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palliative care cymru implementation board

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Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

George Thomas Hospice Home Care Specialist Palliative Care Team

End of Life Care Peer Review

Date of Visit March 14th 2013

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Date of Visit : 14th March 2013

End of Life Care Peer Reviewing Team

Name (Print)	Job Title	Organisation
Dr Caroline Usborne	Clinical Director Betsi Cadwaladr University Health Board (BCU) Consultant Palliative Medicine	BCU Health Board
Tracy Livingstone	Director of Nursing & Patient Services	Nightingale House Hospice Wrexham
Dinah Hickish	Senior Advanced Nurse Practitioner	St Kentigern's Hospice St Asaph
Val Jones	Lay Reviewer	Healthcare Inspectorate Wales (HIW)
Facilitation Support Team: Veronica Snow :Programme Manager Palliative Care Implementation Board Gareth Brydon : Assistant Inspector Healthcare Inspectorate Wales		

Organisation Title	George Thomas Hospice Care	
Team title	George Thomas Hospice Care Team	
Review Date Title	March 14th 2013	
Name (Print)	**Job Title**	**Organisation**
Dr Margred Capel	Consultant Palliative Medicine	George Thomas Hospice Care
Terri Gazzi	Lead Clinical Nurse Specialist	George Thomas Hospice Care
Mel Lewis	Lead Nurse Palliative Care	Cardiff & Vale University Health Board

Review Summary

George Thomas Hospice Care is an excellent service with strong clinical leadership. The service is delivered within a sound framework of Clinical Governance and works in partnership with other local providers and Health Board Commissioners.

The George Thomas Hospice Care Team (GTHC) has a clear and concise Operational policy, Referral policy, Dependency tool to assess need and a Discharge criteria based on regular patient reviews. Multidisciplinary Team (MDT) meetings are held weekly. CANISC is used to record all information. All new patients are seen jointly by the Consultant/SPR and Clinical Nurse Specialist (CNS). All new patients are discussed at the weekly MDT and a care plan is agreed. A communication Policy is in place and GPs are kept informed of the GTHC team involvement in patient care. Patients are reviewed in the MDT as necessary. All CNS Caseloads are reviewed monthly. The team described robust communication systems with other local palliative care service providers, Velindre Cancer Centre and Cardiff & Vale Health Board.

A variety of audits were available, evidencing good use of clinical audit. Patient surveys report high levels of patient satisfaction with the service. Cardiff & Vale Health Board, as sole commissioners, meet with GTHC every quarter at a performance review meeting and report good integrated working, with GTHC participating in the local strategic group.

There are many areas of good practice that can be shared, in particular the commitment to Audit and its use to change practice.

The Palliative Medicine Consultant carries a significant workload; any increase in referrals may require working pattern to be reviewed to ensure the consultant is not overloaded and her clinical expertise continues to be used to maximum patient benefit.

A 5% cut in funding from the Health Board could adversely affect this service in the long term, although currently the reduction is met from GTHC reserves.

Peer Review March 14th 2013

Key Themes

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

Structure and function of the service

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

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

The George Thomas Hospice is a voluntary sector organisation overseen by a Board of Trustees as a Management Council. The Hospice provides Specialist Palliative Care in a Day Hospice setting and in the community within the Cardiff & Vale Health Board area. The service is commissioned by Cardiff & Vale Health Board.

The Clinical Service is led by a Consultant in Palliative Medicine. The Clinical team occasionally participate in the fundraising aspect of the organisation. Within the Clinical team there are : Consultants in Palliative Medicine, SPR, 7 Clinical Nurse Specialists, 1 Social Worker, 1 Welfare Rights Office, 1 Physiotherapist 1 Occupational Therapist , 1 Counsellor and medical clerical support. A further CNS is about to be appointed.

All staff are appropriately trained and all go onto specialist theoretical learning. Allied Health Professionals are linked to other professional colleagues in similar roles, providing mutual support.

There is a clear and concise Operational policy, Referral policy, a Dependency tool to assess need and Discharge criteria based on regular patient reviews.

Multidisciplinary Team (MDT) meetings are held weekly. CANISC is used to record all information.

A Communication Policy is in place and GPs are kept informed of the GTHC team involvement in patient care.

Referrals into the service average 550+ annually.

The Clinical Governance committee meets quarterly.

A Risk management register is in place.

There is a rolling Audit programme on Standards.

Additional Policies are developed by need and are reviewed annually.

Structured Audit & Strategy Meetings are in place.

Any Clinical Governance incidents can be managed through tri-annual performance review meetings with the Health Board.

Coordination of care/patient pathways

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

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

Clinical leadership and communication

Patient Pathway: The majority of referrals are from primary care. Referrals are taken via the Core Services Officer or Clinical Nurse Specialist who contacts the GP and the patient is admitted to the service.

Usually all new patients are seen and assessed jointly by a Consultant/SPR and a Clinical Nurse Specialist on their first visit. The team will then liaise with GP. Urgent cases are seen within two working days, with routine cases seen within five working days.

The Clinical Nurse Specialist Caseload averages 45, using a local dependency tool to assess need.

Caseloads are regularly reviewed to enable patients who have been stable for 6 months to be discharged

Non cancer referrals are 17.6% of overall caseload.

Referral Rates are discussed regularly with the Health Board at quarterly Performance Review meetings.

