

City Health Care Partnership CIC

BD256

Community end of life care

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
1-286634785	Bransholme Health Centre	Health Centre	HU7 4DW
1-279570366	Westbourne Health Centre	Health Centre	HU5 3HP
1-459758269	Bilton Grange Health Centre	Health Centre	HU9 4UY

This report describes our judgement of the quality of care provided within this core service by City Health Care Partnership CIC. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by City Health Care Partnership CIC and these are brought together to inform our overall judgement of City Health Care Partnership CIC

Summary of findings

Ratings

Overall rating for the service	Outstanding	☆
Are services safe?	Good	●
Are services effective?	Good	●
Are services caring?	Good	●
Are services responsive?	Outstanding	☆
Are services well-led?	Outstanding	☆

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service **OUTSTANDING**

We have rated this service as outstanding because:

- There was a good safety record with no never events and no severe harm incidents reported. Staff were familiar with the incident reporting system and received feedback on lessons learned.
- Medicines were well managed and records in patients' homes were organised with information easy to access including assessments for areas such as mobility, pain management and nutrition.
- Staff were familiar with the safeguarding systems in place to protect adults and children from harm and knew how to escalate concerns.
- The nursing staff we spoke to felt their caseload was manageable and that they had sufficient time with their patients. The post of palliative care consultant had remained vacant for some time and the failure to recruit had been escalated to the Care Group Director. Arrangements were in place to access palliative care medical input but these were informal.
- A new advance care planning document provided a record of the patient's wishes for advanced care including their choice of environment, comfort and symptom management and support. Patients and relatives told us that pain was well managed and that staff were accessible to manage symptoms in a timely way. The service worked with four local care homes to increase education, skills and the quality of care given to end of life residents and to reduce emergency admissions. There was a holistic approach to discharge planning from hospital which was facilitated as quickly as possible when required. Arrangements fully reflected individual circumstances and preferences. The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high quality care evidenced by the success of the End of Life Care Academy which provided a structured programme of educational sessions to internal and external staff. Multidisciplinary working was a core element of the community end of life service. This was to ensure that quality care could be maintained closer to home and to prevent unnecessary hospital admissions.
- We observed a very caring and compassionate approach from all staff during their interactions with patients and family members. Patients were addressed appropriately and their dignity protected. We saw how family members were supported in understanding and managing symptoms by being involved in discussions with members of the specialist palliative care clinic team during their assessment of the patient at home. Patients and their families were encouraged to call the team for emotional support whenever it was needed. A widow told us how the Macmillan team and community nurses always returned calls within a reasonable time and spent a good amount of time with her and her husband during his illness.
- Staff were clear that patients' individual needs and preferences were central to the planning and delivery of end of life services. One hundred per cent of all patients referred to the end of life services in April to August 2016 achieved their preferred place of care where stated. The involvement of other services and organisations was integral to how services were planned and delivered. There was a proactive approach to understanding the needs of different groups of people and the service was extending its support to hard-to-reach groups by liaising with specialist healthcare services. People could access the service at a time that suited them through the single point of access service which operated 24 hours a day. Very few complaints were received by the service. Each was dealt with in a timely manner and actions taken where appropriate.
- The end of life service had a clear vision of the quality of care that it wished to provide and collaborated with multiple agencies to deliver it. Staff we spoke to described the chief executive as being visible, accessible and approachable and their managers and lead specialist palliative care clinical specialists as very supportive. Staff were very aware of the strategy and the aims of the service and gave examples of how integrated working assisted the patient to achieve their preferred place of care. There were effective governance systems in place to monitor patient safety and the quality of care and there was an open culture. Staff told us they felt most proud of the difference that

Summary of findings

they made to people's lives and how well the disciplines worked together to achieve this. There were regular activities to engage the public to talk about and plan for end of life care.

Summary of findings

Background to the service

Information about the service

City Health Care Partnership (CHCP) provides community end of life care services to Kingston-upon-Hull, East Yorkshire. It is a nurse-led service providing specialist care and support to patients 18 years and over and their families and carers, with palliative care needs for life-limiting conditions. The service operates out of three community nursing localities in the city (north, east and west) caring for patients with a Hull GP within each locality and surrounding villages.

End of Life Care is operationally managed within Care Group One (Nursing and Conditions Services). The service is made up of the Macmillan clinical nurse specialist team, out of hours palliative care nursing team, health and social care team, Macmillan therapy services, in reach team, out of hours palliative night care service, community specialist palliative care clinics and a carers information support service. Further clinical support is provided by Macmillan palliative care pharmacists, therapists and palliative care specialist GPs. There is a comprehensive palliative care education programme led by the Macmillan practice development nurse specialist. The GPs in the area are supported in end of life care education by three GP Macmillan facilitators.

CHCP is one of six sites in the UK to be implementing the Macmillan Specialist Care at Home Project. This

community-based, Macmillan specialist care at home service was started in 2014 and had recently been evaluated prior to developing future plans for the service. The project seeks to bring specialist care closer to the patient's home, prevent avoidable admissions into hospital and to allow patients to die in the place of their choosing.

CHCP sub-contracts end of life care volunteer support services from the Hull Churches Families Together Team. The inspection did not include this service.

During our inspection, we visited three registered locations and two further locations from which services were delivered. We observed care being delivered by the community specialist palliative care clinic team, Macmillan nurses and health care assistants. We spoke with 26 members of staff including the senior operations manager, clinical team leader, Macmillan practice development nurse specialist, Macmillan nurses, community nurses, therapists, pharmacist, health care assistants, administrative staff, the volunteer co-ordinator and a palliative care specialist GP. We spoke with five patients and seven relatives and visited eight patients in their own homes. We looked at the records of eight patients receiving end of life care.

Our inspection team

Our inspection team was led by:

Chair: Helen Bellaires, Non-Executive Director

Inspection Lead: Helena Lelew, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists: a palliative care consultant and a clinical nurse specialist in end of life care.

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

Summary of findings

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about the core service and asked other

organisations to share what they knew. We carried out an announced visit on 8-11 November 2016. Prior to the visit, we held focus groups with members of the end of life care service including specialist nurses, specialist palliative care nurses and health care assistants. We observed how people were being cared for, talked with carers and family members, and reviewed care or treatment records of people who used services. We carried out an unannounced visit on 22 November 2016.

