Document Title:	**SPECIALIST PALLIATIVE CARE OPERATIONAL POLICY**		
Document Reference/Register no:	13004	**Version Number:**	3.0
Document type: (Policy/ Guideline/ SOP)	Policy	**To be followed by:** (Target Staff)	All staff
Ratification Issue Date: (Date document is uploaded onto the intranet)	18th June 2019	**Review Date:**	17th June 2022
Developed in response to:	National Performance Indicators Service Needs NICE guidance		
Contributes to HSC Act 2008 (Regulated Activities) Regulations 2014(Part 3); and CQC Regulations 2009 (Part 4) **CQC Fundamental Standards of Quality and Safety:**			12
Issuing Division/Directorate:	Cancer Services		
Author/Contact: (Asset Administrator)	Matt Riddleston, Lead Cancer Nurse, Cancer Services Senior Nursing		
Hospital Sites: (tick appropriate box/es to indicate status of policy review i.e. joint/ independent)	✓MEHT □ BTUH □ SUH		
Consultation:	(Refer to page 2)		
Approval Group / Committee(s):	n/a	**Date:**	n/a
Professionally Approved by: (Asset Owner)	Dr Srirupa Gupta, Consultant, Palliative Care - Medical	**Date:**	10th May 2019
Ratification Group(s):	DRAG Chairman's Action	**Date:**	17th June 2019
Executive and Clinical Directors (Communication of minutes from Document Ratification Group	**Date:** June 2019	**Distribution Method:**	Trust Intranet/ Internet

Consulted With:	Post/ Approval Committee/ Group:	Date:
Dr Claire Plunkett Dr Eva Lew	Consultants in Palliative Medicine	April 2019
Wendy Pearson, Tracy Hung, Faye McDowell, Louise Cook, Beverley Trew	Macmillan Clinical Nurse Specialists in Palliative Care and End of Life Care Facilitator	April 2019
Ruth Byford		23rd May 2019

Related Trust Policies (to be read in conjunction with)	04071 Policy for Standard Infection Prevention Precautions 08092 Mandatory Training Policy 04090 Moving and Manual Handling 04083 Fire Safety Policy MSBPO-18006 IT Information Technology (Cyber) Security Policy Patient Safety 08086 Clinical Record Keeping Standards 09124 Cancer Services Clinical Operational Policy 06059 The Care of the Dying Person and the Handling and Care of the Deceased policy 15001 MEHT Spiritual care Policy 07064 Breaking Bad News

Document Review History:			
Version No:	**Authored/Reviewer:**	**Summary of amendments/ Record documents superseded by:**	**Issue Date:**
1.0	Matt Riddleston		23rd May 2013
1.1	Matt Riddleston	(remove ref. to LCP on page 11)	23rd Sept 2013
1.2	Matt Riddleston	General review and update	February 2016
2.0	Matt Riddleston	General review and update	3 May 2016
3.0	Matt Riddleston	Full Review	18th June 2019

Index

1. Purpose

1.1 To define the Specialist Palliative Care service provided by Mid Essex Hospital Services NHS Trust.

1.2 The key objective of the service is to reduce distress caused by a life-limiting diagnosis through offering specialist symptom management advice and emotional/psychological support whilst a person is within the Trust.

1.3 This policy is intended to evidence the differences between the provision of generalist palliative care provided by the Trust, and the specialist service provided by the team.

1.4 This document includes national initiatives that pertain to specialist palliative care which are listed in the references

2. Background

2.1 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, are 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. (Improving Supportive and Palliative Care for Adult with Cancer NICE Guidelines 2004)

2.2 Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life threatening illness, through prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychological and spiritual (WHO, 2004)

2.3 It is important to differentiate between specialist and generalist Palliative Care as an integral part of all clinical practice, whatever the illness or its stage.

2.4 Generalist palliative and supportive care should be provided by all health care professionals. It can be delivered throughout the patient's journey but may need to be re-evaluated at key stages which include:

- Time of diagnosis;
- Commencement of disease treatment;
- Completion of primary treatment plan;
- Disease recurrence or relapse;
- The point of recognition of incurability;
- End of life care/Bereavement;
- Other times requested by the patient/carer.

2.5 Specialist palliative care is provided by a multi professional team who have completed recognised specialist palliative care training.

2.6 The hospital specialist palliative care team becomes involved with patients with complex need. This often reflects a number of problems across the physical, psychological, social or spiritual domains. A major element within the role of specialist palliative care is the education and support of staff, thus empowering them to provide generalist palliative care.

