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Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Hywel Dda Health Board Specialist Palliative Care Team Pembrokeshire Locality

End of Life Care Peer Review

Date of Visit March 15th 2013

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Date of Visit : 15th March 2013

End of Life Care Peer Reviewing Team

Name (Print)	Job Title	Organisation
Dr Mel Jefferson (chair)	Consultant Palliative Medicine	Cardiff & Vale Health Board
Tracey Livingstone	Director of Nursing & Patient Services	Nightingale House Hospice, Wrexham
Helen Rees	Clinical Services Director	Hospice of the Valleys, Tredegar
Mansel Thomas	Lay Reviewer	Healthcare Inspectorate Wales
Facilitation Team		
Veronica Snow :Programme Manager Palliative Care Implementation Board Gareth Brydon : Assistant Inspector, Healthcare Inspectorate Wales		

Site Reviewed		
Organisation Title	Hywel Dda Health Board	
Team title	Pembrokeshire Specialist Palliative Care Team	
Review Date Title	Friday March 15th 2013	
Name (Print)	Job Title	Organisation
David Morrisey	Assistant General Manager	Hywel Dda Health Board
Ann Barnes	Locum Consultant	Hywel Dda Health Board
Lynda Doyle	Macmillan CNS	Hywel Dda Health Board
Caroline Allen	Macmillan CNS	Hywel Dda Health Board

Sharon Jones	Macmillan CNS	Hywel Dda Health Board
Fay Morley	Paul Sartori CNS	Hywel Dda Health Board
Jenny Mathieson	Occupational Therapist	Hywel Dda Health Board
Amanda Every	Community Nurse Manager	Hywel Dda Health Board
Helen Price	Manager & CNS	Shalom Hospice, Pembs
Sophie Thomas	Clinical Services Manager	Paul Sartori Foundation, Pembs

REVIEWERS REPORT

Review Summary

The Hywel Dda Health Board Pembrokeshire locality specialist palliative care team demonstrate dedication in delivering a specialist palliative care integrated service alongside voluntary sector providers Paul Sartori Hospice at Home service and Shalom House.

There is evidence of good joint working to support patients to die in their preferred place of care and a commitment to utilise advance care plans to patients identified early in the disease trajectory with Paul Sartori Hospice at Home service. The services provided by Shalom House Hospice are utilised, but further integration would maximise the expertise and resources offered by Shalom House.

The team do not have a substantive Clinical Medical Consultant lead; this coupled with management reorganisation has highlighted a lack of clarity around management of the service level agreements with the Voluntary Sector and hindered progress with a local service End of Life Care Plan. A locality strategy group has now been established following management reorganisation. It is hoped that a Consultant can be appointed in the near future. This group are undertaking a Baseline assessment and will have a plan in place by June 2013 under the leadership of the County lead.

The existing team are to be commended for their continued dedication to providing a patient focussed service without a Consultant Clinical Lead in post. There is evidence of high levels of respect within the local community and patient satisfaction through the user feedback survey. Multidisciplinary Team (MDT) meetings are held weekly. CANISC is used to record all information. New patients are discussed at the weekly MDT and a care plan is agreed. Patients are reviewed in the MDT as necessary. There are areas of good practice that can be shared, in particular the work done with Out of Hours to flag patients and share information. The service benefits from an Advance Care planning programme and a rapid response equipment loan provision both run by the Paul Sartori Foundation.

Peer Review March 15th 2013

Key Themes

With reference to guidance on Key Themes in the evidence guides, please provide comments including details of strengths, areas for development and overall effectiveness of the team. Any specific issues of concern or good practice should also be noted in the following sections.

Structure and function of the service

Comment in relation to leadership, membership, attendance and meeting arrangements, operational policies and workload. Teams should specifically comment with regard to the following questions:

- *Are all the key core members in place?*
- *Do all the key core members hold appropriate qualifications in Palliative Care?*
- *Is there an Operational Policy in place?*
- *Does the MDT meet weekly and record meetings on CANISC?*
- *Is there a communication protocol?*
- *How many referrals/ admissions were received into the service in the previous year?*

The Hywel Dda Health Board Pembrokeshire locality specialist palliative care team consists of the statutory integrated Specialist Palliative Care team and commissioned voluntary sector providers, namely the Paul Sartori Foundation and Shalom House. The service sits within the Pembrokeshire locality Community services division of Hywel Dda Health Board. Collectively the three services provide End of Life care provision in the acute and community setting with a Paul Sartori Hospice at Home Service and a Shalom House inpatient unit and Day Hospice.