What people who use the provider say

All the patients, relatives and carers we spoke to were positive about the care and treatment they received from the end of life service. Family members spoke about how well services worked together and how they and the patient felt involved in the care planning. Patients, family members, carers and bereaved relatives all spoke about the quality of care that they received and how much it

was appreciated. They spoke about how changes were managed quickly such as moving a bed downstairs or starting a new medicine to relieve symptoms. They felt that staff were sensitive and compassionate, did their best to ensure that patients were as comfortable as possible and were cared for in their preferred place of care.

Good practice

Outstanding practice

- The End of Life Academy attracted staff from a variety of specialisms and services in the area to increase their skills and understanding of needs at the end of life. Following an article appearing in the Macmillan publication Mac Voice, the service had received enquiries from around the UK about end of life educational delivery.
- The End of Life service had established one of six national pilot sites of integrated community end of life services based on the Motala model in Sweden. This model sought to provide direct care and support to patients in the last 12 months of life to prevent unnecessary hospital admissions and enable them to

live at home and die in the place of their choice. This was achieved through early referral, home-based clinical intervention and joint working with community based services including primary care. The service had achieved 100% for a patients preferred place of care.

- The service received professional recognition for their achievements in a number of ways. The Macmillan specialist palliative care team were short-listed for the national Macmillan Team Excellence award in November 2015. The Macmillan practice development nurse specialist won the 2015 International Palliative Journal of Nursing award of 'LPJN Educator of the year 2015' for the work done to develop the End of Life Academy and the success of the project.

Summary of findings

Areas for improvement

Action the provider **MUST** or **SHOULD** take to improve

- Staff should be clear about when the duty of candour would be applied.
- Arrangements for access to specialist palliative care consultant input 24 hours a day should be formalised.
- The service should conduct audits to measure compliance with palliative care guidance from the National Institute for Health and Care Excellence.
- The service should review mandatory training levels and implement an action plan to achieve the expected training levels.

City Health Care Partnership CIC

Community end of life care

Detailed findings from this inspection

Good 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We have rated this service as good because:

- There was a good safety record with no never events reported by the service between October 2015 and September 2016 and no severe harm incidents during the reporting period. Incidents were investigated and reported in line with policy. We saw evidence of the service sharing learning with staff and there was evidence of changes to practice in response to lessons learned.
- There were safeguarding systems in place to protect adults and children from harm. Staff were familiar with the systems in place and knew how to escalate concerns.
- Medicines were well managed. Policies for medicines management were in place and accessible to staff and symptom control medicines were prescribed using guidance from the regional prescribing committee.
- Records in patients' homes were organised with information easy to access including assessments for areas such as mobility, pain management and nutrition.
- The Macmillan nurses we spoke to felt their caseload was manageable and that they had sufficient time with their patients.

- The post of palliative care consultant had remained vacant for some time and the failure to recruit had been escalated to the Care Group Director. Arrangements were in place to access palliative care medical input but these were informal.

However:

- Staff we spoke to did have a broad understanding of the need to be open and honest but were less clear about when the duty of candour would be applied.
- There was no formal arrangement in place to obtain specialist palliative care consultant input out-of-hours. Staff were aware that if a patient was known to the hospice or NHS hospital, they could seek advice from the relevant medical staff.

Detailed findings

Safety performance

- End of Life care services were managed as part of Care Group One. The care group produced a monthly Quality and Integrated Governance report, which monitored and analysed incident trends by service. There were no safety issues raised in the report related to End of Life services for the period April to September 2016.

Are services safe?

- The Quality Monitoring Programme was an audit tool used by the organisation to demonstrate adherence to the Essence of Care benchmarks. From April to September 2016, End of Life services attained an average of 98% for six out of twelve areas including record keeping, communication, infection control, hygiene, self-care, promoting health and well-being, privacy and dignity and safeguarding. It was unclear why data for the remaining six audit areas including pain control was unavailable.
- Safety Thermometer data was collected organisationwide including data on pressure ulcers, urinary tract infections, venous thromboembolism and falls but was not specific to End of Life care as the patients were already known to the community nurses who undertook this.

Incident reporting, learning and improvement

- No never events were reported by the service between October 2015 and September 2016 and there were no severe harm incidents during the reporting period. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Policies relating to the management of incidents were in place and all staff we spoke with knew how to report incidents through the electronic reporting system. Staff told us they were confident that incidents were acted upon promptly, investigated thoroughly and the outcome fed back to the teams.
- The service reported 39 incidents between October 2015 and September 2016. There were 29 no harm incidents, five minor harm and five moderate harm incidents. Themes and trends resulting from incidents were monitored and discussed at the Care Group One Safety and Quality Forum. The care group reported an average of 128 incidents a month of which a monthly average of 61 were directly related to internal services. The remainder were attributed to external agencies such as the GP and staffing agencies. End of Life services reported 13 incidents from April to September 2016 that was directly related to their service. The most common theme was around communication about night sitter arrangements.

- We saw examples of managers investigating incidents and appropriate action taken to alert staff to incidents and the outcomes. Feedback was provided by e-mailing staff through the electronic reporting system and at one to one meetings with staff members. We did not see evidence of discussion of incidents in the three sets of team meeting minutes we reviewed.

Duty of Candour

- The Incident and Near Miss Policy included guidance on the application of the duty of candour and training was included in the information governance training module. The guidance was not clear and did not clearly define the trigger for implementing the duty of candour. Staff we spoke to did have a broad understanding of the need to be open and honest but were less clear about when the duty of candour would be applied.

Safeguarding

- Policies were in place and accessible to staff and the Director for Quality and Non-Medical Professions was the board lead for safeguarding. Staff we spoke to were aware of how to escalate safeguarding concerns and gave one example of an incident where adult safeguarding concerns were escalated and addressed. The Safeguarding Adults Practitioner and Safeguarding Adults Facilitator managed adult safeguarding on an operational basis.
- There was a safeguarding children team, which consisted of a named nurse for safeguarding children, four specialist nurse practitioners, a safeguarding trainer and three administrative staff. An Adults and Children Safeguarding Group monitored and reported on safeguarding issues and lessons learned.
- Training for safeguarding adults and children was mandatory for all staff. Data was supplied for Care Group One, which included End of Life Care services. The training level for adult safeguarding was 93% in September 2016. Safeguarding children training compliance was 95% for Level 1 and 94% Level for 2 in September 2016.

Medicines

- Medicines were well managed. Policies for medicines management were in place and accessible to staff and symptom control medicines were prescribed using guidance from the regional prescribing committee. Staff were updated on medicines management by a CHCP

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publication called 'Medicines Matter' and we saw one edition from December 2015 updating staff on the management of two drugs used for symptom control. The pharmacy also issued Medication Safety Alerts when required.

