

Trinity's Mission: Compassionate Care on the journey towards the End of Life



TRINITY

**Hospice &
Palliative Care Services**

The Trinity 10 Year Strategic Plan 2008 - 2018



Trinity's Philosophy: Light and Help and Human Kindness

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FOREWORD

The next ten years will bring about a transformation in end of life care and what Hospices do. We are delighted to bring you the new Trinity 10 year strategy which outlines what role we want to play in that transformation.

Trinity has grown from strength to strength since 1985 and it has an enviable reputation in Blackpool, Fylde & Wyre. Those that know about Trinity and its family of services value the excellent care we give and our place in the community. People from the community we serve continue to give their time and money to support the commitment of our staff and volunteers.

However, substantial change is upon us and like many in the modern hospice movement we want to embrace that change. It is the change in British society generally that has led to the Department of Health publishing their 10 year End of Life Care (EoLC) strategy. It accepts that the profile of end of life care has been low within the NHS and aims to bring about a 'step change' in access to high quality care. Trinity, like many in the modern hospice movement, recognises many concerns around some aspects of the EoLC strategy, but we recognise many opportunities and welcome the focus on what we do. We will be champions for ensuring the very many positive elements of EoLC strategy are fully implemented and do what we can to play a role in its delivery.

We will embrace change but we will not compromise on our values and will not lose what the philosophy that underpins how we deliver care at Trinity stands for. In short; we will stay true to ourselves. Trinity has always believed that there is no service that cannot be improved upon and we will continue to strive for improvement in all we deliver and in all End of Life care that we can influence.

This 10 year strategy for Trinity will mean significant changes for us and it will be a challenge. Change is never easy to bring about, but to continue to do what we do best: 'ensure compassionate care for those on the journey towards the end of life', we will change. We will make this Trinity 10 year strategy a 'live' document under constant review. Producing a strategy is not an end in itself, it is a beginning.

Rob Woolley
Chief Executive
November 2008

W A Holmes
Chairman
November 2008

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EXECUTIVE SUMMARY

We have included this Executive Summary to try to encapsulate what is in this Trinity 10 year strategic document. However, we will also produce an 'easy to read' summary which will stand alone and be available for all of our supporters.

In the Introduction, we quote definitions of 'Palliative', 'End of Life' and 'Supportive' Care and identify that we will provide "a comprehensive and seamless system of specialist palliative care for those who are living with life limiting and actively progressive diseases or who have complex needs that cannot be adequately addressed by their current caring team".

The background to Trinity and its family of services is examined to show the sound base on which to build further improvements and continue our excellence. The legacy that Trinity's development has given is exceptional - resulting from many years of hard work and dedication from those involved in Trinity and its work.

The importance of us having an updated, comprehensive strategic document is identified and the recent developments in local and central government thinking about palliative care - including the highly significant End of Life Care Strategy [EoLC] 2008 - are used as the basis for developing our strategic thinking and extending our partnerships.

A PEST [Political, Economic, Sociological and Technological] analysis has been undertaken of the external environment and a SWOT [Strengths, Weaknesses, Opportunities and Threats] analysis of the internal environment. The outcomes of these analyses have been related to the main thrust of the national and local EoLC Strategies and tested against our Mission, Values and Philosophy.

Trinity Mission:

We will strive to ensure the people of Blackpool, Fylde and Wyre have:
Compassionate Care on the journey towards the End of Life

Trinity Values:

- 1 To put patients' needs first and focus on the person not their illness;
- 2 To care for, and support, the carers and families;
- 3 To deliver the most effective specialist (but not elitist) palliative care that we can;
- 4 To be a learning organisation and to learn with others who are providing generic palliative care;
- 5 To respect and value the contribution of all Trinity staff and volunteers;
- 6 To use creativity and innovation to continually improve our care;
- 7 To serve the local community of Blackpool, Fylde and Wyre in the best ways we can in the provision of palliative care;
- 8 To behave ethically;
- 9 To collaborate with partners and other organisations to benefit patients, their carers and families;
- 10 To value the dignity and lives of all.

Trinity Philosophy:

Light and Help and Human Kindness

We then determined six key Strategic Aims that, together, give a sense of our priorities and indicate the direction we intend for Trinity over the next 10 years. These aims are the core of the strategy.

STRATEGIC AIM ONE

As the centre of focus for specialist palliative care in the locality we will play a full and active role in the development of a fully integrated and co-ordinated 24/7 specialist palliative care service supported by full implementation of the National End of Life tools (GSF, LCP and PPC).

STRATEGIC AIM TWO

Take a leading role in the delivery of learning, education and training for all Health and social care staff: a) Those providing the day to day care to patients in their homes and hospitals, b) Those that specialise in palliative care in the North West, c) Health and social care staff who rarely come into contact with dying patients. We will develop the Trinity Learning and Research Centre to be a 'Hub' in this leading role and co-ordinate delivery of workforce requirements.

STRATEGIC AIM THREE

Accept a strategic role, with partners, to change the community's attitudes to death and dying to one where conversations within the community about death and dying are open, honest and perceived in a more positive light, work on this aim to address all age groups.

STRATEGIC AIM FOUR

Address the communication issues around EoLC. Establish Trinity as an easily accessible source of information, advice and expertise on all issues related to death and bereavement. Ensure a focus on the needs of patients and carers.

STRATEGIC AIM FIVE

Develop services for people who have advancing, progressive and incurable illness other than cancer in a managed and sustainable way.

STRATEGIC AIM SIX

We will strive for excellence in the provision of all aspects of our work, have high quality and continuous improvement at the core of all that we do.

We have stated clearly that the delivery of Strategic Aims One to Five will need enhanced and new services and conclude that any success will be subject to them being fully funded from statutory sources - see EoLC strategy (page 161)

At the time of writing this strategic plan, it costs up to £6 million a year to run Trinity and our family of services and the NHS provides just under £2 million of that. We believe it is unrealistic to expect the community we serve to fund any new services from voluntary contributions.

We have an ambitious but achievable strategic plan. Over the first year, we will develop details for implementation, review and evaluations of it. This, combined with the development of detailed 3 year business plans, will make our strategic plan a live document that can, and will, make a difference to the End of Life journey for people in Blackpool, Fylde and Wyre.

Trinity welcomes any questions or observations on this 10 year strategic plan. Please direct them to Rob Woolley, Chief Executive email rob.woolley@trinityhospice.co.uk or call 01253 358881

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INTRODUCTION

This Trinity 10 year Strategic Plan is not the first strategic plan that we have developed. It replaces our previous strategic plan and is, arguably, more ambitious. We want to ensure further improvements through a culture of change in end of life care. We will play an active role in effecting that change, through this strategy and incorporating leading edge research, innovation and service improvement. We will be an active partner with all other stakeholders and play a lead role where we can.

Trinity is, at its core, a specialist centre providing care for patients affected by disease and illness where a cure is not available. Trinity provides holistic health care for all its patients combined with the social, psychological, spiritual and caring support as is appropriate for the patients together with their carers, families and friends. For Trinity, this is the essence of 'compassionate care'.

We want to make sure there is a comprehensive and seamless system of specialist palliative care for those who are living with life limiting and actively progressive diseases or who have complex needs that cannot be adequately addressed by their current caring team. We will ensure that, as an organisation, we provide excellent specialist palliative care through evidence based practice and, in doing so, influence the provision of generic palliative care for the wider community.

In developing the Trinity 10 year strategy, we have utilised the existing 'key driver' documents as part of our analysis of the external environment. We see 'drivers' as the things, in this case strategic documents, that are capable of moving issues forward; something that provides impetus or motivation; a strong force. Where we have taken extracts from these key driver documents to help explain the external environment, we have presented them in a box and in a different font to show they are not Trinity generated views and opinions. Details on how to obtain the full documents are given at Appendix 2 to this strategy and later will be on the Trinity website.

For the purpose of this Trinity 10 year strategy, we are accepting the following definitions:

Palliative Care is defined as:

"...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."

National Council for Palliative Care

End of Life Care is defined as:

"...a broad term relating to an active, compassionate approach that treats, comforts and supports individuals who are living with or dying from progressive or chronic life threatening conditions. Such care is sensitive to personal, cultural and spiritual values, beliefs and practices and encompasses support for families and friends up to and including the period of bereavement."