<u>Team Composition</u>

NHS: There is currently no Consultant in Palliative Medicine in the acute sector. A locum consultant oncologist provides support to the team and attends the MDT meetings.
4 Clinical Nurse Specialists, 1 Occupational Therapist and medical clerical support.
The team lacks a consultant in Palliative Medicine and a Physiotherapist.
Shalom House: There is one associate Consultant and a Clinical Nurse Specialist based in Shalom House who provides support to patients seen in the Shalom inpatient and day hospice unit.
Paul Sartori: the Hospice at Home service is led by 2 Clinical Nurse Specialists with a team of Health Care support workers.

All staff are appropriately trained and all go onto specialist theoretical learning. Multidisciplinary Team (MDT) meetings are held weekly. CANISC is used to record all information. Clinical Nurse Specialists work closely with GPs who are kept informed of the teams involvement in patient care and Clinical Nurse Specialists attend primary care MDT's
There is no Operational or Communication Policy in place. The clinical team felt there was little communication between the local County team and the Health Board lead.

The Health Board organisational change which reset the management structure has resulted in a lack of clarity around management of the service including the performance management of the Voluntary Sector Service Level agreements.

The lack of strong Clinical Leadership, usually provided by a consultant in Palliative Medicine and no Service Plan has also inhibited progress toward a fully integrated service.

A Locality Steering Group is now in place and will become the strategic group for End of life Care. This group will work to have a plan in place by June 2013.

There is evidence that in general the teams work well together and patient care is good. However, organisational Leadership is required to formalise arrangements within a strategic plan. Hywel Dda Health Board and the clinical teams recognise this.

Coordination of care/patient pathways

Is there a clear management pathway for patients requiring complex symptom management? E.g. Metastatic Spinal Cord Compression

Comment on coordination of care and patient centred pathways of care,

Clinical leadership and communication

Patient Pathway

Referrals are taken from primary care and the acute sector. Referrals are taken via the Clinical Nurse Specialist team or the Paul Sartori Foundation who contact the GP and the patient is admitted to the service. There is no single point of referral into the service.
Six beds on the oncology ward 10 have been allocated to Specialist Palliative Care. Three beds at Shalom House can be admitted to via the associate consultant. Patients cannot be admitted Out of Hours for Specialist Palliative Care in the Hywel Dda Health Board area.

Seven day working by Clinical Nurse Specialists is delivered via a 1 in 11 rota across Hywel Dda Health Board. This requires covering a vast area and does not provide a responsive face to face service on a regular basis.

24/7 consultant advice is provided from the Carmarthenshire locality.

There is no communication protocol in place but the teams feel they work well together. Problems can arise with patients treated out of county or privately when they return to the local service.

Patients requiring radiotherapy would be admitted to the Cancer Centre in ABMU Health Board. This can take some time and patients will be held on Ward 10 waiting for a bed at the Cancer Centre. The teams have seen an increase in referrals and feel these need to be reviewed.

Integrated Care Priorities

The Health Board participate in the All Wales ICP project for the last days of life and have an ICP coordinator in place. It is planned to appoint a second coordinator in the locality to support this work in the community and in nursing homes.

Patient Experience

Comment on patient experience and gaining feedback on patients' experience, communication with and information for patients and other patient support initiatives. Teams should comment specifically with regard to:

- *What arrangements are in place to support the rapid discharge/ admission of patients at the end of life?*
- *What are the national patient experience survey results (iwantgreatcare) feedback results?*

- Links with District Nurses are good and all practicalities are in place in the home to support Preferred Place of Care.
- A Rapid discharge service, coupled with a Rapid Response equipment loan provision is provided by the Paul Sartori Hospice at Home service.
- The team report communication problems when patients are treated out of county or privately.
- I want great care (IWGC): Each patient is provided with an IWGC survey to complete. Returns report high level of patient satisfaction.
- Feedback from patient satisfaction surveys is provided to the team, although there is currently no feedback and audit cycle to use results to change practice.

Improving Care, Achieving Outcomes

- Audit: Participation in the All Wales Integrated Care priorities for the Last Days of Life.
- Advance Care planning project in place in the community with Paul Sartori.
- Good joint working between both Voluntary and NHS providers.
- A training competency programme developed between Paul Sartori and the Hywel Health Board Dda lead nurse to establish and integrate a Paul Sartori Clinical Nurse Specialist within the nursing team.