- The community nursing teams had a system in place to check that controlled drugs were being administered to patients correctly. Records of administration were kept when patients were being given medicines by syringe driver.
- Community patients who were identified as requiring end of life care were prescribed anticipatory (or 'just in case') medications to manage symptoms that commonly occur at the end of life. These medicines were held in the patient's home and were available as and when needed. Having these drugs available meant that the nurses could administer timely symptom relief and avoid the need for admission to hospital.
- The service ran a Specialist Palliative Care Clinic which included input from a Macmillan nurse, Macmillan pharmacist and GP with a special interest in palliative care. Patients who were referred to the clinic for complex pain or symptom management received a medication review and specialist pharmacological advice was provided by the pharmacist to the team, the patient and family members.
- We reviewed eight medication administration charts and saw that the documentation was completed clearly including times of administration for as required drugs. In one case, we found that anticipatory medications for a syringe driver were prescribed in case it was needed. This is normally done at the time of need when the patient is assessed for symptom management and drugs received in the preceding 24 hours are taken into account. Although the responsibility of the prescribing GP, this was reported to management and followed up.

Environment and equipment

- CHCP used one model of syringe driver device which met the requirements for specific safety features. There was a policy and detailed protocols for the use of the device in order to reduce the risk of medicine administration error. We observed the use of the syringe drivers in the community and saw that regular administration checks were being recorded.
- Staff reported no difficulty in accessing equipment for end of life patients including specialist mattresses which were available as needed.

- We observed that equipment in use was visibly clean and that portable appliance testing was undertaken. Equipment labels indicated that equipment had been tested.

Quality of records

- Staff used a community-wide electronic patient record system accessible to the multidisciplinary team caring for the patient. Hard copy records were kept in the homes of patients receiving end of life care and these were updated by visiting services such as the GP, community nursing and Macmillan services. Electronic records were updated either at the time of the visit or as soon as possible.
- We looked at eight records in patients' homes and these were organised with information easy to access. There was evidence in the records of the discussions that had taken place about the patients' condition, resuscitation status and advanced care planning. There were also completed assessments for pain, falls, pressure areas, nutritional status and moving and handling.
- The advanced care plan for end of life care was used for patients new to the service and was not used for patients already known to the community nursing service as care planning documentation already existed. We visited eight patients in their home and found this document to be present for three patients.
- We reviewed seven Do Not Attempt Resuscitation (DNACPR) forms in the community and a further three in records held at the health centre. The responsibility for the completion of the DNACPR form is the responsibility of the GP and not of CHCP. Of the ten forms reviewed, eight were completed fully. One DNACPR form was not immediately available; although it was recorded in the records as being signed, it was missing from the notes. Staff reported this to the team leader for follow-up and replacement.

Cleanliness, infection control and hygiene

- Systems and processes were in place to manage infection control and prevention. Data was supplied for Care Group One, which included End of Life Care services. The target for infection prevention and control training compliance was 85%; the compliance rate for the care group including was 84% in September 2016.
- We observed clinical staff in the home providing care and saw that they carried out hand hygiene before and after patient contact. They also used personal protective

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equipment such as aprons and gloves when required and observed the practice of bare below the elbow. The compliance level for hand hygiene in End of Life Care services was 86%.

- Offices we visited were visibly clean and tidy. Much of the estate was shared with other services and not directly owned by CHCP.

Mandatory training

- CHCP provided mandatory training to all staff and had a target of 80%. Staff told us that they received email reminders when their training was due to be updated.
- There were 16 mandatory training modules including infection control, basic risk management, information governance and COSHH awareness training. Ten out of 16 modules had compliance rates over 80%. Those at less than 80% were manual handling basic and advanced (67%), basic life support (76%), fire safety awareness (77%), equality and diversity (65%) and DNACPR training (53%) having the lowest compliance rates. We were unaware of an action plan to increase training levels.
- All qualified nurses in the end of life services received syringe pump training and community nurses we spoke to confirmed that they had received syringe driver training.

Assessing and responding to patient risk

- End of Life patients received a holistic assessment of needs through implementation of the advanced care plan including assessments for areas such as mobility, pain management and nutrition. Staff involved patients and those close to them when completing these assessments and made referrals to the specialist palliative care clinic when their expertise was required to manage complex symptoms.
- Staff told us that urgent out-of-hours medical palliative care input was available through the hospice or local trust but we were unable to identify examples of when this had occurred.
- Specialist care was available seven days a week as the In-Reach team worked each weekend and was available to respond to changes in palliative care needs.
- Out of hours, community nursing staff could be contacted through the single point of contact until 10pm. After 10pm, the senior community nurse on-call

took calls in the first instance and depending on the needs of the patient, sought further advice from the patient's GP on-call service, the local hospice or the specialist oncology nurse on-call at the local NHS trust.

- There was an electronic "bed state" board, which acted as an aid to identify patients with end of life needs in the community as well as monitoring and responding to changes in those needs. The board was used as the focal point for handover meetings and discussions of complex problems. The In-Reach team held a daily meeting with the Macmillan nurses to discuss any additional visits and increased needs noted by the community nursing team overnight.
- We spoke to patients and relatives who were aware of how to access help and support if a patient deteriorated when being cared for at home. An average of 86% of patients with an urgent need were seen and assessed within two hours of direct referral April to August 2016. Performance in August 2016 was 100%. There was no stated target for this indicator.

Staffing levels and caseload

- Hull has a population of approximately 270,000. "Commissioning Guidance for Specialist Palliative Care: Helping to deliver commissioning objectives" (2012) recommends that the minimum requirements per 250,000 population are two whole time equivalent (WTE) consultants in palliative medicine and five WTE community specialist palliative care nurses.
- Specialist palliative care nurse staffing met the national guidance with 6.2 WTE Macmillan specialist palliative care nurses. Staffing included a clinical team leader, Macmillan Practice Development Nurse Specialist, Macmillan Nurse band 7 x 3, Macmillan Nurse band 6 x 4, Macmillan Physiotherapist, Macmillan Occupational Therapist x 2, Therapy Assistant, Macmillan Pharmacist and sessional GP with Special Interest. In addition there were Community In Reach Nurses band 5 x 3, Health Care Assistants band 2 x 12, Macmillan GP Facilitators x 2 and a bank of Health Care Assistants providing palliative night care (18 WTE).
- The Macmillan nurses we spoke to felt their caseload was manageable and that they had sufficient time with their patients. We were told that the caseload was usually 10-15 patients per specialist nurse but that this could increase to 20 patients. They conducted up to four visits a day but said that this could occasionally increase to six visits per day.

