over 10 years.

- Recently, comments had been made that our IPU discharge letter did not contain the most helpful and essential information for GPs and our community (and hospital) palliative care teams.
- Junior doctors completing these had commented that there was little guidance on how to complete the letter and community teams had commented that the quality of the information (including its presentation) was variable.

What Do We Want To Achieve?

- Initially to produce a template of a discharge letter that is comprehensive and not onerous to use:
  - Two of our previous GP Specialist Trainees made this a quality improvement project, undertaking a survey of local GPs, out of which a draft discharge letter was produced.
  - The essential data set within the letter needs to be appraised by IPU staff to finalise it.
  - We then need to produce a Word template to pilot in the patient EMIS electronic record.

- Once established, it may be helpful to find a way to audit the ease of use and quality of the letters being produced.

How Will Progress Be Monitored and Reported?

- To finalise the data set for the template and produce an EMIS template to start using by May 2022.
- After six months (pending no problems) to canvas opinion on:
  - ease of completion (relevant IPU staff).
  - quality of completed letters – community and hospital teams.
  - re-run a GP survey.

Clinical Effectiveness and Patient Experience - Improving Referral Rates To Palliative Care For Those Patients With End Stage Liver Disease

How Was The Priority Identified?

We receive very few referrals from the gastroenterology wards for patients with advanced liver disease until the patients are extremely progressed in their illness or actively dying. One of our trainee Advanced Clinical Practitioners (tACP) investigated this further and found that of the 1000 plus referrals received between January - December 2021, only 36 were for patients with end-stage liver disease, (ESLD). Yet, Blackpool had the highest mortality rate in England in 2020 with premature death rates for ESLD.

Early palliative care input is well documented for improving symptom burden, both physical and psychological as well as improving general quality of life.

Symptom burden for patients with ESLD has been documented as comparable to many cancer diagnoses.

What Do We Want To Achieve?

- To improve health care professionals understanding of the role of a specialist palliative care nurse. To encourage earlier referrals, as currently we tend to receive a referral when the patient has only short weeks to days to live.
- To improve education around end-of-life care and what can be offered to the staff on Ward 12. (Gastroenterology).
- To increase referral rates for patients with ESLD.
- Improve communication/collaboration with other health professionals, patients, and carers.
- For other members of the current Chronic Liver Disease Team already in place to develop the skills and confidence to start having Advance Care Planning discussions within their clinic settings.

How Will Progress Be Monitored and Reported?

Data on the referring diagnosis is always documented within EMIS record, so this gives us the numbers needed to monitor our referrals.

To produce a pre and post education questionnaire evaluate the tACP planned educational sessions for the staff on Ward 12. This has been supported by the Ward Manager and Matron.

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

Clinical Effectiveness – Virtual Clinics and Consultations

How Was The Priority Identified?

Ongoing review of existing virtual clinics and consultations to support community and care home colleagues and patients and improve the effectiveness and responsiveness of our care.

What Do We Want To Achieve?

- To extend the service out to all potential users.
- To increase the uptake of this service to reach and positively influence the care of more patients. To increase the opportunities for education and support for more community and care home staff. To provide more opportunities to increase access our services.

How Will Progress Be Monitored and Reported?

- Send out monthly communication updates to GP surgeries, District Nursing bases, care and nursing homes, Clifton Hospital, the Harbour Mental Health Unit, homeless and prison services to remind them of service and how to access.
- Move patient virtual contact from AccRx to Microsoft Teams so all users on same platform.
- Monthly KPI's.
- Establish as part of single point of access project.

Patient Experience – Dementia Carers' Support "Dementia Lounge"

How Was The Priority Identified?

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

What Do We Want To Achieve?

- We want to empower carers to feel supported and well informed and leave the lounge feeling uplifted and connected. With the partnership of staff skills, carer expertise, and lived experience of those living with dementia, we aim to create a safe space to engage in a relaxed environment.
- As a hospice we are working in partnership with Dementia UK sharing a commitment to focus on 'Living well with Dementia'. We are aiming to raise awareness through proactive information sharing across the Fylde Coast, thus making our groups and communities accessible for all.
- Each month we will invite a professional in an area of expertise to present and share information on their service at the Lounge, such as the memory assessment service.
- We will make use of assisted technology, such as a magic table that will display digital games that includes the use of autumn leaves and Japanese fish to aid auditory and visual stimulation.
- We will work in partnership with other valued community organisations and professionals such as Wyre Alzheimer's Society, the Carers Centre at Beaverbrook's House, UCLAN-Best Research in Dementia, Local Solicitors, Lancashire Fire and Rescue Services, N-Compass. and organisations that donate to our fundraising team at the hospice.
- Our hope is that the Dementia Lounge will grow and become more self-sustaining directed by the service users in the longer term establishing similar, smaller groups in local communities across the Fylde Coast facilitated by carers, for carers, in a safe space.
- We eventually hope to grow dementia café's, dementia restaurants, dementia shopping hour, dementia gardens/gardening, building these from the Dementia Lounge at the Trinity Hospice. Our aim is to support the commitment to enabling Compassionate Communities.

How Will Progress Be Monitored and Reported?

- Evaluation forms will be undertaken with carers and professional attendees.
- Progress and outcomes will be reported through our departmental business meetings, Clinical Quality Improvement Group and Clinical Governance Committee.

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

How Was This Identified As A Priority?

Brian House services are going through a period of transformation.

Following meetings with parents of children in our care, a number of new initiatives were suggested to support and improve access to the facilities in Brian House to support the wider families caring for children with life limiting conditions.

What Do We Want To Achieve?

Set up baby, toddler, parents and grandparents groups, incorporating an allotment project and cinema experience.

We also want to extend the reach of our existing sibling group.

How Will Progress Be Monitored and Reported?

- Attendance will be collated via KPIs.
- Feedback from group attendees.
- Increased use of facilities.
- Reported through Clinical Quality Improvement Group and Children's Committee meetings.

Patient Experience – Enhanced Bereavement Care

How Was This Identified As A Priority?

This has been developed from the "IWantGreatCare" service user feedback process through recognition that bereaved relatives would benefit from follow up after the death of their loved ones.

Covid changed all services and processes and has had an enormous impact on experiences of death and bereavement such that patients and their relatives don't feel as supported as they used to do.

We want to have a more open, accessible service without barriers.

What Do We Want To Achieve?

- To improve the timeliness and access to support across our bereavement services.
- To provide support after death for loved ones if needed until they felt strong enough to continue their lives.
- To develop a service that not only enables patients to 'live well' but also their families.
- To develop the skill mix in our psychological service through staff development.
- A staff member has undertaken Levels 2 and 3 in counselling and is now working to support our Clinical Psychologist and the Linden Centre.
- To aim to ensure that individuals access the right person in our team at the right time and that waiting times are reduced.
- To reduce complaints as a member of the team has been able to visit relatives who have voiced adverse comments regarding the care they have received and provided support, information, and advice.
- Collaborative working with the Linden Centre and Clinical Psychology - right health care professional for the right patient.
- Partnership working alongside the SWAN Bereavement Team at Blackpool Teaching Hospitals (BTH) Trust including daily end of life care situation report meetings.

How Will Progress Be Monitored and Reported?

- Reported on KPI's.
- Job review and professional development for roles as service expands.
- Reported through departmental business meetings as part of service review and integration into Living Well Service.
- Reported through our Clinical Quality Improvement Group and Clinical Governance Committee meetings.

Patient Experience - The Introduction of a Spiritual Assessment Tool to the Admissions Process For All Patients

The introduction of a spiritual assessment tool to the admissions process for all patients admitted to the In-Patient Unit at Trinity Hospice (in time to be rolled out across all sites).

To ensure all patients' needs are assessed and addressed holistically and in line with local, national, and international policy.

The tool will furnish nursing and medical staff with appropriate questions/discussion to aid the detection of unmet spiritual pain/distress.

The tool will increase staff confidence in approaching the subject of spiritual care discussions.

How Was This Identified As A Priority?

- Spiritual care is globally accepted as one of the four core pillars of palliative care.
- There is currently no consistent approach to spiritual assessment in use on IPU or any other site across the organisation.
- Policy states all patients with life limiting diagnosis, receiving palliative care should have access to spiritual care support.
- A staff survey concluded a low confidence across the organisation in discussing/identifying spiritual pain/distress. The survey also identified a training need (part of the project will be to introduce mandatory spiritual care training).

What Do We Want To Achieve?

- To design and agree a standard spiritual assessment tool and for this to be added to the clinical record using a standardised template withing the EMIS patient record.
- To undertake a programme of spiritual care assessment training for staff.
- To ensure all patients admitted to IPU have a spiritual assessment using an approved spiritual assessment tool.
- For patients admitted to IPU for symptom management or end of life care to have spiritual care needs identified and referred to Chaplaincy services as appropriate.
- To ensure ongoing yearly mandatory spiritual care training update for all Trinity staff via Blue Stream Academy.

