Humber NHS Foundation Trust

RV9

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)
RV936	Willerby Hill	Trust headquarters	HU10 6ED

This report describes our judgement of the quality of care provided within this core service by Humber NHS Foundation Trust. 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 Humber NHS Foundation Trust and these are brought together to inform our overall judgement of Humber NHS Foundation Trust

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service: Good

Overall, we rated community end of life care as good. This was because:

- People were protected from avoidable harm and abuse. Although there were very few incidents reported, staff understood and fulfilled their responsibilities to raise concerns and report incidents. We found that learning from incidents was shared across teams and staff we spoke with were aware of the duty of candour.
- We found that staff we spoke with were aware of their responsibilities and took a proactive approach to safeguarding. Mandatory training was above the trust target overall, although there was low levels of compliance in some core subjects.
- We found that medication processes used by all teams kept patients safe. Access to equipment in people's homes was good and the trust had systems to ensure timely delivery. Patient care records were mostly completed to a high standard. Staff adhered to infection prevention and control guidelines and the trust had robust systems in place for managing risks including major incident planning.
- We rated effective as good because people's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. Patients were receiving advice about pain relief, nutrition and hydration.
- There was participation in relevant local, national and some international audits. The gold service framework was embedded across the locality. Staff were highly qualified, received timely appraisals, clinical supervision and were supported with further professional development. There was evidence of multi-disciplinary working across all teams. Consent to care and treatment was obtained in line with legislation and guidance, including the mental capacity act 2005.
- We rated caring as good because feedback we received from patients and those close to them was consistently positive about the way staff treated them and we observed consistently sensitive, caring and compassionate staff.
- Staff were highly motivated and inspired to offer care that was kind, promoted people's dignity, and involved them in planning their care. We saw staff providing detailed explanations of procedures and thorough assessment of all needs and reassurance. Patients were supported emotionally. All staff were very responsive to the psychological needs, of not only patients but also those close to them.
- We rated responsive as good because services were planned and delivered in a way that met the needs of the local population. We saw that staff respected the equality and diversity of patients and their families. The needs of vulnerable people were taken into account when planning and delivering services and team worked collaboratively to provide this. Patients were able to access services in a responsive and timely way. In addition to this, there were no complaints about patients receiving end of life care.
- We found that services were well led because the teams providing end of life care had a clear strategy, vision and values, driven by quality and safety. Senior staff were visible and supportive to staff and patients. All staff we spoke with said that senior staff were very approachable. Leaders were actively engaged with staff, people who used services and their representatives and stakeholders.
- We witnessed the culture within teams as being team focused and positive. All staff we spoke with told us that they worked as part of a team and felt supported within their service. We saw good examples of positive staff and patient engagement.
- We saw numerous examples of innovation that the teams had been involved in. There was a strong focus on continuous learning and improvement at all staff levels. New care group structures had recently been introduced. Plans to ensure that governance processes were embedded were being introduced by senior staff in the service.

However, we also found that:

- Some policies were out of date.
- Some teams in community hospitals were not using the appropriate care pathway 'caring for me advanced care plan' for end of life patients.

Summary of findings

- Low numbers of staff had attended mental capacity act training.
- Not all risks were identified on the care group or corporate risk register, for example out of date policies. Some identified risks had no evidence of mitigation to reduce the risk despite being on the register for many months.

Summary of findings

Background to the service

Information about the service

Humber NHS Foundation Trust provided a broad range of services to people living in the East Riding of Yorkshire, covering a large geographical area with a population of approximately 600,000.

The trust employed approximately 3000 staff across more than 70 sites at locations throughout Hull and the East Riding of Yorkshire.

The Macmillan clinical nurse specialist team were based in a central office and provided support and advice for patients with complex needs and symptom management issues at the end of life. The team had an establishment of 9.7 whole time equivalent specialist nurses. This included one whole time equivalent Macmillan nurse consultant and ten (8.7 whole time equivalent Macmillan clinical nurse specialists, three of these posts were band 6 development posts, the other posts were band 7.

End of life care was provided in peoples own homes across the locality, in local hospices and the trusts community hospitals, although there were no dedicated end of life care beds. The Macmillan clinical nurse specialist team supported all of these teams. During our inspection, we spoke to the service manager, the nurse consultant and five other nurses from the team. We attended seven home visits with this team and also two visits to end of life care patients being cared for by the community nursing teams. We visited a newly opened palliative day care unit, which was funded, by one of the local hospices. We visited one of the community hospitals where we spoke with seven staff and saw care being provided for two end of life care patients. We looked at 14 sets of care records for end of life care patients and five medication charts. We spoke with nine patients and 13 carers.

We previously inspected the trust in 2014; this trust was one of the pilot sites for inspection under the care quality commission's revised methodology. We did not rate the services after the inspection however, we did provide the trust with actions that they should or must complete. The actions specifically relating to end of life care were that:

- The trust should review access to prescribed controlled drugs for palliative care patients out of hours
- The trust should audit and review the time taken to provide equipment to patients receiving end of life care.
- The trust should review processes on an on-going basis for accessing specialist end of life care during out of hours and weekends.
- The trust should improve records used to document end of life care so that national guidelines are followed and information is recorded in a consistent way by all staff.

During this inspection, we found that the trust had taken steps to address the actions above.

Our inspection team

Our inspection team was led by:

Chair: Dr Paul Gilluley, Head of Forensic services at East London Foundation Trust and CQC National Professional Adviser

Head of inspection: Jenny Wilkes, Care Quality Commission.

Team Leader: Patti Boden, Inspection Manager (Mental Health) Care Quality Commission.

Cathy Winn, Inspection Manager (Acute) Care Quality Commission

The team included CQC inspectors and a specialist end of life care nurse.

Why we carried out this inspection

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

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 held about the service and asked other organisations to share what they knew. We analysed both trust-wide and service specific information provided by the organisation and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well led. We carried out an announced visit from 12 to 14 April 2016

During our inspection, we visited specialist end of life care team staff base and spoke with the service manager, the nurse consultant and five other nurses from this team. We attended seven home visits with this team.

We visited two community nurse bases and went on two home visits to end of life care patients being cared for by the community nursing teams.

