St Luke's Community team

Who we are:

We are an experienced team which provides advice and support to patients with life-limiting conditions and their families in their own home across Sheffield, wherever that may be. We have a core team of clinical nurse specialists in palliative care, but you may also have a visit from our advanced clinical practitioners, nurse consultant, doctors, assistant practitioners, physiotherapists, occupational therapists, wellbeing practitioners, social workers, or chaplains depending on your needs.

We work every day of the year 9am to 5pm Monday to Sunday including Bank Holidays.

What we do:

We provide specialist palliative care to people who have advanced and progressive illnesses for which there is no cure. We attend to their emotional and spiritual wellbeing, as well as their physical symptoms.

After being referred to us by a Healthcare Professional you will have telephone contact with our Triage Service. This team will discuss more details of your needs, assess if we are the right team to support you and if appropriate book a first appointment. They may arrange a home visit but could also direct you to come to St Luke's Hospice to attend a clinic or specific session with our Patient and Family Support Service (PAFSS). If we are not the right team to support you, we will re direct your referral or advise you about the right team to contact.

Our specialist team have particular expertise in the control of symptoms associated with life-limiting conditions.

We offer:

- Advice on how to manage physical problems caused by your illness or treatment.
- Someone to talk to about your illness, how it affects your life and those closest to you.
- Support to your family and friends.
- Support to your extended care team (your GP or Community District Nurse) by offering clinical advice and suggestions.
- We are also able to give people space to discuss what is important to them as their health changes, and when appropriate their end-of-life care plans. We can help explain treatment options and discuss if these are or are not appropriate for you. We think it is important that people have the opportunity to start these conversations early giving time to weigh up their choices but are happy to respect your wishes if you choose not to. In Sheffield we document these discussions on a ReSPECT plan and share these across your healthcare teams.
- Some people with a serious illness are entitled to specific benefits through the Department of work and pensions; we can complete the relevant form (SR1, formerly DS1500) to ensure timely access.

To help our team focus their assessments on what matters to you we use the IPOS (integrated palliative care outcome scale) questionnaire. This allows you to highlight the problems you want us to address. We will post or email you a copy of this before your first appointment with the team but please do not feel you have to complete this if you feel unable.

What we do not do:

We do not provide hands-on, physical care in the home. This is usually provided by private care companies or the continuing health care team following assessment by Sheffield City Council Social Work or the Community District Nurses. We do not provide an overnight sitting service. This is provided by the NHS Intensive Home Nursing Service following assessment by ourselves or the Community District Nurses. If other specialist clinical reviews are required, for instance, for diabetes, dietetics or continence, your primary care team can refer to those specific specialist nursing teams directly via Single Point of Access (number below).

Why have I been referred to the team?

Patients are referred to our team at various stages of their illness. Sometimes we see people straight after diagnosis, with others later on or during treatment. The usual reasons for referral include.

- Expert advice regarding symptom management
- Emotional and psychological support for yourself or your family
- Advanced care planning – what to do if you become more unwell
- To support patients wishing to have their end of life care in their own home.

Our aim is to empower you to live well with controlled symptoms for as long as possible and to be there to discuss your end of life choices when needed.

How often will I see the team?

Our patients are seen face-to-face as often as required depending upon their clinical needs and are welcome to be accompanied by a family member/ friend. The visits may vary from daily, weekly, or monthly as necessary. We also maintain phone and video contact and conduct some of our support remotely. We do discharge patients once their symptoms are controlled and as their conditions stabilise as this allows our team to have contact with more people across Sheffield. However, even when discharged, patients can contact the service on the numbers below and we are keen that people get in touch if their situation changes.

How is my health information shared?

We share our records with organisations to ensure that your health care needs are fully supported and communicated this includes with your GP, hospital, and community services. If you are not happy with this, please do tell our team when they visit or on your triage call.

How do I contact the team?

The team can be contacted 7 days a week, 365 days a year between 9am and 5pm:

- Patient and Family Helpline: 0114 2357494

We understand it is sometimes difficult to describe the situation you or a loved one is in. We use voicemail so please leave your name, phone number and a brief message if possible and the team will call you back as soon as they can. Calls left toward the end of the working day and overnight will be responded to the next day.

After 5pm you can contact the district nursing service for advice if you are known to their team or the GP out of hours service.
Out of Hours GP: 111

Single Point of Access (SPA) for Community District Nurses: 0114 2266578

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