Welcome to Salford Royal NHS Foundation Trust (SRFT). Salford Royal NHS Foundation Trust aims to be the safest organisation in the NHS through providing safe, clean and personal care to every patient, every time. The Foundation Trust is an integrated provider of hospital, community and primary care services, including the University Teaching Trust. Salford Royal Hospital has 839 in-patient beds of which 38 are designated critical care beds and serves a population of around 240,000. Our team of 7,000 staff provide local services to the City of Salford and specialist services to Greater Manchester and beyond. Since 2008 we have nearly eliminated MRSA blood stream infections, reduced C difficile by 90%, cardiac arrest by 51% and pressure ulcers by 70%.

Our mortality rates are in the best 10% nationally and the best outside of London. In addition fewer Salford Royal patients die if they are admitted over the weekend, due to the changes we have made to our services to ensure patients receive the same high quality care on a weekend as through the week.

Our patients have rated us in the top 10% of all trusts in the 2012 National In-patient Survey and Salford Royal staff rated Salford the best trust in the 2012 and 2013 National NHS Staff Survey.

Written by D.S. Morris/ S.A.Looker/ V.J.McLoughlin
Review Date: Feb 2018

Salford Royals Quality Improvement Strategy aims to be the safest organisation in the NHS by focusing upon four key areas:

› Reducing mortality

› Reducing harm

› Improving the reliability of the care provided, and

› improving the patient experience

The Care Quality Commission (CQC) has reported that Salford Royal is an outstanding Trust.

Palliative care services were described as outstanding in the 2015 CQC inspection. The hospital's Specialist Palliative Care (HSPC) team is a well-developed, strong, motivated team with strong clinical leadership. Seven specialist palliative care nurses provide face-to-face clinical support seven days a week, with the hospice providing out-of-hours cover.

End of life care is embedded in all clinical areas. Clinical/nursing staff are passionate about end of life care and the need to ensure that the wishes and preferences of their patients and families are met as they enter the last stage of their life. All wards have a palliative care link nurse to champion good end of life care.

The Specialist Palliative Care Team (SPCT) works collaboratively with the bereavement team. The bereavement team are available to support carers and families following the death of their relative. Both teams work together to ensure that end of life policies are based on individual need and that all people are fully involved in every part of the end of life journey

Salford Royal achievements; 2011-2015

- Having the lowest mortality rate in the North West, according to the National Dr Foster Hospital Guide;
- Announced as ‘Best Acute Trust in the North West’ in the Department of Health, Cancer Patient Experience Survey 2011;
- The Respiratory Nursing team won the Nursing Times ‘Respiratory’ award in 2011;
- Pioneering the ‘harm free care’ concept for improving patient safety - with some of the highest patient safety results; Department of Health Safety Thermometer recognised that 92% of Salford Royal NHS Foundation Trust inpatients receive harm free care
- Becoming an integrated provider of both acute and community care in April 2011;
- Treating patients in the new, state-of-the-art Hope Building - the major clinical building within our redevelopment programme;
- Opening The Christie at Salford Royal to provide care closer to home for patients with cancer;
- Safely reducing costs by £18m.

Palliative Care

WHAT IS PALLIATIVE CARE?

Palliative care is the active holistic care of patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatments.

Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;

- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patients illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications (World Health Organisation (WHO) 2003).

In the literature palliative care appears to struggle to have an exact definition as it is often used interchangeably with end of life care, terminal care and hospice care. Definitions vary by organisations and countries (Shigeko, Hiroko, Chihoko, and Emiko 2012).

Not only are there inconsistencies in the definitions of palliative care, professionals struggle to identify when patients would benefit from palliative care interventions. Although inclusion of palliative care in the early stage of disease is thought to play a significant role in improving quality of life (Shigeko 2012), in practice it rarely occurs until the end stages of the disease.

Palliative care's connection with the term hospice is generally misunderstood by patients and it tends to be associated with care of the dying (Ronaldson and Devery 2001), causing fears of association with imminent death (Ahmed et al 2004).

WHO PROVIDES PALLIATIVE CARE?

Palliative care is provided by two distinct categories of health care professionals:

A. Those providing the day-to-day care to patients and carers in their homes and in hospitals

B. Those who specialise in palliative care who act as a specialist support and advisory service for people with cancer and other progressive illnesses.