Voluntary Sector Comments

Paul Sartori Foundation: While the monitoring of the clinical care is good, with a robust Clinical governance committee who monitor and report on any significant event analysis, the organisation would welcome a more robust contract quality assurance process. This would enable Paul Sartori to identify which part of the service they provide is funded. Shalom House would look to identify further funding from the Health Board.

Both organisations realise the clinical leadership and a strategy would improve communication help them to feel more fully integrated.

Hywel Dda Health Board Pembrokeshire locality Team Comments

The team feel that they work well together at a local level with all providers. They are well integrated with the Oncology unit. There is good access to resources to maintain patients within their own homes at the End of life stage. The 7 day working by Clinical Nurse Specialists is delivered as part of a Hywel Dda wide rota and the team recognise this cover is not adequate at times. Would be happy to reconsider moving toward a rota of 1in 6 to provide greater cover to the locality at weekends. The team feel unanimously that while the service works well 'on the ground' Clinical Leadership is needed to pull all the strands together. The clinical team felt there needed to be better communication between the local County team and the Health Board Clinical lead. This may improve when a consultant is appointed. The Macmillan Clinical Nurse Specialists have obtained funding from Macmillan Cancer Support to provide laptops which could improve use of Canisc in the community, but there is an embargo on purchasing equipment in the Health Board.

Case Note Review

6 sets of case notes were reviewed.
All notes had a list of assessment and problems.
No copy of Canisc notes in 3 sets.
No ID number in 1 set.
No MDT notes in 1 set.
No plan of care in 1 set.
No patient identifier on page in 1 set.
Indecipherable signature in 1 set.
All Paul Sartori case notes included a Canisc report and POS outcome scores.

Good Practice

Identify any areas of good practice

Good Practice/Significant Achievements:

- Innovation sharing Out Of Hours information sheet and sharing information with Primary Care.
- Rapid response equipment loan provision run by the Paul Sartori Foundation.
- Advance Care planning programme.

Areas for Consideration

- Appoint Consultant in Palliative Medicine into a permanent position who participate in the 24/7 medical advice cover rota.
- Develop and agree with partners a local service plan.
- Develop and agree with partners an operational policy.
- Split the 7 day CNS rota into 2 localities.
- Further integration to maximise the resources offered by Shalom House.
- Robust monitoring of Voluntary Sector Service Level agreements.
- Reconsider the offer from Macmillan Cancer Support to provide laptops for CNS's which could improve use of Canisc in the community.

Overall Findings

This is an integrated service that is highly rated by service users. The Health Board team are complimented by and work well with the Paul Sartori Foundation which enables more patients to die in their preferred place of care. Resources provided through the Shalom House Hospice need to be reviewed within any strategic plan to ensure the best use of resources available. There is a consensus from all sides that the service lacks clinical strategic leadership which will be addressed by the appointment of a substantive Consultant in Palliative Medicine. The Health Board are actively addressing this problem. A recently established locality steering group are currently addressing the need for an operational policy and a local service plan currently.

Concerns

Refer to the guidance on identifying concerns. Any immediate risks or serious concerns must be brought directly to the attention of the core team

Lack of Clinical Leadership due to the absence of palliative medicine consultant.

Serious Concerns:

A ‘serious concern’ was identified during the peer review regarding short term consultant cover. A member of the Clinical team reported that the Health Board were advertising for locum to cover leave of the locum consultant oncologist, but were unable to appoint in time to cover the leave.

This issue was raised with the Management team on the day and it was confirmed the leave will be covered by an agency doctor (either middle grade or consultant). The Associate Specialist in medicine will support the junior doctors if no agency cover is available. The associate Consultant based at Shalom will also provide additional support to the teams. This plan was formally confirmed with the review team within twenty four hours.

This form must be completed at the time of the visit and agreed by the full review team

Identifying Concerns – Issues

Issues	Level of Concern Immediate Risk (IR), Serious Concern (SC), Concern (C)	What is the specific concern?
Medical Leadership	Concern	Lack of Clinical Leadership due to the absence of a substantive palliative medicine consultant This will be addressed when post is appointed in Currently out to advert
Lack of Consultant Cover	Serious Concern	Lack of Consultant Cover during annual leave. Resolved following discussion with Health Board Management team.