Policy:	**East Cheshire Hospice @Home Rapid Response Service Specification and Standing Operating Procedure**		
Executive Summary and associated documents	The East Cheshire Hospice @Home service will be provided by working in partnership with already established services to support patients and enable them to die in their preferred place of care acknowledging the need to identify patient choice. The service will provide rapid access to a skilled and trained care workforce with community nursing support with the ability to be responsive to referrals **RELATED HOSPICE POLICIES/PROCEDURES:** • Complaints • Governance • Gift acceptance • All ECH Health and Safety Policies • All ECH HR Policies • All ECH Insurance Policies • All ECH IT policies • All ECH Clinical Policies • Lone Worker Policies • Driving at Work policies • Weather Conditions Policy • Personal Safety Policy		
Description of Amendment(s)	New Policy		
This Policy will impact on:	Hospice @Home		
Policy Area	Hospice @Home		
Effective Date:	Aug 2017	Review Date:	July 2020
Responsible person for updating policy	Sarah Dale Director Quality, Innovation and Collaboration		
Approval Record			
			Date
Ratified by:	PCCG		Aug 2017

	Board	Aug 2017
CEO:	Karyn Johnston	

East Cheshire Hospice

East Cheshire Hospice @Home (H@H) Rapid Response Service

1.0 INTRODUCTION

NHS England: Actions for End of Life 2014-16 document states approximately ½ million people die each year, with three quarters of deaths expected. High quality end of life care is required and can be facilitated by health care professionals providing they have time, education, training, and support. Around half a million carers provide care to people at end of life with a proportion of these people having complex needs that require access to support and advice from healthcare professionals trained in specialist palliative care.

The Choice in End of Life Care Programme Board (2015) carried out an extensive patient survey that provided the government with advice on improving the experience and quality of care for patients at end of life, generally the evidence suggests that although in many cases PPD was the patient's own home, many patients were not achieving their preferred place of death.

There is an increasing acknowledgment that a significant proportion of terminally ill patients' in the UK would wish to die at home. Population studies of preferred places of death [PPD] indicate that over 60% of people including those who are not facing a life limiting illness wish to die at home, although unfortunately following a population study of just under 10,000 adults across England, only 34 % have been able to achieve their PPD. 28% wished to be in the presence of family and friends and 24% stated they wished to be pain free (British Social Attitudes survey, 2012).

The NICE Quality Standard for end of life care for adults (2011) set 16 quality statements providing a picture of what high quality end of life care should look like and putting more emphasis on timely holistic, personalised care, appropriate to patient need.

All Patients at the end of life should have an individual needs assessment, care plan and provided, enabling them to die supported in their chosen place of care (Palliative and Supported Care Strategy for NHS Birmingham East and North, 2007).

The East Cheshire Hospice @Home service will be provided by working in partnership with already established services to support patients and enable them to die in their preferred place of care acknowledging the need to identify patient choice.

2.0 AIM

The purpose of the East Cheshire Hospice @Home Service (H@H) is to offer additional support to that which is provided by the statutory services already established. H@H aims to support palliative and end of life patients within their usual place of residence and to die at home if that is their preferred place of care as a priority, and where prognosis is anticipated to be a few weeks.

The main objective is to facilitate a dignified and comfortable end of life if the patient's preferred place of death is their home. Carers need to be included in negotiations as support for them is often necessary to fulfil the patient's preference for care.

A high level of communication is required between all health care professionals involved in the patient's care, and they will aim to facilitate the following:

- Providing practical care and emotional support in the last 3 months of life, with the priority given to those in the terminal stage - the last days of life initially, to the general practice registered population of East Cheshire.
- Providing additional support for patients and family when discharged from hospital or hospice, and to support rapid discharge for end of life care.
- Working in collaboration with existing NHS service (District Nurses, Intermediate Care, Marie Curie, Macmillan, and Continuing Health Care).
- Being complementary to the district nursing service and work in partnership to provide seamless care and collaborative working with the statutory services
- Supporting the delivery of the Last days of Life template, with the overall aim being to enable patients at end of life to achieve their preferred place of care and death in the context of dignity and comfort.
- Providing an equitable service to all patients with need across East Cheshire, including hands on practical and social support, rapid and planned response with specialist assessment during the out of hours period.
- Helping to increase the number of patients who die at home by supporting patients to achieve their preferred place of care and death
- Prevent avoidable admissions for patients at end of life by offering support and reduce crisis
- To act as a source of specialist advice and support to generalist staff
- Ensuring regular evaluation of the service using the clinical governance framework.

3.0 EXPECTED OUTCOMES

- Increase the number of deaths at home or the patients preferred place of care
- Reduction of inappropriate admissions
- Increased numbers of patients with a palliative diagnosis other than cancer being cared for at home, eg. Heart Failure, respiratory failure, neurological disorders, dementia, frailty, and elderly
- To decrease the number of patients that die in hospital
- Meeting the standards for End of Life Care

East Cheshire Hospice @Home service will be required to demonstrate that it meets the needs of the patients and their families and that it is done in an effective and efficient way.

Using the Outcome Assessment and Complexity Collaborative suite of measurement tools (OACC) recommended by Hospice UK and the Cicely Saunders Institute, East Cheshire H@H Services aims to capture and demonstrate the impact of palliative care in a validated way.

4.0 EVIDENCE BASE AND COMPLIANCE WITH STATUTORY REQUIREMENTS

- Care Quality Commission (Registration Regulations) 2009 (Part 4)
- Building on the Best' document recognising the importance of choices at the end of life, Dec 2004
- Data Protection Act 1998
- Department of Health; Our NHS Our Future
- Department of Health; National End of Life Care Strategy 2008
- Health and Safety Regulations
- Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3)
- National Audit Office; Report on End of Life Care 2008
- National Forum for Hospice at Home 2007
- NHS England; Actions for End of Life 2014-16
- NICE Guidance (2004) improving Supportive and Palliative Care for Adults with Cancer.
- NICE Quality Standards 2011
- Palliative Care Strategy 2004
- White Paper; Our Health, Our Care, Our Say, focusing on the development pathways in the community

5.0 RELATED POLICIES AND PORCEDURES

- Complaints
- Governance
- Gift acceptance
- All ECH Health and Safety Policies
- All ECH HR Policies
- All ECH Insurance Policies
- All ECH IT policies
- All ECH Clinical Policies
- Lone Worker Policies
- Driving at Work policies
- Weather Conditions Policy
- Personal Safety Policy

6.0 SCOPE

The service will provide rapid access to a skilled and trained care workforce with community nursing support with the ability to be responsive to referrals from District Nurses, Macmillan Nurses, acute hospital nurses, and GPs. The service is not able to deliver a long-term care

package. It is a service that will support people at end of life for an assessed and agreed period by the H@H Rapid Response team.