Those providing day-to-day care should be able to:

- Assess the care needs of each patient and their families across the domains of physical, psychological, social, spiritual and information needs
- Meet those needs within the limits of their knowledge, skills and competence in palliative care
- Know when to seek advice from or refer to Specialist Palliative Care services

Those providing specialist palliative care services:

- Specialist multidisciplinary palliative care teams who provide assessment, advice and care for patients and families in all care settings, including hospitals, community, hospices and care homes.

- Specialist in-patient (hospice) facilities for patients who benefit from the continuous support and care of specialist palliative care teams.
- Intensive co-ordinated community support for patients with complex needs who wish to stay at home.
    - This may involve the specialist palliative care service providing specialist advice alongside the patient's own doctor and district nurse to enable someone to remain in their own home.
    - Patients who live in Salford can also access extended specialist palliative nursing in the community provided by 'Hospice at Home', provided by St Ann's Hospice.
- Day care facilities offer a range of opportunities for assessment and review of patients' needs and enable the provision of physical, psychological and social interventions, within a context of social interaction, support and friendship. Complementary therapies are also offered at St Ann's Hospice.
- Support and advice to all the people involved in a patient's care.
- Bereavement support services are available at Salford Royal which provides support for staff and carers involved in a patient's care following the patient's death.
- The SPCT works closely with and is supported by the Education Team that consists of facilitators working within the hospital, community and care home setting.

Palliative Care is best delivered by a group of people working as a team. The team is collectively concerned with the total wellbeing of the patient and family. Some specialist palliative care nurses

are referred to as ‘Macmillan nurses’. The term ‘Macmillan nurse’ is used when Macmillan Cancer Support initially funded a post.

Meet the team

Specialist Palliative Care Team

Telephone: 0161 206 4609

Dr Katie Hobson

Consultant in Palliative Medicine

Dr Tim Jackson

Consultant in Palliative Medicine

Steve Gene

Assistant Director of Nursing

Palliative & End of life care

Angela Kelly

Clinical Nurse Specialist Palliative Care

Bernadette Wilcox

Clinical Nurse Specialist Palliative Care

Miriam Conhye

Clinical Nurse Specialist Palliative Care

Debra Morris

Clinical Nurse Specialist Palliative Care

Alison Maugham

Clinical Nurse Specialist Palliative Care

Lesley Campbell

Clinical Nurse Specialist Palliative Care

Beth Doughty

Clinical Nurse Specialist Palliative Care

Gail Ledger

Clinical Secretary/ MDT Co-ordinator

Gillian Jevon

Medical Secretary to:

Dr Katie Hobson & Dr Tim Jackson

Caroline Lloyd

Specialist Palliative Care Occupational Therapist (Hospital)

Ruth Hardie

Specialist Palliative Care Occupational Therapist (Community)

Andrea Hollinghurst

Palliative Care Social Worker

Practice Development Team

Telephone: 0161 206 2517

Victoria McLoughlin

Palliative & End of life Care Practice Development Lead

Caroline Rogers

Palliative & End of life Care Practice Development Lead (currently on secondment)

Marie Busuttil

Community End of Life Care Lead

0161 206 2534

Siân A Looker

Clinical Education Facilitator for Palliative & End of Life Care

Care Home trainer Team

Telephone: 0161 206 1868

Anne Mitchell

End of Life Care - Care Home Facilitator

Marie Roberts

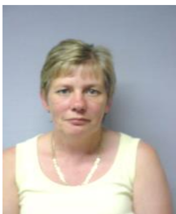
End of Life Care - Care Home Trainer

Jacqueline Kubis

End of Life Care - Care Home Trainer

Sarah Morrissey

End of Life Care - Care Home Trainer



Ann Williams

Support secretary Palliative Care

Referrals to the Team

A patient can be referred to the palliative care team for several reasons:

- Pain management
- Management of other symptoms
- Emotional/psychological support for the patient. Including support and information that may help decision making about care and treatment offered
- Emotional/psychological support for the carer. Helping families adjust to living/caring for a loved one with a serious or progressive illness.
- Referral to other palliative care services including hospice, community support from specialist nurses
- Rapid discharge home with specialist palliative care support
- Placements
- End of life care

How to refer?

A referral can be made via an electronic referral on EPR (Electronic patient Record (EPR) system)

The information required on a referral includes:

- Demographic information
- Reason for referral
- If the patient is aware of the referral
- If the carer is aware of the referral
- If the medical staff are aware of the referral

PLEASE ENSURE THAT ADEQUATE INFORMATION IS INCLUDED ON THE REFERRAL. THIS INFORMATION HELPS THE TEAM PRIORITISE TO ENSURE PATIENTS ARE SEEN IN A TIMELY MANNER.