We visited a newly opened palliative day care unit, which was jointly funded, by one of the local hospices, the League of Friends and the trust.

We visited one of the community hospitals where we spoke with seven staff and saw care being provided for two end of life care patients.

We looked at 14 sets of care records for end of life care patients and five medication charts. We spoke with nine patients and 13 carers.

What people who use the provider say

Feedback we received from patients, about end of life care, was consistently positive. Patients told us they valued the service. One patient told us that she didn't know what she would do without the MacMillan clinical nurse specialist team.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The trust should:

- The provider should ensure that all staff reach the trust target for mandatory training in all core subjects.
- The provider should ensure that all out of date policies are reviewed and ratified.
- The provider should ensure that all risks are highlighted on the corporate and local risk registers and that these are regularly reviewed to ensure that actions to mitigate risks are considered and evidenced.
- The provider should ensure that all staff are trained to enable them to identify and escalate when patients are in pain.

- The provider should ensure that all teams use the recognised care pathway ‘caring for me advanced care plan’ for end of life patients and that staff document patients’ wishes.
- The provider should complete a do not attempt cardio pulmonary resuscitation audit for the patients in community hospitals to benchmark and evidence compliance with policy and national guidance.

Humber NHS Foundation Trust

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 rated safe as good because:

- We found that people were protected from avoidable harm and abuse. Staff understood and fulfilled their responsibilities to raise concerns and report incidents. Learning from incidents was shared across teams. All staff we spoke with were aware of the duty of candour.
- All staff we spoke with were aware of their responsibilities and took a proactive approach to safeguarding.
- Mandatory training was above the trust targets.
- Medicines were stored securely in and staff administered these in line with the trusts policies.
- Access to equipment in people's homes was good and the trust had systems in to ensure timely delivery.
- Patient care records were completed to a high standard.
- Staff adhered to infection prevention and control guidelines.
- The trust had robust systems in place for managing risks including major incident planning.

However we found that:

- Some trust policies needed to be reviewed and updated.

Detailed findings

Incident reporting, learning and improvement.

- The trust used a recognised electronic reporting system. All staff we spoke with told us that they were aware of the system and used it when they needed to report incidents.
- Responding appropriately when things go wrong in healthcare is a key part of the way that the NHS can continually improve the safety of the services provided to patients. Serious incidents should be reported on the strategic executive information system within two working days and reported to the national reporting and learning system or regulator as appropriate. The Macmillan clinical nurse specialist team had not reported any incidents via the strategic executive information system or the national reporting and learning system between April 2015 and April 2016. However learning from incidents reported by other teams involved in end of life care, for example, the community hospitals and community nursing teams were shared at multi-disciplinary meetings.
- We looked at the last three serious incidents for community nursing teams and saw that none of these related to end of life care patients.

Good

Are services safe?

Duty of Candour

- In November 2014, the duty of candour statutory requirement was introduced and applied to all NHS Trusts.
- All staff we spoke with were aware of their responsibilities in relation to duty of candour and were able to give examples of when they would use this.
- The trust used a 'blue light alert' to inform staff of any new initiatives or information that needed to be shared across all trust teams. Staff told us that the trust sent information about the duty of candour via a blue light alert.

Safeguarding

- The director of nursing was the trust lead for safeguarding and the executive member for the trust at the Hull and East Riding safeguarding children and adults boards.
- We saw that the trust had a safeguarding adult's policy & procedures document available to support staff if they had a safeguarding concern.
- All staff we spoke with were knowledgeable about safeguarding, knew how to report safeguarding concerns and were familiar with the policy and guidance available to them.
- Information provided by the trust and staff working in the Macmillan clinical nurse specialist team told us that there had been no safeguarding incidents in the past twelve months. However, staff told us that any potential safeguarding concerns were discussed each week at the multidisciplinary meeting.
- Staff we spoke with told us that information about safeguarding concerns were shared between teams including the local hospice.
- Staff completed children and adult safeguarding as part of their core mandatory training. Staff in the Macmillan clinical nurse specialist team were 100% compliant with both level two adult and level one children's safeguarding training. The team were also 100% compliant with PREVENT training. PREVENT training is part of the government's counter-terrorism strategy.

Medicines

- We saw that medicines controlled under the misuse of drugs legislation were stored securely and appropriate records were in place in patients' homes.
- Anticipatory medicines are 'as required' medicines that are prescribed in advance to ensure prompt management of increases in pain and other symptoms.
- We saw that staff assessed patients to ensure that anticipatory medications were planned for and available in 'just in case' boxes in all patients homes that we visited.
- Patients and those close to them told us that they were well informed regarding what the drugs, in their homes, were for, how to store them, and how to dispose of them when they were no longer required.
- We observed discussions with five patients about the symptoms they may experience and which drugs were in their home to help.
- We saw staff prescribing medications and saw that they did this in line with local policies.
- We looked at five medication administration records in patients' homes and found all medications correctly prescribed and documented.
- There had been no clinical incidents relating to medications between April 2015 and the time of our inspection in April 2016.
- The Macmillan clinical nurse specialist team had eight independent non-medical prescribers. There were three development posts within the team; staff in these posts were prescribers or were in the process of becoming prescribers.
- The staff in the Macmillan clinical nurse specialist team told us that all prescribers receive a blue light alert if any National Patient Safety Alerts were received which related to medications. We saw evidence of a recent alert displayed on the notice board in the team base.
- All staff in the Macmillan clinical nurse specialist team had smart phones, which meant they could access the British National Formulary on line. The British National Formulary is a pharmaceutical reference book that contains a wide spectrum of information and advice on prescribing and pharmacology, along with specific facts and details about many medicines available on the National Health Service

Environment and equipment

- During our previous inspection in 2014, we advised the trust that they should audit and review the time taken to provide equipment to patients receiving end of life care. The trust provided us with the actions that had been taken since the last inspection.

Good

Are services safe?

