

**University Hospitals of North Midlands Hospital Specialist Palliative Care Team**

**Operational Policy**



**UHNM Hospital Specialist Palliative Care Team**

Agreement Cover Sheet

This policy has been agreed by:

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| **Position: Lead Clinician of the MDT** |
| **Name: Sarah Kelt** |
| **Organisation: University Hospitals of North Midlands** |
| **Date agreed: 21.08.2019** |

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| **Position: Lead Clinician of the host organisation** |
| **Name: Chris Luscombe** |
| **Organisation: University Hospitals of North Midlands** |
| **Date agreed:**  |

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| --- |
| **Position: Core Members of the MDT (12-3R-112)** |
| **Organisation: University Hospitals of North Midlands** |
| **Date agreed: 21.08.2019** |

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**1 Introduction**

* 1. The Hospital Specialist Palliative Care Team provides specialist palliative care services for the University Hospitals of North Midlands NHS Trust at the Royal Stoke University Hospital (RSUH) and County Hospital site.
	2. In practice the hospital palliative care team employ the definition of palliative care as identified by the World Health Organization as:

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 the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. 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 patient’s illness and in their own bereavement; uses a team approach to address the needs of patients and their families; enhances 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, and includes those investigations needed to better understand and manage clinical complications. Palliative care can be provided by a range of health and social care staff and may be done alongside treatment intended to reverse particular conditions.

1.3 The Hospital Specialist Palliative Care Team aim to deliver specialist level palliative care which is defined as:

Specialist level palliative care is required by people with progressive life-limiting illness, with or without comorbidities, where the focus of care in on quality of life and who have unresolved complex needs that cannot be met by the capability of their current care team. These needs may be physical, psychological, social and/or spiritual. Examples include complex symptoms, rehabilitation or family situations and ethical dilemmas regarding treatment and other decisions. Specialist level palliative care is delivered by a multidisciplinary team (MDT) of staff with the requisite qualifications, expertise and experience in offering care for this group of people, to support them to live as well as possible during their illness, ensuring their comfort and dignity are maintained as they come to the end of their lives. Input from specialist level palliative care professionals to the care of a person must be based on the needs of the person and not the illness they have. The Specialist Level Palliative Care (SLPC) MDT works with the person to develop their individualised plan of care, including where they prefer it to be delivered. This plan is regularly reviewed to reflect the changing needs of the person and to ensure that care is provided by the most suitable health or social care professional(s). This may be facilitated through shared service agreements. The main components of specialist level palliative care include, but are not limited to:

* in depth specialist knowledge to undertake assessment and management of physical, psychological and spiritual symptoms to reduce symptoms, suffering and distress;
* supporting analysis of complex clinical decisions-making challenges where medical and personal interests are finely balanced by applying relevant ethical and legal reasoning alongside clinical assessment; providing care and support to those important to the person receiving care, including facilitating bereavement care;
* providing specialist advice and support to the wider care team which is

 providing direct core level palliative care to the person.

1. **Team core membership, roles, responsibilities and MDT cover**

2.1 Core team membership and roles RSUH12-3R-101

|  |  |  |  |
| --- | --- | --- | --- |
| **Role** | **Name of core members** | **Additional responsibility** | **MDT cover** 12-3R-106 |
| Consultant in Palliative Medicine | Sarah KeltClaire HookeyCaroline Bruckner-HoltKirsten Tay | SPC Lead clinician | Each other |
| Palliative Care Nurse Practitioners/CNS | Nicki MorganFiona ReadCharlotte ScottLisa CooperLouise MasseyTrish O’NeillNicola AdamsDanielle JervisCarina LoweMaggie HoganClare Darlington | Lead nurseLead for patients’ and carers’ issuesandLevel 2 Psychology practitionerLead for audit, research and recruitment into clinical trials12-3R-101 | Each other |
| MDT co-ordinator | Hazel Bevington |  | Claire Rogers |