2.7 The hospital specialist palliative care team :

- Undertakes detailed holistic assessments of the needs of the patient across physical, psychological, social and spiritual domains;
- Undertakes review of patients who are identified as end of life and where the Individualised last days of life care plan has been initiated;
- Provides expert advice on management of complex symptoms;
- Provides advice in situations of ethical complexity;
- Supports colleagues, patients and carers with advice and information on palliative care issues;
- Facilitates education and training across a variety of topics and according to local need, such as symptom control, advance care planning, support for the use of tools such as individualised last days of life care, communication skills training, etc.

2.8 The specialist palliative care team may make direct contact with patients and carers, or may act in an advisory capacity to support referring healthcare professionals in their own delivery of care.

3. Staffing

3.1 The MEHT specialist palliative care service consists of:

- Consultant in Palliative Medicine 1.0 wte;
- Macmillan Lead Nurse in Cancer and Palliative Care 1 wte;
- Palliative Care CNS 3.2 wte band 7;
- Palliative Care Nurse 1 wte band 6;
- Admin and clerical support 0.38 wte band 3;
- Facilitator for End of Life Care 1 wte.

3.2 When fully staffed a minimum of 2 CNS's Monday- Friday, 1 CNS at weekends, and 1 CNS for the locality specialist palliative care MDT are required to maintain the service. Should levels fall below this; contingency measures will be put in place following consultation with the lead nurse.

3.3 A minimum of one consultant is available for discussion on a daily basis for patient review or telephone advice.

3.4 Consultant review of patients as clinically indicated.

3.5 Weekend working will only continue so long as 4.6 WTE are in post and at work. Should establishment decrease due to vacancy, sickness or other absence a review of the service will take place immediately with the Lead Nurse and remaining team members.

3.6 Staff will have the opportunity via appraisal to develop in line with service and personal objectives and are given the opportunity to attend specialist palliative care events and conferences.

4. Service Availability

4.1.1 The service is available 7 days per week between the hours of 08:00 and 18:00 hours. Out of hours (17:00 to 08:00) advice can be obtained from the palliative medicine consultant on call regarding specialist symptom management via hospital switchboard.

4.1.2 Should staff sickness occur on a weekend the staff member will notify the service co-ordinator and on-call Consultant immediately. If a CNS is not available and cover cannot be arranged, Out of Hours Consultant cover will be available to the clinical teams on call via switchboard for that weekend as usual

4.1.3 Information for staff relating to palliative care and end of life can be accessed via the Trust intranet
http://meht-intranet/clinical-pages/palliative-end-of-life-care/

4.2 **Weekend Working**

4.2.1 NICE guidance recommends the need for palliative care patients to have face to face access to specialist palliative care 7 days per week.

4.2.2 The team will prioritise new patients referred over the weekend and current patients who are registered as HIGH priority (patients of MEDIUM and LOW priority will not be seen routinely unless their priority status changes).

4.2.3 Referrals will continue to be received on LORENZO and triaged on Saturday, Sunday, and bank holiday mornings (as per referral criteria).

4.2.4 Urgent contact can be made with the team via the weekend pager #6555 2052. Other pagers are not in use for weekends/bank holidays.

4.2.5 Team will be supported at weekends by the Consultant in Palliative Medicine who is available for telephone support.

5. Referral Criteria

5.1 Referrals are accepted on the basis of need, not diagnosis, and the service is available to all wards and departments within the Trust**.**

5.2 Referral criteria (refer to Appendix 1) are attached and should be adhered to.

5.3 Referrals to hospital specialist palliative care team can be made by any appropriate health care professional.

5.4 Patients or family/carer can request a referral but a referral will need to be completed by the appropriate clinical team.

5.5 All referrals should be made following discussion and agreement with the medical/nursing team.

5.6 Initial referral is made by LORENZO. In urgent cases only, referral can be made by telephone or pager but must be supported by a referral.

5.7 The clear reason for a referral, and the urgency of the referral, must be identified.

5.8 Urgent referrals will be addressed within one working day of receiving referral. For non-urgent referrals, contact is made within two working days.

5.9 For patients requiring immediate assistance contact should be made as soon as possible via the paging system.
(Refer to point 5.6)

5.10 All new referrals are assessed, triaged and prioritised according to urgency.

5.11 Clinical contact is implemented through three levels of intervention: low, medium and high.

- **LOW** Advice for staff, no contact with the patient/family/carer. Triage form completed by member of HSPCT and recorded in patients' hospital record;
- **MEDIUM** Short-term intervention with patient/family/carer for specific problems requiring assessment**.** Also those patients previously on 'High' who have responded to specialist interventions**;**
- **HIGH** Complex physical, emotional, psychosocial, spiritual issues of patient and or family requiring specialist daily input following unsuccessful first line treatments/ or review of interventions.