Ross, Fisher & MacLean (2000) A Guide to End of Life Care for Seniors, Ottawa, Health Canada

Supportive Care is defined as:

"...helps the patient and their family to cope with disease and treatment of it, from pre-diagnosis, through the process of diagnosis and treatment, to cure, continuing illness or death and into bereavement. It helps the patient to maximise the benefits of treatment and to live as well as possible with the effects of the disease. It is given equal priority alongside diagnosis and treatment."

National Council for Palliative Care

BACKGROUND

Trinity is a very strong and substantial organisation which has a solid base with its excellent modern, high quality buildings and extensive 'family of services'. Trinity has almost 180 employees (120 full time equivalents (FTE) and over 600 active volunteers. It is at the heart of the local community of Blackpool, Fylde and Wyre. This family of services include:

- Adult inpatient unit - 28 beds and over 1000 referrals a year
- Brian House Children's Hospice - 4 beds and a full range of other services : play worker, community outreach etc
- Complementary Therapy - 2 part time therapist/co - ordinators and a team of volunteer therapists
- Day Therapy Unit - 15 places over 5 days with over 2000 patient attendances in 2007
- Linden Centre - With a full range of bereavement support for both adult and children. 7 paid staff and a team of volunteer counsellors and companions.
- Lymphoedema - 4 Specialist nurses in a well established centre
- Trinity Clinical Nurse Specialist Team - 1 Team leader and 12 CNS covering both Hospital and Community settings
- Trinity, Learning and Research Centre - High quality conference and learning facilities - formal links to four local universities (Cumbria, Lancaster, Uclan and Liverpool)

This family of services delivered through the Medical and Clinical Directorates are supported by a wide range of Health Care Professionals; (HCPs) in accordance with NICE guidelines (National Institute for Health and Clinical Excellence) including: physiotherapy, social workers, occupational therapy etc. the services are underpinned by an effective Resources Directorate and a Fundraising Directorate.

The current strengths of Trinity and its family of services means it is a significant partner in the delivery of End of Life Care, Palliative Care and Supportive care in Blackpool, Fylde and Wyre. This position has resulted from many years of hard work and dedication from those involved in Trinity and its work.

How Trinity developed is well documented in the publication of: 'The story of Trinity' which was created and printed in 2007. It details, in words and pictures, caring for the community over three decades and tells many stories. The following is taken from The Story of Trinity:

It is the story also of all the nursing, housekeepers, catering and administrative staff who have worked in and for the Hospice.

It is the story of all volunteers – drivers, fundraisers, flower arrangers, manicurists, hairdressers, marathon runners and coastal walkers, red nosers and stunt organisers, stall holders and tombola ticket buyers who have supported the Hospice.

And of course it is the story of the patients – the centre of the hospice – the relatives and friends from the community beyond these doors.

Each one is a story. Together they make up the story of Trinity.

Impossible though it is to do justice to them all in that book, or here it does give a flavour of this special world. Trinity is a building – or rather, a series of buildings (and still growing!) – but it is more than that: it is made up of human beings, their thoughts, feelings, pains, hopes and desires.

THREE PART HARMONY

There are lots of 3's in Trinity.

There's the 3 handled spade for the 3 Mayors of Blackpool, Fylde and Wyre to turn the first pieces of earth each time a new building or extension to the hospice has begun.

There are 3 interlocking themes in this book

⊗ the theme of birth and maturation – the great efforts to raise money, the drive to extend the provision and the buildings, the dealings with national and local ‘bodies’, with procedures, with committees, with authorities – with all those who stood in the way of, or helped the passage of, the growth of the hospice.

⊗ the theme of the gradual acceptance of palliative care (including its change of name from hospice care or terminal care) from almost an ignored afterthought to an important element of mainstream medicine – the explanations, the arguments, the meetings with health services, the education of (some) GP’s, the slow but successful persuasion of those in power.

⊗ the theme of care - as it says on the plaque at the entrance, quoting Albert Schweitzer, “Here at whatever hour you come, you will find light and help and human kindness” – the day to day business of care in all its manifestations, the importance of each individual, and each relationship, inside the building and outside in Blackpool and the Fylde

There’s even a trinity within the theme of care meeting the 3 needs – physical, psychological, and spiritual – of the patients

More hospice growth has taken place as the acceptance and development of palliative care has occurred – in the health service, in local and national government and, gradually ... unspectacularly... in society at large. Palliative care, social care, counselling care – the awareness of needs (often to fill gaps left by family and social relationships that can no longer be relied on) has deepened. For Trinity, such awareness as an abstract idea has always been marked by practical, physical actions and structures.

However, that story of Trinity and its past and background also makes clear the Hospice, by its very nature, focuses on now. This movement, because tomorrow is not yet here (though it may be very soon) and yesterday has been and gone.

At its Annual General Meeting in 2008, the Trustees and members agreed to change the company and charity name. We had been operating under a few working names. It was agreed that we would be called: **Trinity Hospice and Palliative Care Services**. In many respects the modern hospice movement has come of age and the title of Hospice can and should be ‘upfront’. It could be argued that Palliative Care has been accepted as core and mainstream in health and social care. The challenges of the future will be different challenges than the past. The legacy that Trinity’s development has given is exceptional and we have an excellent platform from which to launch our Trinity 10 year strategy.

STRATEGY GENERALLY

Strategy and strategic thinking is often misunderstood by both those who make strategy and those that deliver services or commission the delivery of services. Often strategy, policy and delivery are used interchangeably and it could be argued this is unhelpful.

Strategic thinking is useful in building a better understanding of plausible futures and as a result an organisation should be in a better position to shape the future as well as react to it.

The Trinity 10 year strategy attempts to capture a vision of the future for end of life and palliative care in Blackpool, Fylde and Wyre and expresses how Trinity wants to behave in that future.

Our strategic thinking process has been goal directed not problem directed. Possible futures brought into focus in order to define the strategic direction in which Trinity wants to move, based on the strategic direction we want the community that we serve to move.

Some of the features Trinity wants in a strategic plan are: A rich and holistic understanding of causes, trends and possible futures, clarity about aims and priorities, an understanding of capacities and 'drivers' and narrative that makes sense to stakeholders.

It could be argued that strategic governance is a high level thinking process that matches the capability of an organisation to the challenges it faces so that its future services will be both successful and cost effective.

We feel this Trinity 10 year strategy meets our aspirations and our understanding of strategy generally.

THE EXTERNAL ENVIRONMENT (KEY 'DRIVER' DOCUMENTS)

There is a great deal changing in the world at the time of writing this strategy and changes in British society have meant familiarity with death has decreased; we do not discuss death and dying openly.

We have suggested in this document that strategy generally is often misunderstood and that strategic thinking is about understanding plausible futures. The modern Hospice movement and Trinity are in the very fortunate position that much of the work about the future and end of life care has been done. Over the last few years 'The Next Stage Review - End of Life Care clinical pathway groups' from all Strategic Health Authorities have examined in fine detail all of the issues around End of Life Care (EoLC). Their findings, thoughts and vision for the future is encompassed in the Department of Health (DOH) End of Life Care Strategy published July 2008.

However, this means that each individual Hospice must make sense of that EoLC strategy and their regions response to Our NHS, Our Future, (In the North West, that is Healthier Horizons for the North West). In addition, the local PCT (Primary Care Trust) or local NHS will develop a local EoLC Strategy.

In addition to all of this, Trinity has utilised its Board, staff and volunteers to use their knowledge to help make sense of the local situation. There are a number of documents which are key drivers for change.

Extracts from the National EoLC Strategy:

Around half a million people die in England each year, of whom almost two thirds are aged over 75.

Most deaths (58%) occur in NHS hospitals, with around 18% occurring at home, 17% in care homes, 4% in hospices and 3% elsewhere.

Although every individual may have a different idea about what would, for them, constitute a 'good death', for many this would involve:

Being treated as an individual, with dignity and respect;

Being without pain and other symptoms;

Being in familiar surroundings; and

Being in the company of close family and/or friends.

Extracts from the National EoLC Strategy:

Some people do indeed die as they would have wished, but many others do not.

Some people experience excellent care in hospitals, hospices, care homes and in their own homes. But the reality is that many do not, many people do not die where they would choose to.