How Will Progress Be Monitored and Reported?

- Ongoing audit of the use of the spiritual assessment tool once it is implemented.
- Audit will review use of tool against historic normal practice.
- Qualitative data to be gathered from patients (if well enough to be taken through a short questionnaire).
- Staff focus groups to gather data from the staff using the tool to address queries or amendments required.
- Reported through department's business meetings. Clinical Quality Improvement Group and Clinical Governance meetings.

Looking Back:

Responses to Emergent Priorities During 2020 - 22:

Like all health and social care provider organisations, the pandemic brought with it enormous challenges to safe and effective delivery of services in the context of need for constant attention to infection prevention and control and significant workforce capacity issues due to Covid related sickness absences.

In responding to emergent patient needs and system support, the pandemic has impacted on the delivery of all our Trinity services, but we are proud to have responded well and flexibly, working extremely collaboratively with our local system partners doing all we can to support where needed.

Patient Safety – Focus on Covid Security and Infection Prevention and Control (IPC)

How Was This Identified As A Priority?

- Global pandemic of new and highly transmissible Coronavirus infection.
- National emergency with need to maintain our hospice services.

What Do We Want to Achieve?

- Ensure Covid security in all our Trinity environments.
- Protect and minimise risk of transmission to ensure patient, staff, student and volunteer safety.
- Ensure service continuity.
- Maintain safe visiting for patients on our In-Patient Unit.

What We Did

- Established a Covid Management Group that met initially daily and continues weekly.
- Sourced and ensured sufficient regular PPE supplies.
- Developed and maintained a Trinity Covid-19 policy.
- Undertook comprehensive Covid risk assessments in all departments and environments and applied mitigations to minimise risk of transmission.
- Kept up to date and ensured compliance with all IPC national guidance.
- Switched to virtual meetings, teaching and training.

- Reviewed and prioritised our housekeeping and cleaning schedules.
- Established excellent supportive relationship with the Blackpool Health Protection Team.
- Ensured consistent IPC messaging and communications to all staff, students and volunteers including national guidance.
- Secured symptomatic patient and staff testing through Blackpool Teaching Hospitals (BTH) from the outset.
- Undertook individual Covid risk assessments for all staff, students, and volunteers. Working from home and adjusting roles whenever necessary.
- Ensured vaccination for all staff, students, and volunteers through BTH, prioritising those at highest risk.
- Established a mandatory asymptomatic Covid testing programme for staff, students, visitors and volunteers.
- Maintained visiting on IPU ensuring IPC information, PPE and regular testing.
- Commissioned an external IPC audit and implemented recommendations.
- Worked collaboratively with our local health and social care system partners.

Clinical Effectiveness – Collaborative, Integrated Working With Our Fylde Coast Health and Social Care Partner Organisations

How Was This Identified As A Priority?

- National emergency with need to maintain our hospice services.
- The value of our services working effectively within our local health and social care system.
- Good palliative and end of life care requires joined up services for co-ordination and continuity of care.

What Do We Want To Achieve?

- To ensure continuity of our services.
- To ensure our services were as effective and responsive as possible.
- To build effective, mutually supportive relationships with our system partners, ensuring best possible co-ordination and continuity of care for patients at end of life and their families.

What We Did

- Ensured we participated in the Fylde Coast System Partners twice weekly "Tactical Command" Covid meetings to share situational awareness and challenges in order to effectively respond to emerging Covid challenges to maintain service continuity and create capacity.
- Ensured supplies of PPE, patient, staff, student and volunteer and visitor testing, staff and volunteer vaccination.
- Increased our community services to work over seven days with excellent collaborative working with our Fylde Coast district nursing and out of hours medical services.
- With funding support from our BTH partners, increased our hospital team to enable seven-day working.
- Established a hospital team in-reach service into A&E.

- Revised our IPU admissions pathway to support hospital discharges for end of life care of frail elderly in particular.
- Weekend admissions into IPU has become routine.
- Utilised our medical and nursing skill mix flexibly across our services to respond to where needs were greatest most effectively.
- Funded four additional Health Care Assistant posts in a pilot to work flexibly between IPU and community.
- Set up a specific Fylde Coast System Partners End of Life Care Group that met initially weekly and continues monthly ensuring:
  - Clinical symptom management guidelines for community, hospital, and care homes.
  - Specific Covid advance care planning guidance for care homes.
  - Sufficient supplies of end of life care anticipatory drugs and key documentation.
  - End of life care training and support for all Fylde Coast care homes.
  - End of life care training and support for Clifton Hospital and The Harbour.
  - Commissioning of a private ambulance service to ensure timely end of life care discharges and transfers.
  - Widely promoted the use of our 24/7 advice line to all system partners.
  - Delivered significant amounts of training to our local health and social care partners in advance care planning, ceilings of treatment, symptom management and use of the patient Electronic Palliative Care Coordination Record (EPaCCS).
  - Established daily morning palliative and end of life care "Safety Huddles".
  - Used learning from case studies to identify gaps in co-ordination or continuity of care, understand and address these collaboratively.
  - Planned and delivered a very successful "Our Compassionate Fylde Coast Communities" launch event during national Dying Matters Week on 6 May 2022.

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

How Was This Identified As A Priority?

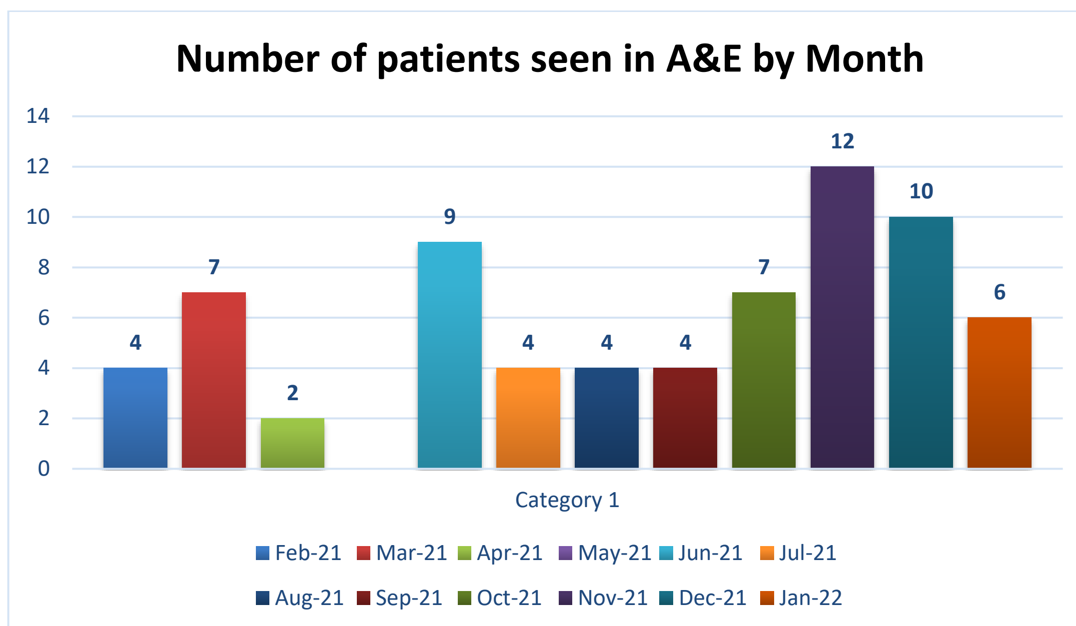
Identified by the Hospital Palliative Care Team, through their current work in the Acute Medical Unit (AMU) and Emergency Department (ED), that a number of patients with a palliative diagnosis were attending the departments and being admitted unnecessarily. It was felt that more could be done at first point of access in the ED to try and prevent admissions or put plans in place to reduce the amount of time they spent in hospital. The learning needs of the staff within the ED department regarding caring for patients with a palliative diagnosis was also identified. This was done via direct contact when we were called to the department and reviewing attendance logs for the end of life study days. Very few ED staff have attended historically.

What Did We Want To Achieve?

The main aim was to try and improve the experience for patients with a palliative diagnosis in addition to making the most efficient use of vital resources. We want to ensure that advance care planning decisions are acted upon especially in relation to a patient's preferred place of care or death, and to ensure we utilise the electronic palliative care record (EPaCCS).

What We Did Next

- Data was collated on a monthly basis and reported to the project group.
- The number of patients at end of life seen in this setting reflects the current pressure on local health care systems. The number of patients attending A&E without a completed EPaCCS record or a DNACPR in place is high.