East Cheshire H@H Rapid Response Service will offer patients within the locality of East Cheshire "timely and equitable access to a high-quality service across all settings, delivered by appropriately trained professionals".

Although the service will be a predominantly an unplanned service, we envisage that there may be the potential to offer a timely responding service to support patients who deteriorate at home and prevent avoidable admissions.

The East Cheshire H@H Service will operate Monday – Friday 6.30pm – 8am weekdays and 24 hours a day Saturday and Sunday and Bank Holidays. There will be a co-ordinator on duty 9.30am -5.30pm Monday to Friday to answer calls and plan care for the out of hours period.

This policy is relevant to all East Cheshire H@H staff and all the staff who work within the hospice and who can inform, refer, promote, and support the service.

The focus of the H@H Rapid Response Service is to provide outreach from a recognised Specialist Palliative Care unit that will support patients out of hours to remain at home during the end stages of their life and facilitate a dignified and comfortable death in the presence of their loved ones.

6.1 Whole System Relationships

East Cheshire H@H Service will work in partnership with GP's, DN's, the Acute Trust and Out of Hours services across East Cheshire, Marie Curie and other Health Care providers within the system, to ensure seamless patient care, and ensure the patient's key worker is informed of patient's progress.

6.2 Interdependencies

- General Practice
- Community Nursing Team
- Hospice Services
- Community Pharmacies
- Out of Hours Urgent Care Services
- Hospital Services
- Therapy services
- Bereavement Services
- North West Ambulance Service
- Chaplaincy Services
- Marie Curie
- Commissioners

6.3 Sub-Contractors

The service does not currently use sub-contractors in the delivery of any aspect of service delivery.

7.0 REFERRAL, ACCESS AND ACCEPTANCE CRITERIA

7.1 Geographic Boundaries

This service is operational across East Cheshire.

7.2 Location of Service

The service is available to patients in their own home wherever it is deemed to be.

7.3 Days and Hours of Operation – To cover 5 nights per week in conjunction with Marie Curie

MON	TUE	WED	THUR	FRI	SAT	SUN
Co-ordinator and assessments 9.30-5.30pm Night shift Rapid Response 6.30pm-8.00am	Co-ordinator and assessments 9.30-5.30pm Night shift Rapid Response 6.30pm-8.00am	Co-ordinator and assessments 9.30-5.30pm Night shift Rapid Response 6.30pm-8.00am	Co-ordinator and assessments 9.30-5.30pm Night shift Rapid Response 6.30pm-8.00am	Co-ordinator and assessments 9.30-5.30pm Night shift Rapid Response 6.30pm-8.00am	Rapid response 24 hours 9pm-8am	Rapid response 24 hours 9pm-8am

7.4 Accessibility

East Cheshire H@H Rapid Response will ensure a seamless approach to the delivery of care via agreed communication systems upon receipt of referral. At all times we will ensure that the District Nurse will retain responsibility for the care of the patient and that Marie Curie continues to be first point of contact when organising night sits.

Palliative and End of Life patients will be assessed and identified by their General Practitioner/District Nurse (GP/DN), Specialist Nurse, Hospital Consultant or other Health Care Professional (HCP).

Patients will access the service through:

- Referral from HCP/GP
- Referral from Hospital
- Referral from DN service
- Self-referral supported by GP
- Care Homes and Nursing Homes

East Cheshire H@H Rapid Response Service will be required to demonstrate compliance and monitoring of:

- Equity of access to service for all vulnerable groups within East Cheshire.
- Reflect a duty to promote racial equality both in service delivery and workforce policies.

7.5 Referral Criteria and Sources

- Adults 18 years and upwards who have a life limiting illness and a choice to be cared for at home or to die at home discussed and documented.
- Have a life limiting illness and be assessed as being in the last 3 months of life with non-reversible deterioration.
- Patients will have a preferred place of care as home, have family and carers in support of this and where possible advanced care plans in place.
- Be on their GP's GSF register or added at point of referral.
- Have an identified need for the East Cheshire H@H service
- Will preferably be known to the District Nursing team and have a plan of care in place.
- Agree to the referral
- Will be agreeable to having a risk assessment of their environment and an initial assessment.
- It is preferable that patients have the appropriate paperwork in place to support the administration of end of life medications and to authorise nurse verification of death.
- DNACPR should be actively explored for patients who are referred to the hospice home service, particularly those referred for symptom control at EOL and whose PPD is home.

The care provided will cover 5 key areas:

1. Symptom management/support
2. Complex social support
3. Psychological and or spiritual support
4. Care and support for families and friends
5. Rapid intervention to support them to remain at home or to return home

Referrals will be monitored accurately with the record of the following made as a minimum:

- Source of referral
- Primary Diagnosis
- Reason for Referral
- Urgency of response

Referrals will be accepted from any Health Care Professionals within East Cheshire, predominantly District and Macmillan Nurses. Patients and Carers may also self-refer if the GP is aware.

When a referral is received the referrer will be notified. Contact with the key worker will be made before any service is provided to ensure sharing of information and partnership working.

7.6 Exclusion criteria

- All patients under the age of 18
- Patients who do not meet the criteria for inclusion on the gold standards register
- Patients' who are not registered with a GP within East Cheshire
- Patient's with no life limiting illness except the frail/elderly at End Of Life
- Patients who have had chemotherapy and or radiotherapy in the last 14 days (oncology advice should be sought first)
- Patients who have been assessed as a risk to staff (each situation will be assessed on an individual basis).

Patients who are not thought to be in the last 3 months of life *do not* fit the criteria for Hospice @Home Rapid Response, although an on-hold referral can be sent so the

patient information is available in case of rapid decline and crisis intervention is needed.