Whole systems and care pathway approaches: A whole systems approach is needed. Within this, a care pathway approach both for commissioning services and for delivery of integrated care for individuals has been strongly recommended. The care pathway involves the following steps:

Identification of people approaching the end of life and initiating discussions about preferences for end of life care;

Care planning: assessing needs and preferences, agreeing a care plan to reflect these and reviewing these regularly; Coordination of care; Delivery of high quality services in all locations; Management of the last days of life; Care after death; and Support for carers, both during a person's illness and after their death.

THE STRATEGY SETS OUT KEY AREAS THESE KEY AREAS CAN BE SUMMARISED AS FOLLOWS.

Raising the profile - Improving end of life care will involve Primary Care Trusts (PCTs) and Local Authorities (LAs) working in partnership to consider how best to engage with their local communities to raise the profile of end of life care.

Strategic commissioning - As the services required by people approaching the end of life span different sectors and settings, it is vital that an integrated approach to planning, contracting and monitoring of service delivery should be taken across health and social care.

Identifying people approaching the end of life many health and social care staff have had insufficient training in identifying those who are approaching the end of life, in communicating with them or in delivering optimal care. To address this, a major workforce development initiative is now needed, with particular emphasis on staff for whom end of life care is only one aspect of their work.

Extracts from the National EoLC Strategy

Care planning - All people approaching the end of life need to have their needs assessed, their wishes and preferences discussed and an agreed set of actions reflecting the choices they make about their care recorded in a care plan. Preferred priority of care documents (PPC).

Extracts from the National EoLC Strategy:

Co ordination of care - Within each local health economy mechanisms need to be established to ensure that each person approaching the end of life receives coordinated care, in accordance with the care plan, across sectors and at all times of day and night.

Rapid access to care - As the condition of a person may change rapidly, it is essential that services are marshalled without delay. If a person is likely to live for only a matter of weeks, days matter.

Delivery of high quality services in all locations - Commissioners will wish to review the availability and quality of end of life care services in different settings. These will include services provided in hospitals, in the community, and in care homes, sheltered and extra care housing, hospices and ambulance services.

Last days of life and care after death - Increasingly, the Liverpool Care Pathway (LCP), or an equivalent tool, is being adopted by those providing end of life services. The LCP, which was first developed for use with cancer patients, has now been successfully modified for use for people with other conditions.

Education and training and continuing professional development - Ensuring that health and social care staff at all levels have the necessary knowledge, skills and attitudes related to care for the dying will be critical to the success of improving end of life care. For this to happen, end of life care needs to be embedded in training curricula at all levels and for all staff groups.

Measurement and research - Good information on end of life care is needed by patients, carers, commissioners, clinicians, service providers, researchers and policy makers. Each group will have somewhat different questions to ask and therefore different priorities for information. The NHS Choices website contains information which may be helpful.

Funding - It is difficult, if not impossible, to calculate the cost of end of life care in this country. This is partly because of the difficulty in defining exactly when end of life care starts. However, the key elements of expenditure can be identified.

These are: Hospital admissions; Hospices and specialist palliative care services; Community nursing services; and Care homes.

However, in reviewing local areas, commissioners will need to consider the financial implications of:

Establishment of coordination centres/facilities; Provision of 24/7 home care services; Improved ambulance transport services for people near the end of life; Additional specialist palliative care outreach services to provide advice and care for non-cancer patients and to increase input into care homes and community hospitals; and Improved education and training of existing staff in care homes, hospitals and the community.

Extracts from the National EoLC Strategy

The challenge for the NHS and social care services now, is to extend this quality of care from the minority of patients (mainly those with cancer) who currently come into contact with hospices and specialist palliative care services, to all people who are approaching the end of life.

Trinity welcomes the publication of the DoH End of Life Care Strategy. Over the next 10 years, the life cycle of that strategy and of this Trinity strategy, we will be champions for ensuring the EoLC strategy is fully implemented.

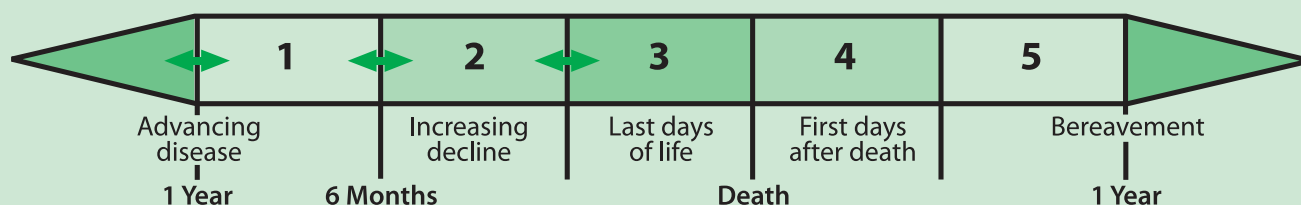
Throughout that period we will play our part in the delivery of the EoLC strategy. We will lead and co-ordinate where we can and make sure our work is driven by our values. In relation to the EoLC strategy, our values will specifically help us but we also hope they will help others as we adhere to one value in particular. To collaborate with partners

Case for change

The End of Life Care CPG aims to create a world class end of life care service for people in the North West that enables choice and ensures quality. We aim to achieve a 10% reduction in hospital deaths through enhanced community services by 2012.

The pathway model identifies five key phases

Figure 28 The North West End of Life Care Model



There is also consistent evidence that shows that well over half of patients would choose to die at home. Despite this understanding just under 20% die at home and the most common place of death is in hospital.

Hospital admissions at the end of life are often essential but it is clear that a significant number of these admissions are due to poorly co-ordinated or inadequate palliative and supportive care services being available in the community.

There is a professional and public ethos of keeping people alive no matter what, which means death is perceived as negative or a failure and is not openly discussed.

Aspirations

In order to form a sound structure for the delivery of end of life care services it is vital to have a robust, integrated commissioning framework based on the North West end of life care model, across health, social care, voluntary, charitable and independent sectors, with strategic leadership identified in each PCT.

It is vital that the health and social care staff at all levels have the necessary knowledge, skills and attitudes related to care for the dying to improve end of life care.

In order to change negative public perceptions a public campaign will be established to raise awareness about end of life care, and promote a more open conversation within society, engaging people's views about death and dying.

End of life care services need to be comprehensive and available to all 24/7. **A single point of access** for individuals and their carers also needs to be put in place and would include access for carers and family during the bereavement phase, ensuring the provision of appropriate support.

One Service

It is important to develop a strategy between all stakeholders, including CPG group, SHAs, PCTs and local authorities in order to support a culture of change in end of life care, incorporating leading edge research, innovation and service improvement.

Recommendations

Recommendation 1

Develop a robust, integrated commissioning framework based on the North West end of life care model with strategic leadership identified in each PCT. The framework will be fully supported by a financial investment programme and monitored against the national quality standards to be piloted in autumn 2008. By 2012 we aim to achieve a 10% reduction in hospital deaths by enhancing community services and establishing electronically based advance care planning across all sectors.

Recommendation 2

A consistently high standard of end of life care will be ensured by: a comprehensive holistic assessment of the patient's and carer's needs; a fully integrated and co-ordinated service with 24/7 access to specialist palliative care services; a single point of access for individuals and their carers; full implementation of the national end of life tools (GSF,LCP,PPC)

Recommendation 3

An education and training strategy incorporating core competencies for health and social care staff will be developed to ensure end of life care is embedded in all training curricula. Mandatory training and education in end of life care emphasising effective and sensitive communication for all relevant clinical and non clinical staff should be included as part of local delivery plans 2008/09.

Recommendation 4

A public health framework will be put in place and a public campaign established to raise awareness about end of life care, resulting in a more open conversation within society, that engages people's views about death and dying.

Local Position

Trinity has two PCTs that operate across the community it services. Blackpool PCT covers the unitary Local Authority (LA) areas of Blackpool. North Lancashire PCT covers two of LA Boroughs that are coterminous with the area Trinity serves; The Boroughs of Fylde and Wyre. North Lancashire PCT also covers Lancaster which is outside the Trinity 'patch'. The PCT structure has a satisfactory fit in respect of Adult Services but as Lancaster has no Children's Hospice the fit can be problematic in some specialist areas.

