katharine house hospice

embracing life and living

Our New Care strategy

"Patients and their families at the heart of everything we do"

HAVE YOUR SAY...

Last year Katharine House Hospice undertook a review of our care services . The aim of the review was to determine how our charitable funds should be used to help patients, families, friends and carers in the future. We engaged with our staff, volunteers, patients, families, supporters and other members of our community. A survey was sent to members of the public and several focus groups took place in the Autumn for key people working within the local healthcare system. Based on the results of our research and feedback from our community we have developed a clear direction for our care. As someone so important to Katharine House Hospice, we would like to share this with you.

The overwhelming majority of participants felt that we should focus our resources on the provision of specialist palliative and end of life care. Whilst most of these participants were also keen for us to still meet the other needs of patients (like their social needs), they felt that...

Katharine House Hospice should focus on delivering the care that cannot be found elsewhere and for which we have most expertise.

As a charity we will continue to:

- Provide free, high quality, responsive specialist palliative care and end of life care to people in mid-Staffordshire
- Provide services based on peoples' needs and our capacity to meet these needs
- Focus on excellence, quality of care, and quality of life, especially dignity.
- Offer support in our hospice, at home, and in other community settings including nursing homes.
- Recognise that our staff and volunteers remain our greatest resource.

Our specialist services will continue to be delivered by our community specialist nurses, inpatient care, specialist therapy services and in-reach provision to other providers such as County Hospital, Nursing Homes, and prisons. These clinical specialist services will be supported by the hospice at home team and Embrace Quality Care as specialists in end of life care, to provide responsive services to meet needs identified by the specialist teams. We also will improve access to these services.

We aim to...

1. Provide **flexible** and rapid access to **specialist** palliative and end of life care
2. Seek to develop new opportunities for **collaboration** and integration
3. Support improved **forward planning** for patients at the end of life
4. **Target** support for patients who deteriorate rapidly
5. Meet the supportive needs of **patients and families**
6. **Educate** and Train

What will Change?

There will be a shift in approach in some areas, **day therapies in its pre-pandemic format will not return** however we will:

- Prioritise the provision of **specialist** palliative and end of life care.
- Establish specialist **out-patient clinics.**
- Continue our **Wellbeing** Programme.
- Provide guidance, education, awareness, signposting and the development of community networks.
- Improve **accessibility** to our services.
- Support patients and families as needed at **any stage** from diagnosis onwards.
- Develop new roles for **volunteers** across services.
- Prioritise partnership and **collaborative** working, for example providing specialist support to GP's and working with other community teams.

Our Mission...

"We help local adults with complex, progressive illnesses from diagnosis to the end of life through free, high quality, specialist palliative care, advice and guidance, and we support those close to them."

Our new approach to care will...

Provide flexible and rapid access for patients to specialist palliative and end of life care. We will continue to deliver and develop our existing specialist services:

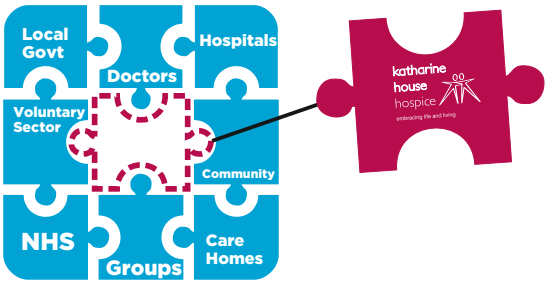
- A community clinical nurse specialist team
- Inpatient care for up to 8 patients
- Support from Healthcare Assistants delivered in patients' homes
- Specialist palliative medical input at County Hospital
- A lymphoedema service
- In-reach work with other providers
- Psychological and bereavement support

We will develop:

Outpatient clinics (both at the hospice and at other places) for consultations with doctors and clinical nurse specialists, occupational therapy, physiotherapy, counselling, complementary therapy, wellbeing services and lymphoedema support. Access to a telephone helpline for patients, families, and healthcare professionals. Guidance and educational resources for patients and families.

Seek to develop new opportunities for collaboration and integration

- Explore with general practitioners how we can better collaborate to meet the needs of patients
- Explore with the community provider (MPFT)* how we could share clinical resources within community teams
- Engage in the development of integrated care records for people at end of life
- Work with other providers to enable rapid and effective transitions for patients into and out of our services



*Midlands Partnership Foundation Trust

Support improved forward planning for patients at the end of life

We will try to anticipate and respond to the future needs of patients by working with community teams and GP practices to first help identify palliative and end of life patients and then to develop:

- Advance Care Plans (future wishes for care as expressed by patients)
- ReSPECT documentation (a communication tool between professionals developed in discussion with patients)
- Assessments of potential future needs such as equipment and care packages

Target support for patients who deteriorate rapidly

- Improve early identification of these patients
- Ensure our services are responsive to meet the needs of these patients
- If resources become available, collaborate with others to establish a rapid response community service.