- All staff we spoke with told us that they had timely access to equipment for end of life patients. In addition to an external contract, staff had access to equipment stores throughout the area.
- Staff we spoke with told us that equipment could be ordered as urgent, same day delivery for end of life patients.
- Staff planned anticipatory equipment in patients homes which would ensure that once needed the equipment was in place and available. In one patients home, we saw that a commode, shower chair, moving and handling equipment and a pressure-relieving cushion had all been arranged and delivered for future use.
- We saw that staff caring for end of life patients were also able to assist in providing other equipment such as key safes and neck pendants.
- The trust had a syringe pump policy and procedure (including procedures for commencing key palliative care medication) policy to support staff.
- We asked to see the yearly service and maintenance records for the syringe pumps and were told by the team that new syringe pumps had been purchased by the trust six months prior to our inspection; therefore, there was no maintenance due on these items at the time of our inspection.
- We spoke with staff in one community hospital who told us that they had enough equipment available. We looked at four moving and handling devices and eight other medical devices for example, observation-recording machines that were available on the ward we visited and found that all of the equipment was maintained and serviced in line with policy.

Quality of records

- Each patient had an electronic and paper care record. All paper records in patients' homes were kept in a standard folder used by both the Macmillan clinical nurse specialist team and community nurses.
- We looked at seven sets of the paper-based care records in patients' homes and seven electronic records completed by staff from community nursing teams and the Macmillan clinical nurse specialist team. We also looked at the paper records for two patients receiving end of life care in a community hospital. All records had consent and risk assessments in place. There was evidence of the discussions with families and patients.
- Families and patients were also encouraged to document any concerns, questions and findings in to the file of those patients being cared for in their own home.
- In addition to this, patients in their own home had personalised care plans with appropriately completed do not attempt cardio-pulmonary resuscitation, advanced care plans contact information, medicine charts and information and guidance for patients and their carers.
- We found that all records in patients' homes were accurate, complete, legible, up to date and stored securely. This meant that records were completed and stored in line with staffs registering bodies. However, we did identify some gaps in the care records of two end of life care patients that we reviewed in a community hospital.
- The trust used an electronic records audit tool that the Macmillan clinical nurse specialist team contributed to. In addition to this, every eight weeks a sample of records were reviewed during clinical supervision. The results were available in clinical supervision notes, which we saw during our inspection.
- Within the team, there was a MacMillan nurse consultant who reviewed the band 7 records and band 7 staff reviewed the band 6 development post staff records. Records were reviewed using the knowledge and skills framework.
- We looked at this information and found comprehensive records of clinical supervision relating to care records.

Cleanliness, infection control (IPC) and hygiene.

- There had been no cases of trust attributable clostridium difficile or methicillin-resistant Staphylococcus aureus (MRSA) reported by the Macmillan clinical nurse specialist team in the twelve months prior to our inspection.
- 100% of the Macmillan clinical nurse specialist team nursing staff had completed the trusts infection, prevention and control training. We also saw copies of hand hygiene competency assessments for all of the Macmillan clinical nurse specialist team.
- The Macmillan clinical nurse specialist team had access to personal protective equipment, such as gloves, aprons and alcohol gel. We observed that staff were bare below the elbow and using personal protective equipment when we accompanied the team members

on home visits. This meant that staff were adhering to infection prevention and control policies. We also saw hand hygiene competency records for all staff in the Macmillan clinical nurse specialist team.

Mandatory training

- The trusts thirteen core mandatory training elements included control of substances harmful to health (COSHH) awareness, display screen equipment, equality & diversity, health & safety, fire safety, infection control, information governance, mental capacity act, conflict management, moving & handling, PREVENT, safeguarding adults, and safeguarding children.
- The trusts compliance target for mandatory training compliance was 75%.
- Data provided by the trust showed the following compliance for the Macmillan clinical nurse specialist team :
  - 40% for equality and diversity and conflict management.
  - 50% for mental capacity act.
  - 80% for health and safety, COSHH, moving & handling and information governance.
  - 90% for display screen equipment.
  - 100% for adult and children's safeguarding, fire safety, infection prevention and control and PREVENT training.
- This meant that overall the team were 80% compliant with all mandatory training and were meeting the trust target; however, compliance in three subject's areas was well below the 75% target.
- Other teams providing end of life care, for example community nurses and community hospital staff had overall compliance of 68% and 70% respectively.
- Mandatory and other role specific training dates were communicated to staff via a weekly global e-mail.
- The trust had a statutory and mandatory training policy however; this had been due to be reviewed in July 2015. In addition to this the trusts fire safety policy had also been due for review in November 2015.

Assessing and responding to patient risk

- Advice is issued to the NHS as and when issues arise, via the Central Alerting System. National patient safety alerts are crucial to rapidly alert the healthcare system to risks and provide guidance on preventing potential incidents that may lead to harm or death.
- We saw evidence that patient safety alerts were discussed in the end of life discharge facilitation and patient pathway meeting. In addition to this, all staff received a blue light alert via e-mail from the trust. We saw these displayed at the Macmillan clinical nurse specialist team base; we also saw an example in a weekly global e-mail, sent to all staff, relating to an equipment alert.
- We saw comprehensive assessments of patients needs and care plans in place to manage the risks in the patients electronic care records.
- We also saw paper records in patients home and found that these were consistent with the information that had been logged on the electronic system.
- We saw patient risk assessments fully completed in care records including pressure risk assessments, falls, malnutrition, moving and handling and mobility. We saw the Macmillan clinical nurse specialist team and community nurses reassessing patients at risk during home visits.

Staffing levels and caseload

Macmillan clinical nurse specialist team

- The Macmillan clinical nurse specialist team had an establishment 9.7 whole time equivalent nurses in the team.
- At the time of our inspection, the team was fully established. We were told that there had been no bank or agency cover in the last twelve months. Information provided by the trust showed that in December 2015, there were 16.8% vacancies and 5.9% sickness within the team.
- Staff we spoke to told us that, because there was a number of part time staff in the team, they were able to cover these absences by offering existing staff additional hours on a temporary basis. This meant that there had been no disruption to the service, staffing was consistent to help keep patients safe.
- The team included a Macmillan nurse consultant in palliative care and Macmillan clinical nurse specialists. Three posts within the team were band 6 development roles.
- We were told that the average caseload was sixteen patients with a maximum of twenty. However at the

time of our inspection, one of the nurses had twenty-four patients on her caseload, therefore a colleague from the adjacent 'area' was assisting with the care of some of the patients.
- The team members were attached to general practitioner practices. If one member of the team had a greater caseload than the others, the team would share the caseload allocation.