At the time of writing this Trinity 10 year strategy, the two PCTs are in the process of having a name change and 'new branding'. Blackpool PCT will be called NHS Blackpool and North Lancashire PCT will be called NHS North Lancashire.

NHS North Lancashire has a draft End of Life strategy and NHS Blackpool will be developing such a local strategy very soon. Both local strategies will follow the National EoLC strategy and fit into the Regional 'Healthier Horizons'.

Local issues and local strategies will be of most importance in Trinity making sense of its local external environment. Generally about 50% of the work of Trinity comes from the Blackpool area and 50% from Fylde and Wyre. We expect both local EoLC strategies to be similar in structure to meet the aspirations of the Strategic Health Authority which oversees both. Some highlights from the NHS North Lancashire draft EoLC strategy includes;

Extracts From the Local NHS EoLC Strategy

End of life care services must be of a consistently high standard regardless of disease or condition or where they live. Consequently to ensure equity of service the national team will develop quality standards with associated measure. These standards will be used to guide the commissioning process and to ensure the quality of end of life care remains high.

Who provides palliative care?

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

- Those providing the day-to-day care to patients and carers in their homes and in hospitals (e.g. GPs, District Nurses, Community and District General Hospitals).
- Those who specialise in palliative care (e.g. consultants in palliative medicine and clinical nurse specialists in palliative care).

Extracts From the Local NHS EoLC Strategy

However the National End of Life Care Strategy identifies a third group of health and social care professionals. This is the group of staff who will rarely come into contact with dying patients but whom still needs to be informed of end of life care provision.

Role of Hospices

Hospices tend to be referred to as specialist units. However, the role of the Hospice is often broader and whilst 'specialists' would tend to lead people into thinking they are absolute end-of-life facilities, many users dip into Hospice services, largely as part of their life in the community and then increasingly rely on the more specialised aspects of Hospice services as a disease progresses.

In order to achieve the targets set out within national strategy, this local strategy will:

- Cover all conditions and care settings
- Build on the experiences of hospices and specialist palliative care services
- Build on the existing End of Life Care Programme
- Build on recent experience from the Marie Curie Delivering Choice Programme and other innovative service models

In addition to the National End of Life Strategy, Cancer Networks, on behalf of their local organisations, have been tasked with developing and implementing action plans for the implementation of NICE Guidance on Improving Supportive and Palliative Care Services for Adults with Cancer (2004). These action plans include a number of key targets. Whilst these targets are not specifically focused on end of life care there are implications for service delivery.

The key targets are:

- Co-ordination of care
- User involvement
- Communication
- Information
- General palliative care
- Psychological services
- Social support services
- Spiritual support services
- Specialist palliative care
- Rehabilitation services
- Complementary therapy
- Services for families

Some of the key statistics are:

- A total of 4013 deaths across the North Lancashire footprint with indications that this figure is set to rise (2005).

Extracts From the Local NHS EoLC Strategy

Decreasing percentages of home deaths (the national average is 25%). The average numbers of home deaths across the North Lancashire PCT footprint are between 17 and 19%. Trend data predicts that this situation will become ever more prevalent with the home death rate predicted to drop to 15.9% by 2010 whilst the hospital death increases to 60.4% by 2010.

The main pressure areas appear to be regarding communication and coordination of care, especially during out of hour's periods, particularly in primary care and care home settings.

GPs are expected to provide good end of life care as part of core services, with minimal drivers from within the Quality and Outcomes Framework (QOF). Many do provide excellent care, but in a world of competing pressures end of life care way to support GPs and primary health care teams to do this may be to develop Advancing Quality Initiatives.

Overall Strategic Aim

The overall strategic aim of this document is to provide the most appropriate care to patients in the most appropriate setting in a timely way. This could mean the use of rapid response style teams to meet urgent need and/or having well co-ordinated flexible community teams.

Vision of services in North Lancashire for 2012 –2017

By 2012 the following will have been delivered for the patients of North Lancashire in relation to End of Life Care:

Patients will experience a single point of access to services.

- A range of services will enable care in the most appropriate place including at home and in the community. Greater access to diagnostics and therapy will be available at home so that only those who require secondary hospital treatment are admitted.
- Patients will be offered an informed choice about location and range of care interventions. They will be supported in achieving their preferred place and care priorities will be adhered to.
- Health and social care provision will be integrated and the patient will be cared for seamlessly.
- Services during Out of Hours periods will be as equally coordinated as during in hour's periods and all appropriate services will be available 24/7.
- Services will be flexible and able to respond adequately and timely to differing levels of patient need.
- Services will be available according to patient need. They will not be diagnosis or care setting restricted

What this strategy will mean for patients and carers

Patients and carers will have access to:

1. The opportunity to discuss your personal needs and preferences with professionals who can support you. This means that:
 - All health staff will be trained in communication regarding end of life care.
 - Health professionals will be trained in assessing the needs of patients and carers and, where necessary, reconciling differing requirements.
 - A care plan will be offered to every patient and carer, to help ensure services are provided to meet their needs and Preferences.
2. Coordinated care and support, ensuring that your needs are met, irrespective of who is delivering the service to you.
 - The Gold Standards framework will be adopted across primary care and in the care home setting.
 - Local coordination centres will be established to coordinate care.
 - End of life care registers will be established to ensure that everyone who is involved in care is aware of patient's wishes.
3. Rapid specialist advice and clinical assessment wherever you are:
 - Patients and carers will have access to dedicated 24/7 telephone helplines and rapid access home services.
 - Specialist palliative care outreach services will be appropriately resourced.
4. High quality care and support during the last days of your life:
 - The Liverpool Care Pathway for the Dying will be used in all care settings.
5. Services which treat you with dignity and respect both before and after death.
 - All health care staff will undergo training in end of life care. Patients and Carers will participate in identifying training needs of staff.

Extracts from the Local NHS EoLC Strategy

NHS North Lancashire has adopted the following milestones for the achievement of the end of life related goals.

Milestones	<i>2008/09</i>	<i>2009/10</i>	<i>2010/11</i>	<i>2011/12</i>	<i>2012/13</i>
<i>Increase % of deaths occurring at home</i>	18%	20%	25%	27.5%	30%
<i>Increase % of deaths in preferred place of death</i>	25%	30%	35%	37.5%	40%
<i>Increase % of deaths occurring outside of hospital (nursing home, residential home & Hospice)</i>	45%	47%	52%	54.5%	57%
<i>Increase in use of Liverpool Care Pathway for the Dying (all care settings)</i>	25%	40%	45%	47.5%	50%
<i>NI135 carers receiving needs assessment or review & a specific carer's service, or advice & information.</i>	23.3%	24.5%	25.7%	26.9%	28%

NB. NHS Blackpool have suggested that their key themes will be around social care, rapid response and co-ordination of out of hours EoL Care.

THE EXTERNAL ENVIRONMENT (AN ANALYSIS)

In the previous section we acknowledged that over the last few years much of the work about understanding issues around the end of life care has been done. This has helped enormously in looking at plausible futures. Trinity welcomes the EoLC strategy and will be a champion for it. However, Trinity will not simply become a delivery arm of the NHS, nationally, regionally or locally. We have analysed the plausible futures set out in the various Key Driver Documents and used our local knowledge of the community we serve to make sense of it all. We have overlaid this complex picture with our own values, philosophy and organisation capability and capacity to examine what role we feel we can play in those plausible futures.

Part of that analysis involved a mini conference at Trinity with colleagues from other North West Hospices. We also spent a Trustee and management Development Day looking at a PEST analysis of the external environment looking at Political, Economic, Sociological and Technological changes.

Summary of the mini conference analysis.