- The total number of patients seen in A&E was 69.
- 28% of patients seen were turned around the same day to an alternative, more appropriate care environment.
- 19 admissions were avoided, equating to 28% of total patients seen.
- Acute bed days saved – 78.
- 10 patients died the same day, equating to 14.5 % of total patients seen.
- 55% of total patients seen whose clinical picture would indicate an EPaCCS should have been in place prior to attending A&E did not have one.
- 29% of total patients seen whose clinical picture indicated a DNACPR decision should have been in place prior to attending A&E did not have one.

Where We Are Now

- We are continuing to visit the department daily, proactively seeking patients suitable for our support, liaising with the nurse in charge of the department, reviewing patients and providing any appropriate care and collecting data as we go along.
- We have liaised with IT and the Quality Improvement Department at BTH regarding creating a Palliative Care in ED digital dashboard so 'live' data can be seen more easily, trends identified promptly and action sought to address any issues. This should be completed within the next few weeks.
- New posters with the Palliative Care Team contact details have been created that are bright and stand out more. These have been circulated to all areas of ED to encourage referral to palliative care at an earlier stage.

- Our tACP has completed eLearning on the MAXIMS system which is the clinical system used in ED. Access to the live system is being sorted out this week. This will allow us to see live data of who is in the department to proactively identify patients who may be suitable for our support. This will be looked at each morning and lunchtime. The training will be rolled out to the other ACP and clinical leads in the team soon.
- A box with syringe driver equipment has been placed in the resuscitation area. This includes all of the consumables that are needed to set up a syringe driver and some short reference guides detailing how to set up a syringe driver. This was created as ED do not routinely stock the equipment needed and time was being wasted having to go to different departments for equipment. Stock levels are going to be checked regularly by a member of the ED team.

What Next?

- Questionnaire being circulated to ED staff regarding training needs in palliative care. Syringe driver competency is included within this. Results will be analysed to identify what training is needed and the best way to deliver this considering the current pressures within the department. This is potentially a large piece of work.
- Looking at obtaining a syringe driver to be permanently based in ED to enable syringe drivers to be set up more promptly.
- Identifying the best way to circulate the data from the first year and address some of the concerns highlighted, such as the need to increase EPaCCS and DNACPR's being completed.

Patient Experience – Staying Connected and Supporting Our Day Therapy Unit Patients

How Was the Priority Identified?

Day Therapy Unit closed at the start of the pandemic which left a group of patients unable to come into Trinity. These patients were receiving weekly support both from nursing staff and their peers at a vulnerable time in their lives and the pandemic caused further uncertainty and fear.

What We Did

Provided ongoing support for these patients so they didn't feel forgotten and/or lonely. We took the day unit out to their homes via an activity pack. This pack went out via our Community Team and contained a quiz, ingredients for baking, biscuits and chocolates, information about what was happening in Trinity and followed a different theme every week. Staff across the hospice wanted to be involved and helped provide additions to the bags.

The Community Team put together a plan for the year for 'special days', including Valentines Day, Easter, Halloween etc to take out to our most vulnerable and lonely patients. This included patients and relatives known to the Admiral Service raising awareness of our Trinity services with a wider group in our community.

Clinical Effectiveness – Collaborative Working With Intensive Care Unit (ITU) Staff

How Was the Priority Identified?

- Patient wanted to go home to die.
- Ensuring PPD wishes were met.

What We Did

- Collaboration with ITU to ensure the patient's and relative's final wishes were met.
- Removal of assisted ventilation at home.
- Collaboration with other health care workers.
- Symptom management.
- Support for family.
- Regular education sessions with the ITU team.

What next?

- Consultant and team build good relationships with ITU staff through this collaborative working and hope that this can be further developed with mutual learning to enhance staff skills and patient experience.
- Further integration within these teams to improve communications and collaborative working.

Improvement Priorities Identified During Our Quality Accounts 2020-21 and Progress Made:

Patient Safety - Safety Charts and Intentional Rounding

Our Aim Was

Patient safety is at the heart of the IPU philosophy; we have seen an increase over the last twelve months of pressure ulcers, often on admission. We wanted to further improve our care and documentation to evidence this safety culture. The concept of rounding is based on the work of the Studer Group (2007) and Meade et al (2006), and was developed as timed, planned and purposeful interventions addressing specific elements of nursing care. Rounding involves checking the four 'P's for each patient:

- **P**ain.
- **P**osition (checking that the patient is comfortable).
- **P**ersonal needs (offering help with toileting or hygiene).
- **P**ossessions (ensuring everything the patient needs is within reach).

What We Did

We reviewed our current admissions booklet and ways in which we documented care across our electronic patient record, we identified that although confident that the four P's were being undertaken and audit of the documentation didn't make this easily identifiable. We developed a series of templates on EMIS that helped to capture in more detail the care being provided in a more consistent way; a care summary template; an end of shift summary template completed by

senior nurses. All individual care plans reviewed weekly; overall care plans were reviewed for efficiency and minimising duplication.

Patient Safety – Deliver Targeted Education and Training to Staff within the Acute Hospital Setting to Improve Patient Care

Our Aim Was

- To empower healthcare professionals to deliver good care to the generalist - palliative and end of life care patients within the hospital setting.
- To identify clinical areas and provide periods of targeted informal training and support.
- To promote the use of the end-of-life nursing care plans throughout the Acute Hospital Trust.
- To continue to deliver monthly formal palliative and end of life care study days.

What We Did

- Increased frequency of formal study days to twice monthly to meet demand.
- Delivered end of life care training as part of the HCA induction and nursing preceptorship programme.
- Continued to support medical students spending time with the service to shadow our role.
- Audited the use of the nursing care plans within the Trust and fed the findings back at Trust Board.

What Was the Outcome? Audit Results

Twentythree of the 40 case notes had nursing care plans (58%) which was an improvement on 38% (15/40) from the previous audit .

Twentyone were reviewed and the results were follows:

- Compared with the previous re-audit more than half of the case notes selected had evidence of nursing care plans to support care for the dying person in their clinical record (58% vs 38%.).
- 95% of records had documented evidence of four-hourly review which was a significant improvement from the previous (40%).
- In 80% of patients there was evidence of personalisation of care which is, again, a significant improvement from the previous audit (53%) along with the care plans replacing documentation in the case notes (85% vs 13% from previous audit).
- Evidence of personalisation was significantly improved from the previous audit (80% vs 53%).
- Analysis of the communication care plans highlight that information booklets are not being given out consistently with evidence found in only three of 21 sets of notes. This is in keeping with previous results.

Recommendations from the audit:

- Twice monthly the Palliative Care Nursing Team offer end of life training for staff within the Trust and the plan is to present the recent audit findings for discussion and learning. Following on from this, there will be the opportunity to provide ongoing support and training, particularly targeting areas where performance does not meet the standards in this recent audit.

- The Palliative Care Nursing Team each have cohort areas that we provide training and support to and the plan is to ensure that all wards have “grab packs” which include all the relevant paperwork and leaflets and offer ward-based training on the documentation. This will be monitored by the end-of-life link person in each area and supported by the Palliative Care and SWAN teams.
- Communication/plan of care leaflets to be incorporated into one booklet to ensure patients and those important to them are fully informed.
- To discuss with the Chaplaincy Team recording dates and times of visits in nursing care plans to enable a more accurate picture for future audits.
- Reaudit 2023.

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

Carried forward from 2020/21 due to national Covid-related delays.

Our Aim Was

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

What We Did

We initially formed an LPS Implementation Task and Finish Group involving safeguarding leads from each area of our services including our Consultant Paediatrician, Admiral Nurse and social worker. However, the pandemic has meant that the implementation of the Liberty Protection Safeguards date was initially moved to April 2022 and this has been further extended, now out to consultation with an expectation that the new Code of Practice will be published later in 2022.

What Was the Outcome?

As we await publication of the national Code of Practice, we have brought this action forward and included the implementation of LPS as a standing agenda item on our regular Safeguarding, Clinical Governance and Education & Training Group meetings to ensure progress is maintained, monitored and reported throughout the year in readiness for implementation as and when required.

Clinical Effectiveness – Primary Care Network (PCN) Bereavement Groups

Our Aim Was

- To train, support and enable PCN staff to develop and sustain their own local community bereavement support groups.
- To help PCN staff to recognise and appropriately support normal symptoms and patterns of grief as well as those with red flags, who may need referral for more specialist support.
- To reach out further into our local communities to raise awareness of Trinity’s services and resources.

- To raise awareness of criteria for referral and reduce the number of inappropriate referrals for those experiencing normal bereavement and grief.
- To enable support for more people living with grief and bereavement in our local neighbourhoods promoting compassionate, resilient communities.