8.0 SERVICE DELIVERY

8.1 Service Description

- Input from H@H Rapid Response service can be offered within the last 3 months of life providing that H@H Rapid Team have the capacity to commit to undertaking the care alongside community services during the out of hours period.
- The team will offer specialist skills of hospice staff in a person's home, providing support at night and during the weekend hours.
- The team will consist of trained nurses and health care assistants.
- Hospice @Home Rapid Response Service works collaboratively with other health and social care providers aiming to work in conjunction with, and in addition to such services, utilising open and free communication between organisations.
- The integrated service will provide End of Life care incorporating the NICE guidance and using the End of Life tools. The service will be integral to the existing tools such as the Last Days of Life template, the Gold Standard Framework, and the Preferred Priorities of Care.
- Where involved, the community key worker eg. District Nurse, Community Matron etc. will retain autonomous responsibility for co-ordinating care requirements. Other key professionals may be Continuing Health Care Co-ordinator, Social Worker or Macmillan nurse.
- Referrals will be accepted by the H@H Rapid Response Service co-ordinator and can be made directly to the H@H Rapid Response Service team by any health care professional working within East Cheshire. All referrals will be co-ordinated by a registered nurse from East Cheshire H@H Rapid Response Team.
- All referrals will need a completed electronic referral form emailed to the team.
- Telephone referrals can also be accepted when the referral is urgent, **but must be** followed up with a referral form as soon as possible.
- The referral information needed contributes to a key aspect of co-ordinating care services and enables the registered nurse to review and assess the current care provision which will enable appropriate prioritisation and allocation of resources.
- Once a referral is received and accepted, arrangements will be made for a trained nurse to visit and carry out a first assessment prior to care commencing.
- Urgent referrals must be followed up with a phone call to the coordinator to facilitate a timely response.
- East Cheshire H@H Rapid Response will support rapid discharge from the hospital for patients requiring end of life care, alongside other community services, if this is the patient and families wish to be at home. Where relevant patients who are waiting to be admitted to the hospice/hospital or wish to go home and are awaiting other service input, can be supported by the H@H Rapid Response Service team.
- East Cheshire H@H Rapid Response will support patients being discharged to a nursing home following an In-Patient Unit (IPU) admission in accordance with this Standard Operating Procedure (SOP).
- East Cheshire H@H Rapid Response will support patients within residential and Nursing Home environments at end of life. The support given will be advice on symptoms and care, not hands on nursing care.
- Practical nursing care and emotional support will be provided between the hours of 6.30pm – 8am Monday – Friday and over the 24-hour period at weekends and Bank Holidays

- H@H Rapid Response Service will provide rapid and planned response to patient need regardless of diagnosis at end of life.
- Hospice @Home will provide Rapid response when required to prevent inappropriate admissions to hospital at end of life.
- H@H Rapid Response Service will provide access to specialist palliative advice
- A patient information pack will be provided and given to the patient and their family at the commencement of the service.
- H@H Rapid Response Service will provide pre-bereavement support and bereavement follow-up can be arranged with other key healthcare professionals as appropriate. Carers and relatives will be supported and invited to attend the remembrance and light up a life service.
- Ongoing audit and governance to be in place across the organisation to establish ongoing standards of practice.

Referrals may be declined if it is deemed that the needs of the patient **do not** fit the criteria. In these instances, the referrer and main keyworkers will be contacted.

9.0 THE TEAM

The team will consist of:
- Clinical Lead 9.30 -5.30pm Monday – Friday (times will be flexible to need)
- A Team of Trained Nurses and Health Care Assistants working Out of Hours and during the day weekends
- Administration support Monday – Friday.

9.1 Clinical Lead
To direct the overall running of the service and support the team with annual appraisal, clinical supervision, objective setting, and continual service development.

The Clinical lead will report to the Director of Clinical Services and will engage with regular 1:1's and receive a documented yearly appraisal.

9.1.1 Role of the H@H Team Clinical Lead

- To manage and develop the team as per the Operational Policy
- Communication with all stakeholders
- To manage the on-going development of operational policies
- To facilitate the service off duty rota and annual leave
- To monitor standards of clinical care of the team
- To manage absence as Hospice policy
- To liaise with the Hospice's Senior Management Team, District Nursing Managers and other stakeholders in the review and future development of the team
- Undertake holistic assessments of referred patients and building on the information recorded in the District Nurse assessment to reduce the number of times the patient gives the same information.
- To liaise with the Continuing Health Care Team, to take referrals for packages of care, dependant on capacity.
- To ensure data on clinical activity for Domiciliary Care is recorded correctly, to enable correct reporting for Finance Team.
- Undertake a risk assessment

- Will support the family, registered nurses within the team and HCA's, and build and promote good working relationships with the families, referrer and Hospice staff.
- Agree with the patient and family a plan of care that H@H Domiciliary Care Service will implement coordinating with the DN Care Plans and will liaise with all members of the MDT to provide seamless care.
- Assist and support rapid discharge from hospice or hospital.

9.2 Care Co-ordinator

To support the clerical function of the team, including the collection and collation of activity data and feedback to demonstrate the worth and value of the service.

A care co-ordinator will have access to Clinical and Medical support and links with the Sunflower Centre Day Services and In-Patient Unit at the Hospice.

The Care Co-ordinator will report to the H@H Clinical Lead and will engage with regular 1:1's and receive a documented yearly appraisal.

9.2.1 The Co-ordinator: -

- Support the Clinical Lead to review and prioritise the referrals and will be a contact for phone enquiries
- Support the Clinical Lead to manage the organisation of patient visits for the shift and delegate appropriately to other members of the team.
- Support the Clinical lead to ensure all Domiciliary Dare data is collated for reporting to finance.
- Liaise with the referrer and patient/carer if needed.
- Offer bereavement support via the telephone and signpost if necessary

Support a handover of patient changes at the end of each shift

9.3 RGN / Shift Lead in absence of Clinical Lead

Provide cover in the absence of the Co-ordinator and carry out the necessary duties to ensure the service remains functioning.

The registered nurses will support the Clinical Lead to ensure the service meets high standards of care delivery and support the HCA's in delivering the care.

The registered nurse will have access to medical support and links with the In-Patient Unit at the Hospice OOHs .

The Registered Nurse will:

- Review and prioritise the referrals and will be a point of contact for phone enquiries OOH
- Manage the organisation of patient visits for the shift and delegate appropriately to other members of the team.
- Liaise with the referrer and visit the patient if needed.
- Undertake holistic assessments of referred patients and building on the information recorded in the District Nurse assessment to reduce the number of times the patient gives the same information.
- Undertake a risk assessment if not already completed
- Will support the HCAs within the team and build and promote good working relationships with the families, referrer, and Hospice staff.
- Offer bereavement support via the telephone and signpost if necessary
- Conduct a handover of patient changes at the end of each shift

- Agree with the patient and family a plan of care that H@H Rapid Response will implement coordinating with the DN Care Plans and will liaise with all members of the MDT to provide seamless care
- Assist OOH Doctors to support patients in their preferred place of care e.g. home, nursing home, and residential homes.
- Assist and support rapid discharge from hospice or hospital.

A full induction programme will be completed, including some practical clinical experience within the Hospice and community (see education programme).
On-going education and training will be delivered to all staff to enable the Hospice at Home Team to develop a good skill and knowledge base in the specialist and complex areas of end of life care.

