eWIN GOOD PRACTICE CASE STUDY

NHS North West

CHESHIRE END OF LIFE CARE SERVICE MODEL

INTEGRATING END OF LIFE CARE COMPETENCES INTO COMMUNITY STAFF APPRAISALS

SUMMARY

The **Cheshire End of Life Care Service Model,** operational since 2010 ensures that the national end of life care tools are fully utilised across all care settings in Central and Eastern Cheshire. The model is a collaborative partnership across primary and acute care, hospices, care homes, further voluntary sector partners and social care.

One of the model's long-term aims is to integrate End of Life Care (EOLC) competency frameworks into workforce development for health and social care staff working in EOL care. It was recognised that these service-specific competencies would complement KSF core standards and that uptake of these frameworks would directly support staff and could lead to a more confident workforce, more able to demonstrate best practice in EOLC. A local Community CQUIN was established, which focuses on the expectations on staff to deliver complex care to patients at end of life. As such it was recognised that the model needed to better address the learning and development needs of its staff involved in EOLC, so that they can meet these expectations.

Taking guidance from the original evidence-based frameworks from St Christopher's Hospice in London, the Cheshire End of Life Care Service Model developed EOLC c ompetency frameworks specific to their local workforce. These have now been integrated into the professional development appraisals of staff within the Community Business Unit of East Cheshire NHS Trust. Future intentions are that staff within acute care, the voluntary sector and social care could adopt the frameworks in order to enhance their EOLC practice.

KEY OUTCOMES

Adoption of the EOLC competency frameworks have benefits, linked to the QIPP agenda:

- **Improved appraisal process–** the frameworks can improve the relevance and quality of appraisals for staff, and hopefully prevent appraisals from being a paper exercise, or a missed opportunity for the identification of gaps in learning and therefore the seeking out of learning and development opportunities.
- **Learning and development –** it has also fuelled innovation, as it encourages staff and managers alike to seek out new informal learning and development opportunities. A feedback mechanism has been created between the appraisal process and the commissioning of training, which ensures that training is bespoke to the needs of the workforce.
- **Improved Service Delivery –** Every band of staff now has a specific document outlining the knowledge, attitudes and skills necessary to deliver best practice in EOLC, thus giving them a benchmark from which to work, representative of best practice.
- **Staff recognition –** As part of the process, job descriptions were collated and the specific staff roles considered. As a result the huge contribution made by community nurses to EOL care was recognised. By engaging staff and teams in recognising what their roles actually consist of, this can increase productivity and boost confidence.
- **Increase in staff confidence –** Each member of staff working within the community business unit who have EOLC as part of their role were given the opportunity to consider what competencies they already had in EOLC, and which ones they would benefit from developing. Appraisors felt this was a useful exercise as it boosted the confidence within teams as they identified the work they were delivering, and subsequent benefits to patients and families.

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BACKGROUND

EOLC Strategy

The End of Life Care Strategy 2008 and the National End of Life Care Programme highlight the importance of both health and social care staff at all levels having the necessary knowledge, skills and attitudes related to care for the dying. The strategy further states that for this to happen, EOLC needs to be embedded in training curricula at all levels and for all staff groups. End of life care should also be included in induction programmes, in continuing professional development and in appraisal systems.

EOLC Clinical Pathway Report

This issue has been further highlighted in a report written by the clinical fellow for the North West End of Life Care Clinical Pathway Group which places a *'Skilled and Competent Workforce'* as one of the top five priorities aimed at improving End of Life Care for all. This report states that high quality care will come from continuing education and training for all staff providing EOLC. It is also a recommendation within this report that EOLC competencies are used to guide local planning and delivery of end of life education and training

Cheshire EOLC Service Model

The model serves the population of East and Central Cheshire Primary Care Trust, which has around 4,400 deaths per annum and the fastest aging population in the North West, with an 80% predicted population increase in the over 65 year old age group. There are also around 35,000 people living with long-term ill health including conditions such as cardiovascular disease, cancer and long-term conditions.

See Appendix 6 for the most up-to- date Cheshire EOLC Service Model.

KEY AIMS

- Support the workforce through the provision of competences specific to their roles in EOLC.
- Improve staff knowledge required for the job, and the application of that knowledge in best practice end of life care.
- Highlight the valuable contribution staff are making in this area, but also identify specific areas where appropriate training could be developed.
- Make appraisals relevant and a vehicle through which staff can identify their learning and development needs, and access appropriate learning opportunities.