What We Did

We delivered training virtually to a cohort group of nine practitioners across two Primary Care Networks. The feedback from all those attended was excellent stating that they completely agreed the training met the objectives below:

The training was relevant to me
The training covered the objectives set
This training will be relevant in my job
The trainer spoke clearly and explained things well
I was able to make comments and ask questions
I have a better understanding of the impact of bereavement now
Teams delivery was appropriate for this training

Our aim will be to offer this to all PCN areas in 2022/2023.

Recent feedback from Lytham St Annes PCN care co-ordinator:

"Your training with us was a massive bonus and we still talk about how much we appreciated it".

"We did start the group during lockdown and because we offer it as a peer support drop-in with occasional guests or services to come along as point of interest for people, we can never say how many, but it is successful and we do have between five and 12 most weeks, people have really gelled and do things outside the group. We meet every Friday between 1 - 3 pm. We also meet monthly at Freckleton, but this group isn't as busy yet. We would like to promote and really make them well known! We have moved into a quieter room now at Ansdell. I would say you informed us and we learnt tips and understanding to give us more confidence".

Clinical Effectiveness Individualised Care Planning

Our Aim Was

Audit how effective individualised care plans are by having a robust audit process that feeds back key learning to the staff. Care planning isn't just about the patient's stay but what happens before and after our care. We want to adopt a more holistic approach that is multi-disciplinary to ensure what's important to the patient and loved ones continues whilst in our care.

What We Did

We undertook an audit of care plans to determine how personalised these were.

What Was the Outcome?

Care plans are tailored towards individual needs of patients in our care. When changes occurred, the care plan was updated and reflective of the ongoing care needs of individuals. The correct context was used, she/her/him and the use of the patient's name. Linking with the four P's, the EMIS record also demonstrated that patients care was tailored to their unique needs. All individual care plans reviewed weekly; overall care plans were reviewed for efficiency and minimising duplication.

Clinical Effectiveness: The Mysupport Study

Our Aim Was

To participate in the Mysupport Study which is a trans-national multi-disciplinary implementation study. The aim of the study is to adapt, implement and evaluate the use of a 'Comfort Care' booklet in six countries. The 'Comfort Care' booklet has been designed to support care home staff to engage in decision-making with family carers about fundamental aspects of care for people living with advanced dementia.

What We Did

Research Project – The Family Carer Decision Support Intervention.

From August 2020 until October 2021, alongside our Admiral Nurse, was involved in a research project, with the support of the Lancaster University Research Team. Two local nursing homes – Belsfield House and St Stephen's Nursing Home were involved in the project.

A summary of the research project was provided to us as noted below from Lancaster University Researchers:

A research team from Queen's University Belfast, Alzheimer's Society UK, Lancaster University, De Montfort University, Dementia UK and London School of Economics and Political Science are undertaking a study about planning for end of life care involving care homes, care staff and family carers of people living with advanced dementia. The study will identify the best ways to implement a tool called the Family Carer Decision Support (FCDS) intervention

The FCDS intervention has been designed to inform family carers about end of life care options available to a person living with advanced dementia who is resident in a care home. It involves an information booklet for family carers and a family care conference conducted by a trained member of staff. Results from previous research show that the FCDS intervention helps family carers to make decisions about care at the end of life with more certainty and improves family carer satisfaction with the quality of care their loved one receives.

The aim of the research was to understand how the FCDS intervention can be used most effectively and to evaluate its outcomes with the aim that the research will produce:

- Guidelines to help care homes use the FCDS intervention.
- Training and education materials for care home staff.

- Information for family carers.
- Tools to evaluate the uptake and outcomes of the FCDS intervention.

There was international involvement in this study incorporating teams in North America, Canada, Italy, the Netherlands and the Czech Republic. The UK arm of the study was funded by the Alzheimer's Society.

This study has now come to an end. The results of the study appear to indicate:

- The study was extremely difficult to get off the ground due to Covid-19 and restrictions in visiting the two local nursing homes that were involved in this project. Due to these difficulties, meetings were planned virtually.
- Lack of capacity to undertake training and deliver these FCDS interventions by the care home staff was an added difficulty in these pressing times.
- One FCDS was held in Belsfield House but unfortunately St Stephen's Nursing Home did not undertake any FCDS's.
- This picture was replicated internationally and within the teams in the UK unfortunately.
- Some of the nursing home staff were anxious about introducing the FCDS tool as it was new to them but they appreciated the support given from our Admiral Nnurses. The staff really like the Family Care Comfort booklet which is introduced in the FCDS and wish to continue to give this out to families in the future.

Clinical Effectiveness- Leadership Training

Our aim was: To develop a bespoke training programme to be delivered to middle managers across the hospice, to help facilitate and bring to life our values and ways of working and to provide some peer supportive time to help develop and practice the skills.

What We Did:

Due to Covid Challenges This Has Been Delayed to 2022

Clinical Effectiveness - Developing a Cross-Organisational Strategy Around Workforce Planning, Recruitment and Retention, Focusing on the Skillsets Required Across the Organisation and Developing Pathways to Achieve This

Our Aim Was

To develop a cross-organisational strategy around Workforce Planning, Recruitment and Retention, focusing on the skillsets required across the organisation and developing pathways to achieve this.

What We Did

Several meetings took place to review our current position and to plan for what the future has the potential to look like, undoubtedly Covid has changed the picture in particular for the In-Patient Unit. The numbers of inpatients have increased by almost 20% over the past 12 months, but with a shortened average length of stay and sadly 20% more deaths.

The group have considered all aspects of what contributes to the appropriate level of care taking into account the statutory requirements of CQC, ensuring care provided meets the fundamental standards set out in the Health and Social Care Act that we are regulated against.

We have considered:

- What “good” care looks like.
- Nursing establishment requirements.
- Skills and competences of the future workforce.
- Rotation.
- Supervision of nursing and medical “trainees”.
- New ways of working (bay nursing).
- IT and process efficiencies.
- Review of admission process and criteria.

What Was the Outcome?

We have taken a paper to the Executive Team and we have been successful in increasing our staffing structure initially with four Health Care Assistant posts that will work flexibly across hospice and community. We have commenced some work with our system partners to look at the concept of “system recruitment” and a system workforce development strategy for palliative and end of life care and continued to develop both the Advanced Clinical Practitioner and Trainee Nurse Associate roles.

A strong focus on workforce development will continue through 2022/23, aligned to a wider Fylde Coast workforce development strategic plan.

Clinical Effectiveness In-Patient Unit Development Group

Our aim Was

Review staffing structures and systems in the In-Patient Unit to increase effectiveness.

What We Did

A small group will work to look at how the clinical team looks to ensure the correct skillset is future proofedL

- Develop the role of the Associate Nurse to support the nursing team.
- Development of the ACP roles to support seven-day admissions and out of hours on-call.
- Review recruitment strategy.

What Was the Outcome?

We met as a Task and Finish Group to determine areas within the In-Patient Unit where we implement new initiatives to increase effectiveness, these included:

- Implementation of an evidence-based tool that helps to identify the priority of needs for patients put forward for admission.

- Develop a work-based tool that measures acuity and dependency of patients and demonstrates the impact on nursing hours available to inform the numbers of beds available, based on acuity and dependency against staffing ratios.
- Develop the "Trainee Nurse Associate" role, having three staff commencing the university degree pathway.
- Develop a clinical scope of practice for the TNAs.
- Develop further the Advanced Clinical Practitioner role, being successful in securing Health Education England funding for a further two trainee placements
- Develop a workforce strategy that encourages rotation and experiential learning across departments and flexible ways of working across our internal systems and with wider partners.

This IPU workforce development focus will continue through 2022/23 and going froward to ensure we have the best possible skill sets and effective skill sets on IPU to flexibly meet projected needs.

Clinical Effectiveness- Developing the Use of Intravenous (IV) Therapy on the Adult IPU

Our Aim Was

- Enable all qualified nurses to administer IV therapy.
- To reduce avoidable admissions to hospital.
- To enable patients to be transferred to the hospice whilst on IV therapy to avoid delays.
- Develop a formulary for IV interventions.
- Develop competencies for nursing staff to ensure good governance.

What We Did

- IV therapy policy developed and signed off.
- Antibiotic formulary and ordering process through hospital pharmacy completed.
- Training in IV therapy skills sourced for all IPU qualified nurses through BTH.
- IV therapy competency framework agreed.
- Self and objective assessments of individual staff IV therapy competencies continues.

What Was the Outcome

- The majority of IPU nurses have completed training in IV therapy administration.
- We've completed an antibiotic formulary and guide to treatment that will help us manage patients in the hospice.
- We have treated approximately 15 patients with IV therapies (antibiotics, fluids, blood transfusion or treatment for hypercalcaemia) preventing several hospital admissions and reducing hospital lengths of stay for those patients transferred from hospital improving the overall care experience for our patients.
- Recognition of need to ensure we complete all staff training, maintaining the skills and competencies necessary to continue grow this service for our local community.
- We did not receive as many referrals as we would have expected from hospital and need to raise awareness with our wider hospital colleagues regarding availability of this service for the right patients.