2.2 Extended team membership and roles RSUH12-3R-114

|  |  |
| --- | --- |
| **Name**  | **Role** |
| Charmaine Butcher | EOLC facilitator |
| Claire Rogers | Clinical administrator |
| Michelle Palmer | Clinical Psychology |
| Laura Bates, Caroline GilbertShona Tolmie-Fisher | Occupational therapy |
| Leo Varquez/Chris Wright/Vivienne Flanaghan/ Father Michael PuljicVlahic | Chaplains |
| Victoria Poole | Bereavement Services |
| Sue Thomson  | Pharmacist |
| Dr Emer McKenna  | Consultant in Palliative Medicine |
| PCNS by rotation | DMH community palliative care team |
| Paul Garner | Nurse Consultant |
| Dr Rajanee Bhana | Consultant oncologist |
| Beccy Elwell  | Lymphoedema CNS |
| Claire Cooper, Rachel Agar, Maggie Brennan, Sue Dodd | Stafford Macmillan Team |
| Katrina Brown, Dr. Stala Polyviou, Rebekah Bourne, Carina Lowe | KHH |

2.3 Responsibilities of lead clinician

The clinical lead is Dr Sarah Kelt. 12-3R-101 This is agreed with Mr Chris Luscombe, Trust Lead Cancer Clinician.

* Overall responsibility for ensuring that the MDT meeting and the team itself meet Peer Review Quality Measures.
* Maintain the multidisciplinary core and cover membership and inform Cancer Services Team of any change.
* Ensure attendance levels of core members are maintained in line with Quality Measures.
* Provide a link, either by personal attendance or delegation to the Network.
* Lead on, or nominate a Lead for service improvement.
* Ensure MDT activities are audited and results documented.
* Ensure that outcomes of the MDT are clearly recorded, clinically validated and that appropriate data collection is supported.
* Ensure that communication of the MDT decision to primary care takes place according to Quality Measures.
* Organise and chair at least one meeting a year of the MDT, the purpose of this meeting to include the review of team function and operational policies.
* To work with the MDT to develop patient pathways and protocols to refer to other centres where appropriate.
* Collate any activities that are required to ensure optimal functioning of the team (e.g. training team members).
* Maintain the Cancer MDT key documents for inspection by Cancer Services Team and Peer Review as required.
* To meet twice a year with the Cancer Services Management team for discussion on progress and difficulties with the service.
* Inform the Cancer Services Team on an ad hoc basis of immediate difficulties that cannot be resolved with the MDT, so that documentation and possible solutions can be instigated in partnership with the directorate manager.
* To meet with the head of department of the directorate in which the cancer site belongs to negotiate up to 0.5 programmed activities in recognition of this post.

2.4 Responsibilities of core nurse members 12-3R-112

* Contribute to the MDT discussion and patient assessment/care planning decision of the team at their regular meetings
* Provide expert nursing advice and support to other health care professionals in this specialist area of practice
* Act as the access route to other members of the MDT for patients/carers who wish to discuss problems or concerns
* Ensure involvement in clinical audit
* Lead on patient communication issues and co-ordination of the pathway for patients referred to the team, acting as the key worker or responsible for nominating the key worker for the patient’s dealings with the team.
* Ensure that results of patients’ Holistic Needs Assessment are taken into account in the decision making.
* Contribute to the management of the service
* Utilise research in this specialist area of practice

2.5 Core team members’ specialist study 12-3R-111, 12-3R-113, 12-3R-102, 12-3R-103

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| --- | --- | --- | --- | --- | --- | --- |
| **Name** | **Degree** | **Higher degree** | **Physical****Assessment** | **V300****Independent/****Supplementary****Prescribing** | **Advanced****Communication****Skills** | **Level 2****Psychological****Support** |
| NicolaMorgan | BSC (Hons) Community Health 1999BSC (Hons) Nursing Studies 1995 | MA Ethics in Cancer and Palliative Care 2012 | 2015 | 2008 | 2012 | 2012 |
| LouiseMassey | BSC (Hons) Specialist Practitioner – District Nursing 2001 | MA Ethics in Cancer and Palliative Care2012 | 2005 | 2013 | 2011 | 2012 |
| LisaCooper | BSC (Hons) Nursing 2005BSC Palliative and end of life care module. (20 credits) |  | 2009 | 2014 | 2010 | 2012 |
| Trish O’Neill | Acute care module 2009Intermediate care module 2008 |  | Masters level module 2013 | 2014 | 2012 | 2012 |
| Nicola Adams | BSc Adult Nursing Practice2007 | MSc module- research methodology2013 | 2015 | 2017 | 2011 | 2015 |
| Danielle Jervis | Generic Pathway – on-going |  |  |  | 2016 |  |
| Carina Lowe | Diploma in HE Adult Nursing 2009 |  | 2017 | In progress 2018 | 2016 |  |
| Charlotte Scott | BSc (Hons) Adult Nursing 2006 |  |  |  | 2012 | 2012 |
| Sarah Kelt | MBChB |  | NA | NA | 2005 | 2012 |
| Claire Hookey | MBBS | MSc Palliative MedicinePGCMedEd 2018 | NA | NA | 2007 | 2012 |
| Kirsten Tay | Medical State ExamGermany |  |  |  | 2012 |  |
| Caroline Bruckner-Holt | MBBSBSc | MSc |  |  | 2009 |  |
| Clare Darlington | BSc in Healthcare 1998 |  |  |  | 2010 |  |
| Maggie Hogan | BSc in adult nursing 2003  |  |  |  |  |  |
| Fiona Read | BSc hons adult nursing 2009 |  |  |  | 2012 |  |