Medical Staffing

- The trust employed two general practitioners with specialist interest in end of life care. Both of these posts were part time. One was a 0.2 whole time equivalent (7.5 hours) and the other was 0.1 whole time equivalent (4 hours).

Community Nursing Teams

- At the time of our inspection, seven of the Neighbourhood Care Teams areas were operating below the established staffing levels identified by the trust. One serious incident in relation to a grade four pressure ulcer had also identified poor district nursing caseload management as a contributory factor.
- At the time of our inspection, 13 from 30 staff groups had vacancy rates higher that the trust average of 11.6%. In total, the service had 25.8 whole time equivalent qualified staff vacancies and 3.6 whole time equivalent nursing assistant vacancies.
- Five district nursing teams had qualified nurse vacancy rates above the trust average of 11.6%. The highest of these was the Withernsea team with a rate of 28% (2.3 whole time equivalent staff). The Bridlington team had a slightly lower rate at 27.2%, but had a higher number of vacancies at 5.6 whole time equivalent staff.
- This meant that end of life care may be compromised due to a lack of staff availability.

Community Hospitals

- Senior nursing staff had daily responsibility for safe and effective nurse staffing levels. Staffing guidelines with clear escalation procedures were in place. Senior nurses provided site cover out of hours with access to an on-call manager.
- Numbers of staff on duty was displayed clearly at ward entrances. On all inpatient wards, actual staffing levels were in line with those planned. Variations were appropriately made to meet activity and patient acuity and nurse-staffing levels were managed day to day.
- Nurse sickness rates were between 8.4% and 8.9%, vacancy rates were 0% and the average 'fill rate' was 101% for nursing staff and 96% for health care assistants (February 2016).
- The trust had an established staff 'bank', which provided cover for short notice.

Major incident awareness, training and managing anticipated risks

- The trust told us that all senior managers had undergone the trusts major incident training, this included all band 8 and above staff who participated in the trust manager on call rota.We were told that refresher training at this level was booked again for 2016.
- The Emergency Preparedness, Resilience and Response work plan had training identified to be introduced to all staff in the future.
- We were told that if an incident was declared trained staff would go to assist regardless of the service they work in. The emergency planning team would lead any incident within the trust.
- The trust had a policy to support staff in the event of a major incident being declared.
- We saw a business continuity plan for the Macmillan clinical nurse specialist team displayed at the staff base. This included details of contact numbers and policies available for staff in the event of major incident, heatwave, pandemic, adverse weather, health and safety and fire.
- Staff we spoke with were aware of the business continuity plan for the service.
- Many staff in community services in particular those visiting patients home often do so alone. Therefore, they are more vulnerable to attack and assaults, more exposed to hazards and more likely to be injured.
- The trust had a lone worker policy however; this had been due for revision in July 2015.
- The Macmillan clinical nurse specialist team had lone worker systems in place that included having a mobile phone, signing in and out of their base and one team member checking that all staff have reported in after the last visit of the day.
- Any risks in patients home were flagged on the patients electronic care record, this included if there was a dog in

Good

Are services safe?

the home or if there was a need for two staff to visit. We saw an example of this being when a patient's son was a known drug user and the actions that were in place for the protection of staff.

Good

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 rated effective as good because:

- Most people's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. There was a centrally hosted clinical computer system, which allowed the majority of staff to access and share records.
- Patients were receiving advice about pain relief, nutrition and hydration.
- There was participation in relevant local, national and some international audits. The gold service framework was embedded across the locality. Patient outcomes were collated; improvements in the mechanisms for collecting this data had been recognised and were being implemented.
- Staff were highly qualified, received timely appraisals, clinical supervision and were supported with further professional development.
- There was evidence of multi-disciplinary working across all teams and also evidence of collaborative working with the local authority. Referral processes were straightforward and staff did not raise any concerns about these.
- Consent to care and treatment was obtained in line with legislation and guidance, including the mental capacity act 2005. We saw evidence that patients were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded.

However we also found that:

- Not all teams were using the appropriate care pathway 'caring for me advanced care plan' for end of life patients.
- Do not attempt cardio-pulmonary resuscitation forms were not always fully completed for patients in community hospitals. The trust did not complete an audit of do not attempt cardio-pulmonary resuscitation forms.
- The trusts consent policy was out of date for review and low numbers of staff had attended mental capacity act training.

Detailed findings

Evidence based care and treatment

- Staff used both the National Institute for Health and Care Excellence and Royal Colleges guidelines to determine the care and treatment they provided.
- We saw that trust policies referenced best practice and other appropriate clinical guidance. For example, the do not attempt cardio-pulmonary resuscitation policy referenced guidance from the resuscitation council, the British Medical Association and the human rights act.
- All staff we spoke with were aware of and spoke to us about evidence-based practice relating to their patient group, for example, National Institute for Health and Care Excellence guidance for palliative care and end of life care. Staff told us that any new guidance was discussed at peer supervision meetings and paper copies were available in a folder at the Macmillan clinical nurse specialist team staff base.
- We saw minutes of the Macmillan clinical nurse specialist team meetings that showed that new National Institute for Health and Care Excellence guidance was shared and discussed.
- The trust had developed an evidenced based end of life care pathway, the 'caring for me advanced care plan'; following the withdrawal of the Liverpool care pathway in 2014. We saw this used, by district nurses and Macmillan clinical nurse specialists, in patients' homes however, this was not evident in the care records we reviewed in one of the community hospitals. When we spoke to senior staff, at the hospital,about this, they told us that they were not using the pathway, despite having had training and education, because staff did not feel confident. The Macmillan clinical nurse specialist told us that more education and support was being implemented.

Pain relief

- We saw that all patients we visited in their own homes had been assessed for pain and had appropriate supplies of the medications being used and also anticipatory medications to manage their future needs.

Good

Are services effective?

- Staff in the Macmillan clinical nurse specialist team, community nursing and inpatient units used a one to ten pain-scoring tool and also verbal pain assessments.
- We visited patients in their own homes with community nurses and members of the Macmillan clinical nurse specialist team and saw that staff gave a thorough explanation of the medications the patient was taking, including the pain relief. Staff took time to explain the importance of keeping the patient pain free and on several occasions suggested using a pain diary.
- We saw that the Macmillan clinical nurse specialist team, community hospitals and community nursing teams managed most patients' pain effectively.
- We were told that patients' wishes were respected when choosing types of pain relief.