Identify concerns – The concerns that the EoLC strategy raised

Compromising existing care; Lack of local/community focus and loss of independence/identity – loss of the essence of the movement/care (ethos); Poor NHS standards – excellence for all; Funding/value for money/tariff may mean bureaucracy and higher management costs; over commissioning/regulation; Plan properly - fear of non delivery by NHS; Fear of competition and lack of proper local plans; Over focus on home care; Marginalisation of hospices in the 'new' world; Public want versus needs; Community ownership and being part of the community; Idea of charges is alien to ethos of hospice movement

Identify opportunities – The opportunities that the EoLC strategy raised

Puts end of life care on the top of the agenda; Education and Training – use hospice expertise, partnership opportunities. Will be paid for. Offering support across community; Development of outreach services and public engagement; Value for money/transparency/public awareness; Excellence and influence. To be at the centre of patient care services, hub and driver within the community offering equitable, sustainable service solutions; Whole system; meaningful collaboration; Funding. Secure future for core services and more funds for expansion of service; Equitable and sustainable services for all responding to local needs not national formula; Greater general awareness; Wider access – greater opportunity to alleviate suffering;

What will my hospice services look like by 2018 – Perceptions from the groups

Unknown future but exciting and full opportunity; could be hub but should be involved; One size does not fit all; Hospices have experience. Build on the expertise; Last 10 years have seen massive change. Will next 10 years be full of change or more of the same? How many independent hospices? Structure and shape may change, collaboration essential, partnerships with other hospices and other providers; Combined services and economies of scale; Fewer beds (?), complex, wider range of patient conditions and increasingly dependent patients; Care provided in different settings; Perhaps pressured to take patients inappropriately from acute care; Outreach to other settings. Support patients and staff in other areas such as nursing homes; Staff education necessary to support wider range of conditions: Need flexible, innovative workforce; Funding will increase but should meet core needs as well as new services; Access to care will widen and funding will have increased; Choice for patients will increase.

The role of hospice care in 2018 – Ideas on 'plausible futures'

A number of different options: Hospice as 'specialist providers'; Hospices as 'centres of excellence'; Hospice as co-ordinators of services (the 'hub'); Hospice as one of the 'spokes': Hospices as co-ordinators of a wider palliative care community.

At the Trinity Development Day, we used our local knowledge to make sense of this analysis.

In order to work towards aims and priorities, we developed an exercise to give emphasis to what we collectively felt were the most important aspects.

Opportunities

- To research, evaluate and write up our Brian House model
- To work out what it costs
- Fundraising for Brian House
- Medical consultant (we need more)
- Utilise, Education (ours and in schools)
- Service provision (more of)
- Co - ordination of various aspects related to EoLC
- Public health

Concerns

- Whole spectrum?
- Spread too thin
- Specialist VS generalist
- Funding
- What does co - ordination really mean
- Our 'brand' and marketing
- Increasingly complex (small numbers)
- Short break - competition
- Fundraising for Brian House
- Voice of local community in all of this

SUMMARY OF THE PEST ANALYSIS (FROM TRINITY TRUSTEES AND MANAGERS DEVELOPMENT DAY)

<u>POLITICAL</u>	<u>ECONOMIC</u>
Government/Regime Policy	Accelerate change of funding for capital to revenue support - threat to resources
Lack of funding compared to demands for results	Competition
Raise people expectation -but do not deliver, by government	Threat to funding - both money/people
Political interference diluting the quality of care provided through national directives	Funding of 'soft' non measurable care is at nil cost
Greater monitoring by a government committing to target areas	Economic pressures will put more people to paid employment rather than volunteering
Change of government? Available funds	Investments very important extra funding
EoLC may not stay 'fashionable' for 10 years - something else will be higher priority	Uncertain economic times - people less likely to support charities
Government cannot afford to keep providing the current services	Individuals to contribute funding
Political parties will interpret issues around with EoLC strategy to try to gain advantage or allocate blame	More people having more income to purchase their own healthcare
Expansion of provision - i.e. NHS, care homes, private because hospices may lose perception as 'expert' provider	Reduced giving/effort on resources More dependable on stats funding/cut/no expansion of services
Political interference to make 'headlines' what defining difference between 'needs and wants'	Economic - will there be enough money in the 'kitty' to have a carer (relative or professional) to satisfy the needs of the patient
Death not popular topic. near ...very well take over as priority	No growth in economy - no money for any priority- environmental action may become higher need for government
Over regulation leading to loss of funding as public disillusioned by perceived reduction in service provision	Staffing issues recruitment difficulties

<u>SOCIOLOGICAL</u>	<u>TECHNOLOGICAL</u>
Demographic time bomb	Medical advances - keeping pace
Scale of 'client' group - massive increases	Online help in the home: video as well as sound
Ageing population more demand on people needs	A workforce that is able to enhance the various arms of technology
Lack of volunteering among young/fitter individuals Loss of interest in community and potentially the vulnerable	Use of internet to access information - both high quality and poor quality. Medical advances - lengthening life but with multiple disabilities
Competition from care homes and new providers	Power of internet through mobile phones to provide knowledge
Social?	Keeping up with technology and the cost
<ul style="list-style-type: none"> • Ageing • More people in care homes 	Information overload
Ageing population people will want to remain in the home	Technology With help people to stay in their own homes
Demographics and increased demand expectation of EoLC services	Internet access and lots of 'experts' but are they?
Post-war boom generation - higher numbers of 'young' old and their expectation of 'best' - all services	Telemedicine - experts desire to use (such as vitaline. Cost effective) clashes with desire for personal medicine from community
Breakdown of close knit family scattered around country/world social unit of community breaking down	Technology can make many areas 'grey' and black and white and defining different opinions and approaches to 'treating people' is healthy and normal
Pressure for 'choice' - euthanasia versus spend on end of life care	Technology gap for poorest groups in society - internet access no good if living in cardboard box - how to equalise and access to technological advance
A demand on service lack of family support	Loss of personalisation use of technology

Following this PEST analysis we again devised a process to give emphasis to the points we collectively felt were most pressing. We agreed:

POLITICAL

EoLC may not stay "fashionable" for 10 years something else will be higher priority
Political parties will all fiddle around with EoLC strategy to try to gain advantage or allocate blame
Government cannot afford to keep providing the current services
Greater monitoring by a government committing to target areas
Raise people expectations - but do not deliver by government
Over regulation leading to loss of funding as public disillusioned by perceived reduction in service provision

ECONOMIC

Will there be enough money in 'kitty' to have carer (relative or professions) to satisfy the needs of the patient?
Staffing issues recruitment difficulties
Reduced giving/effect on resources - more dependence on state funding/cut/no expansion in services

SOCIOLOGICAL

Demographics and increased demand/expectation of EoLC services
Scale of 'client' group - massive increases
Competition from care homes - new providers
Ageing population more demand on peoples needs
Breakdown of close-knit family scattered around country/world social unit of community breaking down
Ageing population, more people in care homes

TECHNOLOGICAL

Use of intranet to access information - both high quality and poor quality
Medical advances - lengthening life - but with multiple disabilities.

TRINITY: MISSION, VALUES AND PHILOSOPHY

In order to prepare for a revision of the Trinity strategic plan, an examination of the Trinity mission, values and philosophy was undertaken. We wanted to ensure that the essence of what we should be doing was agreed and made clear. We felt these three things should: hold the organisation together, convey the values that drive us, give criterion to judge ideas and possible projects against, give organisational focus, make clear the boundary and limits for Trinity, show our distinctive characteristics.

We realised that there is a plethora of information and advice on this subject matter and guidance about what these things mean, should mean and how to produce mission statements and the like. However, the Board and managers did not need a great deal of help and advice. We are driven by our values and finding agreement on what they are was painless. The philosophy that underpins the essence of how we do, what we do is longstanding: Light and Help and Human Kindness. We agreed "palliative care requires a breadth of vision and huge versatility" (Dame Cicely Saunders) and that it is about people not their illness. We agreed it is both highly complex and very simple.

Because the mission needs to convey so much to so many people that don't know Trinity, the wording became more problematic. We wanted it to meet some criteria if that was possible: Results terminology, salient, authoritative, ubiquitous and with horizontal and vertical integration to other elements of Trinity. The Board and managers at the Development Day agreed a draft wording which was consulted upon throughout the organisation. It was agreed by everyone involved.

TRINITY MISSION

We will strive to ensure the people of Blackpool, Fylde and Wyre have:

Compassionate Care on the journey towards the End of Life

TRINITY VALUES - THE TRINITY TEN

Trinity has been an organisation driven by its values for a very long time, well before it became fashionable to say such things. The previous Trinity strategic plan had the values stated in it. We have agreed that we will undertake some work in the next year or so to make the values even more explicit to set out what each value means for everyone at Trinity. We will live the values.