5.12 All new patients will be discussed at the weekly locality palliative care MDT meeting at Farleigh Hospice. Discussion and agreed care plan to be documented on the MDT pro forma and placed in patients' medical notes. If consent has been gained MDT outcome will documented on System 1.
MDT discussion and outcome will be recorded in patients' medical record.

5.13 Patients who are placed on the Individualised last days of life care plan will be reviewed by a member of the HSPCT. Patients are identified by VITALPAC system or referral from clinical area via LORENZO.

6. Scope of the Service

6.1 The service supports the care of patients who are accessing services at MEHT (this includes inpatients, outpatients and A and E).The facilitator for end of life care works collaboratively with the team, supporting clinical areas with the delivery of care through the use of effective evidence based practice in line with agreed national standards.

Patients in the community setting will be referred to the appropriate team; inpatients at Farleigh Hospice will be under the care of the Farleigh Hospice clinical team.

6.2 **Inclusion Criteria**

6.2.1 Patients aged 18 and over, who have a life-limiting illness.

6.2.2 People who are accessing other services at MEHT e.g. in-patients, attending a clinic at the Trust.

6.3 **Exclusion Criteria**

6.3.1 Patients under the age of 18.

6.3.2 The team will not be able to see patients who only require discharge planning from MEHT – patients who are imminently dying and PPD is home will be referred to the Farleigh hospice in reach team for rapid discharge.

7. Work Flows

7.1 Patients enter the specialist palliative care service from both the emergency and out-patient pathways. Please see appendix 2 for detailed work flows.

8. Patient Information

8.1 Patients and relatives are given a hospital specialist palliative care team leaflet plus business card on the first visit.

8.2 Further information needs are assessed by the CNS according to patient/carer diagnosis and request. Information can be accessed through NHS Choices Electronic Prescriptionswww.nhs.uk, NICE and the Macmillan website. Commonly requested leaflets are kept in the specialist palliative care Office for immediate dissemination or patients/carer's can be signposted to the Macmillan Information pod.

9. Bereavement

9.1 The significant other of the patient will be given the Trust's bereavement booklet by ward staff at the time of a patient's death. This contains contact details of local bereavement support groups. The Bereavement Office provides additional information to next of kin/relatives when they attend to collect the notification of death.

9.2 The significant other of patients, who have died in Mid Essex Hospital Services Trust (MEHT) and previously under the care of Farleigh hospice, will be followed up by the Mid Essex Adult Bereavement service, Circle if they have consented to this service.

9.3 The significant other of the patient who have not been previously under the care of Farleigh hospice but have been seen by the hospital specialist palliative care team are sent a letter detailing Circle's service after the patient's death, if they live in the Mid-Essex area.

10. Medical Records Management

10.1 All patients' specialist palliative care records will be managed confidentially at all times and stored securely in locked office when not in use.

10.2 After the patient's death, the specialist palliative care records are combined with the patient's medical record.

11. Multi-Disciplinary Team Meetings

11.1 The team are core members of the locality specialist palliative care MDT jointly undertaken with the palliative care team based at Farleigh Hospice. There is a separate operational policy to detail this meeting and key responsibilities.

11.2 The team provides core membership support to the lung cancer, upper GI, HPB, CUP and Renal MDT's providing more than two CNS's are on duty.

11.3 The team are available to attend other site specific MDT's (cancer and non-cancer) following discussion with the site specific CNS or lead clinician when expert specialist palliative care advice is required.

12. Education

12.1 The Hospital Specialist Palliative Care Team deliver education for medical, nursing and allied health care professionals based at MEHT e.g. Trust induction, Preceptorship programme, Health Care Assistant and Healthcare Professionals study days, regular participants in the medical training programme.

12.2 The team support both in-house and locality wide education programmes in palliative and end of life care for all interested health and social care professionals.

13. Audit

13.1 The team carry out regular audits to assess and improve care for patients within the Trust. Opportunities to undertake audit are taken as staffing levels permit and presented to the oncology audit meeting and others as appropriate.

14. Service Management

14.1 The clinical lead is Dr Srirupa Gupta (consultant in palliative medicine) supported by Dr Eva Lew , Dr Claire Plunkett and Dr Zoe Helman (consultants in palliative medicine).All consultants work in the hospital as well as Farleigh hospice.

14.2 The day to day operational responsibility lies with the Macmillan lead nurse for cancer and palliative care.

14.3 The budget is held by the Macmillan lead nurse for cancer and palliative care.

14.4 The strategic planning for the service is a partnership between the consultants, the Macmillan lead nurse for cancer and palliative care, and the clinical nurse specialists, and is in keeping with the wider Trust and locality objectives.