Holistic Assessment of Patients' and Relatives' Needs

Assessment of needs is not new but the Department of Health's (DoH) NHS and Community Care Act (1990) makes it a legal requirement to assess the needs of the population. This challenges health professionals to make an accurate assessment of patient's needs and appropriate management plan that is the corner stone of care.

When assessing patient need it is important to take into account the patients priorities. There will be information that is essential to collect immediately and some information that can wait until a second or subsequent visit.

The principle factors which are important in any assessment include

- Developing a relationship of trust
- Identifying the patients and relatives need
- Prioritising the patients and families problems
- Developing a multiprofessional approach to need
- Making a diagnosis of nursing need

Initial Patient Assessment

- Why has the patient been admitted to hospital?
- What is the patient's past medical history?
- Has the patient had any other recent interventions? (CT Scans, MRI Scans.)
- Are there any other agencies involved? (Community Macmillan Nurse, Hospice Services, Disease Specific Specialist Nurses)
- What Physical problems is the patient experiencing?
- How is the patient affected psychologically?
- What are the patient's social circumstances?
- What gives the patient's life meaning?

SPARC Holistic Assessment Tool

The SPARC tools use in the hospital began following requirements to improve the process and content of patient assessment that was highlighted following the NICE Guidance in Improving Supportive and Palliative Care for Adults with Cancer (NICE 2004).

The document is aimed at highlighting the nature of care that should be provided to help patients and their carers. Such a tool also aids appropriate referrals to professionals.

A need for a holistic assessment tool has been endorsed by cancer networks nationally and it was accepted that many supportive and palliative care needs are still unrecognised and unmet for many patients and their families.

The SPARC tool stands for 'Sheffield Profile for Assessment and Referral of Care' (SPARC), and is designed to be completed by the patient (with support from the carers if needed). It is the starting point for the holistic needs assessment process.

As the SPARC tool is essentially a screening questionnaire the Hospital Palliative Care Team in Salford has decided to use it as an initial assessment document. The contents will be discussed with the Palliative Care Team professional and a plan formulated.

It is important that on completion of a SPARC tool the contents are actively discussed in a conversational style with the patient.

It is clear that not all patients will be able to complete a SPARC tool, for example those with cognitive impairment or the very frail and so where possible the patient will be assessed by the domains of the SPARC tool itself, rather than self-rating their concerns.

Palliative Care Link Champions

Research has highlighted that the actual practice of palliative care can be enhanced by link nurses on hospital wards (Cotterall, Lynch and Peters 2000, McKeeney 2003, Froggatt and Hoult 2002).

Salford Royal Foundation Trust palliative care 'link champions' are invited four times a year to SPLASH, **S**pecialist **P**alliative care **L**inks **a**cross **S**alford **H**ealth & social services study day**s**.

The term 'Link champions' refers to staff who are prepared to act as links between specialist services and the staff and patients in the clinical areas where they work. Palliative care Link champions are staff with a keen interest in palliative care.

Their responsibilities include;

- Acting as a role model
- Assisting to develop processes and systems that improve palliative care delivery in their clinical area
- Facilitate ongoing best practice palliative care in clinical settings
- Provide ongoing means of distributing palliative care updates to staff
- Assist in initiating policy and procedural change in clinical settings
- Promote the use of end of life care tools
- Identifies palliative care training and education needs of staff and works with their manager to enable training to be provided or accessed
- Attends Link nurse meetings and conveys information from meetings to clinical areas

The 'Link' role is underpinned by education and training, ensuring 'links' have the clinical knowledge to fulfil the requirements of the role. 'Link' meetings will be scheduled throughout each calendar year. The meetings will be hosted by Palliative and End of Life Care Facilitators.

Rapid Discharge Plan

The Rapid Discharge Plan was developed in response to an identified clinical need to enable imminently dying patients to die in their place of choice, when a clinical situation has changed rapidly and there has been an urgent request for a patient to die at home.

The aim of the Rapid Discharge plan is to facilitate a safe, smooth and seamless transition of care from hospital to community for patients at the end of life who choose to be cared for in their preferred place of care for their last hours and days of life.

The plan is initiated once a clinical assessment by the patient's multi-disciplinary team agrees that:-

1. The patient has an advanced, progressive medical condition.
2. The patient's condition is deteriorating.
3. All reversible causes for deterioration that could benefit from hospital treatment have been excluded.
4. Senior medical team (consultant or registrar) agree the above and the prognosis.
5. Patient wishes to be discharged from hospital for end of life care.