Nutrition and hydration

- All care records we looked included risk of malnutrition assessments.
- We also witnessed staff from the Macmillan clinical nurse specialist team and community nursing teams offering advice and support about diet and fluids,
- This included suggesting and prescribing nutritional supplements and also giving advice about how to fortify food to help patients maintain their dietary needs.
- We saw that food diaries were in use in the community hospitals for patients who were assessed as being at risk of malnutrition.

Technology and telemedicine

- All members of the Macmillan clinical nurse specialist team had smart phones and laptops and staff could access connectivity in a wide range of buildings across the locality, which meant that they did not need to return to the central base to update care records. However, they were not able to complete records in patients' homes because connectivity was not available.
- We spoke with senior staff who told us that mobile working was in place in other teams and that the trust had plans to roll this out to all community teams.

Patient outcomes

- The gold standards framework is a model that enables good practice to be available to all people nearing the end of their lives, irrespective of diagnosis. It is a way of raising the level of care to the standard of the best. Through the gold standards framework, palliative care skills for cancer patients can now be used to meet the needs of people with other life-limiting conditions. The gold standards framework provides a framework for a planned system of care in consultation with the patient and family. It promotes better coordination and collaboration between healthcare professionals. The tool helps to optimise out-of-hours' care and can prevent crises and inappropriate hospital admissions.
- We were told that all general practitioners in the area used the gold standards framework for their patients.
- The Macmillan clinical nurse specialist attached to each general practitioner practice attended their gold standards framework meetings each week.
- The Macmillan clinical nurse specialist team were contributing to an international initiative to create a collaborative for pharmacovigilance in hospice and palliative care clinical practice.
- The Macmillan clinical nurse specialist team were starting to utilise the integrated palliative care outcome scale via the electronic record system, this would enable them to collate palliative care and end of life outcome measures more effectively.
- A do not attempt cardio-pulmonary resuscitation audit was not undertaken by the trust. The Macmillan clinical nurse specialist team staff told us that the patients general practitioner audited this for patients dying in their own home, however this meant that the quality of do not attempt cardio-pulmonary resuscitation forms completed for end of life care patients dying in community hospitals were not audited.

Competent staff

- We saw evidence that all of the Macmillan clinical nurse specialist team had an up to date appraisal.
- We saw information provided by the trust, which showed that all nursing staff in the team received clinical supervision. We also looked the clinical supervision records during our inspection and found that these were comprehensive.
- Staff members from the team attended an end of life education group. This meeting was a joint meeting with other providers including City Health Care Partnership, Hull & East Yorkshire Hospitals, NHS East Riding Clinical Commissioning Group, Hull Clinical Commissioning Group, East Riding of Yorkshire Council, Hull City Council and other partner organisations such as local hospices, Marie Curie and Hull University.

Good

Are services effective?

- Staff we spoke with told us that they were encouraged to attend training as desired and there was plenty of funding to support this.
- We saw evidence that the Macmillan clinical nurse specialist team were a highly skilled team with most of the team having several post graduate qualifications appropriate to their line of work including the care of the dying course (diploma level 5), working with people affected by cancer (degree level 6), specialist practitioner – adult nursing (continued care for the dying patient and family (degree level 6), Bachelor of Arts (honours) palliative care degree (adult), management of breathlessness (3 day course) and other similar courses.
- Three posts within the team were band 6 development roles, these staff were completing the required competencies for the role, for example, a postgraduate qualification in palliative care and/or non-medical prescribing.
- End of life care was provided in conjunction with other teams, for example community nurses and community hospital inpatient wards. We were told that approximately seventeen to twenty community nurses were completing degree level palliative care postgraduate modules each year. This meant that many community nursing staff had or were developing the skills needed to care for end of life patients.

Multi-disciplinary working and coordinated care pathways

- We saw minutes of a multidisciplinary meeting that showed that a comprehensive review of all patients on the Macmillan clinical nurse specialist team caseload was undertaken. This included patients who were being cared for collaboratively with community nurses and community inpatient units.
- In addition to this, we also saw that staff attended the end of life discharge facilitation and patient pathway meeting. This was a multi-disciplinary meeting involving members of the trust team along with City Health Care Partnership, Dove House Hospice, East Riding Clinical Commissioning Group, East Riding of Yorkshire Council, Hull City Council, Hull & East Yorkshire Hospitals NHS Trust and Hull Clinical Commissioning Group.
- We observed positive liaison with other service providers, including community in patient units, community nurses, the local hospices and the patients general practitioner to share concerns, risks and updates regarding end of life care patients.
- There was a clear pathway for transfer from hospital to community and evidence that the multidisciplinary approach to coordinating care was robust. For example, the team used a shared electronic palliative care coordination system.
- All members of the Macmillan clinical nurse specialist team were attached to a general practitioners practice and attended their monthly gold service framework meetings.
- All patients on the gold service framework were identified on the electronic care records, which meant this information was shared with out of hours care services.
- Staff in the Macmillan clinical nurse specialist team told us that they had close links with the nurse consultant for older people and mental health.

Referral, transfer, discharge and transition

- The Macmillan clinical nurse specialist team accepted referrals from any health care professional, self-referrals from patients and also from carers and relatives.
- Following an initial consultation, the Macmillan clinical nurse specialist team would liaise with community nursing teams who provided generalist care for end of life patients.
- If a patient was stable and did not require specific input from the Macmillan clinical nurse specialist team, they were advised that open access back to the service was available at any time. The patients were taken off caseload until they or a family member recontacted the team.
- The Macmillan clinical nurse specialist team also had referral rights to admit to the trust community hospitals.

Access to information

- Staff could access connectivity in a wide range of buildings across the locality, which meant that they did not need to return to the central base to update care records.

Good

Are services effective?