- 1 To put patients' needs first and focus on the person not their illness;
- 2 To care for, and support, the carers and families;
- 3 To deliver the most effective specialist (but not elitist) palliative care that we can;
- 4 To be a learning organisation and to learn with others who are providing generic palliative care;
- 5 To respect and value the contribution of all Trinity staff and volunteers;
- 6 To use creativity and innovation to continually improve our care;
- 7 To serve the local community of Blackpool, Fylde and Wyre in the best ways we can in the provision of palliative care;
- 8 To behave ethically;
- 9 To collaborate with partners and other organisations to benefit patients, their carers and families;
- 10 To value the dignity and lives of all.

TRINITY PHILOSOPHY

Light and Help and Human Kindness

The philosophy is the underpinning philosophy for all our work. The history of how this came about is well documented in the story of Trinity. It is enshrined in all we do and is set out in the 'T' at the entrance to Trinity main reception.

We have agreed that, over the first year of this strategy, we will undertake work, with the staff and volunteers, to make explicit what the values and the philosophy mean for everyone at Trinity. We will also look to gain a quality standard: Investors in People (IiP), to ensure Mission, Values, Philosophy, strategic plan and any business plans are fully understood by everyone at Trinity. Indeed, all of the above have been shaped by the Board, Directors, Managers, Staff and Volunteers. They will be able to shape the delivery of the plans as we implement them and make them real.

THE INTERNAL ENVIRONMENT

We have already stated our values in this Trinity 10 year strategic plan. These have a significant impact on the internal environment; they are the 'operating principles' that guide our internal conduct and our relationship with the outside world. Values can be defined as the:

Principles, fundamental convictions, ideals, standards or life stances which act as general guides to behaviour or as reference points in decision making or the evaluation of beliefs or action.

We will live our values, internally and externally.

The strategic plan, like any other, needs to include a realistic assessment and appraisal of the organisations strengths, weaknesses, opportunities and threats. This standard management tool takes into account the past history and current performances. We have done this in the context of developments in the external environment and internal developments. The strengths, weaknesses, opportunities and threats (SWOT) analysis was led by the Trinity Management Team (TMT). The TMT's terms of reference make clear it is the most senior decision making group in Trinity with regard to operational management issues. It will influence decisions about strategy and will lead in delivering the Trinity strategic plan.

One of the reasons to assess the internal environment is to utilise the assessment, together with the analysis of the external environment, to help define the strategic aims. The SWOT analysis shows things that the organisation can change, subject to resources being available. Often things are neither an opportunity nor a threat, they move around the middle. Sometimes, if there is a strategic fit, you need to ask, "What do we need to do to make sure that it is a positive opportunity?" We have done this at Trinity and will develop those opportunities further in a business plan.

SWOT analysis.

<u>STRENGTHS</u>	<u>WEAKNESSES</u>
<p>Specialist knowledge Experienced practice Already know what works what doesn't Committed and dedicated staff Customer/client focused Clinical expertise Support and continuity Skills and knowledge Specialised care High standard holistic patient & family care Support/understanding Staff/people Access to services Reputation, high standards of care Community spirit High standards Relationships/partnerships Educational facilities Knowledge of palliative care We've seen difficult changes though come out the other side We are very good at what we do Quality care we give to patients/families Value staff & volunteers Quality of buildings/resources Caring committed workforce Excellent opportunities for learning and development Working to the same goals Established track record Community support Image Specialist Reputation Adult-children hospice - broad range of service Local charity</p>	<p>Spreading staff too thin with extra workload responsibilities Need to train up juniors to carry more responsibility to give seniors flexibility External communication Closed Insular Communication - between departments Support Availability Each department may not have understanding of each others Effective communication (better now though) Lack of knowledge of other life threatening diseases Dependence of community for funding Insular Doubling up of work Not standardising what is required Lack of involvement in wider community Communication Not having enough time Still people who do not know about us Improvement in communication Closed organisation Inpatient unit/day unit not accessible 7 days Communication Very reliant on volunteers Public awareness Communication Expensive Too insular Too reluctant to change</p>

<u>OPPORTUNITIES</u>	<u>THREATS</u>
<p>To take lead and offer experience Take the initiative More recognition of actual workforce already in place Partnership with bodies outside NHS Not only cancer patients Education Interaction with community Strengthen community Support Increase awareness with whole area Extra available to community services For staff to improve cont. learning to develop themselves and Trinity Good communication /relationships between departments Workforce leading in Palliative care Learning and development Change Looking for information required - to standardise Time saving - one source of information To be leaders End of Life Care Learning & development Leader in EoLC just not locally but nationally Partnership To be accessible to all 7 days per week To admit patients with non-malignant illnesses To promote part time staff into senior posts EoLC Economic climate Positioning as centre of excellence Expand/develop our service Promote more wider audience Economy - support local Provide our wider service</p>	<p>NHS takes lead NHS takes initiative to move forward Lack of funding ie donations Political changes Competition from other providers ie care homes People - poor/bad/indifferent Financial stability Conflicting interests Maintaining expertise of nursing staff within Trinity Government demands new strategies etc Society demands/expectations Finances Ability to maintain our standards as staff change and organisation grows Other organisations - specialist nurses Change- new leadership Too many changes Training needs Balance of teams Not focusing on what we do best trying to be all things to all people Money - lack of it Lack of worthiness - problems inc recruitment Competition Funding/donations Staff may be overworked or stressed due to pressures of work Loss of specialise staff to other organisations EoLC Economic climate Other providers/charities - local and national</p>

PRIORITISED POINTS FROM THE SWOT ANALYSIS

<u>S</u>	<u>W</u>
<p>People/volunteers/staff - caring committed Community spirit Reputation Changes - makes us stronger Expertise - specialist knowledge/ skills High standards Quality of buildings Examples of best practice Image Quality of care we give to patient and families</p>	<p>Volunteers Communication - external - internal Insular Dependence - community fund - legacy Expensive Duplication of information Learning/training junior staff to release other senior staff Public perception Reliance on community support Public awareness Not standardising what is required Each department may not have understanding of each others Different methods of doing the same thing in various areas</p>
<u>O</u>	<u>T</u>
<p>Partnerships Organisation Development of Training & learning centre Leader of EoLC regional and National Focus on trinity re EoLC Interaction with community Income generation End of Life Care Admit patients with non-malignant illnesses Change Whole brand awareness and growth Expansion of care based upon new eligibility criteria</p>	<p>Funding EoLC /Government/ NHS Change Workforce - recruitment/development Competition including other charities Care homes Losing focus Economy/recession Too many changes Maintaining expertise of nursing staff within Trinity People working as a team NHS takes initiative to move forward</p>

THE CURRENT TRINITY FAMILY OF SERVICES

We have set out in the background to this strategy a snapshot of our current Trinity family of services. It is not an accident that we title them here 'current'. We have thought about what we have and made a conscious decision that they are current and we expect to keep them all over the life of this strategy. They will all face challenges of change and we expect that changes in these services will be in line with what we have set out in this strategy. All of the services in our family of services are important to Trinity. We have set out some of the specific challenges to Brian House Children's Hospice below because children's palliative care is not covered by the key driver documents utilised in other areas of this strategy.

BRIAN HOUSE CHILDREN'S HOSPICE

The Trinity Board and Management Development Day looked at the other documents that are driving the 'agenda' in respect of children's palliative care and considered these in its analysis. Later, the management team leading on this area met, along with some Board members and the paediatric consultant to consider some of the specific issues affecting Brian House Children's Hospice. The key driver documents are: Aiming High for Disabled Children and Better Care - Better Lives which is the DoH National Strategy.

Trinity has agreed that there are a number of issues that we need to address for Brian House Children's Hospice. These include: Data collection, costs and a full understanding of them, Local and Regional 'competition' in respect of attracting funding that, in the past, Brian House has depended upon.

We also agreed on a number of issues to be addressed in the Business Plan: Care pathways and 'Best Interest' documents; Increasingly complex nature of the children referred to us; Transition work as children and young people under our care get older. In common with other services, in the Trinity family of services, improvement to services will be a theme in the business plan and in ongoing work.