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- CHCP had no community palliative care consultant despite continued efforts to recruit to this post. A specialist doctor had provided regular clinical support to the service but had left eight weeks prior to the inspection. The post of palliative care consultant had remained vacant for some time and the failure to recruit had been escalated to the Care Group Director.
- Medical staffing did not meet national guidance; however, actions had been taken to mitigate the risk. A senior nurse told us that there were three palliative care consultants at the local trust and one at the hospice who were available via an on-call rota. Staff we spoke to did not refer to this rota, but were aware that if a patient was known to the hospice or NHS hospital, they could seek advice from the relevant medical staff. Informal arrangements were in place to obtain advice from these consultants 24 hours a day but no formal service level agreement was in place. Specialist palliative care input was also sourced via the GP with a special interest who was employed by CHCP.
- At the time of inspection, management told us they planned to explore provision of a consultant who would jointly lead on specialist palliative care between the hospital, hospice and community.
- As part of the Macmillan Specialist Care at Home project, a Macmillan volunteer service provided additional support to manage patient referrals. At the time of the inspection, nine volunteers were managed by the volunteer co-ordinator and provided bereavement, dementia, caring and befriending support.

Managing anticipated risks

- Business continuity plans were in place to address such issues as staffing shortages and bad weather affecting services. We were provided with an example of when the regional 111 service was not functioning overnight and was affecting access to emergency services. Managers called each end of life night carer to let them know and confirm whether the patient needed any assistance. The Care Group Director attended the regional emergency planning group.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

We have rated this service as good because:

- A new advanced care plan document had been developed by the service and was due for review. This replaced the Liverpool Care Pathway that was discontinued in 2014. The document provided a record of the wishes for patients in relation to advanced care including their choice of environment, comfort and symptom management and support.
- Patients and relatives told us that pain was well managed and that staff were accessible to manage pain needs in a timely way. There was clear guidance on symptom management and prescribing of anticipatory medicines for end of life patients.
- As part of the Macmillan Specialist Care at Home Project, monthly Gold Standard Framework multi-disciplinary meetings were held at four care homes, with key priorities being the reduction of emergency admissions and improved education for care home staff.
- The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high quality care. The end of life care service prioritised education and the development of palliative care skills in a range of healthcare roles to support the learning, competence and confidence of all community health professionals. The Macmillan practice development nurse specialist led the development of the End of Life Care Academy that provided a structured programme of educational sessions to staff.
- The single point of access service received and co-ordinated all referrals and enquiries to ensure information was sent to the relevant part of the service. They had full access to the electronic management system.
- Multidisciplinary working was a core element of the community end of life service. This was to ensure that quality care could be maintained closer to home and to prevent unnecessary hospital admissions.
- There was a holistic approach to discharge planning from hospital which was facilitated as quickly as possible when required. Arrangements fully reflected individual circumstances and preferences.

However:

- Management reviewed and implemented relevant palliative care guidance from the National Institute for Health and Care Excellence (NICE) but we were told that the service did not conduct audits against compliance with palliative care NICE guidance.

Detailed findings

Evidence based care and treatment

- End of life care needs were assessed and treatment was delivered in line with current legislation, standards and recognised evidence based guidance. Policies and procedures were based on guidance produced by the National Institute for Health and Clinical Excellence (NICE) or other nationally or internationally recognised guidelines including Actions for the End of Life 2014/2016 (NHS England). The service referred to best practice tools including the Sheffield Profile for Assessment and Referral (SPARC), the Supportive and Palliative Care Indicator Tool (SPICT) and the Macmillan Clinical Nurse Specialist template.
- A new advanced care plan document had been developed by the service and was due for review. This replaced the Liverpool Care Pathway that was discontinued in 2014. The document provided a record of the wishes for advanced care including their choice of environment, comfort and symptom management and support. The service provided guidance on how to use the care plan to staff and to the patient and their family / carer. The plan was based on recommendations in the national guidance on end of life documentation, "What's important to me. A Review of Choice in End of Life Care (February 2015).
- As part of the Hull Macmillan Specialist Care at Home Project, the service was working in partnership with one of the community care of the elderly consultants from the local NHS trust to improve and develop the quality of end of life care for patients residing in four designated care homes. They introduced monthly multidisciplinary Gold Standard Framework (GSF) meetings and a

Are services effective?

programme of education for the care home teams. The Gold Standard Framework is a provider of quality improvement, accredited, evidenced based end of life care training for health and social care staff.

- Management reviewed and implemented relevant palliative care guidance from the National Institute for Health and Care Excellence (NICE) but we were told that the service did not conduct audits against compliance with palliative care NICE guidance.

Pain relief

- Patients and relatives told us that pain was well managed and that staff were accessible to manage pain needs in a timely way.
- There was clear guidance on symptom management and prescribing of anticipatory medicines for end of life patients. This was printed on the back of the medication administration record for ease of access. There were suggested medicines and doses to manage pain, restlessness, nausea and excess secretions as required and for administering symptom relief via continuous sub-cutaneous infusion. The information also included contact telephone numbers for advice on specialist palliative care drugs.
- We saw nursing staff assessing and recording levels of pain during visits and a review of pain management by the Macmillan pharmacist as part of the specialist palliative care clinic home visit.
- The supply of diamorphine injections was affected by a manufacturing problem in December 2015 and we saw evidence of a 'Medicine Matters' alert to staff and alternative prescribing recommendations using morphine.

Nutrition and hydration

- The advanced care plan included assessments of nutrition and hydration needs and patient choices about their food and drink preferences. We also saw evidence in patients' records of staff completing the malnutrition universal screening tool (MUST) risk assessments. Where required, staff monitored the patients' weight and could make a referral to dietitian services.

Patient outcomes

- The service reported on a wide range of performance indicators to their commissioners. The target for the number of patients who achieved their preferred place

of care where their preference was stated during the reporting period was 60%. The service achieved 100% from April to August 2016. Ninety nine per cent of all patients referred to the end of life services in 2015/2016 achieved their preferred place of care. This outcome was monitored on a monthly basis.