Educate and Train

Provide education and training:

- To continually develop our own staff and volunteers.
- For GPs, junior doctors, nurses, allied health professionals, and healthcare assistants
- Through work placements within our services for students and practitioners
- Through the gradual creation of a teaching resource, in collaboration with other educationalists, open to the health economy through our website

Meet the supportive needs of patients and families

- Redeploy resources formerly used for Day Therapies
- Develop a new social care model centred on the principles of:
  - extended use of volunteers
  - community engagement with social prescribers and other voluntary resources
  - signposting to other providers
  - Compassionate communities
- Help the community to develop its own resources such as support groups, carers' groups, bereavement groups, etc.

We believe...

That as a result of our support patients should:

- Receive care that anticipates their needs, is well planned and co-ordinated, based on their choices and wishes, and is compassionate, professional, caring, and responsive.
- Feel empowered to direct and shape their plan of care.
- Be able to die in their preferred place, with well-controlled physical, psychological, and spiritual symptoms.

In addition families, friends and carers should feel well informed and supported.

Our Vision...

"People live well and die with dignity in a place of their choice"

How will we provide our services going forward?

Palliative care relies on a Multi-Disciplinary Team approach that offers a unique, holistic specialist service. Our approach is to offer this specialist care to patients who need it the most. Our care focusses on the individual needs of our patients and their families. Regardless of how a patient is referred in to the hospice they will have their own unique experience. Patients may access our services at different stages in their journey and some may need continuous support whilst others might require services periodically. Our care is not a group of individual departments e.g. lymphoedema or IPU. This means patients will move between services, dependent on their condition and particularly as their condition deteriorates.

How will day therapies change?

Day therapies provided services for up to 60 people a week, combining access to specialist services with social activities. We will be replacing this concept with a model based more on an outpatient approach in which patients will visit to see one or more of a range of specialists for an appointment. As a specialist unit we have the skills and resources to meet the individual needs of patients, our new approach means that we can help more patients in a very personal way. The Wellbeing Programme will continue. Patients will be referred in for particular treatments and therapies that meet the needs of the individual e.g. someone may need complementary therapies to help their anxiety, a meeting with a medical professional and a physio appointment over 3 sessions. We will be able to provide a more individual service for patients accessing our services.

How do we aim to improve access to our services?

Whilst day therapies was an attractive service for some patients, others would or could not access it. Our new approach will be more flexible. Now we can base appointments around the patients who may just pop in for a single appointment or have more during the day and access such things as advice mornings and talks. It will allow us to adapt according to the needs of patients.

What services will we be offering for families and carers?

Our team has grown to support a growing need to provide expert support for those dealing with grief in particular. Our structured approach involves spiritual support, bereavement counselling and other support for families and carers.

What are "Compassionate Communities" and how can our community support our care?

Compassionate Communities aims to enable people to work together to create informal support networks and improved resilience within their communities. There is no one way of doing this and it is for communities to form what is needed. These informal networks may include hospices and other charities, community groups and individuals who can for example act as a "buddy" to someone who lives alone. Research suggest that people above 65 who live alone tend to present to A and E far more than those who are married or live with someone, this puts huge pressures on the NHS and also means that these social needs are not being met in the community. This is a new venture for us which will take time to grow organically but one that we hope will help to reduce hospital admissions in the long run.

What types of volunteer roles will be needed to support the new approach to care?

Our new approach will create a number of volunteer opportunities to support our care at the hospice and in the community. Volunteers can support Inpatients by serving meals, hot drinks and water jugs making beds as well as spending time with patients. We will also explore how volunteers can act as "buddies" for patients in the community and help support services outside the hospice buildings.

Where will our care be provided

We aim to explore further opportunities at hospitals and other sites to provide the most effective care in those settings. Our support of patients on Ward 12 at County Hospital continues to be a success - ensuring people in our local area are getting appropriate palliative care in a hospital setting supported by our medical consultants and on discharge are getting the support of the hospice.

Thank you...
for your support of Katharine House Hospice. We shall update you as our care continues to evolve to meet the needs of our patients and their families

www.khhospice.org.uk reg charity 1011712