14.5 Palliative care reports to the Directorate of Clinical Oncology, Haematology and Related Services via the Macmillan lead nurse for cancer and palliative care.

14.6 HSPCT activity is recorded on Info-flex. This includes reason for referral; diagnosis; length of stay; number of contacts; level of intervention; outcome.

14.7 Monthly activity reports will be circulated to all team members.

14.8 An annual report will be completed and circulated to team members, clinical lead and corporate team.

15. Information Security

15.1 Patient identifiable data or sensitive data will not be emailed out of the Trust unless the information is encrypted or sent from and to an nhs.net account or by encrypted attachment.

15.2 Patient information must never be downloaded onto any unencrypted mobile device.

15.3 All routine sharing of patient information must be agreed with a signed Data Sharing Agreement.

15.4 All routine data flows in and out of the service that include person identifiable information must be recorded and notified to the information governance manager.

15.5 All staff must adhere to the Trust information governance and IT security policies listed in the Information Governance Handbook.

16. Auditing this Policy

16.1 Breaches of this policy will be reported via the datix web system, where trends can be identified and brought to the attention of the management and clinical stakeholders. This will include failure/breakdown of equipment impairing service delivery, management of staff sickness and resultant treatment capacity deficits.

16.2 Directorate Governance Group Meetings will be supplied with datix trend data, and incidents requiring immediate assessment will be fed back directly.

17. Equality Impact Assessment

17.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.
(Refer to Appendix 4)

18. References

National Palliative and End of Life Care Partnership Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020
National Palliative and End of Life Care Partnership
www.endoflifecareambitions.org.uk

National Institute for health and Care Excellence (2015) Care of dying adults in the last days of life: NICE guidelines [NG31] London: NICE
https://www.nice.org.uk/guidance/ng31

National Institute for health and Care Excellence (2017) Care of dying adults in the last days of life Quality Standard (QS 144). London: NICEhttps://www.nice.org.uk/guidance/qs144

National Council for Palliative Care (2012) Commissioning Guidance for Specialist Palliative Care: Helping to deliver commissioning objectives.
Department of Health (2011) End of Life Care Strategy: 3rd Annual report. London: Department of Health

National Institute for health and Care Excellence (2004) Improving Supportive and Palliative Care for Adults with Cancer. Cancer Service Guideline (CSG 4) London: NICE https://www.nice.org.uk/guidance/csg4

Preferred Priorities of Care http://endoflifecareambitions.org.uk/wp-content/uploads/2016/09/preferred_priorities_of_care_pdf.pdf

LiveWell - DieWell Strategy Mid Essex 2016-2020

National Institute for health and Care Excellence (2012) Palliative care for adults: strong opioids for pain relief
Clinical guideline [CG140] London: NICE
https://www.nice.org.uk/guidance/cg140

Appendix 1

Mid Essex NHS Hospitals Trust
Broomfield Hospital
Chelmsford

Referral Criteria for the Hospital Specialist Palliative Care Team

Palliative care is shared with the hospital clinical admitting/caring team and/or Hospital Specialist team.