- The target for all patients who had a preferred place of care discussed following referral to end of life services was 60%. The achieved percentage was 75%.
- The number of patients being actively managed on the recently introduced advance care planning document was audited monthly and found to be an average of 17% April to August 2016 with a general upward trend in use. This was an area of focus for the service and was the main theme of the annual end of life care educational forum.
- The target for service users seen within 10 days of referral to the specialist palliative care clinic was 95% and the service achieved 98% from April to August 2016.
- The number of deaths at the place of usual residence (including care homes) in Kingston-upon-Hull was 42.7% for July 2015 to June 2016, which was slightly lower than the England average of 45.7% (National End of Life Care Intelligence Network) but had increased over the past seven years from 17.8%.
- The Macmillan practice development nurse had developed an education programme for care home staff. The service was working with four care homes with a high incidence of avoidable hospital admissions. Monthly Gold Standard Framework multi-disciplinary meetings were held at the care homes, with key priorities being the reduction of emergency admissions and improved education for care home staff. Data for the impact on emergency admissions was not available.
- The Retrospective Death Audit Group was a multidisciplinary group of healthcare partners in the city that reviewed the management of care for end of life patients who had recently died. The group evaluated the quality of the integrated service and whether the patient experience could have been improved.

Competent staff

- The end of life care service prioritised education and the development of palliative care skills in a range of healthcare roles to support the learning, competence and confidence of all community health professionals. The Macmillan practice development nurse specialist

Are services effective?

led the development of the End of Life Care Academy that provided a structured programme of educational sessions to nurses, pharmacists, therapists and health care assistants.

- The academy ran the programme three times a year and was aimed at registered nurses and allied health professionals; however it was recently extended to healthcare assistants. Healthcare assistants we spoke to felt that the course was a valuable tool in improving their palliative care skills. There was also an education programme for care home staff and we spoke to one health care assistant during a visit to a care home who was very positive about what she was learning and keen to complete the course.
- Community nurses were expected to attend the programme as part of their annual professional development reviews. Attendance up to May 2016 was 116 of which 81 were band 5 nurses from community nursing, long term conditions, intermediate care, the local prison, the out-of-hours team and the in reach team. Sessions included sensitive communication, advance care planning, pain management, recognising dying and bereavement. Feedback from staff to us was universally positive on the value of the programme.
- An end of life course specifically for community pharmacists was delivered over three sessions and could be recorded as continuing professional development.
- Two members of the Macmillan nursing team had degree level specialist training in oncology and palliative care. The remaining members of the team had completed the End of Life Academy programme which included follow-up sessions every six months and attendance at forum events. We visited a forum event which focussed on advance care planning. Staff we spoke to were very positive about what they had gained from the day and the impact on their practice.
- Three Macmillan nurses were qualified as non-medical prescribers with another planning the training for the coming year. One of the specialist palliative care GPs acted as supervisor for these prescribers.
- The clinical commissioning group contracted with CHCP to provide GP Macmillan Facilitators. There were two GP Facilitators working across Hull and East Riding who supported the development of primary care capability in end of life care. The key outcomes for this service

included to increase the number of cancer and non-cancer patients on the GP palliative care registers, and support the use of anticipatory prescribing and the DNACPR policy in general practice.

- The appraisal rate for the service was 100% and staff we spoke to confirmed that they received an annual appraisal. Educational objectives were supported by the in-house End of Life Care Academy and access to external courses.
- The Macmillan practice development nurse specialist provided clinical supervision to the Macmillan nurses by reviewing their caseload and visiting their patients with them. The operations manager provided managerial supervision at one to one meetings.
- The Macmillan therapists met every six to eight weeks with therapists from the local NHS trust oncology team and the local hospice to discuss practice development.
- Managers planned for the Macmillan nurses to attend the monthly multidisciplinary meetings held at the local hospice. This was to access a regular review of case management and expert advice from the hospice palliative care consultant. These arrangements were not in place at the time of inspection but were planned in response to the consultant vacancy on the end of life team.

Multi-disciplinary working and coordinated care pathways

- Multidisciplinary working was a core element of the community end of life service. This was to ensure that quality care could be maintained closer to home and to prevent unnecessary hospital admissions. The end of life service multidisciplinary (MDT) team included Macmillan nurses, palliative care GPs, pharmacists, occupational therapists and a physiotherapist. There was daily communication between the Macmillan team and community nursing, GPs, care homes and specialist nurses. Macmillan nurses were based at the same offices as long term conditions matrons and community nurses; this facilitated access for consultation on a daily basis to discuss end of life patients and their management.
- Macmillan nurses held monthly Gold Standard Framework MDT meetings with GPs to discuss patients on the palliative care / Gold Standard Framework register. Similar meetings were held monthly onsite with staff at four care homes as part of the Macmillan Specialist Care at Home project. The purpose of these

Are services effective?

meetings was to highlight any need for specialist input and support and educate staff in the care of end of life patients. Macmillan nurses also participated in joint visits with the community nurses who provided continuity of care and strengthened communication.

- We observed a joint meeting between the community nurse and the specialist palliative care nurse at a patient's home to discuss the plan of care and symptom management.
- The specialist palliative care specialist clinic enabled a multidisciplinary team to visit patients at home and provided a combined approach to supporting the needs of the patient and family and preventing hospital admissions. More recently, this service extended to the third locality in the city ensuring equitable access for the population.
- The in reach team worked with the local NHS trust's discharge liaison team to arrange for safe discharge home. Arrangements included liaison with hospital staff, ambulance service, community nursing and equipment providers in facilitating discharges.
- Twelve health care assistants on the Health and Social Care service provided supportive care to end of life patients and shared care arrangements with social services.
- Approximately 40-50 patients per year were affected by motor neurone disease in the locality and Macmillan nurses attended the locality MDT meeting to discuss the management of these patients.

Referral, transfer, discharge and transition

- The single point of access was well publicised and available for patients, family members, carers and health and social care professionals to access the palliative care team 24 hours a day, seven days a week. This meant that eleven different referral routes could be accessed through one telephone number. At the time of inspection, weekday nights and weekends were covered by community nursing staff but a 24-hour seven-day call centre service was being considered.
- The In Reach team worked with hospital, hospice and care home staff, families, Macmillan nurses, community nursing, GPs and the ambulance service to organise transfer and discharge arrangements. These included fast track continuing health care funding, equipment, medicines, transport and night care.