- We saw a copy of a weekly global; this was a communication e-mail sent to all staff within the trust from the communications officer. This included a wide range of information for staff including updates, training and social events.
- The Macmillan clinical nurse specialist team and community nurses provided care to patients across a large geographical area. They used a recognised electronic records system, which meant that they could view the records of all of the patients each team's caseload. 67% of the general practitioners in the area used the same electronic system, which enabled sharing of records.
- For the remaining 33% of general practitioners, where shared records were not available, for example when a different electronic system was used, staff faxed information to the doctors practice to ensure that a record of the care they had provided was available to the patients doctor.
- The local doctors out of hours service used the same system as the trust staff, so were able to access the care records of patients receiving end of life care if they were called at night or on a weekend to the patients own home or to one of the trust community hospitals.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Consent to treatment means that a person must give their permission before they receive any kind of treatment or care. An explanation about the treatment must be given first. The principle of consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing.
- For consent to be valid, it must be voluntary (the decision made by the person themselves) and informed, and the person consenting must have the capacity to make the decision.
- If a person does not have the mental capacity to make a decision about their treatment, professionals can make a 'best interest' decision. However, the professional must take reasonable steps to consult with the patient's family or closest person before making these decisions.
- The trust had a consent to assessment, examination and treatment policy however, this had been due for review in September 2014.
- We saw evidence within the records on the electronic system that staff sought consent to share patient information.
- All staff we observed sought verbal consent prior to providing care and treatment.
- We looked at three do not attempt cardio-pulmonary resuscitation forms completed in patients' homes and found that these were completed in line with guidance and stored in the front of the patients care folder.
- We looked at eleven do not attempt cardio-pulmonary resuscitation forms which had been completed for patients in community hospitals and found that four of these were not fully completed. These forms had no evidence that patients had been involved in a discussion about the decision despite them having capacity. However, we also saw evidence of good practice on one form that showed that a best interest decision had been made in conjunction with the patients' family, for a patient who lacked mental capacity.
- The trust had a mental capacity act and best interest decision-making policy to support staff.
- We had concern that the overall compliance rate for mental capacity training in the Macmillan clinical nurse specialist team was 50%; this was lower than the trust target of 75% and meant that not all staff had appropriate training in place to support them when dealing with patients who lacked capacity. We also found low compliance in other teams caring for end of life care patients including community nursing teams and community hospital staff.

Good

Are services caring?

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

Summary

We rated caring as good because:

- Feedback we received from patients and those close to them was consistently positive about the way staff treated them. Patients told us that staff go the extra mile and we witnessed this during our inspection.
- We observed a number of staff and patient or carer interactions during our inspection. We observed consistently sensitive, caring and compassionate staff.
- Staff were highly motivated and inspired to offer care that is kind, promotes people's dignity, and involves them in planning their care.
- We saw staff providing detailed explanations of procedures, thorough assessment of all needs and reassurance.
- Relationships between patients, those close to them and staff were strong, caring and supportive.
- These relationships were highly valued by staff and promoted by leaders.
- Patients were supported emotionally. All staff were very responsive to the psychological needs, of not only patients but also those close to them. We saw psychological assessment and depression-scoring tools being used for patients when appropriate.

Detailed findings

Compassionate care

- We observed care approaches adjusted to meet needs of vulnerable patients, some of who had difficulty accepting help and had always been independent. We saw that the staff were very sensitive to their patients' feelings and very creative in finding ways to get them to consider support at home that would be successful.
- Staff maintained patients' privacy and dignity, for example by asking others to step outside the room whilst they checked a wound.
- We saw an e-mail sent to a relative, asking for their consent to use a patient's story to present to the trust board. The response from the patients' relative showed that the family had received holistic compassionate care from Macmillan clinical nurse specialist team.
- We saw that staff allowed the patients to talk about things that worried them and staff using recognition of cues to discuss things that were difficult.
- The Macmillan clinical nurse specialist team did not actively take part in the NHS Friends and Family Test due to the sensitivities of the patients and the families in their care. They collated compliments and told us about donations they had received from families.
- We saw Friends and Family Test cards in the patient care folder in patients' homes that we visited, who were being cared for by community nurses. However, staff did not actively seek this feedback from the patients or their families when providing end of life care.

Understanding and involvement of patients and those close to them

- We witnessed respectful and considerate care provided which was not rushed to patients and their families.
- We visited a patient who was very frightened about being alone at night. Reassurance was given and following careful investigation, it was established that this stemmed from comment made by a doctor in hospital which was interpreted by the patient as them being expected to die in their sleep. The nurse immediately arranged a night sitting service to support the patient and to help the patients' family get some rest.
- We visited an end of life care patient with a district nurse and found the interactions with both the patient and the patients' family were excellent. We witnessed a whole family assessment, which took in to account the needs of the patient and those close to them.
- The patients' family asked the patient if they would mind if they spoke to the nurse in private about some sensitive issues and the patient gave consent for this. The nurse told us that she felt privileged that the family felt that they could share their concerns with her.
- One patient said to one of the staff 'it's a good job I've got you'.
- A community nurse told us that she likes to remind families that time with their loved one is precious and in order to make the most of this, she likes to say to families to let the staff do the caring and for the families to be the family.

Good

Are services caring?

- A member of the Macmillan clinical nurse specialist team told us that they used memory books and boxes; in particular, they found that these were helpful to younger families that they were involved in however they also told us that grandparents were also using these to give to grandchildren.

Emotional support

- The Macmillan clinical nurse specialist team were able to refer patients to a variety of psychology services. This included appointment and drop in services across the area to enable patients to attend a service close to their home.
- We saw that when necessary, patients were assessed using recognised anxiety tool by all staff providing end of life care.
- We saw that staff constantly reassured patients that their wishes were paramount, and that the nurse was only there to make suggestions and ensure they had all the facts.
- Patients and relatives we spoke with told us that the nurses and general practitioners had gone out of their way to provide everything that was needed and that they felt well supported and were so grateful this enabled them to stay in their own homes.
- The trust had a bereavement team and we were told that the Macmillan clinical nurse specialist team had close links with this team for their patients and families.

Good

Are services responsive to people's needs?

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

Summary

We rated responsive as good because:

- Services were planned and delivered in a way that meets the needs of the local population.
- Staff respected the equality and diversity of patients and their families.
- The needs of vulnerable people were taken into account when planning and delivering services.
- We saw evidence that staff were responsive to meeting the needs of vulnerable patients including those living with dementia and learning disabilities.
- Patients were able to access services in a responsive and timely way.
- There were no complaints about patients receiving end of life care.