9.3.1 Clinical Role of the RGNs in the H@H team:-

- The ability to make a full assessment, plan care and document all details of visit on Emis as per policy guidelines
- Liaise with the District Nurse Team following the assessment outlining plan of care to be offered by Hospice @Home Rapid Response team.
- Liaise with the District Nurse team if there are any changes with the patient following Hospice @Home Rapid Response visits.
- Provision of high quality palliative care to patients and carers, using enhanced communication skills, offering emotional, psychological and spiritual support
- The administration of medication if required during the H@H visit, as prescribed on the blue community form following the 'Standard Operating Procedure' – **Administering Medicines in the Community Setting - Standard Operating Procedure.** The SOP has been agreed between the Hospice and ECNHS Trust.
- Work to a shift pattern that covers Out of Hours Monday to Friday and 24 hours cover over Saturday and Sundays and Bank Holidays.
- Discharging patients from the service following review of their needs
- Use moving and handling equipment as provided by the DN service and working directly with DNs providing nursing care to patients
- Use of other equipment supplied on FP10, AHPs or DNs within the Registered Nurse' knowledge and limitations

9.3.2 Non-clinical role of the RGN

- Participate in education and conduct reflective and training sessions for H@H staff
- Participate in the collection of data and audits of the H@H Rapid Response service
- Ensure knowledge and skills are up to date
- Support for Health Care Assistants
- Mentoring Health Care Assistants, Student Nurses, other HCP visiting the team
- Attend meetings with GPs, District Nurses if requested
- Participate in clinical support meetings

9.4 Health Care Assistants

- Will offer care and support to patients and their families within the patient's home.
- A full induction programme will be completed, including some practical clinical experience within the Hospice and community (see education programme).
- On-going education and training will be delivered to all staff to enable the H@H Rapid Response Team to develop a good skill and knowledge base in the specialist and complex areas of end of life care.

9.4.1 Clinical Role of the Health Care Assistant

- Provision of high-quality palliative care to patients and carers, using effective communication skills, offering emotional, psychological, and spiritual support
- To assist in the implementation and delivery of holistic patient care as directed by the Registered Nurses including personal hygiene, supervision of patient's self-administration of medication
- Use moving and handling equipment as directed by the Registered Nurse and joint working with members of the DN team using recommended safe M&H procedures
- Use other equipment supplied on FP10, by AHPs or DNs within own knowledge, skills and limitations
- Work to a rota pattern covering Out of Hours Monday - Friday and 24-hour cover Saturdays and Sundays and Bank Holidays.
- Organisation of daily workload in conjunction with the coordinator and other members of the team
- Documentation of care given on Emis as per policy and guidelines.
- Participate in daily handovers and ensure information regarding changes in the patient's condition is reported to the coordinator and/or DN team

9.4.2 Non-clinical Role of the Health Care Assistant

- Participate in education and training sessions for the team and Hospice staff
- Participate in the collection of data and audits of the H@H Rapid Response service
- Assist in the stocking and ordering of supplies for the East Cheshire H@H and ensuring equipment is returned and maintained correctly
- Participate in clinical support meetings

9.5 Recruitment and Training of staff

The H@H Rapid Response service is a cost-effective high-quality service, all new staff will receive an induction which will include:

- Understanding standard operating procedure - Health and Safety; Moving and Handling; Undertaking risk assessments; Managing conflict; Lone working; and Infection control
- Communication skills
- Symptom management/ Symptoms experienced at the end of life
- End of Life Care (Personal care, mouth care, suction if available at home)
- Medication management
- Management of palliative care emergencies
- Supporting families and managing distress
- Process of the verification of death
- Record keeping and Documentation
- Use of Emis and Lone worker devices
- Working safely- clocking in, contact numbers, partnership working, communication, handover

We envisage the staff will need to work with other health care providers during the induction period, which may include:

- Shadowing other community team- Macmillan, District nursing team - twilight and overnight service, Social Care teams.

10.0 RESPONSE TIMES AND PRIORITISAION

This is a seven day a week service. The Team Co-ordinator will be available to accept referrals between the hours of 9.30am-5.30pm. Thereafter it will be the registered nurse on the evening/night service from 6.30pm and 24 hours during the weekend and Bank Holidays. On receiving the referral, the Team Co-ordinator/registered nurse will use a RAG system to prioritise the referral and will respond accordingly with the family and referrer.

There will be a same day response for urgent patient need and a RAG tool will be used to assess and respond to other patient need.

- RED – *high/urgent needs* – rapid change in condition, complex symptoms in the last hours or days of life, rapid discharge, carer crisis, pre-admission – rapid response to need by making contact with the patient / carer within 30 minutes -1hour
- AMBER – deterioration in the last days or weeks of life, awaiting care package, potential breakdown foreseen, respite for carers – planned care response to referral in 2 hours with a planned assessment within 24-48 hours
- GREEN – may not be appropriate for Hospice @Home Rapid Response at this stage, or the team can make contact and hold on file

Assessment of urgency will be carried out and agreed between the service assessor and the referrer.

Priority will be given to patients fulfilling the criteria for the end of life care pathway, usually in the last few days to 2 weeks of life. A framework for prioritisation is used as a guide to support clinical decision making.

If the patient requires further ongoing personal care then a referral will need to be made to an appropriate care provider.

11.0 DISCHARGE CRITERIA AND PLANNING

11.1 Discharge Criteria

The service decides that a patient is ready for discharge if the patient is stable, able to self-care or the prognosis improves.

Patients on the scheme will be assessed at least weekly by the MDT as this service is not a long-term care package

Patients may be discharged from the service when:

- the patient's condition no longer meets the service criteria, however if any patient should require the service in the future a re-referral can be made.
- the family express no input is required
- the patient is admitted to another inpatient setting or their care can be met by another community care provider
- the hospice multi-professional team, in conjunction with the patient and their family, agree the service input is no longer beneficial
- the patient dies

- Assessment and planning is undertaken
- Referral to other agencies if needed

- Contact with GP/Key worker
- Ensuring that the patient / carer knows who to contact if their needs change and they have concerns

Longer term care packages will be pursued (and discussed with care managers ie District Nurses) if the care is needed for longer than 3 months.

12.0 RE-REFERRAL

Patients can be referred back into the service after discharge if their care needs change and they meet the referral criteria.

13.0 ACCOMODATION/CONTACT

Health Care Professionals, pateints and carers can contact the service on the land line number **01625 664999** (with answerphone availability) or mobile. Answer phone messages will be checked on a regular basis and out of hours calls will be diverted to the mobile phone.

In the first instance, patients should contact the District Nurse (Key Worker/caseload holder) for medical and nursing support. Patients and relatives can contact the team at the Hospice to make visit changes.

Each member of staff on shift will be allocated a mobile phone, working iPad for professional use only when attending an allocated visit and a lone worker device and a bag with supplies.

Use of satellite navigation on the mobile phones

Equipment required to assist a patients' needs will be assessed at the point of referral and form part of the risk assessment. Any equipment required and not in situ will be recommended by the team to the current caring team during the handover process from nights to days.