KEY STAGES OF SET-UP

So far there have six stages for which there was a project lead from the EOLC team.

Stage 1: Developing the Competency Frameworks

St. Christopher Competencies (Level 1 – 4) were mapped into the existing job descriptions and Knowledge & Skills Framework outlines. Once these competency documents had been drafted they were then sent out for comment to staff at the various bands to see if the competences matched their roles. Senior managers within the service, specialist palliative care staff and key palliative care educationalists were also asked to comment.

The competences that would be used for staff working within social care were compared to the National Occupational Standards (NOS) for social care staff, in order to crosscheck the relevance of the competences.

Final copies for each job role were produced and a PDF version saved to avoid any changes being made.

Stage 2: Gaining Approval

Approval was gained from the Community Services Managers that the competences could be an integral part of the 2012 appraisals for staff within the Community Business Unit of the Trust.

Stage 3: Pilot Project

A pilot project was run with five community teams to test the documents for user-friendliness and accuracy, across various job roles and bands within the teams.

The pilot included:

- Two district nursing teams,
- Community matron team
- Specialist palliative care team (Community Macmillan team)
- Non-specialist palliative care team (Integrated respiratory team)

The pilot resulted in the documents being amended according to the useful suggestions made by the five teams. One of the changes included removing abbreviations, changing wording from 'bereavement period' to 'bereavement period and beyond' as staff felt that their role continued with many families in the year after the death of their loved one, and they felt this should be recognised. This also highlighted possible training opportunities in supporting families who were experiencing grief and loss. Several other specific competences were added in such as nurse verification of death, and confidence to commence the care pathway for the dying patient.

The pilot teams felt strongly that more reference to 'carers' should be included, as this was also part of their role. The Community Matron Service in particular made reference to long-term conditions in their frameworks and a move away from cancer diagnoses alone. This is clearly specific to their role as 'generalists' who do provide palliative care for patients with non-malignant disease.

Further findings from the pilot revealed that staff found the documentation relatively easy to use, however they did request examples of the type of evidence they could bring to the appraisal. Unanimously it was

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felt that the mapping of specific training opportunities to the specific staff bands would enable a more proactive approach to be adopted when seeking out relevant training courses.

Appraisors felt the documents helped to highlight staff abilities as well as any gaps.

They also felt very positive that the loop-back mechanism to learning and development via training summaries could inform the commissioning of appropriate training, for example, advance care planning.

Stage 4: Launch

The documents were launched at the team meetings for all services involved and also talked about widely at EOLC champions meetings, giving everyone the opportunity to become familiar with the document relevant to their role.

Stage 5: Evaluation

Following year one the Trust will evaluate the process through discussions with the appraisors and appraises, and through the training summaries, collated by senior managers

Stage 6: Wider roll-out

The Cheshire EOL Service Model is seeking opportunities to pilot the competences within social care and in the acute care settings. A particular opening is the development of integrated teams, which is mentioned further under the 'Next Steps' section.

HOW IT WORKS

Appraisal Procedures

Staff appraisals run from December to May, and throughout the year staff now have access to EOLC competency documents specific to their role, as part of their appraisal and professional development review.

Staff are given time to consider and collate evidence to bring to their appraisal, and the opportunity afterwards to identify learning opportunities in the form of an Action Plan which can then lead to the fulfilling of any gaps in knowledge, attitudes and skills they may have.

The action plan as asks the following:

- What knowledge & skills do you wish to develop?
- How will you develop these? (encourage work-based learning, shadowing, e-learning)
- Over what time frame?

This then translates into a 'Training Summary', which an appraisee or their appraisor can follow up by seeking out specific learning and development opportunities to meet the appraisees needs.

Senior managers collate these summaries and identify any training required for the teams for which they are responsible. This information is feedback to both the EOL service model team and the Learning and Development department of the Trust.

COMPETENCY FRAMEWORK

Considering the specific appraisal process, the competency frameworks consider the knowledge, attitudes and specific skills which constitute best practice in EOLC.

The key areas highlighted for reflection include:

- Knowledge & Attitudes - Early discussions between the appraisor and appraised, determine that the framework provides a baseline of the knowledge and attitudes necessary to underpin good palliative care.

  Both parties sign the appraisal documents after discussions to show commitment to the ongoing achievement of these aims. Much of the 'Knowledge & Attitudes' competencies achieved can be elicited through reflective conversations.