Clinical Effectiveness - Cornea Donation

By consenting to cornea donation, a person is enabling the improvement or restoration of sight to the recipient. Cornea donation requires whole eye retrieval, a donation from one person can improve/restore the sight of up to eight people. The majority (88%) of the hospice service users have a malignant diagnosis. A diagnosis of cancer restricts tissue donor potential however for the majority, cornea donation is still possible. Many patients, especially those with cancer, think they cannot donate anything due to their diagnosis. This lack of information and often healthcare professionals fear of upsetting patients by discussing donation, have previously prevented conversations regarding cornea donation.

In normalizing this conversation, we aim to give our patients information and choice to make their own informed decision, for many this leaves a positive legacy and is comforting to them.

Our Aim Was

Through our Trainee Advanced Practitioners (TACP) MSc Dissertation:

- We wanted to increase awareness and potential options for organ and tissue donation on the In-Patient Unit (IPU).
- Introduce organ and tissue donation to Advance Care Planning discussion (focussing especially on corneal donation) on IPU.
- Provide training to increase knowledge, awareness and confidence within the IPU team to increase the number of corneal donations and retrievals performed.

What We Did

- Networked and sought advice from National Health Service Blood and Transplant Unit (NHSBT).
- Developed a training package that was delivered by our trainee ACP to the In-Patient Unit clinical staff, alongside other clinical teams across the hospice.
- Developed a leaflet which provided both patients and those important to them with information about how "the gift of sight" could be achieved with their support donating corneas following a death.
- Created a referral process and documentation backed up with coaching and staff peer support in leading conversations.
- Created an EMIS data template to capture when discussions have taken place and set up a system to monitor the number of corneal harvests performed.

What Was the Outcome?

- After teaching sessions were held, the project was implemented in July 2021. Corneal donation conversations and referral information was captured between July 2021 and November 2021.
- An evaluation of this data was undertaken which demonstrated within this timeframe corneal conversations increased by 24%, resulting in 21 referrals being made to NHS Blood and Transplant (NHSBT) for cornea retrieval after the death of a patient on Trinity's IPU. This

resulted in 15 cornea retrievals. NHSBT retrieval service allowed staff to witness eye retrieval which supported staff in future conversations.

- This is a very positive start to the project which now requires further reinforcement to achieve our aim that all patients admitted to IPU who are eligible to donate their corneas are made aware of this possibility.

Clinical Effectiveness - Restart the Dementia Wellbeing Group, Widening Access

Our Aim Was

To develop a sustainable group that provides support and expert advice to both the carer and those they are caring for. Increase the number of carers attending our local Dementia Hub for further support and help carers to gain more knowledge around support networks available to them.

What We Did

- We reviewed the name of the service and incorporated the previous "Dementia Hub", and renamed the service "The Dementia Lounge", the ethos is to promote all opportunities for those living with dementia and their carers to remain well.
- To prevent social isolation, so they feel less alone in their diagnosis and caring roles. and to share information, knowledge, education, and best practice.
- Empowering carers to feel supported and well informed and leave the lounge feeling invigorated and connected.
- With the plethora of staff skills, the expertise of the carers and lived experience of those living with dementia, this is a safe space, to engage in a relaxed environment.
- We at the Trinity Hospice and Dementia UK, have a focus on 'Living well with Dementia' thus putting an emphasis on proactive information sharing, across the Fylde Coast and making our communities accessible for all.

Each month a professional in an area of expertise presents their service and share information at the Lounge, the first month was the memory assessment service, and they presented assisted technology. We use digital technology to support this and includes the magic table which displays digital games to aid auditory and visual stimulation which includes autumn leaves and Japanese fish. Wyre Alzheimer's Society have also joined us.

Evaluation forms reflected that carers found this an excellent service and two carers left having swapped numbers and have remained in contact, providing informal peer support to one another.

Our hope is the Dementia Lounge will grow in the direction the service users wish this to expand, eventually having smaller groups in the community which can then be facilitated by carers, for carers, and to have a carers safe space. We eventually hope to grow Dementia café's, Dementia restaurants, Dementia shopping hour, Dementia gardens/gardening, and all this from the Dementia Lounge at the Trinity Hospice and created with love for our community.

What Was the Outcome?

We commenced the lounge in November 2021 and after the first two here at Trinity Hospice, we outreached into the community due to the rise in Covid numbers, meaning we could meet in smaller groups but keep the ethos of the lounge, by keeping our communities connected. This proved successful. We could meet closer to those living at either ends of the Fylde Coast, even social prescribers managed to link in with the outreach events.

On bringing the lounge back to the hospice, we listened to what our carers felt was more meaningful to them and they appear to enjoy chatting with one another and activities, keeping their loved ones engaged, rather than talks from professionals. Therefore, we have listened and moved more towards reminiscence, memory boxes, namaste, hand massage, and a more informal way of sharing information.

From the Dementia Lounge we have recruited two new Trinity volunteers, and one of those ladies is a representative at the Dementia Action Alliance; she is due to speak at the next DAA, sharing her personal story.

We sent 70 invites to our last DAA with around 40 attending, all key players with a keen interest in making the Fylde Coast a dementia friendlier community for all.

One of our new volunteers has also opened her own dementia café which is going from strength to strength and she represented dementia at the launch of our Compassionate Fylde Coast Communities event during Dying Matters Week.

Patient Experience – Chaplaincy & Spiritual Care Proposal to Purchase Fifty Copies of *"The Boy, The Mole, The Fox and the Horse"* by Charlie Mackesy

Our Aim Was

Prior to the publication of *The Boy, the Mole, the Fox and the Horse* in the autumn of 2019, many pictures of the characters had already appeared widely and gathered a large following via social media and the 'On the Board' signs across London's Underground network. Our chaplain, Paul Berry, recognised the potential the book may have in our work with patients, families, and staff. In early 2020, he approached the Clinical Director to request that the hospice purchase the book. The hospice has a supply of Bibles provided by The Gideons and the proposal was to supplement these with a non-religious book which could be enjoyed by all people. As the book is very pictorial with few words, we felt it wouldn't demand too much of those who glanced through it. The pictures and words explore feelings, and challenge some of the wrong thinking many of us have about ourselves. It has a strong theme of 'hope in adversity' running through its pages. We felt that the book would be both a comfort to many and provide a talking point with others for all who looked through it. We hoped it would have wide appeal to patients, families, and staff members alike and serve to 'speak' in the many circumstances when spoken words may fail.

What We Did

The books arrived at the same time as Covid-19 in March 2020 and couldn't have come at a timelier moment. As the early days of the pandemic moved into lockdown, the book served an

even higher purpose with its gentle words of honest wisdom and hope at a time of great fear and uncertainty.

We have used them extensively on the In-Patient Unit and, when the book is handed to patients, they are encouraged to flick through the pages and chose one or two which might 'speak' to them. This has resulted in countless deep and meaningful conversations with many tears and breakthroughs. The response from patients and visitors, who also are encouraged to use the book, has been overwhelmingly positive. The same is true in their use in bereavement support where they have been used very effectively with families. Many staff members have gone on to purchase their own copy of the book and report that it has enabled them to get through the dark times of the pandemic.

Paul continues to regularly post pictures from the book on the staff Facebook group as a means of support and connection with the book itself and this has had very good feedback. Books are stored at nursing stations and staff feel very confident in offering them to patients and families alike.

The investment in this resource has been repaid countless times and it will have a lasting impact in the care and support which is offered to all.

Patient Experience – Using Play As A Therapy

Our Aim Was

For children and young adults, play and creative therapy is an essential part of the care we provide here at Brian House. It was identified as a priority to develop further for all those in our care, to help support new children referred to us, in order to help them settle in and build positive relationships with staff caring for them. Play allows children to express themselves in a unique way, process and understand their emotions or worries and improve overall well-being and resilience to the challenges they may be facing.

What We Did

- We introduced "Makaton" boards to help children articulate how they wanted to play.
- We reviewed all "play plans for children" in our care.
- We enhanced the role of the health care support worker to include play.
- We facilitated external training.

Patient Experience – Opening Access to Brian House Facilities

Our Aim Was

To promote the use of this space to families to enhance the care experiences offered by Brian House by providing a booking system in which they book a slot in the sensory room or cinema. Parents can bring the child known to Brian House, siblings and other family members to use the facilities for some special time and memory making. We arranged parent groups as the Covid restrictions lifted and discussed the needs of the families with the parents. Parents identified feelings of isolation, not being able to access community groups due to lack of confidence/support, feeling that they were being stared at. We discussed toddler and baby groups where the parents could share experiences whilst their child played in a safe environment with others in the secure

knowledge their children were being cared for in safe hands. We are currently recruiting volunteers to offer baby massage sessions in the baby group and parent complementary therapy sessions in the parent/grandparent groups.