2.6 Level 2 psychology provision

Several core team members have undergone a programme of training in level 2 psychological support which has been approved by the Network. They receive an hour of clinical supervision per month provided by clinical psychologist in order to maintain competence.

**3 Working practices**

3.1 The Hospital Palliative Care Team offers:

* Advice about pain and symptom control
* Support in the care of patients in the last few days of life
* Emotional, psychological and spiritual support for patients, relatives and carers
* Advice to the MDT regarding clinical management plan
* Advice on complex discharge planning
* Assessment for hospice inpatient care on behalf of hospices e.g. Katherine House Hospice and Douglas Macmillan Hospice
* Information about services which can provide social or financial help

3.2 Hours of service

* The service is available for 9am to 5pm, 7 days per week. On Saturday and Sunday the service is available for urgent issues.
* There is no member of staff at County Hospital on Saturday and Sunday but the nurse at RSUH is available to give telephone advice on those days.
* Outside of service hours, telephone advice is available from the Douglas Macmillan Hospice 24 hour advice line 01782 344300.

3.3 Referrals 12-3R-105

* Referrals are made by ordercomm and require the consent of the Medical team and the patient where applicable.
* Referrals will be prioritised according to need
* A response to the receipt of a new referral will be made to the ward within 1 working day (working days are Monday to Friday).
* Urgent referrals be seen within 1 day (7 days a week at RSUH, Monday to Friday at County Hospital)
* Non urgent referrals will be assessed within 2 working days (working days are Monday to Friday).
* Upon assessment the core team member will:
* agree an appropriate level of intervention and plan of care with the patient and the clinical team
* list them for discussion at the next specialist palliative care MDT meeting (see operational policy MDT meeting)
* provide feedback as appropriate to patient/carer and staff
* document the needs of the patient in the patient’s medical notes and on the Somerset cancer register in relation to the following areas:
	+ Physical
	+ Psychological
	+ Social
	+ Spiritual
	+ Information needs
	+ Carers’ needs
	+ Preferred place of care
	+ Preferred place of death

3.4 Discharge

Patients will be discharged from the Hospital Specialist Palliative Care service under the following circumstances:

* When symptoms are controlled and their needs can be met by primary carers (i.e. there is no specialist role required)
* At patient’s own request
* When they are discharged from the hospital trust
* Re-referral is accepted if appropriate

3.5 Patient/carer information, feedback and involvement

The Hospital Specialist Palliative Care Team collects patient feedback on an ongoing basis and reports this annually. The results are presented at the MDT operational policy meeting and an action plan developed. 12-3R-116. Patient and public involvement is sought in any service development.

All patients reviewed by the team are given a team information pack. This includes information about the services offered, contact details and other local services as well as information on the option to have a written summary of the team’s input. 12-3R-115 In addition the team have access to a wide range of written information for patients and carers from the Cancer Information Centre located in the hospital main reception at RSUH and County Hospital and from the Information Prescriptions website [www.nhs.uk/ips](https://webmail.uhns.nhs.uk/OWA/redir.aspx?C=5753a07dabd64d739ca70f8052a6c098&URL=http%3a%2f%2fwww.nhs.uk%2fips). The team also maintains a list of resources that patients and carers can access. 12-3R-117

The leaflets commonly used by the team include:

* Cardiopulmonary Resuscitation Leaflet
* Coping with Dying Leaflet
* The Hospital Palliative Care Team Information Leaflet
* Cancer Information Centre Service Leaflet
* Cancer Psychology Service
* Douglas Macmillan Inpatient Information Booklet
* Taking strong opioids to treat pain
* T34 Leaflet
* Planning your future care booklet (NHSIQ)
* Chaplaincy
* Katharine House Wellbeing Service
* Memory Box Leaflet
* Dove Service

3.6 Key worker 12-3R-110

For the purposes of the Key Worker Policy the Key Worker will be defined as ‘The person who, with the patient’s consent and agreement, takes a key role in co-ordinating the patients care and promoting continuity, ensuring the patient knows who to access for information and advice’.