13.1 Hours of Operation

East Cheshire Hospice @Home Rapid Response will operate: -

9.30-5.30 Clinical Lead (weekdays)
Week Nights - 6.30pm -10pm
Weekends – 8.00-3.30 pm early shift assessments & rapid response
Weekends – 2.30 – 9.30 pm late shift, assessments & rapid response
Every Night – 9.00pm -8.00am night assessments & rapid response

14.0 SYSTEMS OF WORKING

14.1 Rapid Response

H@H Rapid Response will have a registered nurse and health care assistant available during out of hours Monday – Friday 6.30pm -8am and 24 hours a day Saturday and Sunday and Bank Holidays to respond rapidly dependent on patient need and capacity within the service.

14.2 Assisted Discharge Home

- H@H Rapid Response can offer assisted discharge support in individualised cases that are considered by the discharging MDT to be complex to support patients to be transferred from Hospice or hospital to their own homes.
- In the case of a patient's own home being a residential care setting, support can be agreed in the discharge planning process with the residential home staff and community services.
- The support required will be patient centred and offered on assessment of identified need. It will not replace community support but enhance and enable an integrated care approach to sustain a discharge. The service offered is provided in terms of days.
- H@H Rapid Response will offer support for a transitional, agreed time, in accordance with the care manager/s ie District Nurses and H@H Rapid Response team. This will be documented and agreed in the patient's record and care plan.
- A designated date will be set to review the support after the discharge to home to ensure a timely and co-ordinated handover to the community.

14.3 Assisted Discharge to Nursing Home following IPU Admission

- H@H Rapid Response will support a patient transfer to nursing home following an inpatient admission.
- Referral to H@H Rapid Response from IPU will enable a plan of support for a period of time to enhance the discharge process.

14.4 Administration

- Following completion of each patient's period of care a feedback form will be sent by the H@H co-ordinator to the named carer/patient for feedback to inform further service development.
- Patients on the active caseload should meet criteria stipulated above and require regular contact from the H@H Rapid Response team (from several times a week to monthly depending upon need).
- The H@H co-ordinator will be responsible for supporting the Clinical Lead in recording the activity data and collating evidence of quality indicators as determined by the steering group.
- Team members utilising the H@H pool car will need to complete the required documentation inside the vehicle following each use – mileage, driver, passenger.
- Each team member will submit their mileage claim forms (if using their own vehicle) which will be countersigned by the Clinical Lead on a monthly basis.
- The Clinical Lead will hold team meetings to gain feedback, offer support and discuss service development and identify continual education and training.
- The Clinical Lead will set quarterly team meetings to ensure support and service development is maintained.
- The Clinical Lead will ensure clinical supervision and appraisal is available for the team.

14.5 Documentation

The H@H Rapid Response service complements existing care services and will utilise existing assessments which provide the details of the patient's clinical condition. These will include the community care plan, district nursing records and Emis.

The H@H Rapid Response team will undertake an assessment which will identify the problem that they have been asked to help support and an overview of the patient's clinical condition. This will include clinical observations where appropriate, and the use of clinical tools to support the assessment. This will be completed on the Holistic assessment on Emis, ideally during the

patient visit using the virtual desktop portal on the mobile tablet. An action plan/summary of care will be completed following the assessment. If Emis fails there will be paper notes available which can be copied and will be scanned onto Emis at ECH.

14.6 Patient / Professional Information

Information regarding the service is available in a booklet for patients and professionals. There is also accompanying information to support the referral form. Patients will be given a booklet on the first assessment with details of the service and the visits planned.

14.7 Service Communication

The team will communicate with the GP and District Nursing Teams as follows:

- Completing the clinical documentation on Emis at each visit contemporaneously
- RGNs administering medication will follow the **Administering Medicines in the Community Setting - Standard Operating Procedure** as agreed with the ECNHS Trust.
- The team will contact the District Nursing team following any input of care as they remain the main co-ordinators of patient care.
- The team will handover between the early and late shift.
- Team Meetings will be planned monthly to review the service, discuss compliments and complaints, incidents, and changes to the service.

14.8 Handover and Review of Patients

The Hospice @Home Rapid Response team will participate in a dial-in handover at 7.30am and 9.30pm with district nursing colleagues to support the transition of care from Nights to Days and vice versa.

Patients known to district nursing services will be visited as standard by the district nursing team if a rapid response visit has been facilitated overnight. A handover, either by phone or Emis, will be given directly to the DN team involved if any interventions have been required overnight.

Handover contact details for Tel numbers of all DN services locally can be found in the H@H office.

15.0 Multidisciplinary Team

A multidisciplinary team meeting will be held with the specialist palliative care medical team at 09.15am on a Thursday. The H@H Rapid Response team will prepare the MDT proforma (Handover list) for all patients on the current caseload for discussion. This MDT will provide clinical supervision for staff.

15.1 Referral to the Specialist Palliative Care Team

Patients known to H@H Rapid Response team will be handed back to the district nursing service for review, if the patient is unknown to the SPCT and staff feel a visit is required, a discussion will take place and a referral to the service actioned in the usual manner.

15.2 Referral to District nursing services

Patients assessed by Hospice @Home Rapid Response team who are not known to District nursing services, a referral can be made for district nursing input via the usual referral process.

15.3 Referrals to other services (Marie Curie)

Discussion should take place with the current caring team regarding a referral for services for Marie Curie input and the care co-ordinators (DNS) will make the referral on behalf of the H@H Rapid response team.

15.4 Assessing for an inpatient admission

Following handover, if an admission to the inpatient unit is required for a patient from the H@H Rapid Response service these patients will be presented to the senior nurse on duty who will present the patient to the nurse Co-ordinator for the In-patient unit for that shift. The H@H Rapid Response staff will complete the inpatient inbound referral request.

An admission should have the full consent of the patient or family member and the patient should be well enough to be moved safely.

16.0 VERIFICATION OF DEATH

If the patient dies whilst the H@H Rapid Response team is on duty, the registered general nurse would follow the guidance as per policy for verification of death and complete the required documentation, ensuring all partner agencies are notified. Verification of death can only be carried out by a nurse if a GP Authorisation form is in situ and available.

Patients whose death is witnessed by the team - a CQC form requires completion

17.0 SELF-CARE AND PATIENT CARER INFORMATION

The service will develop and make clear and up-to date information, which is accessible and appropriate for all members of the population.

The service will support patients and their carer to assist in their self-management by signposting to all professional and voluntary sector organisations for support and advice as necessary.