The parents expressed concerns about the siblings that they were, in some cases, supporting caring for the child with the life limiting condition and sometimes parents couldn't spend the time they would like to with the siblings. The sibling group was identified as being able to offer siblings an opportunity to meet others in a similar situation and share experiences whilst having some fun time just for them. We want to offer families the opportunity to network with each other to prevent feelings of isolation and being different, to gain confidence in accessing community services and to support them with the care of their child whilst ensuring the family feel they have support from Brian House and other families who attend.

We want the families with babies and young toddlers to gain the confidence in Brian House and the staff to be able to accept the much-needed respite so that they can recharge their batteries and not end up exhausted and in crisis. We use “Iwantgreatcare” for feedback, but we are also developing an evaluation sheet for parents to offer suggestions on how we can constantly improve things providing that vital support.

What We Did

- Consulted with parents about how they wanted Brian House to develop to meet their child’s needs.
- Toddlers group, baby group and parents groups are now running with good attendance.
- Daytime activities, respite, groups and respite visits both community and inhouse on a monthly basis using an electronic calendar that all staff access.
- Facilitated group days for older teens.
- Facilitated days to bring together children with cancer to support and make friends and make memories.
- Themed “Harry Potter” party for a child at end of life for family and friends.
- Provide sibling support days.
- Developed family cinema nights.

Review of Service

During 2021/22, Trinity Hospice provided the following services in conjunction with Blackpool NHS Clinical Commissioning Group and Fylde and Wyre NHS Clinical Commissioning Group in the provision of specialist palliative care services:

- In-Patient Unit with 18 beds offering 24 hour care for the most complex patients and their families.
- Community Nurse Specialist Team supporting patients and their primary care teams in the community over seven days.
- Hospital Nurse Specialist Team supporting patients and colleagues within the hospital over seven days.
- We have commenced the development of a new “Living Well” service to replace our previous Day Therapy services.

- Lymphoedema service supporting patients, adults and children, with both primary and secondary lymphoedema.
- Bereavement and counselling services run from the Linden Centre supporting adults and children, individually or in groups. We also run a Schools Link Service, helping schools to support children experiencing bereavement.
- Quarterly bereavement and annual bereavement events such as "Light Up A Life".
- Specialist palliative and end of life care psychology services.
- Complementary therapy offering patients and carers a range of complementary therapies.
- Physiotherapy – supporting palliative rehabilitation, promoting independence, and improving quality of life and supporting discharge from the In-Patient Unit.
- Social worker helping patients to stay in their own homes and supporting discharge planning for the In-Patient Unit.
- Spiritual care and support by our Spiritual Co-Ordinator and chaplains.
- Hospice at Home overnight service, seven nights a week, supporting people in their own homes, care homes and nursing homes, working with out-of-hours medical services, district nursing teams and ambulance service.
- Admiral Nursing service in partnership role with Dementia UK, providing support and assessments for those caring for loved ones with a dementia diagnosis and education and training across the health care sector of the Fylde Coast.
- Education, training, and research – a Learning and Research department that facilitates education internally and externally to the hospice. Co-ordinates educational events, supports opportunities for learners and palliative care research projects.
- Brian House Children's Hospice supporting children and young people and their families with respite and end of life care (mainly funded by our charity's monies with a small emergency grant from the Department of Health).
- Medical and nursing student training.
- A 24/7 palliative care advice helpline manned by the community and In-Patient Unit staff.
- Trinity website with an increased focus on education.
- Covid has meant that our support via the Hospice Neighbours scheme had to be suspended, but we continue to work with our trained volunteers to support patients in the community
- Volunteers – all aspects of the above services are supported by over 850 volunteers.

Trinity Hospice is an independent charity which provides all services free of charge. The income generated from the NHS in 2019/20 represents 35% of the overall costs of service delivery with the remaining income to fund our services coming from voluntary charitable donations, legacies, events, corporate and community fundraising, hospice shops and lottery.

Care Quality Commission – OUTSTANDING

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

- Treatment of disease, disorder or injury.

During this period we have not had an inspection by the Care Quality Commission (CQC) so we currently retain the following rating from our inspection in July 2016: We receive data from CQC monthly regarding our rating and at present CQC have determined from a variety of sources that

our current rating remains. We hold quarterly engagement meetings with a CQC relationship inspector.

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

What They Said

Is the Service Safe?

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

Is the Service Effective?

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

Is the Service Caring?

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

Was the Service Responsive?

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

Is the Service Well Led?

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

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

Trinity's Values and Ways of Working

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

Trinity C.A.R.E.S

Caring

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

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

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

Respect and value individual differences.

Support colleagues and volunteers at all times.

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

Adaptable

Respond positively, appropriately and flexibly to challenges.

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

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

Develop effective external collaborations based on mutual respect and trust.

Responsible

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

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

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

Share compliments and celebrate successes to learn from good practice.

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

Maximise our impact by effective team working.

Excellence

Constantly develop and apply our professional expertise in palliative care.

Encourage others to share ideas and learning.

Aspire to provide exceptional professional performance in all roles.

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

Recruit capable and committed volunteers.

Strive for improvement every day as everyone makes a difference.

Continuously challenge assumptions and strive for cutting edge solutions.

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

Socially Engaged

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

Provide meaningful and satisfying employment and volunteering opportunities.

Fund our services through ethical and transparent fundraising.

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

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

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

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

Working Smarter

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

A Flexible Medical Team Model

Historically, Trinity's medical resource has been inequitably distributed between the different arms of our services. The hospital team has never had an Advanced Clinical Practitioner (ACP) or junior doctor and the community team has only had a part time consultant and no ACP or junior doctor despite the fact that the greatest and increasing need for end of life care lies out in the community. The Coronavirus pandemic catalysed the need to address this.

To respond to urgent identified service needs, we deployed an ACP and a junior specialty doctor to work full time with the hospital service and increased the consultant and senior specialty doctor support to the community team to daily, latterly adding a junior doctor to this resource.

What Do We Want To Achieve?

Our learning from our pandemic experience has only served to reinforce the considerable value of the ACP role, enhancing our medical team in realising our mission and service goals, supporting seven-day working across all of our services and enhancing our effectiveness and responsiveness with the ability to work flexibly across our community, hospital and in-patient unit services where needed.

How Will Progress Be Monitored and Reported?

Overall, these changes have proven extremely beneficial, enhancing patient care and staff learning and professional development, with very positive staff feedback from staff so far, informing a successful business case to Blackpool Teaching Hospitals funding support for a seven-day hospital service to include a permanent specialty doctor and ACP, a successful bid to Health Education North West GP school for two recurrent full time rotational GP training posts starting in August 2021, and a Health Education England bid for funding for twofurther ACP training posts.

We will continue to evolve this service, working with our teams to understand how the medical resource can be used most effectively to add most value to clinical care and workforce development, rotating our trainee ACPs and GPs between IPU and the community and hospital services.

We will continue to evaluate the impact of these changes and report back through the Clinical Quality Improvement Group and Clinical Governance Committee.

Staff Development

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

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

Developing the Advanced Clinical Practitioner Role (ACP)

We have been fortunate to receive a further three funded places on the ACP course to assist in our strategy to future-proof hospice care in a time when recruitment for both medicine and nursing staff is challenging. The roles will support the medical team on the In-Patient Unit and enable access to admissions to the In-Patient Unit over seven days. The ACPs currently are from both nursing and allied health care, with a skill mix to enable the hospice to respond to the projected increase in end-of-life care for and aging population living with dementia, frailty and complex long-term conditions. The role is also being developed in our children's hospice to enhance and ensure more robust systems are in place in the absence of medical cover.

Developing the Nurse Associate Programme

We have been able to launch our trainee nurse associate programme, having initially three students undertaking the course from our in-patient service, community and Brian House. We plan to develop this role over the next three to five years to assist in our workforce development strategy and to enhance recruitment opportunities for the future. The role has a specific "Scope of Practice" supported by training and the provisions under the Code of Professional Conduct for qualified nurses. Once qualified they will be autonomous registrants working in partnership with our registered general nurses and paediatric nurses to bridge the gap between health care assistants and registered nursing staff. Nurse associates will remain close to our patients and families.

Management and Leadership

We have started reviewing our approach to appraisals and the development of personal development plans, using a cross-organisational approach to streamlining the process whilst providing additional training to all those who will undertake those "crucial conversations" to ensure a more effective process. We have implemented 360-degree feedback mechanisms for members of the Trinity Management Team and hope to roll this out to staff who undertake appraisals in 2022

Investors in People Gold

Trinity Hospice was first awarded Investor in People (IiP) Gold accreditation in 2016, having achieved Silver for the first time in 2015. Re-accreditation occurs every three years and in 2019 the hospice was delighted to retain its IiP Gold following a three-day assessment, which reflected extremely well on the contribution of everyone across the organisation. In the autumn of 2022, the

next three-year re-accreditation is due. A Gold IiP accreditation is not easy to retain but everyone involved will be working hard towards the goal of once again retaining Trinity's Gold accreditation status.