- Staff told us about how patients were transferred home from hospital in order to achieve their preferred place of care at the time of death. In one case we discussed, a patient transferred home from intensive care within four hours of the decision to discharge and died eight hours later in their place of preferred care at the time of death. We saw evidence of funding arrangements being agreed on the same day for fast track discharges.
- The End of Life Discharge Facilitation and Patient Pathway quarterly meeting was attended by health and social care services from across the community including the acute NHS trusts, local councils, the hospice and representatives from CHCP including from the Macmillan and community nursing team. Members discussed topics related to discharge and care pathways such as fast track funding, patient transport, the after death audit outcomes, implementing the advance care plan and arrangements for verification of death. The forum facilitated an integrated approach to discharge management into the community.

Access to information

- The service used an electronic record management system that was used by multidisciplinary healthcare professionals across community services although not all members of the healthcare community used the same system.
- The single point of access service received and co-ordinated all referrals and enquiries to ensure information was sent to the relevant part of the service. They had full access to the electronic management system.
- Hard copy notes including the advance care planning document were held in the patients' home and used by the team to record changes and assessments. Management planned to transfer the advance care plan onto the electronic system to make it more accessible for all staff involved in the patient's care.
- The electronic "bed state" board was used as the focal point for a number of MDT hand over meetings throughout the working day. This helped the teams to integrate and network and to gain team support for complex problems.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Are services effective?

- Policies were in place and accessible to staff providing guidance on obtaining consent and assessing mental capacity.
- Staff received training on mental capacity within adult safeguarding training. We saw that mental capacity was considered in the discussion with patients about end of life, preferred place of care and advance care planning. We saw no instance of implementation of Deprivation of Liberty safeguards but staff we spoke to were aware of the legislation through their training.
- The DNACPR forms we reviewed demonstrated consideration of mental capacity in the decision-making process. Audits of the quality of documentation for DNACPR forms were not undertaken as these were the responsibility of the GP service and the hospital consultants.
- We observed staff interacting with patients and obtaining consent in an appropriate manner prior to providing care.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

We have rated this service as good because:

- We observed a very caring and compassionate approach from all staff during their interactions with patients and family members. Patients were addressed appropriately and their dignity protected.
- We saw how family members were supported in understanding and managing symptoms by being involved in discussions with members of the specialist palliative care clinic team during their assessment of the patient at home.
- Patients and their families were encouraged to call the team for emotional support whenever it was needed. A bereaved relative told us how the Macmillan team and community nurses always returned calls within a reasonable time and spent a good amount of time with her and her husband during his illness.
- We saw how family members were supported in understanding and managing symptoms by being involved in discussions with members of the specialist palliative care clinic team during their assessment of the patient at home.
- We saw the Macmillan pharmacist explain changes in medication to the patient and family carer with the administration instructions and benefits clearly stated.
- We saw that the health care assistants involved family members while providing physical care to the patient and were sensitive in their interactions while explaining what they were doing to the patient.
- Staff told us about how the physiotherapist taught a patient with pharyngeal cancer and family members how to clear secretions in the throat with suction. This had enabled the patient to gain more control of his symptoms and improved his well-being.

Detailed findings

Compassionate care

- We observed a very caring and compassionate approach from all staff during their interactions with patients and family members. Patients were addressed appropriately and their dignity protected, for example by keeping the patient covered while they were being turned. Staff expressed their pride in the quality of service they provided.
- Patients and families were offered comment cards by the end of life service to provide feedback. Family members told us that they were very happy with the timeliness and level of support and the quality of care provided.
- We were told about one patient who refused to have their bed downstairs but had difficulty managing the stairs. The team arranged for a chair lift to be installed and the patient was able to go out shopping and socialise with friends which had previously not been possible. The patient was very appreciative of the considerable improvement to the quality of their life.

Understanding and involvement of patients and those close to them

Emotional support

- Patients and their families were encouraged to call the team for emotional support whenever it was needed. A widow told us how the Macmillan team and community nurses always returned calls within a reasonable time and spent a good amount of time with her and her husband during his illness.
- A family told us that they had received information about a Macmillan grant to assist with recent expenses related to end of life care.
- Staff referred bereaved children to the family support team at the local hospice where they could receive art therapy and music therapy to assist in coping with the loss of a family member.
- Therapists offered alternative therapies to end of life patients including relaxation and massage techniques to support symptom management. They also offered guidance on fatigue management.
- The Carers' Information and Support Service (CISS) was a service dedicated to supporting carers. The service helped them access respite breaks, register with their GP for assistance with arranging appointments and managing prescriptions, attend outreach sessions throughout the city and receive support over the phone.



Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

We have rated this service as outstanding because:

- Staff were clear that the key priority was ensuring that patients were cared for in their preferred place of care at the time of death where possible. Ninety nine per cent of all patients referred to the end of life services in 2015/2016 achieved their preferred place of care where stated.
- There were innovative approaches to providing integrated person-centred pathways of care that involved commissioners and other service providers including the local NHS trusts, council and local hospice.
- The service was extending its support to hard-to-reach groups by liaising with specialist healthcare services and local volunteers to deliver care in a way that met people's needs and promoted equality of access.
- Patient and carers individual needs and preferences were central to the planning and delivery of tailored services. As part of keeping care closer to home and preventing unnecessary hospital admissions, the Specialist Palliative Care Clinic team managed referrals to assess complex symptom control needs and provided this service through home visits.
- Very few complaints were received by the service. Each was dealt with in a timely manner and actions taken where appropriate.
- A palliative care steering group was in operation that included partners from all sectors involved in end of life care for malignant and non-malignant disease including cardiovascular, respiratory, neurological disorders and dementia.
- The community end of life service could offer treatments and procedures that were traditionally hospital based in the community setting. These included an ultrasound to diagnose abdominal ascites, abdominal paracentesis (this is a bedside procedure in which a needle is inserted into the peritoneal cavity in the abdomen and ascitic fluid removed), sub-cutaneous fluid administration and intravenous therapies such as antibiotics and diuretics, any of which could reduce the need for hospital admission. The demand for these treatments had been low so far but two of the GPs and one Macmillan specialist nurse had received additional training to perform one or more of these procedures.
- The use of the virtual ward model for palliative care patients meant that they could be referred in by GPs, health and social care professionals, patients and family members and staff could monitor their condition and level of need using an electronic information board. This formed the hub for effective communication between community and specialist palliative care services.
- As part of keeping care closer to home and preventing unnecessary hospital admissions, the Specialist Palliative Care Clinic team managed referrals to assess complex symptom control needs. The Macmillan pharmacist, Macmillan nurse and specialist palliative care GP visited patients in their home and provided an integrated approach to improving the quality of end of life care.