18.0 ABSENCE

18.1 Annual Leave

Annual leave entitlement is pro-rata depending upon hours worked within the service. The annual leave will be requested via SMI and await authorisation from the Clinical Lead. Annual leave should be recorded on the shared calendar.

18.2 Sickness

All staff should ring and speak to the Clinical Lead (or deputy) to report sickness if possible, the day before the shift or 2 hours before the commencement of the shift. Night staff should ring by 12 noon. Text messages or emails are not acceptable. If possible, they should indicate how long the absence will be and inform the manager when they will be returning (see employee handbook for details of fit notes and pay).

All staff will have a return to work interview at the beginning of the first shift after sickness.
The Team Co-ordinator/Lead will stay in contact with staff when absent on sick leave (see handbook).

18.3 Other Absence

See handbook, Dr's appointments etc. should be arranged for days off. Other absence to discuss with Team Co-ordinator/Lead.

18.4 Off Duty and Requests

Off duty is completed for the current and the following month only. A minimum of 6 weeks off duty will be published. Requests maybe declined for operational reasons and will be accommodated if the service provision allows.

19.0 QUALITY AND PERFORMANCE STANDARDS

19.1 Quality Monitoring

ECH prides itself on providing the best End of life Care and is keen to measure the levels of quality within this new service. Quality can be measured in several ways and as an organisation we are keen to capture and engage services users and their families.

Key performance indicators are used to assist in the monitoring and effectiveness of the service.

We will measure quality using several strategies which include:

- OACC suite of measures in palliative care. (appendix 2)
- Accompanied and supervised visits
- Monitoring of the complaints, compliments, and incidents processes
- Undertaking Audits
- Monitoring our Key performance indicators for the service
- Training of staff/ Mandatory training
- Fulfilling our obligations for CQC monitoring

As an organisation, we believe that our staff are our biggest asset, we will provide supervision to staff to assist in maintaining their own health and resilience in supporting families with distressing and complex psychological needs.

19.2 Activity

Activity will be reviewed on a quarterly basis once data collection systems are agreed and collaboratively implemented.

Activity and Data collection is a priority and fundamental data requirements will be established.

19.3 Data Collection

The team will:

- complete an admission template on Emis when referred into the service for each patient.
- complete a discharge template on Emis when discharged from the service for each patient.
- Qualitative user feedback will be collected after each intervention period and analysed for key themes and trends.
- MDS reporting.
- Audit

The service will collect data to support and evidence the team's intervention. The data will be recorded contemporaneously to build up a live picture of information to inform relevant parties. All the team will participate in data collection by accurate documentation, audit data, incident reporting and feedback from patients and stakeholders.

The data recorded will include:

- Demographics
- Source of referral
- Response times
- Purpose of the service intervention (EOLC, crisis intervention, respite, admissions avoidance)
- Interaction with other services
- Admissions to acute service
- Admission to inpatients unit
- PPC/ PPD
- Deaths (including those when a staff member leaves the site)
- Referrals unable to be authorised
- Priority using High and medium
- Duration of care

19.4 Continual Service Improvement

As part of the monitoring and evaluation procedures, the service will identify a method of measuring to continuously improve the service being offered, and work to ensure unmet need is both identified and brought to the attention of the service lead.

Key Performance Indicators will be set to indicate areas for required development.

19.5 H@H KPI's & Operational Standards

KPI 1 – To maintain utilisation of all clinical services at specified levels as set out within the operational standards
KPI 2 – The impact and quality of care given at ECH will be measured and evaluated for all patients accessing clinical services
KPI 3 – Patients accessing clinical services within ECH will have the opportunity to discuss and plan for their future care

Operational Standards
75% of patients with a referral for H@H will be contacted within 24 hours during working week and 48 hours at a weekend.
100% patients have outcome measurement documentation
75% of all patients have documented ACP discussions
75% of patients have a PPD recorded
75% of patients achieve their PPD
At least one member of the senior clinical team will attend joint MDT meeting each week
All clinical incidents are reviewed & responded to by a senior clinician within 24 hours (or the following working day, dependent on department)
All CQC & HSE SAEs reported within specified timeframes (24 hours and 1 week)
All patients have MDS (equivalent) data completed

20.0 CONFIDENTIALITY

- All patient information is confidential. You must follow and adhere to the Confidentiality Policy and Procedure and the Data Protection Policy and Procedure.
- All information regarding patients and documentation that is identifiable to your role or the visit should not be left on view in the car.

- All documentation relating to patients should not be left on view in the office including patient names on office whiteboards and message books. All documentation with patient identifiable information should be locked away when not in use.
- Patient details should not be discussed in open places where there is a possibility of being overheard.
- All information relating to staff and patients at East Cheshire Hospice is confidential and should not be shared outside or commented on social network sites (see NMC guidance and hospice policy)

21.0 EQUALITY AND DIVERSITY

East Cheshire Hospice @Home Rapid Response aims are to create a workforce that is diverse, promotes positivity, and instils a can-do attitude in everyone, no matter their background or characteristics.

East Cheshire Hospice will not discriminate any member of staff, patient, or carer on the grounds of any protected characteristics and will promote an environment free of discrimination and prejudice. Everyone will be treated fairly, with respect, and will be given equal opportunity in every aspect of their working role or care.

22 .0 CLAIMING EXPENSES

- The base will be at East Cheshire Hospice. Therefore, their mileage will be calculated from the Hospice to patient's home and return to Hospice.
- The H@H pool car is available for use by the team delivering care. ID checks and supply of documentation needs to be completed and given to HR by each member of staff before they can drive the car. All mileage needs to be documented before and after journey on the paperwork supplied in the vehicle.
- All mileage forms when a staff own vehicle is used, should be completed with the postcodes of the homes visited and the mileage covered during the day. Mileage starts when leaving the Hospice and finishes at the Hospice at the end of the shift.
- Mileage forms are completed, signed, and given to the Clinical Lead by the dates supplied monthly, by the finance team.

23.0 GIFTS AND DONATONS

No gifts or money for personal use can be accepted by staff. Donations for the Hospice should be placed in an envelope and countersigned by the donator and member of staff accepting the donation.

24.0 HEALTH AND SAFETY

24.1 Health and Safety within H@H Rapid Response Team

All employees must adhere to the East Cheshire Hospice Health and Safety Policy and have suitable training and be competent to be able to do their job. With respect to health and safety training all new employees must attend induction training on the first day of employment.

The Clinical Lead will ensure all staff have access to training.
It should cover:

- The basic rules and procedures for the department

- Explanation of what to do in an emergency
- First aid arrangements i.e. The Nurse in Charge is a nominated person
- Health and safety responsibilities on a day-to-day basis
- How to report incidents and near misses
- How to report faulty equipment
- In the event of a fire, staff should report to the nominated fire marshal for instruction.