Part Three: Review of Quality Performance

Trinity Hospice and Palliative Care Services

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

Clinical Nurse Specialist Team Community	2017/18	2018/19	2019/20	2020/21	2021/22
Total number of patients referred	1113	1402	1448	1429	1425
% of patients with a non-malignant disease	20%	19%	16%	22%	18%
% of patients who died outside hospital	94%	93%	95%	94%	98%
% of patients that died in stated PPD	82%	84%	77%	85%	86%

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

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

Hospice at Home	2017/18	2018/19	2019/20	2020/21	2021/22
Total number of patients referred	916	1159	1264	1301	1075
Face to face contact	2152	1940	1921	2962	4279
Telephone advice	5838	6861	3684	1571	1251
% with malignant primary diagnosis	61%	62%	61%	53%	55%
% with non-malignant diagnosis	47%	43%	36%	43%	42%

These above figures go some way to demonstrate how our patient services have been sustained, with a steady increase in referrals and patient contacts in our hospital, Hospice at Home and hospital services in particular.

2021-22 has seen a change to our experience on our In-Patient Unit, where, despite the need to limit our bed capacity to ensure safe staffing due to significant numbers of vacancies and Covid related absences, we have seen:

- A 15% increase in admissions.
- Weekend admissions (previously exceptional if urgent need) are now the norm - 57 weekend admissions in 21/22.
- Average length of stay has reduced from 11-13 days to eight days.
- More IPU admissions for end of life care with a 25% increase in deaths in 21/22 over 20/21
- An increase in admissions from hospital to 58% (49% previous year).

Our Participation in Clinical Audit

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

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

Membership of the Audit Group continues to comprise of a representative from each area of the clinical directorate, the medical directorate, and services. The group meets quarterly, and this is fed back into the Clinical Quality Improvement Group. Audit activity has been more limited due to the constraints of Covid-19 but there is still very much a keenness within the group to share with colleagues the need for and benefits of robust audit.

Research

We have participated in several research studies in 2020-22 which include:

- Developing palliative and end of life care research partnerships and capacity in the Northwest Coast of England (March 2022).
- Rapid evaluation of the Covid-19 pandemic response in palliative and end of life care:. national delivery, workforce and symptom management (CovPall) (November 2020)
- Moral and ethical issues surrounding the practice of palliative sedation according to professional caregivers: a multicentre, qualitative study of Moral Case Deliberations (May 2021).
- Exploring the views of health and social care professionals on using The Guide to Deathbed Etiquette in End of Life Care (February 2021).
- Scaling up the Family Care Decision Support Intervention (FCDS): A multi-site implementation evaluation (January 2021 - this was part of a dementia study undertaken by our Admiral Nurse – detailed above).

Safeguarding and Implementation of the Liberty Protection Safeguards

Safeguarding is a high priority for our organisation, having recently moved to a new mandatory training provider we have a more robust system in place to ensure staff complete essential training in this area. We have taken the decision to ensure all our clinical staff are trained to Level 3, in accordance with the intercollegiate document 2019 ensuring they have access to appropriate

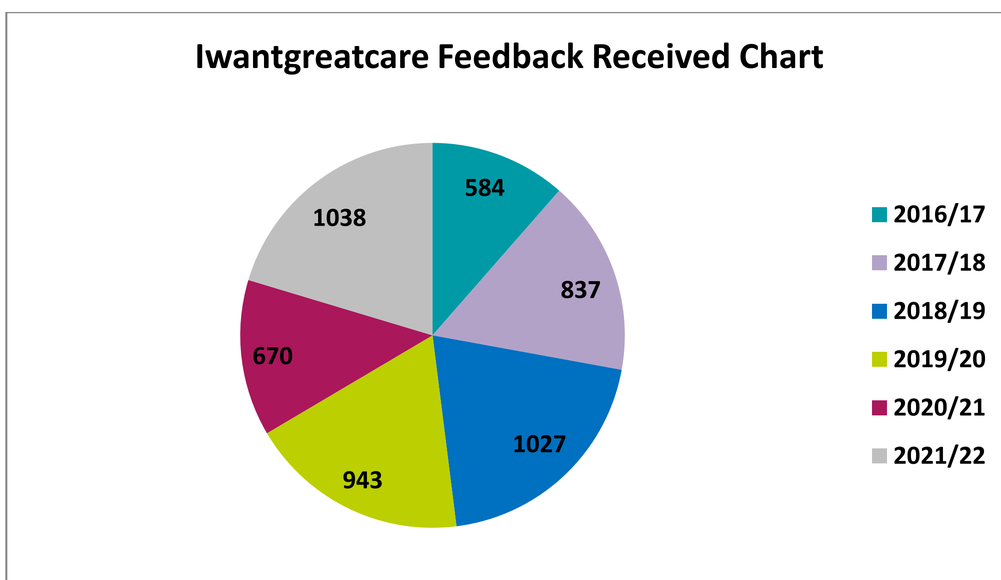
training, supervision and ongoing development in this area. We have recently developed an organisational risk assessment for safeguarding to ensure our systems and processes keep people safe and free from harm and have undertaken additional training with the NSPCC.

We take our approach to mental capacity seriously, providing additional face to face training with the Mental Capacity Act (MCA) lead from our acute trust. This training led to improvements in the way in which we record capacity assessments and best interest meetings, as well as improvements in literature for patients and families. We have a Task & Finish Group to support the implementation of the Liberty Protection Safeguards; this has implications for our older young people in Brian House. We are on the regional review group and are currently awaiting the "Code of Practice" to assist us in determining the changes to practice required.

''Iwantgreatcare''

What Do Patients Say About Us?

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



Brian House – a total of 241 'iwantgreatcare' feedback forms completed during this period.	
How likely are you to recommend our services?	**99%**
Average score for year for all questions	**5.00**
These are comments received:	
• The staff totally understand **** complex needs. When coming to Brian House for respite care **** gets out of the car and runs into the building, so obviously loves her time there. We feel like we are part of the Brian House extended family. The outreach (community) team also takes **** on trips whenever they can. Nothing in our opinion could be improved. • Good support from all the staff who are kind and caring we have only just started coming to Brian House and are looking forward to meeting other parents in a similar situation once Covid	

restrictions ease. So far there is nothing that could be improved. • Each child is treated individually and the staff show great knowledge of every child's needs, great care is provided. • The care given to both our foster children is first rate. The staff are very knowledgeable and understand the needs of both children and are very supportive towards us. The respite care stays are much appreciated when caring for children with such complex needs. • Excellent support always given to us parents. Staff came out to visit in hospital, this gave us time to go home for six hours rest, which was greatly appreciated. Our child loves seeing Brian House staff, both in hospital and at home. Respite stays in Brian House are always looked forward to. • Staff came out to Alder Hey to visit **** in hospital. This gave mum much needed respite time being in hospital alone with **** for two weeks this was greatly appreciated. • Each child and their parent is treated individually. The staff go out of their way to provide excellent care. They have been coming out to home to take the patient on outings and bring her into Brian House for bathing. They are maintaining the patient's personal hygiene to a high standard which I could not do alone. • Brian House is a safe secure environment for him to be in and express himself independently. The staff are very professional and caring. • **** care has been tailored to his needs and age. He participates in activities that are appropriate to him which makes him feel wanted.

Community Clinical Nurse Specialist Team – a total of 202 'iwantgreatcare' feedback forms completed during this period.	
How likely are you to recommend our services?	**100%**
Average score for year for all questions	**4.99**
These are just a few comments received:	
• The nurse that came was very kind, caring and understanding. I was able to talk to her easily, she listened to both me and my wife and gave me the reassurance I needed. Before I spoke to her I felt really down and felt much happier when she had gone. • Timely help when we needed it. Things started moving once staff member was involved and Mum's care felt well fitted to her changing needs caring knowledgeable and forthright! Thank you! • So kind and supportive and bereavement support excellent too. • Member of staff was punctual and professional. She has all the information I needed at this stage to hand. • The Clinical Nurse Specialist service received was excellent in every aspect, staff were knowledgeable, kind, caring, easy to understand, and available in person or by phone. Could not have managed without you. • Very professional approach questions asked sensitively and good answers to my condition also gave me a sense of ability. Pre knowledge of the individual and possibly the best carer/ nurse I have encountered recently. Improvements - none! W,hat she promised she carried at and responded back by phone great! • I gave top marks because they were there for me when I needed comforting and things	

explaining to me. They gave the best care that could be possible to my husband.
• I felt totally supported by the team, this extended to my whole family.
• She was very honest with us like we asked her to be. She seemed to give us enough information without overloading us.
• It has given me confidence in all the help I am going to get.
• Happy they could keep Dad at home to die peacefully.
• Amazing team. Great follow up for bereavement also.