The local model for Children's palliative care and local children's hospice that Trinity, through Brian House Children's Hospice, provides could come under threat with the policies in the key driver documents. Brian House Children's Hospice is one of only a handful of such models in the UK. In this strategy and development through the business plan, we will prioritise having a robust external evaluation of this local model and, where possible, compare and contrast with other models prevalent in England. Children's Hospice and palliative care for children and young people is complex and the Trinity Board has agreed to devote a themed Board meeting on the subject during the next year to increase its knowledge and understanding of the complexity.

STRATEGIC AIMS

It could be argued that a strategy is simply a sense of priorities and direction for the organisation over a stated period. A series of connected aims that set out the direction for all aspects of the organisation. This Trinity 10 year strategic plan could be seen in that context. What follows, as those 'connected' aims have been developed and decided upon, is the basis for everything else in this strategic plan and related information gathered in the process of defining these strategic aims.

It is clear that, the further away, in respect of a time horizon, you set your plans, the less confident you can be about achieving the desired outcomes Trinity is confident that now is the time to develop a 10 year strategic plan. The publication of the EoLC strategy confirms that confidence. However, in order to keep the Trinity 10 year strategy live and current we will develop detailed 3 year business plans, with SMART (specific, measurable, achievable, realistic and time banded) objectives to ensure we are effecting change in the way we desire and going beyond service reconfigurations.

The whole organisation will be involved in implementing these strategic aims. Everyone will have a role and we will set out how all of the Trinity family of services can be involved. Trinity will play its part in the cultural shift required in EoLC and have its own 'whole systems' approach.

Our six key Strategic Aims are:

STRATEGIC AIM ONE

As the centre of focus for specialist palliative care in the locality we will play a full and active role in the development of a fully integrated and co-ordinated 24/7 specialist palliative care service supported by full implementation of the National End of Life tools (GSF, LCP and PPC).

STRATEGIC AIM TWO

Take a leading role in the delivery of learning, education and training for all health and social care staff:

a) Those providing the day to day care to patients in their homes and hospitals, b) Those that specialise in palliative care in the North West c) Health and social care staff who rarely come into contact with dying patients. We will develop the Trinity Learning and Research Centre to be a 'Hub' in this leading role and co - ordinate delivery of workforce requirements.

STRATEGIC AIM THREE

Accept a strategic role, with partners, to change the community's attitudes to death and dying to one where conversations within the community about death and dying are open, honest and perceived in a more positive light, work on this aim to address all age groups.

STRATEGIC AIM FOUR

Address the communication issues around EoLC. Establish Trinity as an easily accessible source of information, advice and expertise on all issues related to death and bereavement.
Ensure a focus on the needs of patients and carers.

STRATEGIC AIM FIVE

Develop services for people who have advancing, progressive and incurable illness other than cancer in a managed and sustainable way.

STRATEGIC AIM SIX

We will strive for excellence in the provision of all aspects of our work, have high quality and continuous improvement at the core of all that we do.

It is always difficult to find a way to have strategic plans stay just that, strategic, but make the link into the operational plans and work that is real to those involved in the organisation. At Trinity, we see Strategic Aim Six as a bridge to the operational work and the thrust for our 3 year Business plans. Strategic Aim Six can drive all we do and act as our own driver to shape the other strategic aims. This, combined with working through the mission, values and philosophy, should give us the momentum required to play our role in the changes required in End of Life Care.

Clearly, the outcomes from Strategic Aims One to Five will be new services and subject to it being fully funded from statutory sources - see EoLC strategy (page 161).

IMPLEMENTATION, REVIEW AND EVALUATIONS

Strategies, policies and business plans most often fail because the early thinking and planning necessary for success has not been done thoroughly, properly, or in some cases, at all. Trinity is keen to make sure this strategy succeeds and we are addressing these issues at the outset. We want to do what we need to do to make our strategic aims achievable.

This section and this kind of evaluation planning is not about solutions, which are the means to achieve our strategic aims, but rather about what the solutions will have to do in order to achieve our desired outcomes. This can help us, over time, to identify the right solutions.

Over the first year of this strategic plan, we will develop an evaluation plan to meet the needs identified above. It will include: the desired outcome and evidence to be used to judge whether it has been achieved, the starting point, available resources (inputs), constraints and obstacles, Intermediate objectives (to help define the output activity), milestones/targets and indicators or measures of effectiveness.

This evaluation plan, in conjunction with the detailed 3 year business plans, will influence the implementation of this 10 year strategic plan.

We will develop a process for a formal annual review of this Trinity 10 year strategic plan which will be separate from any review process of the business plan.

We will make this strategic plan a live document and when it is required change and update it in line with it being live and able to grow and develop. We will publish an annual update in the Trinity Annual Review.

APPENDIX 1

DEFINITIONS OF GOLD STANDARDS FRAMEWORK (GSF), PREFERRED PRIORITIES FOR CARE PLAN (PPC) THE LIVERPOOL CARE PATHWAY FOR THE DYING PATIENT (LCP)

The Gold Standards Framework

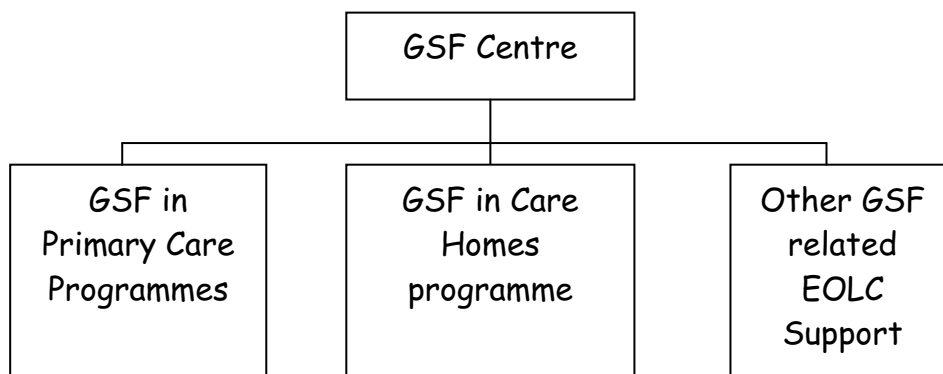
The Gold Standards Framework (GSF) is a framework to enable a gold standard of care for all people nearing the end of their lives.

GSF is a systematic evidence based approach to optimising the care for patients nearing the end of life in the community. It is concerned with helping people to live well until the end of life and includes care in the final year of life for people with any end stage illness.

The aim of the Gold Standards Framework (GSF) is to develop a locally-based system to improve and optimise the organisation and quality of care for patients and their carers in the last year of life.

GSF developed in 2001 from clinical experience in primary care, as a grass roots initiative to improve primary palliative care and collaboration with specialists. Since 2004 the framework has been adapted for use in care homes and a new GSF in Care Homes programme has been developed.

From November 2007 the GSF team became the National GSF Centre and moved to new host Walsall tPCT. A [GSF Position Paper](#) was written in October 2007 setting out the achievements to date and plans for the future.



GSF in Primary Care

Essentially the GSF is a simple common-sense approach to formalising best practice, so that good care becomes standard for all patients every time.

Primary care teams find it affirms their good practice, standardises quality palliative care activities and improves consistency of care.

GSF is a tried and tested framework of strategies, tasks and enabling tools to help primary care teams deliver the best possible care for people nearing the end of their lives. GSF is a generic improvement tool, developed for primary care by primary care, initially for cancer patients, but now used for ANY patient with a life limiting illness and in other settings such as care homes.

GSF embodies an approach that centres on the needs of patients and their families and encourages inter-professional primary care teams to work together. GSF is underpinned by the best available evidence of key issues and effective solutions in this field and at every stage there has been concurrent evaluation and research.

Practice review and audit is an integral part of GSF, as are measures to improve consistency and dependability of care provided.