With the agreement of the patient, the Key Worker will:

* Act as the main contact person for the patient and carer at a specific point in the pathway.
* Offer support, advice and provide information for patients and their carers, accessing services as required.
* Ensure continuity of care along the patient’s pathway and that all relevant plans are communicated to all members of the MDT involved in that patient’s care
* Ensures that the patient and carer have their contact details, that these contact details are documented and available to all professionals involved in that patient’s care.
* Ensure that when handover of Key Worker role is indicated, it is implemented in full consultation with the patient and carer and the patient is provided with revised contact details.
* Ensure that the next Key Worker has the appropriate information about the patient to fulfil the role.
* Support the patient in identifying their needs, review these as required and co-ordinate care accordingly.
* Liaise and facilitate communication between the patient, carer and appropriate health professionals and vice versa.
* Assist to empower patients as appropriate.

It is important to ensure that the patient and carer understand the role of the key worker as early as possible on the patient’s pathway. The patient notes are clearly labelled with the appointed Key Worker details to ensure communication is available at all points throughout the journey.

It is recognised that the Key Worker will change over time as the patient’s needs change during their journey. Any changes will be negotiated with the patient and career prior to implementation and a clear handover provided to the next Key Worker.

It is unusual for a member of the Palliative Care Team to be a key worker. However, for the duration of our involvement with the patient, there is a core nurse member allocated to be the lead and they are responsible for presenting at the MDT.

**4 MDT meetings**

4.1 MDT meetings 12-3R-105

The multidisciplinary team meeting of the Hospital Specialist Palliative Care Team takes place weekly on a Wednesday morning from 09.15 to 10.30 in meeting room DTCO008. Attendance records of meetings are maintained on the Somerset database.

4.2 Patients included for discussion 12-3R-109

All newly referred patients are recorded on the MDT list for the purpose of clinical coding and communication to community teams. The list will identify the patient by name, NHS number, date of birth, consultant, GP and religion. Patients listed for discussion are chosen by the core members of the MDT due to complexity, educational value or need to share information.

Somerset will be used during the meeting to provide information for effective discussion. The secretary/co-ordinator will be notified of all patients requiring case presentation by the core member who has undertaken the primary assessment.

4.3 Record of discussion 12-3R-118

The MDT will record the following information on the Somerset database for all patients discussed:

* Patient identity
* Diagnosis of underlying disease or cancer type
* A care plan for the patient (and if identified by the MDT as requiring it, a plan for the carers).

4.4 Process for action

The core team member responsible will ensure that the agreed actions are completed. In cases where the MDT has initiated a change in management, including referral to another professional, the patient will be made aware of this decision by the referring core team member.

**5 MDT operational policy meeting** 12-3R-108

Besides the regular meeting to discuss individual patients, the team will meet at least annually to discuss, review and agree the operational policy. Minutes of the meeting, including attendance, will be recorded and agreed.

**6 Other activities**

* 1. Audit

The Hospital Specialist Palliative Care Team collate continuous information related to patient activity. An annual report is produced in order to document the team’s activity, achievements and future goals.

The team participates in national audits on EOL when they take place. The team contribute to regional audits.12-3R-124. In addition the team undertakes at least one local audit per year. The results of all national, regional and local audits are presented at the MDT operational policy meeting and actions agreed.

* 1. Membership of cancer site specific MDTs

Named core team members of the Hospital Specialist Palliative Care Team are core team members of the site specific cancer MDTs for Lung, OG, HPB, CUP and CNS/brain malignancies and are audited against their attendance at these MDT meetings. In addition extended team membership of the remaining cancer MDTs is provided and responsibility for cancer sites is allocated to named core nurse members.

6.3 The team contributes regularly to education including mandatory training and contributing to training programmes for doctors and nursing staff. In addition, ad hoc teaching is provided based on request.