- Specific Skills -'. Skills are appraised in the following areas; Communication, Education & Training, and Clinical Practice. The development of specific skills in these areas forms a key and practical part of the assessment, with evidence of these skills and their development discussed at the appraisal. This evidence section takes various formats and will often help demonstrate staff 'Knowledge & Attitudes as well as specific skills

- **Communication skills –** these skills are indicated by competence in the often challenging conversations and interactions that occur within EOLC with patients, relatives, colleagues, and the multidisciplinary team. Evidence for this competency may be in the form of a personal reflection, a significant event analysis or an anonymised case study.

- **Education & Training** The development of the individual and their peers in reflective practice, critical evaluation of own practice, attendance at courses, completion of course work, shadowing and study days, attendance at Champions meetings etc. all provide key sources of evidence for education and training.

- **Clinical Practice** Skills in clinical practice will demonstrate holistic care, assessment of needs, best practice use of the care pathway for the dying patient, participation in multidisciplinary meetings, medications management for palliative patients, engagement in advance care planning, and the demonstration of clinical practice that reflects the patient's 'best interests'. As such, evidence of clinical practice could take the form of an anonymised holistic assessment and subsequent actions taken, or the application of good principles of medications management for a patient near the end of life.

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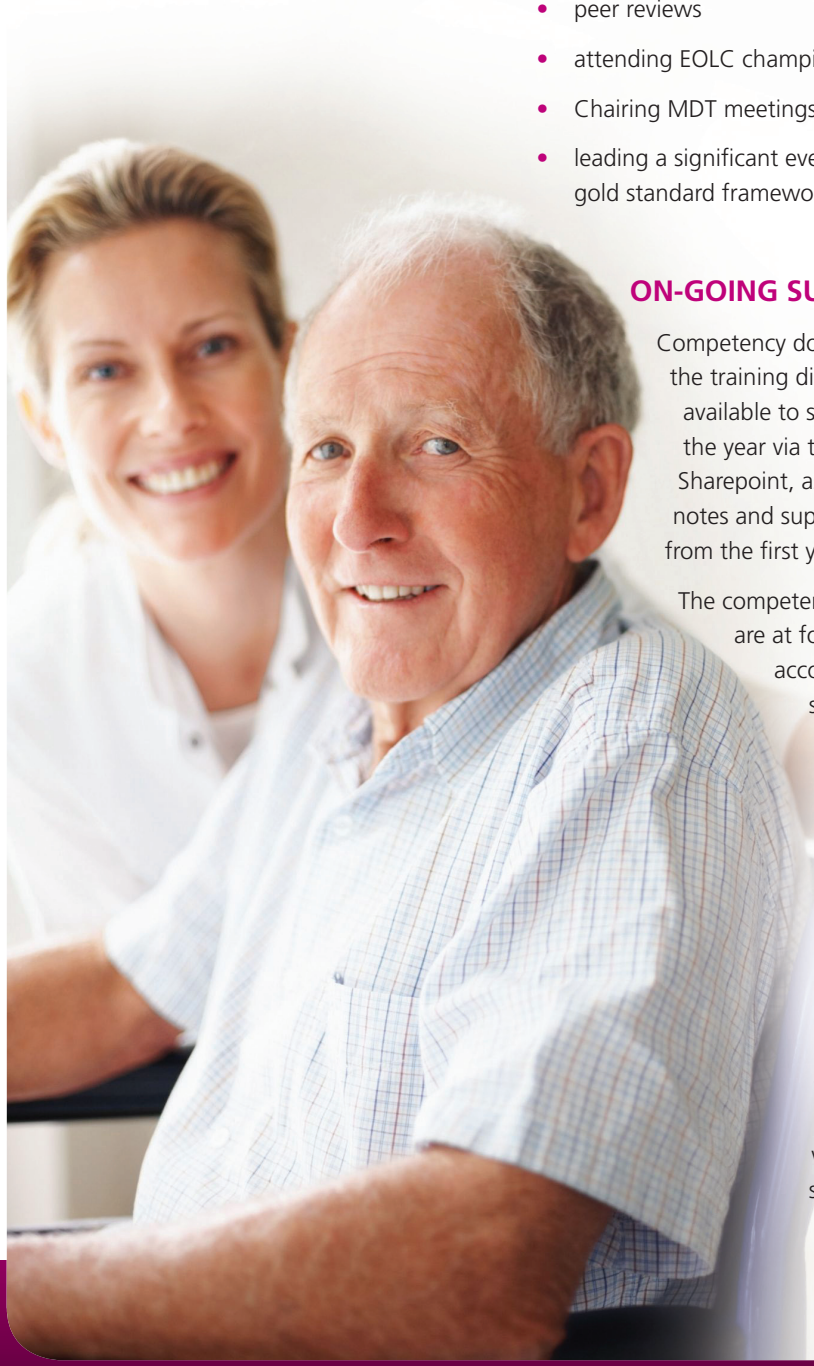
TRAINING OPPORTUNITIES