Detailed findings

Planning and delivering services which meet people's needs

- Staff were clear that the key priority was ensuring that patients were cared for in their preferred place of care at the time of death where possible. In 2014, the service became one of six pilot sites for an integrated model of palliative care, which facilitated holistic care being given closer to home. The service worked with the local clinical commissioning group, NHS trust, city council and the local hospice to deliver the Macmillan specialist care at home service to better meet the population's palliative care needs and achieve the preferred place of care for each patient.

Equality and diversity

- There was an equality and diversity policy which was accessible to staff on the intranet. Staff received training on equality and diversity as part of mandatory training.
- The single point of contact service monitored patients' age and ethnicity at the point of referral. This data was reported in the Macmillan team annual report to inform the assessment of how well the team was reaching diverse groups.



Are services responsive to people's needs?

- Staff could arrange for translation services when needed and have the translator accompany them on visits when required although it was reported that there was a low demand for this facility.

Meeting the needs of people in vulnerable circumstances

- The service was extending its support to hard-to-reach groups by liaising with specialist healthcare services. We were told that the service was developing links with the Huntington's Disease Nurse specialist and we spoke to cardiovascular specialist nurses about their links into palliative care and joint care planning with the Macmillan team. The service also worked with mental health and learning disability professionals to provide palliative care support for these patients. The Macmillan team worked with the local prison nursing team to support them manage complex symptom control for prisoners.
- In addition, the specialist palliative care team worked with church-based volunteer nurses who supported vulnerable or hard-to-reach groups such as travellers, people who were homeless, housebound, lived with dementia or were isolated. The end of life service had a team of volunteers who also supported dementia patients as part of their role. We were told that the volunteers received dementia training to support them in this role.
- Following the death of a patient, Macmillan nurses made a bereavement call to each family and offered a visit and further support if needed. We spoke to family members who had received this service who said how much they appreciated the service being available. A bereavement support group was available for relatives and carers who could have a cup of coffee and talk in a relaxed environment.
- The senior operations manager told us that CHCP had purchased an allotment and were planning a sensory nature garden for patients and families to enjoy. The occupational therapy team were planning to offer container gardening and create a garden that offered a peaceful environment.

Access to the right care at the right time

- The target for the number of patients who achieved their preferred place of care where their preference was stated during the reporting period was 60%. The service

achieved 100% from April to August 2016. Ninety nine per cent of all patients referred to the End of life services in 2015/2016 achieved their preferred place of care. This outcome was monitored on a monthly basis.

- The percentage of patients or carers receiving a visit within seven days of the initial referral from April to August 2016 was 95%. The monthly target was 98%. However we were told that all patients in need of an urgent referral received a visit within two hours.
- One relative told us that the community nurses responded quickly after a discussion about moving her husband downstairs and organised this on the same day.
- The service provided access to night sitters to enable family members to rest at night. These were arranged through the single point of access and the service was supported by a local staffing agency. Continuing health care funding supported patients to receive this service.
- We saw evidence of sitters contacting the senior community nurse on-call at night to access support if the patient required additional medication for symptom control. Community nurses told us that they would contact the patient's GP in the first instance for medical needs related to symptom control. If the patient was known to the hospice or hospital-based oncology services, the nursing service or GP could contact the consultant on-call for specialist advice if required. These were not formalised arrangements. We were unable to confirm that specialist palliative care expertise was accessed for ad-hoc enquiries out-of-hours and there was no audit of the demand and outcome of these enquiries.
- The Carers Information Support Service (CISS) could assist carers of end of life patients access respite breaks. Once a request was received, CISS contacted the single point of access to arrange an assessment of the carer and patient's needs. Once completed, CISS would arrange for carers to attend the patient for the respite period.
- We were told that access to therapy services had improved since the launch of the Specialist Palliative Care at Home project which included therapy services within the team.

Learning from complaints and concerns

- Very few complaints were received by the service: three complaints were received in the previous twelve months and no trends were identified. Each was dealt with in a



Are services responsive to people's needs?

timely manner and actions taken where appropriate. One change in response to a complaint included addressing the short gap between the community nursing night shift ending and the start of the day shift. This interrupted continuity of service and had

contributed to a communication problem. A continuous service was in place at the time of inspection. Learning from complaints was given to individual staff members and in team meetings when appropriate.

- Information about how to submit feedback and complaints was on the CHCP website including leaflets in five alternative languages.



Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We have rated this service as outstanding because:

- End of life service management had a clear vision of the quality of care that it wished to provide and collaborated with multiple agencies to deliver it. Staff were aware of the strategy and the aims of the service and gave examples of how integrated working assisted the patient to achieve their preferred place of care.
- There was evidence of strong collaboration within the service and with external stakeholders and a common focus on improving end of life care and experience for patients, their families and carers.
- There was a clear and proactive approach to seeking out and embedding new and more sustainable models of care. In 2014, the service became one of six pilot sites for an integrated multidisciplinary model of palliative care, which facilitated holistic care being given closer to home. This was successfully implemented.
- Staff we spoke to described the chief executive as being visible, accessible and approachable and their managers and lead specialist palliative care clinical specialists as supportive.
- There were effective governance systems in place to monitor patient safety and the quality of care.
- Staff told us they were very proud of the service they provided. They said they felt most proud of the difference that they made to people's lives and how well the disciplines worked together to achieve this.
- There were regular activities to engage the public to talk about and plan for end of life care.

Detailed findings

Leadership of this service

- The senior operations manager was supported by the operations manager and clinical lead to manage the end of life service and resources. CHCP had an internal end of life 'Macmillan Specialist Care at Home' Steering Group overseeing the service.
- The Palliative Care and End of Life Working Group met every two months and was managed and led by the local clinical commissioning group. The CHCP palliative

care specialist team and service managers were well represented on the group and attended regularly. Discussions included the development of the citywide end of life care strategy.

- Staff described their managers and the lead specialist palliative care clinical specialists as very supportive. They felt comfortable discussing their feelings when discussing the regularity of death and dying. Nurses also told us that they felt well supported in developing their palliative care clinical skills and becoming autonomous practitioners. Administrative staff told us that they received support through one to one supervision every eight weeks.
- Staff we spoke to described the chief executive as being visible, accessible and approachable. Two staff members said they liked the fact that he was a health professional. Staff told us he attended staff team meetings and was the end of life lead at executive level.