Detailed findings

Planning and delivering services which meet people's needs

- We saw services that were planned, delivered and coordinated taking the complex needs of patients in to account.
- The trust provided end of life care across a wide geographical area. Community nursing teams, the Macmillan clinical nurse specialist team and community hospitals were situated in localities and cared for the patients living in that area.
- We saw that the end of life care teams worked collaboratively with partnership agencies and other stakeholders to discuss and plan care for the patients in their care.
- During our inspection, we visited a palliative care day centre, which had opened on the day of our visit. This local hospice venture was being held in one of the trusts community hospitals. The Macmillan clinical nurse specialist team member who covered the local area would be arranging to see patients who were visiting the day care centre, using an appointment system that would ensure better use of the staff members' resource.

Equality and diversity

- We asked staff we spoke with about equality and diversity in relation to the patients they cared for. They told us that all patients received a holistic assessment including any specific needs relating to equality and diversity.
- All staff we spoke with in the Macmillan clinical nurse specialist team told us, that there were low numbers of patients needing translation services.
- We saw the trust interpretation and translation policy. Staff we spoke with were aware of this resource. The policy identified how to access both telephone and face-to-face interpretation, both during and out of hours.

Meeting the needs of people in vulnerable circumstances

- We found that there was excellent partnership working between the Learning Disabilities team and the Macmillan clinical nurse specialist team who were based in the same building.
- We were also told that joint visits were arranged with the Macmillan clinical nurse specialist team and learning disabilities team when a patient with learning disabilities needed end of life care support.
- One member of staff we spoke with told us that, close working links with other specialist teams had enabled them to support patients, for example those with learning disabilities , to die at home and also learning disabilities patients living in residential homes.
- Another staff member told us about how they had worked with the learning disabilities team to provide end of life literature to a severely dyslexic patient.
- Staff in the Macmillan clinical nurse specialist team had all team received dementia awareness training and were using the dementia butterfly scheme. The butterfly scheme provides a system of care for people living with dementia.
- We saw that the Macmillan clinical nurse specialist team had presented two end of life care patient stories to the board. One of these related to a patient with a mental health illness who was nursed collaboratively by the Macmillan clinical nurse specialist team and mental health teams.

Good

Are services responsive to people's needs?

- We spoke with staff in one community hospital and were told that the ward had a dementia champion and used the butterfly scheme, however we did not see any evidence of aids such as dementia friendly clocks and coloured crockery.

Access to the right care at the right time

- The Macmillan clinical nurse specialist team was available Monday to Friday 09:00 until 17:00. Outside these hours end of life care was provided by the out of hour's doctor's service and community nurses from the trust who provided 24-hour care, seven days a week.
- In addition to this, four local hospices were available to provide clinical advice.
- We were told that the Macmillan clinical nurse specialist team triaged all referrals. Most patients were seen on the next available working day. We were not able to corroborate this, as the data was not formally collated however; this was documented in the teams' operational standards and audited by the staff when completing clinical supervision.
- The team were able to refer patients to the local acute NHS trust oncology wards.
- Eight members of the Macmillan clinical nurse specialist team were independent non-medical prescribers. There were three development posts within the team, staff in these posts were prescribers or were in the process of becoming prescribers. Non-medical prescribing is undertaken by a health professional who is not a doctor. It concerns any medicine prescribed for health conditions within the health professional's field of expertise. Research has shown that non-medical prescribing has improved the quality of service to patients; there is evidence of not just greater convenience but also of improved clinical outcomes.
- During our inspection in 2014, we said that the trust should review access to prescribed controlled drugs for palliative care patients out of hours. Staff in the Macmillan clinical nurse specialist team told us that there was now a twenty-four hour chemist identified for trust staff and the team ensure that medications were available patients' homes early.
- The Macmillan clinical nurse specialist team had worked collaboratively other partnership agencies, the Humber Drugs and Therapeutic Committee, the trust community pharmacist and the Macmillan teams across the area to agree guidance in relation to key palliative care medications across all care areas. This included the development and agreement across all Trusts and City Health Care Partnership (Social Enterprise Community Care providers in Hull) of a joint community medications administration sheet. End of life patients who were transferred home to die had these completed within the acute trust and anticipatory prescribing medications were sent home with patients to ensure a seamless transfer.
- During our inspection, we saw a member of the Macmillan clinical nurse specialist team responding after seeing a patient in a day centre who was having difficulty sleeping; this was subsequently affecting the patients' family. The patient was not currently active on the specialist nurses caseload however; they immediately contacted the patients' community nursing team and asked if they would discuss the option of an overnight sitting service when they next visited the patient. The community nurse advised that she had a routine visit planned for the next day and would talk to the patient and family about this.
- The Macmillan clinical nurse specialist team monitored patients preferred place of care and achieved high levels (86.6%) of patients dying in their preferred place of care. The care of all patients not achieving this was reviewed at the retrospective mortality meeting. We were told that in most cases, this was due to patients needing to be admitted for acute hospital care and that there was usually appropriate rationale for this. All patient deaths were discussed at this meeting to share learning and feedback.

Learning from complaints and concerns

- Information received from the trust showed that the Macmillan clinical nurse specialist team had not received any formal complaints in the twelve months prior to the inspection. One complaint had been received, by a community nursing team, about a patient with a cancer diagnosis. This complaint related to communication issues and was resolved appropriately. There were no complaints for end of life patients being cared for in community hospitals.
- Patient Advice and Liaison Service leaflets were part of the patient care folders given to all patients and carers by the Macmillan clinical nurse specialist team and community nurses. We also saw this information displayed in community hospitals.

Good

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 rated well led as good because:

- The teams providing end of life care had a clear strategy, vision and values, driven by quality and safety, which was recognised and integrated within the teams.
- Senior staff felt that they had a voice to the board through the director of nursing.
- Senior staff were visible and supportive to staff and patients. The majority of staff in the service told us that senior staff for the trust were also engaged with the services provided in the community. All staff we spoke with said that senior staff were very approachable.
- Leaders were actively engaged with staff, people who used services and their representatives and stakeholders.
- We witnessed the culture within teams as being team focused and positive. All staff we spoke with told us that they worked as part of a team and felt supported within their service.
- We saw good examples of public engagement.
- Staff were proud of the teams they worked in and told us about innovation they had been involved in. There was a strong focus on continuous learning and improvement at all staff levels. Staff shared innovations and improvement work that they were involved in.