Formal bespoke training is subsequently offered in the following areas:

- Integrated Care Pathway Training
- Advance Care Planning & Preferred Priorities for Care
- Advanced decisions to refuse treatment
- Do Not Attempt Cardio-Pulmonary Resuscitation
- Gold Standard Framework working
- Best Practice utilising end of life care pathways
- Prognostication
- Cheshire EOLC Service Model's innovative Electronic Prognostic Information and Assessment Guide (epaige)
- End of Life Care Medications/ Symptom Management
- Holistic Assessment
- Rapid Discharge Pathway

Staff are also able to undertake other informal learning opportunities such as:

- hospice placements
- shadowing colleagues
- peer reviews
- attending EOLC champions meetings
- Chairing MDT meetings
- leading a significant event analysis at a gold standard framework meeting.



ON-GOING SUPPORT

Competency documents and the training directory are available to staff throughout the year via the Intranet and Sharepoint, as are guidance notes and support documents from the first year.

The competency documents are at four levels according to the seniority of the staff, so appraisers and appraisees are given a guide within the Learning and Development training prospectus as to which course would be most appropriate for which level of staff.

RESOURCES

The resources required for the development of the competences was in essence the staff time that it took, and the effort to roll out a new initiative with a community nursing service that was already working at full stretch. The provision of written materials was from within individual teams, as all necessary documents were made available via the Intranet.

KEY CHALLENGES

Integration of the framework into existing appraisals was difficult at first. When the competency documents were finalised they were first of all presented to the community services managers from the acute trust's community business unit for their approval. The key challenge at that stage was to formulate a rationale for integrating the documents into an already established appraisal system. The rationale was developed from national and local guidance, coupled with the fact that service specific competences would complement the core standards being used in the KSFs. This rationale won the day and allowed the framework to be properly integrated into the existing process.

There also were immediate questions about whether this was duplicating the work of the existing appraisals. Once team leaders understood the specificity of the EOLC documents, and that in many instances where staff were meeting a specific high standard for EOLC, this achievement could also symbolise achievement of the same competence in a non-palliative setting.

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KEY LEARNING

- Change is never easy and people undergoing change deserve a full explanation, as well as the time and information necessary to steer them through the change.
- Sound rationale is key to engagement.
- Competency frameworks are very useful for new starters. Therefore there was significant interest from the Out of Hours nursing service, Macmillan development posts and hospice staff to use the frameworks, specifically with new staff.

SUSTAINABILITY

The framework is firmly embedded within appraisals from 2011/12 onwards and has gained approval from Community Services Managers.

NEXT STEPS

The EOL Service Model has established a three year work plan (2012 – 2015) with the aim of rolling out competency frameworks to staff within the acute care sector of the two Trusts that the EOLC model work with.

Having piloted the competency frameworks within social care the EOL Care Service Model will also seek opportunities to ensure that these competences are made available to other social care colleagues who are engaged in EOLC. For example, within care homes and domiciliary care agencies.

A particular opportunity has arisen within integrated teams, as these teams consist of health and social care professionals who share responsibility for EOLC patients. As such adoption of the competency framework for this group of staff would be of clear benefit to the development of EOLC skills amongst generalist staff.

SUPPORTING MATERIAL

The following resources are available as an appendix to this case study

- **Appendix 1 –** EOLC Competency Framework for Band 5 Nurse
- **Appendix 2 –** Core competencies Guidance for EOLC
- **Appendix 3 –** St Christopher's Competency Framework
- **Appendix 4 –** National Occupational Standards for Social Care
- **Appendix 5 –** eWIN Case Study – EOLC Model
- **Appendix 6 –** Cheshire EOLC Service Model

CONTACT FOR FURTHER INFORMATION

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