Service vision and strategy

- End of life service management had a clear vision of the quality of care that it wished to provide. It had established one of six national pilot sites of integrated community end of life services based on the Motala model in Sweden. This model sought to provide direct care and support to patients in the last 12 months of life to prevent unnecessary hospital admissions and enable them to live at home and die in the place of their choice. This was achieved through early referral, home-based clinical intervention and close collaboration with community based services including primary care. Staff were very aware of this strategy and the aims of the service and talked about the impact of the specialist palliative care clinic and the virtual ward as two examples of integrated working assisting the patient to achieve their preferred place of care.
- CHCP did not have a local strategy for end of life services as they formed a part of the strategy for end of life services across the city. This was under development at the time of inspection and led by the clinical commissioning group through the Palliative Care and End of Life Working Group.



Are services well-led?

- Staff were aware of the corporate values and felt particularly supported to achieve 'service and excellence' and 'creativity and innovation' through their work.

Governance, risk management and quality measurement

- The end of life service formed part of Care Group One and was led by an operational management team that reported to the care group director. The care group produced a quality and integrated governance report which covered incident reporting and identified trends, implementation of duty of candour, complaints and compliments, claims, patient experience data, training levels, implementation of NICE guidance, central alerts and the care group risk register. The report we reviewed also included questions from the corporate quality and integrated governance team for the care group quality and safety forum to consider. These were questions about specific incidents and more general queries about how well the incident reporting process was working. There was no risk recorded in the care group risk register that related to end of life services.
- The end of life service contributed to service quality and performance reporting to the local clinical commissioning group. They reported on key indicators such as the percentage of people achieving their preferred place of care where the preference was stated, the percentage of referrals to first contact within seven days and the percentage of people with an urgent need seen and assessed within two hours of the direct referral being received.
- The Quality Monitoring Programme (QMP) was the organisation's approach to measuring adherence to the essence of care benchmarks such as record keeping, privacy and dignity and safeguarding. The Quality and Integrated Governance report included the end of life service results.
- The palliative care team meeting held operational meetings weekly and their team meeting monthly. The monthly meeting was led by the senior operational manager and attended by members of the multidisciplinary Macmillan specialist palliative care team. The agenda included new guidelines and policies, service staffing, education and an update on the strategy and Macmillan specialist care at home project. We reviewed three sets of minutes and found no reference to incidents that had occurred, subsequent

learning, service performance, QMP audit outcomes or any risks relevant to the service. However, at the focus group, staff told us that managers cascaded key learning from incidents and complaints to staff in discussion and by email and they felt informed about patient safety issues.

Culture within this service

- Staff were enthusiastic and passionate about the service they provided and the quality of care they gave to patients and their carers. Staff told us they felt most proud of the difference that they made to people's lives and how well the disciplines worked together to achieve this. They fully supported the pilot care at home project and the changes that had increased integrated working for the benefit of the patient.
- Staff were encouraged to be part of the solution to problems. A staff member gave an example of raising a concern about the medicines reconciliation process. This became an objective on their personal development plan at appraisal and they became involved in solving the issue.
- Staff were particularly positive about the educational opportunities available through the End of Life Academy, the quarterly forums and the annual end of life care conference which in 2016 was about advance care planning at end of life. We spoke to a Band 7 nurse who felt that the educational offering was excellent as were the opportunities for personal development. We spoke to a senior community nurse who was undertaking a master's degree course which was supported by study leave offered by the organisation.
- The 2016 staff survey showed that 96% of staff knew where to raise concerns if they were aware of bullying or harassment.
- Some staff told us that they felt unsettled by the level of change happening in the organisation but felt that there was a good level of communication from management and the chief executive and that they were involved in the service reviews.
- CHCP had a lone working policy in place and employees who were lone workers were supplied with a specific software application on their mobile phones. This had a GPS locating facility and panic alarm function. Staff could work in pairs at night and a stock of mobile



Are services well-led?

phones was available for use to maintain contact with their base. Referring staff could record on referral forms if there were known risks associated with visiting a patient to alert staff visiting the patient.

- The staff survey 2016 showed that 73% of employees in Care Group One felt that CHCP CIC acted fairly with regard to ethnic background, gender, religion, sexual orientation, disability or age.

Public engagement

- The Macmillan team were involved in engaging the public and raising awareness about end of life care at through various activities including Macmillan Coffee mornings and the annual Dying Matters Week. Dying Matters Week aims to help people talk more openly about dying, death and bereavement, and to make plans for the end of life. This involved Macmillan Cancer Support volunteers, Macmillan Specialist Care at Home team members and Carers Information and Support Service (CISS) staff being based on a bus and visiting two sites in the city to talk to the public and hand out information leaflets.
- The Carers Information and Support Service had a Facebook page, which provided information about events, courses and how to access support for unpaid carers. During the annual Carers Week, the service had a mobile unit that attended events in the city to reach as many people as possible.

Staff engagement

- The total number of staff across the organisation responding to the 2016 staff survey was 852 giving a response rate of 63%. Results were available by care group but not service specific. Ninety percent of employees in Care Group One were likely to recommend CHCP to friends for treatment and 66% as a place to work.
- The survey also showed that 80% of staff knew what their goals and objectives were and 78% felt they were able to do their job to a standard with which they were personally pleased. This was reflected in the conversations we had with a range of staff involved in end of life care.

- The care group had an action plan in place to respond to areas in the 2016 staff survey where staff engagement needed to improve.
- The chief executive sent out a weekly blog each Friday to update staff on the latest news about the organisation and at a more local level, all end of life teams had regular meetings to receive and discuss information including the bank night health care assistants who attended a three monthly communication meeting to update them on changes.

Innovation, improvement and sustainability

- The end of life service was focussed on achieving a high quality service that ensured as many people in their care as possible achieved their preferred place of care at the end of their life. Management had successfully implemented an evidence based model of care and worked closely with a number of citywide health and social care partners to achieve this.
- The service received professional recognition for their achievements in a number of ways. The Macmillan specialist palliative care team were short-listed for the national Macmillan Team Excellence award in November 2015. The Macmillan practice development nurse specialist won the 2015 International Palliative Journal of Nursing award of 'LPJN Educator of the year 2015' for the work done to develop the End of Life Academy and the success of the project.
- The End of Life Academy attracted staff from a variety of specialisms and services in the area to increase their skills and understanding of needs at the end of life. Following an article appearing in the Macmillan publication Mac Voice, we were told the service had received enquiries from around the UK about end of life educational delivery.
- The community end of life service sought to offer treatments and procedures that were traditionally hospital based in the community setting to reduce hospital admissions. The demand of these treatments had been low so far but two of the GPs and one Macmillan specialist nurse had received additional training to perform one or more of these procedures.