Departmental environmental risk assessments will be completed yearly

All patients will have environmental and moving and handling risk assessments completed on during the first assessment and will be updated at a change in condition or reassessed weekly.

24.2 Incident Reporting
All patient and staff accidents should be reported by completing the hospice incident form on the East Cheshire Hospice intranet which will be submitted to relevant individuals automatically. Any untoward incidents that occur in the home should be reported to the shift coordinator. Any Significant Events should be reported to the shift coordinator and a Significant Event Analysis Form completed.

24.3 Skyguard Devices/ Lone worker devices
Team members are issued with a device for their personal protection and safety whilst on domiciliary visits. This remains the property of the Hospice (see Employee Handbook for care of Hospice equipment). Training will be given, and procedures must be followed including the testing of the device monthly. It must be fully charged whilst on duty and switched off at other times.

N.B. Each employee is responsible for replacing the hospice mobile phone and Skyguard device once they have finished with its use.

24.4 Laundry
Slide sheets may need to be laundered - soiled slide sheets should be placed in a red bag inside a clear bag and labelled “to be returned to H@H team”. The bag should be left in the laundry bin outside the laundry office, located near the in-patient unit. The slide sheet should then be replaced in the team bag

24.5 Medication checking and monitoring
- The H@H Rapid Response service will use the medication checking pro-forma when instigating medications in the patient’s home for the management of symptoms.
- This form /blue book should be completed at the time of the intervention and used to assist the RGN and HCA to document fully what has been administered on Emis. This acts as a reference point for the hospice and district nursing service.
- Blue prescription booklets will be used for administering medication.

24.6 Stock
A limited supply of dressing, gloves, aprons etc will be available in the equipment bags which each team will take with them during the shift. Hospice @Home Clinical Lead or administrator will complete an order form for supplies and in preparation for ordering on a Friday morning along with the IPU stock requests. This will enable Hospice @Home to keep a comprehensive list of consumables.

25.0 RESPONSIBILITY AND ACCOUNTABILITY

- The Hospice CEO and Clinical Director of Patient Services has ultimate responsibility for the strategic direction of the service and the reporting outcomes to the board of trustees.
- The Clinical Lead has overall management responsibility for the service, and for managing the staff within the team
- The co-ordinator for the team will support the day to day running of the service
- Each team member has the responsibility to adhere to the hospice policies and best practice when delivering care.
- Staff need to remember that the behaviours of the team will impact on the reputation of the entire hospice.

26.0 GOVERNANCE

Clinical governance ensures that patient care is the focus and priority in hospices and each patient receives safe, high quality care from everyone involved in looking after them.

The term hospice governance is used to emphasise the governance framework of East Cheshire Hospice and its policies apply to all areas of the organisation. The governance principles apply to all employees and volunteers.

See East Cheshire Hospice Governance Policy

The five pillars of the framework are set by the CQC are:

- ❖ **Safe**
- ❖ **Caring**
- ❖ **Effective**
- ❖ **Responsive**
- ❖ **Well-led**

26.1 Policies and Procedures, Monitoring and Review

- The service will operate within this standing operating procedure and utilise the East Cheshire Hospice organisational policies. The staff can access the policies via the hospice intranet.
- Additional policies include
- Lone worker
- Personal safety
- Weather conditions
- Driving
- Administration of medicine in the community

26.2 Services Available across East Cheshire at Evenings/ Night

- **East Cheshire OOH**
  Provide medical cover across East Cheshire
- **North West Ambulance Service (NWAS)**
- **District nursing services evening and night service**

Twilight service- 5 members of staff working from 6.30-10pm based at MDGH
Night service- one qualified nurses covering East Cheshire supported by an HCA 10pm-8am

- **Social Care**
  Marie Curie- Primary Night Service
- **Continuing Health Care Team [CHC]**

NHS funded continuing healthcare is the name given to a package of care arranged and funded by the NHS for people outside of hospital who have ongoing healthcare needs.

People receiving continuing healthcare can be living in any setting including their own home or a care home. NHS continuing healthcare is free, unlike help from social services for which a financial charge may be made, depending on your income and savings. This means that the NHS will pay for assessed health care needs. In a care home, the NHS also pays for care home fees including board and accommodation.
01625 663 808.

26.3 Discharge Team

Based at MDGH, the service works from 9-5 pm Monday-Friday and 9-12 Saturday, Sunday, and Bank Holidays. The team support ward staff to facilitate complex discharges, and fast track discharges for patients at the end of life wishing to be at home. They support the commissioning of packages of care and support discharges to home or nursing home environments and undertake Continuing health care assessments and place patients in nominated homes

Appendix A

INTERNAL PROTOCOL FOR HOSPICE @HOME

PURPOSE

An internal protocol for the Hospice @Home team to ensure that all staff are aware of housekeeping, organisation of the team and expected standards and behaviours.
Reference –

- East Cheshire Hospice Employee Handbook
- NMC Code of Conduct
- East Cheshire Hospice Policies and Procedures

OFFICE EQUIPMENT

Mobile Phones

All team members are issued with a mobile phone to use whilst on duty. This remains the property of the Hospice and staff should read the relevant section in the Employee Handbook before signing for the phone.

The phone is to be switched on whilst on duty and turned off at other times. The phone is integral to the Lone Worker procedure and important for communication with other members of the team. All mobile phones should be put on silent whilst in a patient's house and diverted to voicemail.

Use of Personal mobile phones are prohibited whilst on duty.

Laptops / Tablet devices

For shared use within the Hospice @Home team

- All staff are to start and finish their shift at the Hospice
- All laptops/tablets must be taken on patient visits to complete the documentation whilst in the patient's home
- It must be signed out at the beginning of each shift in the designated book
- It must be signed back in at the end of the shift and placed on the docking station to be charged for the next person
- Laptops/tablets must be transported in the bags provided and always stored out of view in the car
- Laptops/tablets must be taken into the patient's home to complete documentation unless there are exceptional circumstances discussed with the team manager or coordinator
- The laptop/tablet should be cleaned with Clinell wipes between visits and when returning to the Hospice (including the case).
- Refer to the Employee Handbook re personal use

Clinical bags

- All bags must be signed in and out at the beginning and end of each shift
- At the end of the shift ensure that the bag is restocked ready for the next user
- Bags must be stored out of view whilst in the car and not left in cars overnight
- Bags must be taken into the patient's home

STANDARDS FOR CONDUCT

Appearance

Remember that you are a visitor in the patient's home and a representative of the Hospice. As such your appearance must be smart and professional. Your uniform should be clean and ironed and free of any badges other than hospice identity badges. You are supplied with a coat and cardigan. Cardigans must not to be worn during any clinical procedures.