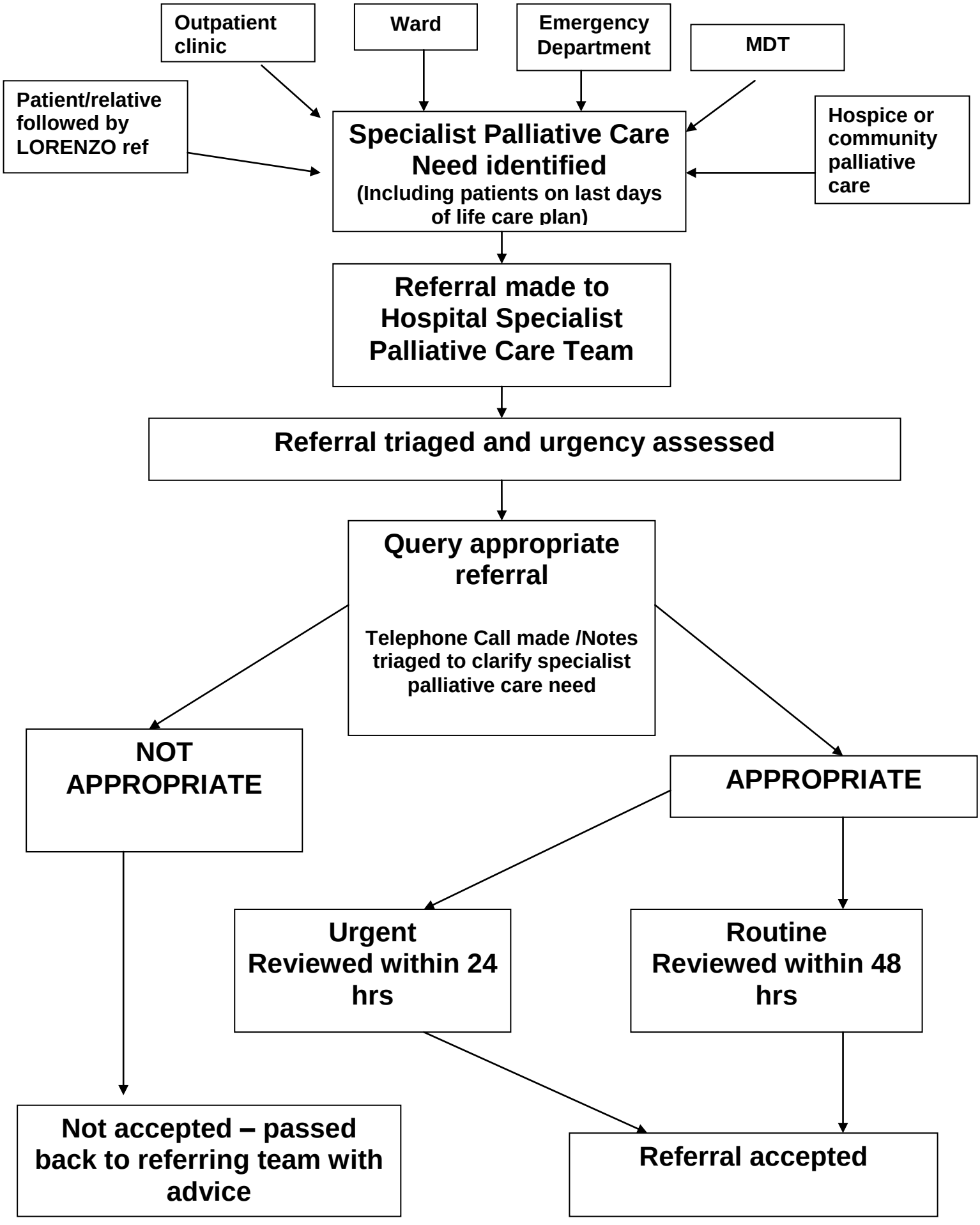
Hospital Specialist Palliative Care Team will be involved in providing advice to the clinical team.

Hospital Specialist Palliative Care Team involvement may be for the duration of a particular problem or on-going until death and bereavement or discharge.

While referring to Hospital Specialist Palliative Care Team, the following should be considered
• Progressive incurable disease *or* the patient has refused treatment if has capacity to do so • There are complex symptoms, psychosocial or ethical issues important to the patient /carers, secondary to the life-threatening disease that cannot readily be managed by the team responsible for care. Symptoms may include pain, nausea/vomiting, secretions, breathlessness, agitation where first line treatment was initiated but not effective • Patient is in the terminal phase and staff need support/education while commencing appropriate treatment • The patient agrees to referral to the Hospital Specialist Palliative Care Team if they have capacity. • If the patient does not have capacity referring team should complete MCA 2 and make referral for patient “in best interest” • Patient is currently an in-patient at Broomfield Hospital • Patient has been identified as at end of life and an individualised last days of life care plan has been initiated • Patient is above 18 years of age

Appendix 2

Work Flow Chart



Appendix 3

Link to Specialist Palliative Care Team Information

http://meht-intranet/clinical-pages/palliative-end-of-life-care/

http://www.meht.nhs.uk/services/a-z-of-clinical-services/c-services/cancer-services/

Appendix 4: Preliminary Equality Analysis

This assessment relates to: Specialist Palliative Care Operational Policy (13004)

A change in a service to patients		A change to an existing policy	**X**	A change to the way staff work	
A new policy		Something else (please give details)			

Questions	Answers
1. What are you proposing to change?	Full Review
2. Why are you making this change? (What will the change achieve?)	3 year review
3. Who benefits from this change and how?	Patients and clinicians
4. **Is anyone likely to suffer any negative impact as a result of this change?** If **no**, please record reasons here and sign and date this assessment. If **yes**, please complete a full EIA.	No
5. a) Will you be undertaking any consultation as part of this change? **b) If so, with whom?**	Refer to pages 1 and 2

Preliminary analysis completed by:

Name	Matt Riddleston	**Job Title**	Lead Cancer Nurse, Cancer Services Senior Nursing	**Date**	May 2019