If support is needed with a rapid discharge home the SPCT/ facilitator will provide support to the ward team and family/ carer to ensure a comprehensive and safe discharge.

Advance Care Planning

The End of Life Care Strategy set out several key areas for improving end of life care. One of the areas identified for improvement was better co-ordination of services, so that end of life care supports patient's wishes and enable more patients to die in the place of their choosing with their individual care package.

Lord Darzi's report **Healthcare for London: A Framework For Action (2007)** identified, amongst other things, 'inconsistent approaches to supporting individuals to state their preferences for End of Life Care' due to factors such as lack of consistent systems for recording and updating end of life care preferences and communicating them to different healthcare professionals, and a lack of designated responsibility for documenting these preferences. The working group recommended the development of End of Life Care Registers as a means of providing an opportunity for a structured conversation about preferences, support, and anticipatory care planning.

Advance care planning (ACP) is a process through which a patients preferences of care can be elicited, discussed and documented.

(GMC, 2009; Royal college of Physicians, 2009; DH 2008).

ACP will usually take place in the context of an anticipated deterioration in the individual's condition in the future.

There are several tools that can be used. “Planning my future care” has superseded the “Preferred Priorities for care” document. “My wishes: My lung care”, and “My wishes: My kidney care” are person centred hand held records of an individual's preferences and priorities for care, designed to facilitate patient choice in relation to end of life care issues.

If the individual wishes, their family and friends may be included in discussions. These discussions should be documented, regularly reviewed and communicated, with the individuals agreement, to key person's involved in their care. An ACP might include the individual's concerns, their important wishes, values or personal goals for care, their understanding about their illness and prognosis, as well as particular preferences for types of care or treatment that may become necessary in the future. It allows the patient to make specific statements about their wishes as they approach the end of life. The patient should be encouraged to show the document to all the people who are involved in their care. Through good communication and by documenting patient and carer choices they may become empowered through the sharing of information with all professionals involved in their care.

ACP provides the opportunity to discuss sensitive issues that may not otherwise be discussed or addressed. Explicit recording of patient and carers wishes can form the basis of appropriate care planning minimising inappropriate admissions and interventions.

Electronic Palliative Care Co-ordination Systems (EPaCCS) known in Salford as “Communicate my care” has been developed in Salford to communicate end of life information and discussions with patients in the last year of life. When patients are identified as being in the last years of life

- ACP discussions offered
- Consent gained to share information
- Communicate my care entry completed
- Once saved information is disseminated to healthcare professionals involved in the care

Six Steps to Success in Care Homes

The end of life care strategy (Department of Health 2008) recognised that a high number of care home residents are inappropriately admitted to hospital during the last year of their life. A high proportion of these residents die on hospital wards, in an unfamiliar environment with little or no control over their care. This highlighted a need for investment and training in end of life care education for care home staff.

The route to success in end of life care-achieving high quality in care homes (2010) outlines a workshop style step by step approach to training taken from the National End of Life Care Quality Markers. The programme aims to facilitate organisational change within Care Home and supports staff to develop in their roles.

In Salford the programme takes approximately a year to complete and the care home representatives attend a work shop each month. The representatives are then tasked with actions to complete within the care home. The progress of each care home is monitored closely and monthly support visits are completed by the end of life care facilitator. The title of each workshop is described below-

Induction and Step 1- Discussions as end of life approaches

Step 2- Assessment, care planning and review

Advance care planning, communication skills and

Step 3- Co-ordination of care

Step 4- High quality care, environment and dignity

Step 5- Care in the last days of life

End of life Care Plan Study Day

Step 6- Care after death

Audits are completed by the care home representatives throughout the programme.

Which include:-

Knowledge and skills audit

Pre programme post death audit

On-going post death audit

Quality markers audit

This data provides the home with the evidence to support the changes and is often presented to CQC, safeguarding and commissioners to highlight their good practice.

The Care Home End of Life Care facilitator works collaboratively with the wider health and social care community teams including safeguarding, NHS funded care, the district nursing service and the Salford Care Homes Medical Practice.

If you want further information on the Six Steps Programme please contact the team on 206 1868

Palliative care placements

Hub and Spoke placement staff need the learners to decide which 'spokes' / experiences will enable them to achieve their objectives /outcomes and liaise directly with the relevant staff to arrange, in conjunction with their mentor. This is not an exhaustive list (table below) however the palliative care team will make every effort to work with the learner to meet their objectives, educational needs and spoke placement needs.