GSF in Care Homes

The GSF in Care Homes programme is built on the same basic principles as those used in primary care, but has been modified and developed specifically for staff in Care Homes (initially in Nursing Homes). It uses some tools and resources that have been developed whilst working with grass roots staff in Care Homes over the last 4 years, to improve end of life care for all residents - see [GSF Care Homes Section](#).

www.goldstandardsframework.nhs.uk Tel: 0121 465 2029

The Preferred Priorities for Care Plan (formerly Preferred Place of Care)

The Preferred Priorities for Care Plan (PPC) is a document that individuals hold themselves and take with them if they receive care in different places. It has space for the individual's thoughts about their care and the choices they would like to make, including saying where, if possible, they would want to be when they die. Information about choices and who might be involved in their care can also be recorded so any care staff can read about what matters to the individual, thereby ensuring continuity of care. If anything changes, this can be written in the plan so it stays up to date. It is never too early to start a PPC plan particularly for residents in care homes, which for many is their permanent and final place of residence. The PPC provides an opportunity for care homes residents and staff to work together to develop advance care plans in accordance with the new Mental Capacity Act. Residents can initiate the PPC at any time and this will help staff follow their wishes and act as an advocate if the resident loses capacity towards the end of their life.

www.cancerlancashire.org.uk/ppc.html Tel: 01772 647041

The Liverpool Care Pathway for the Dying Patient

The Liverpool Care Pathway for the Dying Patient (LCP) was developed to take the best of hospice care into care for people in hospital and other settings, including care homes. It is used to care for residents in the last days or hours of life once it is known they are dying. The LCP involves promoting good communication with the residents and family, anticipating planning, including psychosocial needs, symptom control (pain, agitation and respiratory tract secretions) and care after death. The LCP has accompanying symptom control guidelines and information leaflets for relatives.

www.mcpcil.org.uk Tel: 0151 706 2273/2274

APPENDIX 2

Documents used in producing this Trinity 10 year strategic plan.

- End of Life Care Strategy - Department of Health July 2008
www.dh.gov.uk/publications Tel - 0300 123 1002
- The Story of Trinity
- Scoping Report of the North West Hospice Provision,
- A Report for the NHS North West "End of Life Care" Team
- Draft Interim for End of Life Care in Blackpool www.Blackpool.nhs.uk
- Help the Hospices - Commission for the Compact www.thecompact.org.uk
- NHS North West - Healthier Horizons for the North West www.northwest.nhs.uk
- NHS North Lancashire's Strategic Plan www.northlancshealth.nhs.uk
- North Lancashire Health Community End of Life Strategy
www.northlancshealth.nhs.uk Tel 01524 519333

APPENDIX 3

A Glossary of Terms used in this strategy

Advance care plan	Advance care planning (ACP) is a process of discussion between an individual and their care providers irrespective of discipline. The difference between ACP and planning more generally is that the process of ACP is to make clear a person's wishes and will usually take place in the context of an anticipated deterioration in the individual's condition in the future, with attendant loss of capacity to make decisions and/or ability to communicate wishes to others.
Care Home	A residential home which provides either short or long term accommodation with meals and personal care (e. g help with washing and eating). Some care homes, known as nursing homes, also have registered nurses who provide nursing care for more complex health needs.
Carer's Assessment	An assessment, carried out by a social worker or a member of social services, which enables an unpaid carer to discuss with social services the help they need to care, to maintain their own health and to balance caring with their life, work and family commitments. Social services use the assessment to decide what help to provide and cannot refuse to meet an identified need solely on the basis of funding. They may, however, set eligibility thresholds according to the availability of resources.
Care Plan	An agreed set of actions reflecting the choices made by a person about their care following an assessment of their needs. In the case of people approaching the end of their life, this may set out how they wish to be cared for and where they would wish to die.
Commissioning	The processes of local authorities and PCT's undertake to make sure that services funded by them meet the needs of the patient and improve quality of life and health outcomes.
Emergency admission	When a patient goes into hospital at short notice, also known as urgent admission and unplanned care.

End of Life	<p>"...a broad term relating to an active, compassionate approach that treats, comforts and supports individuals who are living with or dying from progressive or chronic life threatening conditions. Such care is sensitive to personal, cultural and spiritual values, beliefs and practices and encompasses support for families and friends up to and including the period of bereavement."</p>
End of Life Care	<p>Ross, Fisher & MacLean (2000) <i>A Guide to End of Life Care for Seniors</i>, Ottawa, Health Canada Services to support those with advanced, progressive, incurable illness to live as well as possible until they die. These are services that enable the supportive and end of life care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support. This support is not confined to discrete specialist services but includes those services provided as an integral part of the practice of any health or social care professional in any setting.</p>
Full Cost Recovery	<p>In the context of HM Treasury's Cross Cutting Review on the <i>Role of the Voluntary and Community Sector in Service Delivery (2002)</i>, 'full cost recovery' refers to relevant overhead costs. The Review recommended that funders should recognise that it is legitimate for voluntary sector providers to include in their cost estimates for providing a given service under a contract of service agreement. In the context of hospice care, this does not mean the full costs of the hospice, but rather those services provided by the hospice that are commissioned by the PCT.</p>
Hospice	<p>Hospices provide care and support to people at the end of their life and their carers, through a range of services such as in patient care, day care, community services, out patient appointments, sitting services, respite care and bereavement counselling. The first modern hospice was opened in South London in 1967 and, since then, hospice care has developed into a movement to change the way in which end of life care is delivered. Most hospices in England are independent local charities which are part funded by the NHS, although some hospices operate nationally and a small number are provided by the NHS. For the purpose of this report, the term, 'hospice' covers both independent and NHS run facilities unless specifically stated otherwise.</p>
Local authority	<p>National policy is set by central government, but local councils are responsible for day-to-day services and local matters. This includes the provision of social support and long-term nursing and care for individuals who can no longer live unsupported in their own homes. Local authorities are funded by government grants, Council Tax and business rates.</p>
National Institute For Health and Clinical Excellence (NICE)	<p>An independent organisation covering England and Wales, responsible for providing guidance on the promotion of good health, NICE provides objective guidance in the clinical and cost effectiveness of drugs and treatments.</p>

Needs assessment	Needs assessments are carried out by local authorities to establish the needs of an individual who requires help from local social care services and to arrange services to meet their needs. Local authorities may set eligibility thresholds on the services they provide according to the availability of resources.
Palliative Care	<p>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."</p> <p style="text-align: right;">National Council for Palliative Care</p>
Payment by Results (PbR)	The aim of Payment by Results (PbR) is to link income to work actually performed and, by so doing, reward efficiency and encourage innovation. It is based on a prospective payment system where the price for a given unit of activity is set in advance, and income is based on multiplying the relevant price by the amount of activity actually delivered. The key components of PbR are the Healthcare Resource Group (HRG) and the tariff or price. The HRG is based on an 'episode' of care which is a defined package of treatments, alongside a typical hospital stay, for a particular condition.
Primary Care	The collective term for all services which are people's first point of contact with the NHS (e. g GP's, dentists)
Primary Care Trusts	A statutory body and part of the NHS responsible for delivering healthcare and health improvements to local residents, for example by commissioning care from providers such as hospitals.
Quality and Outcomes Framework (QOF)	A component of GP's' contracts, the QOF sets targets for GP's against evidence-based criteria covering a range of general and condition-specific indicators. Payments to practices are calculated on the basis of the extent to which these targets are met.
Secondary care/acute care	Care often provided in a hospital or particular specialised centre, which may be accessed directly or following a referral from primary care.
Social Care	Services which support people in their day-to-day lives to help them play a full part in society. Services provided range from home care and nursing homes to the provision of a personal assistant for a disabled person, or support for an individual in emotional distress. Each of the 150 local authorities in England has a statutory duty to assess the social care needs of individuals and to arrange for the provision of appropriate services to address the needs of those who are considered eligible for support following an assessment of need (see needs assessment).

Social Care Institute
For Excellence

An organisation that aims to improve the experience of people who use social care by developing and promoting knowledge about good practice in the sector.

Specialist Palliative Care

See Palliative Care. Specialist Palliative Care is provided by multi-disciplinary teams that might include consultants in palliative medicine, nurse specialists, specialist social workers and experts in psychological care. Such staff are specifically trained to advise on symptom control and pain relief.

Strategic Health Authorities

The body responsible for the supervision of the NHS Trusts within its boundaries to ensure that local services are commissioned and run effectively and efficiently.

Supportive Care

"...helps the patient and their family to cope with disease and treatment of it, from pre-diagnosis, through the process of diagnosis and treatment, to cure, continuing illness or death and into bereavement. It helps the patient to maximise the benefits of treatment and to live as well as possible with the effects of the disease. It is given equal priority alongside diagnosis and treatment."

National Council for Palliative Care