Smoking

Smoking by staff is not permitted in any area of East Cheshire Hospice, the Hospice Pool Car or in vehicles that are being used during community shifts. For staff working overnight it is always prohibited on duty. The use of electronic cigarettes is also prohibited; the charging of E-cigarettes is against the Fire Policy.

Sickness/absence reporting

Report to Clinical Lead as soon as it is apparent the staff member is unfit for duty. In hours, this should be via the hospice telephone number. Should a member of staff become unfit for duty during the shift this should be reported to the nurse on duty in the In-patients unit and arrangements be made for the other team member to return to the unit in accordance with the lone working policy. Patient visits should be re-organised and communicated to the district nursing service.

Complaints, Compliments and Concerns

The appropriate Hospice policy should be followed in relation to complaints and concerns.

Compliments provide a balanced view for the service, any compliments, verbal, in writing should be forwarded to the Clinical Lead to be included in the clinical governance report.

Appendix 2

Expected Outcomes

The OACC suite of outcomes can be divided into six measurement tools.

1. **IPOS** - Integrated Palliative Care Outcome Scale is a measure of physical, psychosocial, social and spiritual wellness in line with a full holistic assessment. IPOS allows patients to list their main concerns, to add any other symptoms they may be experiencing and to state whether they or their family have unmet information or practical needs. IPOS is coded within EMIS & ECH templates have been built. The IPOS has been shown to be valid and reliable as a clinical tool and is used to measure the global symptom burden that patients encounter when entering the end stage of their lives. IPOS can be completed by the patient or staff, and when completed the severity of the problems can be assessed through discussion with the patient or their family. The information collated will be used to monitor the effectiveness of service interventions and improve patient's quality of care.

2. **Phase of Illness** – Describes the patient's distinct stage in illness (see table below). It is recommended that the phase of illness is recorded at first assessment / on admission, at subsequent assessments during spell of care (every 3 days) and at discharge from service. Phases are classified according to the care needs of the patient and their family and give an indication of the suitability of the current care plan. At East Cheshire Hospice [ECH] we also record phase of illness at the weekly Multi-Disciplinary Team meeting. Phase of illness is coded within EMIS & ECH templates have been built.

	This is the current phase if…	**This phase ends when…**

Stable	Patient's problems & symptoms are adequately controlled by established plan of care ***&*** further interventions to maintain symptom control & quality of life have been planned ***&*** family / carer situation is relatively stable & no new issues are apparent.	The needs of the patient & / or family / carer increase, requiring changes to the existing plan of care.
Unstable	An urgent change in the plan of care or emergency treatment is required ***because*** the patient experiences a new problem that was not anticipated in the existing plan of care ***& / or*** rapid increase in the severity of a current problem ***& / or*** family /carer circumstances change suddenly impacting on patient care.	The new plan of care is in place, it has been reviewed & no further changes to the care plan are required. This does not necessarily mean that the symptom / crisis has fully resolved but there is a clear diagnosis & plan of care (i.e. patient is stable or deteriorating) ***& / or*** death is likely within days (i.e. patient is now dying).
Deteriorating	The care plan is addressing anticipated needs, but requires periodic review, ***because*** the patient's overall functional status is declining ***&*** the patient experiences a gradual worsening of existing problem(s) ***& / or*** the patient experiences a new, but anticipated, problem ***& / or*** the family / carer experience gradual worsening distress that impacts on the patient care.	Patient condition plateaus (i.e. patient is now stable) ***& / or*** urgent change in the care plan or emergency treatment ***& / or*** family / carers experience a sudden change in their situation that impacts on patient care, & urgent intervention is required (i.e. patient is now unstable) ***or*** death is likely within days (i.e. patient is now dying).
Dying	Dying: death is likely within days.	Patient dies ***or*** patient condition changes & death is no longer likely within days (i.e. patient is now stable & / or deteriorating).
Deceased	The patient has died; bereavement support provided to family / carers is documented in the deceased patients clinical record.	Case is closed.

The phase of illness provides a clinical indication of the level of care required dependant on the stage of illness the patient is currently at. The information obtained from the measure helps ensure the care plan is modified to incorporate the needs of the family and the patient. During the triage process the phase of illness can help with prioritising the allocation of resources.

3. **Australia-modified Karnofsky Performance Status [AKPS]** – This is currently coded and used as part of the admission procedure to ECH to determine performance status of patient. AKPS is coded within EMIS & templates have been built. The overall performance status is assessed in three dimensions: activity, work and self-care and provides basic information on overall functional status thus giving an indication of the resources required to care for the patient. The AKPS will be used as an aid for prognostication and discharge planning if required.

4. **Views on Care** – derived from St Christopher's Index of Patient priorities (SKIPP), used to assess the patient's own views on care and quality of life. Views on Care is coded within EMIS and built into ECH templates. The questions assess the patient's own rating of their quality of life and their view of the impact of the service on their main problems. This tool is designed to be used alongside the patient version of the IPOS. The measure will provide staff with an indication of whether or not they are having a positive impact on the patients' lives and is indicative of how the service is affecting this important outcome.

5. **Carers Measures** – (Not currently in use by East Cheshire Hospice) Measures the main care giver (unpaid) strain. Each question asks the caregiver to scale how they have been affected by the role of 'Caregiver'. This measure will allow the service to capture the extent of the burden on care givers and if appropriate prompt action to support them in their role. (This is not yet coded on EMIS). **This measure will not be utilised as part of the H@H outcome assessments.**

6. **Barthel Index** – (recommended for inpatients) measures the patient's ability to perform 10 common Activities of Daily Living. The Barthel Index is coded on EMIS but no templates have been developed at ECH. **This measure will not be utilised as part of the H@H outcome assessments.**

As established services, the Inpatient Unit and Sunflower Centre and H@H rapid response team at East Cheshire Hospice have already adopted the use of Phase of illness, the Australia-modified Karnofsky Performance Status [AKPS] and IPOS.

East Cheshire H@H will aim to utilise 1-4 tools listed in the above outcomes and will capture the phase of illness, AKPS, IPOS and Carer measure as part of the initial first contact assessment. During each contact, the phase of illness will be reviewed and updated. If the phase of illness changes or the patient is discharged from the service, AKPS, IPOS and Carer measure will need a review and update also.

The outcome measures will be used to drive quality improvement, deliver evidence on the impact of the service, improve team working, inform commissioners and achieve better results for the patients and their families.

Appendix B – H@H flow Chart criteria
Appendix C H@H assisted discharge procedure.
Appendix D H@H collection of equipment prior to the start of the shift
Appendix E H@H returns of equipment following the end of a shift
Appendix F Discharge procedure
Appendix G No Access Procedure
Appendix H Referral to Family Support Team
Appendix I Ward Procedure