Hospice at Home – a total of 241 'iwantgreatcare' feedback forms completed during this period.	
How likely are you to recommend our services?	**100%**
Average score for year for all questions	**5.00**
These are just a few comments received:	

• Such a great help and support to know they are on the end of phone or can visit.
• Such a great team kind and supportive.
• Amazing team. Could not have managed without team.
• The Trinity Hospice at Home could not have done anymore for my mother and myself. Each and every nurse was kind and compassionate I am so grateful.
• So kind and supportive, explained things to me and good to know they are there in the night.
• Your team were amazing to our son and myself, and bereavement support as well.
• So kind and supportive. Could not have asked for better.
• Care home, so good to know they are there every night for support.
• Supported in such a difficult time.
• Excellent service.
• Excellent care always came out.

In-Patient Unit – a total of 213 'iwantgreatcare' feedback forms completed during this period.	
How likely are you to recommend our services?	**100%**
Average score for year for all questions	**4.98**
These are just a few comments received:	

• Your care for my mum was amazing, felt so safe.
• I was nervous on arrival but my worries were put at ease. Every day has been a pleasure. Staff have been wonderful and nothing has been any trouble. I cannot think of anything negative to say.
• Everything was great. And though we're in pandemic it was still excellent.
• A lovely reception on arriving. Made to feel welcomed and well informed. Everything perfect. Nothing could be better.
• They couldn't have been more caring to both ****, her sister and myself. An incredible service. Thank you. Improvements - I can't think of anything. It really was like a 5 star hotel/private hospital.
• I was made to feel very welcome and settled straight away. I was even offered a room the next day with en-suite shower to suit my needs. Every single member of staff worked at the highest standard giving the best care. Nothing was too much trouble at any time of the day.

For that extra personal touch - keep reminding us as patients your names. As it is very difficult now with Covid-19 - facemasks to remember and put a name to a face. Thanks. You are all so lovely. • I was newly diagnosed so everything was new to me the staff were so kind to me helping me understand what happens next. Improvements - Nothing that I could see from my two weeks visit. I have been made to feel special and not a person who is dying.

Linden Centre Counselling and Support – a total of 81 'iwantgreatcare' feedback forms completed during this period.	
How likely are you to recommend our services?	**100%**
Average score for year for all questions	**4.89**
These are just a few comments received:	
• As always with your organisation, wonderful support, consideration and understanding was reflected in your support. • The treatment I received was first class, the person looking after me was really brilliant and helped me an awful lot. It helped me a great deal. Nothing more could have been done because the girl that was looking after me was first class and very understanding. • Absolutely amazing service cannot thank you enough my son is going from strength to strength. •Thank you to **** and all members of Linden Centre, Trinity Hospice. I feel privileged, I know how pressured all services are in this current Covid crisis. To have had my opportunity of counselling in my hour of need has held me up. **** walked with me and truly listened to ask I had to say. **** supported me and gave me courage to look and ponder and look again at extremely painful events. Thank you for being there when I needed a friend. • They were very polite all times and respected my deafness problem. **** wrote everything down for me that she wanted to ask me. I got very good help in my grieving and depression and would use them again if needed and will advise people to use them. You could not do better help than you did for me. Always polite and caring at all times. Very good with deaf and hard of hearing people. • I was apprehensive about having counselling, but it turned out to be a godsend. Right from the start I felt at ease with my counsellor she took her time and listened to me, at the start I felt a great weight on my shoulders, but by the end of the course I was just able to think of happy times with my husband.	

Lymphoedema – a total of 31 'iwantgreatcare' feedback forms completed during this period.	
How likely are you to recommend our services?	**100%**
Average score for year for all questions	**5.00**
These are just a few comments received:	
• Member of staff has been very professional, caring and efficient. Excellent advice given and received. • Really welcoming, very well explained. Excellent communication from both nurses.	

- The service was excellent very comfortable in appointment.
- Always listen and happy to give advice.
- They were very supportive and gave me valued information and can continue with the knowledge after four years of trying to find out my problem. Member of staff is so nice and caring.
- I was made to feel comfortable; it was a great experience with my dignity 100% intact. **** and **** were brilliant. Improvements - No, it was perfect, simple informative but not overwhelming. Thank you.
- Professional, informative, dignity and respect.
- Excellent service. **** was professional kind and considerate to my needs.
- I was very impressed when I came for my appointment and so was my daughter-in-law. The staff were very friendly and had time to explain things to us. Looking forward to the next visit. **** could not have done more.
- Kind explained everything well, no wait - running on time. No rush - had time to care about me.
- The care I received was first class and very professional. I felt very comfortable and at ease, in fact a very enjoyable experience. Thank you. Improvements - Difficult to improve on excellence.
- I was treated with compassion, understanding and dignity.

Key Quality Indicators

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

Complaints

Trinity Hospice welcomes both positive and negative feedback from patients and families about their experience of our services. Negative feedback enables us to reflect and consider what we could have done differently. It is only through valuable feedback that we can understand and improve the care we provide. All complaints received are dealt with as per policy and procedure. This includes an apology, investigation, an outcome, and actions put in place from lessons learnt. During this period, we received adverse/verbal comments and formal complaints.

Summary of Complaints Received

Brian House

Adverse Comments Received: Negative comments made on parents' Messenger Group about child being discharged from service. Followed up by a letter to Brian House regarding discharge.

What We Did: Clinical Director met with family. Explained discharge process and reasoning and confirmed in a letter. Patient discharged; no further action required.

Community Team

What Was Said: A letter was received written by the brother of a patient regarding the brother not being admitted into Trinity's In-Patient Unit at end of life and perceived lack of communication.

What Was Done: The Clinical Director met with complainant and issued a formal written apology following the meeting. It explained that we are currently reviewing the admissions and referrals process. The complainant was satisfied with the response.

What Was Said: Perceived lack of support and co-ordinated care from Community team.

Response: Letter from Clinical Director following investigation. Apology given.

Hospital Palliative Care Team

What Was Said: Palliative Care Team intervention and perceived breakdown in communication involving the ward staff led to confusion for a family on care and medication.

What Was Done: Recognised as a breakdown in communication between Palliative Care team and the ITU staff and family. Planned for improved co-working. Following discussions with ITU team processes tightened up to ensure better referral process and communication. Care Team to

communicate with senior medical staff before doing initial assessment to ensure family are informed of their involvement and role.

In-Patient Unit

What Was Said: Negative adverse comments regarding a patient on the In-Patient Unit left on Google reviews by their son. Family already known to IPU staff and complex situation.

Response: On speaking to the family, they do not wish to complain, just have the patient discharged to a nursing home as planned. This was facilitated by staff.

What was said: Verbal feedback was given to the In-Patient Unit Manager regarding how a family felt the staff treated them when their relative died. There were no negative comments regarding care, just feedback on the interaction of the staff when their relative died. They were insistent it was not raised as a formal complaint, but they felt lessons could be learned.

Response: They were apologised to for the way the staff had made them feel when their relative died. Some of the processes were explained to help with the families understanding. Feedback was reviewed with staff to ensure they understood how they had come across and help them do things differently in the future.

What Was Said: Email received in the general enquiries mailbox regarding some adverse comments regarding the In-Patient Unit and visiting. Comments related to access when reception was closed and restrictions on the number of visitors and the wearing of masks.

Response: In-Patient Unit Manager met with the email's author and discussed points raised. There had been a problem with the doorbell being switched off at the plug on this occasion which has been rectified and a sign put on the doorbell to prevent it being switched off again. The reasoning behind the visitor process was explained due to Covid. Also, the wearing of masks being challenged was discussed and it was agreed that when drinking a hot drink this would not be possible to wear the mask, this was discussed with staff as it seems there was a misunderstanding. A verbal apology and explanation were given and accepted.

What Was Said: A lady was calling to say she didn't require our counselling service as she had organised private counselling herself, she went on to express some adverse comments about the In-Patient Unit following her husband's death.

Response: An HCA who specialises in bereavement support called the lady. She thanked us for our speedy and compassionate reply to this. At this time, she feels she is not able to come here but thanked the Linden Centre for escalating it and for the bereavement HCA for getting in touch with her. She feels maybe in time she would like to come. We offered to keep in touch, but she said she will call the HCA as they have a good connection. She thanked us for dealing with it so quickly

Part Four – Statements from the Clinical Commissioning Groups

Blackpool Clinical Commissioning Group

Fylde and Wyre Clinical Commissioning Group