Quarterly meeting with Health Board include the Board lead, finance manager and operational lead.

Integrated Care Priorities: GTHC lead on a local death audit. They work closely with the District Nurses, GPs and the Health Board. Links with District Nurses are good and all practicalities are in place in the home to support “Preferred Place of Care.” However, there are not enough resources in place. There is a lack of ‘Hands

on Care' but there is a strategy to fill any gaps by working seamlessly with partner organisations to offer a comprehensive service e.g. Velindre Cancer Centre and Community services provide additional services such as Dietetics.

Patient Experience

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

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

I want great care (IWGC): Each patient is provided with an IWGC survey to complete. Completed returns report a high level of patient satisfaction

An annual patient satisfaction survey is also undertaken, again reporting high levels of patient satisfaction.

Feedback from patient satisfaction surveys is provided to the team. There is a feedback and audit cycle and the results are reported to the Clinical Governance Committee

Links with District Nurses are good and all practicalities are in place in the home to support PPC. However, there are not enough resources in place. The gap in the service is a local Hospice at Home service.
Information leaflets are handed to every patient.

The Hospices is working to address lack of uptake of palliative care in the Black Minority Ethnic community.

Improving Care, Achieving Outcomes

- Audit. Example: Audit of Nursing Homes - Nurses not recognising the Dying Process. GTHC took the lead on supporting Nursing Home staff in talking to patients and relatives. This led to more patients remaining in the Home at the End of Life, a reduction in 999 calls and increased Advanced Care planning to support achieving choice in Preferred Place of Care. The next stage will be to cascade this into more Nursing Homes.
- Clinical Trials: meet with GTHC regularly and email to flag patients. One patient in trials. Some patients are already in trials when referred. One nurse involved in a current trial study.
- Effectiveness of Symptom management intervention is recorded through STASS.
- STASS Audit in place since 2009, reporting symptom scores between first and final visit.

Commissioners Comments

Cardiff & Vale Health Board

- GTHC attend the quarterly local Palliative Care Implementation Group (LCPIG).
- Participating members of the Health Board Governance Group.
- Participate in future service planning.
- Referrals from the Cardiff & Vale Health Board secondary care providers to GTHC would be between 20 to 40 a month.
- The Health Board are satisfied with the service provided and there is evidence of well established joint working through Performance management and Clinical Governance meetings. Any areas of concern can be discussed through the Local Palliative Care Implementation Group. There is a strategic plan in place and GTHC are integral to this.

George Thomas Team Comments

- Cardiff & Vale Health Board as sole Commissioners: Feel they have good communication in place with quarterly meetings which support good joint working.
- GTHC are using CANISC, but believe it would be more useful if it could generate letters
- Links with District Nurses are good and all practicalities are in place in the home to support PPC, but there are not enough resources in place. The gap in the service is a local Hospice at Home service.
- Iwantgreatcare surveys: It would be useful to identify I want great care responses in more detail so they can be better interpreted.
- There will be a cut of 5% funding from Health Board in the financial year 2013-2014. Cardiff & Vale Health Board considers the service as both core and non core e.g. Social worker would be non core. The organisations financial governance says they are sustainable but this may affect services 'on the ground', which is working at maximum capacity.

Case Note Review

6 sets of case notes were reviewed.

All notes were well laid out, easy to understand with evidence of good care planning. All notes were signed and had printed signatures alongside.

Good Practice

Identify any areas of good practice

Good Practice/Significant Achievements:

- Use of Audit Cycle to improve service.
- Professional support identified for Allied Health Professionals.
- Excellent working relationship with Health Board evidenced through quarterly Performance Reviews.
- Example of joint working to deliver Clinical Nurse Specialist seven day working in the community.
- Links to Clinical Trials team.

Areas for Consideration

- Review Organisational Chart.
- The Palliative Medicine Consultant carries a significant workload; any increase in referrals may require her working pattern to be reviewed to ensure the consultant is not overloaded and her clinical expertise continues to be used to maximum patient benefit.
- A 5% cut in funding from the Health Board could adversely affect this service in the long term.

Overall Findings

There is a clear and concise operational policy, referral policy, a dependency tool is in use and discharge criteria based on regular patient reviews. Multidisciplinary meetings are held weekly. CANISC is used to record all information. All new patients are seen jointly by the Consultant and CNS. All new patients are discussed at the weekly MDT and a care plan is agreed. GPs are kept informed of the GTHC involvement in patient care. Patients are reviewed in the MDT as necessary. All CNS Caseloads are reviewed monthly. The team described robust communication systems with other local palliative care service providers, Velindre Cancer Centre and Cardiff & Vale Health Board. A variety of audits were available, evidencing good use of clinical audit to drive care.

The GTHC Team is an excellent service with Strong clinical leadership. The service is delivered within a sound framework of Clinical Governance and works in partnership with other local providers and Health Board Commissioners. There are many areas of good practice that can be shared, in particular the commitment to Audit and its use to change practice.

Concerns

Refer to the guidance on identifying concerns. Any immediate risks or serious concerns must be brought directly to the attention of the core team
Immediate Risks Identified? None

Serious Concerns:
Immediate Risks Identified? None

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

Identifying Concerns – Issues

Issues	Level of Concern Immediate Risk (IR), Serious Concern (SC), Concern (C)	What is the specific concern?