However we also found that:

- Not all risks were identified on the care group or corporate risk register, for example out of date policies. Some identified risks had no evidence of mitigation to reduce the risk despite being on the register for many months. However, we identified that new care group structures had recently been introduced and plans to ensure that governance issues were being introduced by senior staff in the service.

Detailed findings

Service vision and strategy

- We saw the vision and strategy for the Macmillan clinical nurse specialist team displayed in the staff base**.**
- Staff in the team were aware of the teams' vision and strategy.
- We also saw the community Macmillan clinical nurse specialist team operational standards 2016 /2017 which included a definition of specialist palliative care, the team mission statement and philosophy of specialist palliative care and also the principles of the service and the teams service objectives.

Governance, risk management and quality measurement

- The trust had a corporate and a care group risk registers. We looked at these and saw that there were no risks specific to end of life care patients or the Macmillan clinical nurse specialist team whilst staffing in community nurse teams was highlighted as a risk, out of date policies were not evident on the corporate or care group register.
- We saw that the risks were rated red, amber or green, however we saw no evidence that any risks had been reviewed since December 2015 or earlier. In addition to this, some risks dated July, August and September 2015 were still shown as 'new risks' with no actions to mitigate the risks.
- The service manager explained that all risks were managed locally. We saw evidence of completed risk assessments for the Macmillan clinical nurse specialist team at the staff base during our inspection. These risks were scored and any risk scoring twelve or above were forwarded for risk register insertion. These risks were then subsequently discussed at the Governance Care Group and if accepted they were added to either the care group register and, if necessary, the corporate risk register.
- We saw a recent document called Minding the GAP. We spoke with the service manager about this and were told us that team meetings would be based on this initiative in future to ensure that governance, assurance and performance (GAP) were standard items on all team-meeting agendas.

Leadership of this service

Good

Are services well-led?

- All staff we spoke with spoke positively about their clinical and operational leadership.
- New care structures were becoming embedded. Staff we spoke with spoke positively about the new care group leader and also viewed new initiatives such as Minding the GAP positively.
- All staff were able to access the nurse consultant and service managers diaries.
- We were told and saw that the clinical and operational leads for the Macmillan clinical nurse specialist team were visible, approachable and supportive of the team.

Culture within this service

- All staff in the Macmillan clinical nurse specialist team told us that the team was supportive and that they 'get on very well 'and' lean on one another when required.
- We saw positive working relationships between the Macmillan clinical nurse specialist team, local General Practitioners, the community nursing teams, the staff in community hospitals and other partner agencies.
- Staff told us that there was a positive culture within service based on 'openness, leadership, support and being well informed.
- We saw that the Macmillan clinical nurse specialist team worked collaboratively and liaised with local acute trusts and many other stakeholders.

Public engagement

- We saw evidence of the compliments received by the Macmillan clinical nurse specialist team from families and carers of end of life care patients.
- The Macmillan clinical nurse specialist team had recently presented two patients stories to the board, with the patients or their families consent.
- We saw an e-mail sent to a relative of one of the patients' stories, asking for their consent to use the story. The response from the patients' relative showed that the family had received holistic compassionate care from the end of life care staff.
- End of life patients relatives were invited to a carers group. Initiatives such as the 'caring for me' document and all patient leaflets were presented at to this group, patients and their carers were encouraged to be involved in the consultation about these documents.
- We also saw details of a project that the Macmillan clinical nurse specialist team had been involved in with East Yorkshire County Council patient voices team and 2000 members of the public who were asked to contribute their thoughts and preferences in relation to end of life care.
- We saw carers support and drop in centre leaflets within the patient care folders given to all patients and their carers.

Staff engagement

- We asked members of the Macmillan clinical nurse specialist team what they felt were the strengths of the team and were told that they are very autonomous, high level thinkers. They also told us they had excellent relationships and good communication with members of the other multidisciplinary teams they worked with.
- We saw that staff received a wide range of information through a weekly global e-mail. This included trust updates and both clinical and social information for staff.
- Staff in the Macmillan clinical nurse specialist team felt that they had strong links to the trust board through the director of nursing.

Innovation, improvement and sustainability

- The Macmillan clinical nurse specialist team were contributing to the International RAPID pharmacovigilance in hospice and palliative care clinical practice audit. They were the only nurse led team in the world who were involved in this. This program is an international, multi-site, post-marketing study of the real world net clinical effects of medications used in hospice and palliative care. The aim is to have a large number of sites around the world in different care settings each entering a very small amount of data on a small number of patients in order to quickly improve the evidence base for clinical care.
- The band 7 Macmillan clinical nurse specialist team staff delivered the palliative care degree module; all band 7 staff from the team contributed to teaching on the course. This module was delivered as part of a unique collaboration with a social care provider. 100% of the 17 trust staff in the last cohort passed the accredited level 6 course, which was moderated, through the University of West London. This course had run for four years and 78 clinicians from all care groups (community, mental health, learning disability and forensic services) have achieved a pass in this module.

Good

Are services well-led?

- The team were also involved in the redesign and delivery of the health care assistant, end of life module (Level 4 assistant practitioner) course that was delivered through Hull University.
- In December 2015, the Macmillan clinical nurse specialist team started a unique monthly collaboration with the "Living with Cancer" service from Hull and East Yorkshire Hospitals. This service provided information, advice and follow up appointments for patients and their carers who are at the end of their active treatment at one of the trusts community inpatient units. Long-term condition patients were also able to attend the breathlessness management, nutritional advice, and activity and exercise sessions irrespective of diagnosis.
- In January 2016, the Humber Palliative and End of Life Care Group was relaunched. Clinicians attend this from all four care groups, leading to joint learning and sharing across mental health, community services and learning disability and specialist services. This group also fed in to the Humber Clinical Care Group Networks.
- In 2013, three members of the Macmillan clinical nurse specialist team had been awarded the Henry Garnett Award. This award recognises the exceptional contribution that inspirational professionals make beyond their core professional role.