Placement	Contact Person	Telephone
Bereavement Office	Louise Jones	0161 206 5175
Bereavement Specialist Nurse	Melanie McDougall	0161 2068341
Care Homes Trainer team	Anne Mitchell	0161 2061868
Community Palliative Care Specialist Nurses	Kathryn Waiganjo	0161 7025406
Coroner's Court (Bolton)	See Caroline Rogers/ Victoria McLoughlin	0161 206 8532
End of Life Care Support Workers (Community)	Victoria Allen	07810 153332
Hospice@Home Team	Nurse in charge	0161 7025405
Macmillan Cancer Information Service	Ian Ainscough	0161 2061455
Mortuary	Michael Coombes	0161 2064482
Pain Team	Martin Howarth	0161 2064169
Palliative Care Pharmacist	Kath Mitchell	07623617115
Palliative Care Occupational Therapists	Caroline Lloyd Ruth Hardie	0161 2064609
Palliative & End of Life Care	Andrea Hollinghurst	07713998344

Social Worker		
Palliative Care & Bereavement counselling service	Victoria Wilmot	0161 206 2362
St. Ann's Hospice Inpatient Unit	Nurse in charge	0161 7028181
Tissue Donation Centre (Speke)	Adam Edwards	07872636799
Dementia Team	Janice McGrory	0161 2060447
Specialist Nurses in Organ Donation	Amy Preston Alison Toyne	0161 206 8014 07889304118
Chaplains	Jennifer Hood	0161 2065617

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HELPFUL WEBSITES

- http://www.nhs.uk/Planners/end-of-life-care/Pages/planning-ahead.aspx
- http://www.dyingmatters.org/overview/why-talk-about-it
- http://www.cancerresearchuk.org/cancer-help/coping-with-cancer/dying/
- http://www.helpthehospices.org.uk/about-hospice-care/
- https://www.gov.uk/make-will

- http://www.macmillan.org.uk/Cancerinformation/Livingwithandaftercancer/Relationshipscommunication/Talkingtochildren/Ifyouarenotgoingtorecover.aspx
- http://www.cruse.org.uk/
- http://www.bereavementadvice.org/
- http://www.mariecurie.org.uk/en-GB/patients-carers/for-patients/end-of-life-nurse-hospice-services/
- http://www.ncpc.org.uk/
- http://www.endoflifecare.co.uk/journal.shtml
- http://www.scie.org.uk/adults/endoflifecare/index.asp
- http://www.endoflifecare-intelligence.org.uk/home
- http://www.nao.org.uk/report/end-of-life-care/
- http://publications.nice.org.uk/quality-standard-for-end-of-life-care-for adults-qs13
- http://www.endoflifecumbriaandlancashire.org.uk/six_steps.php
- http://www.nhsiq.nhs.uk/8203.aspx
- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136486/End-of-Life-Care-Strategy-Fourth-Annual-report-web-version-v2.pdf

Palliative & End of Life Care Journals

International Journal of Palliative Nursing

The leading journal for nurses working in palliative and hospice care.

BMJ Supportive & Palliative Care

An international journal that aims to improve supportive and palliative care for patients through research, evidence and innovative practice.

Journal of the European Association for Palliative Care

Established in 1994 to provide an information and communication resource for all professionals involved in the provision of palliative care across Europe. The EJPC is an official journal of the European Association for Palliative Care (EAPC)

End of Life Journal

Free journal for nurses caring for dying people at home, in hospitals and care homes.

BMC Palliative Care

An open access, peer-reviewed journal that considers articles on the clinical, scientific, ethical and policy issues

Journal of Palliative Medicine

Peer-reviewed journal covering medical, psychosocial, policy, and legal issues in end-of-life care and relief of suffering for patients with intractable pain.

Journal of Palliative Care

Publishes important and compassionate advances in discoveries of Palliative Care that builds our understanding of, and treatment of, end of life treatment.

Search on-line for other palliative & end of life care journals.

End of Life Care for All (e-ELCA) is an e-learning project, commissioned by the Department of Health and delivered by e-Learning for Healthcare (e-LfH) in partnership with the Association for Palliative Medicine of Great Britain and Ireland to support the implementation of the Department of Health's national End of Life Care Strategy (July 2008).

e-ELCA aims to enhance the training and education of health and social care staff involved in delivering end of life care to people, so that well-informed high quality care can be delivered by confident and competent staff and volunteers, across health and social care, wherever the person happens to be.

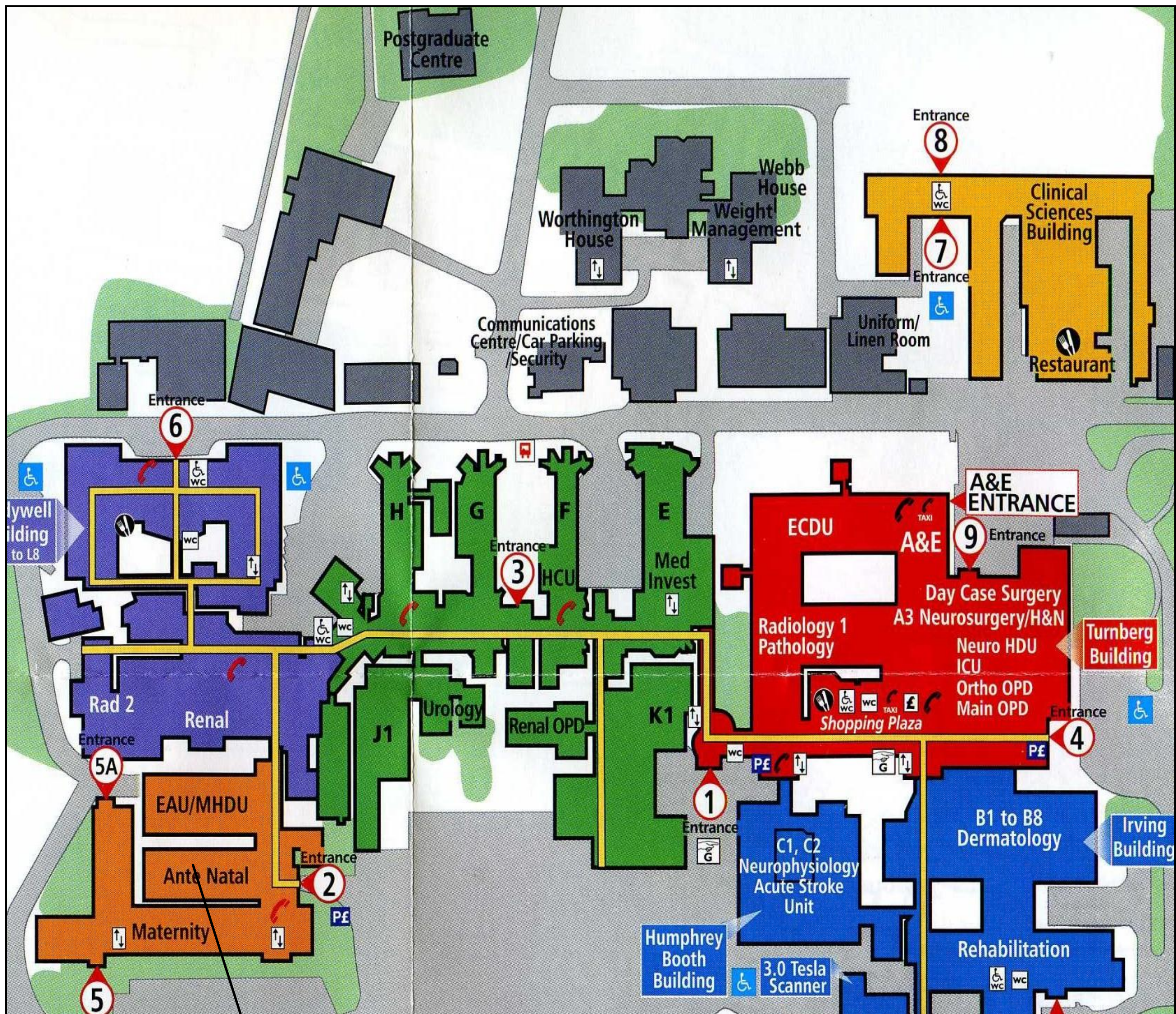
There are over 150 highly interactive sessions of e-learning within e-ELCA. These are arranged in 4 core modules:

- Advance Care Planning
- Assessment
- Communications Skills
- Symptom Management, comfort and well being

as well as 3 additional modules (social care, bereavement and spirituality) and one Integrating Learning module which helps to consolidate and apply understanding in different situations. Click here to see the range of sessions available.

Fourteen of these sessions are also freely available to volunteers and clerical and administrative staff on an open access website: www.endoflifecareforall.org.uk. For further details see 'Access the e-learning'.

Departmental Map



Palliative Care office 2nd Floor