

The Pennine Acute Hospitals NHS Trust

<Provider ID>

# Community end of life care

## Quality Report

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Date of inspection visit: 23 February - 3 March 2016  
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# Summary of findings

## Locations inspected

<b>Location ID</b>	<b>Name of CQC registered location</b>	<b>Name of service (e.g. ward/unit/team)</b>	<b>Postcode of service (ward/unit/team)</b>
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This report describes our judgement of the quality of care provided within this core service by The Pennine Acute Hospitals NHS 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 The Pennine Acute Hospitals NHS Trust and these are brought together to inform our overall judgement of The Pennine Acute Hospitals NHS Trust

# Summary of findings

## Ratings

Overall rating for the service	Good	●
Are services safe?	Good	●
Are services effective?	Good	●
Are services caring?	Outstanding	☆
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

We rated community end of life care services at The Pennine Acute Hospitals NHS Trust as good because:

- Staff delivered end of life care in the community setting that was caring, compassionate and supportive of patients and their families.
- The service had a comprehensive framework and strategy for end of life care.
- The advanced care plan document developed to replace the Liverpool Care Pathway in July 2014 was comprehensive and person-centred.
- The trust had appointed a board member with a specific lead role for end of life care and staff were aware of whom this executive lead was.
- Safety was a high priority and there was measurement and monitoring of safety and performance within the service.
- Risks were appropriately managed and identified.
- We found that the care delivered to patients was evidence-based and in line with key documents such as National Institute of Clinical Effectiveness guidance and priorities of the dying person, particularly personalised care.
- There was routine monitoring of patient outcomes of care and treatment, and patient feedback was actively sought on a regular basis.
- The training for staff involved with the delivery of end of life care was appropriate and provided on a regular basis.
- The end of life care team worked effectively and engaged with other professionals to ensure patients received the required level of care and support.
- Staff appraisals were completed and staff had sufficient clinical supervision.
- Staff spoke positively about the support they were given by seniors and management.
- A consultant with a responsibility for end of life and was co-located with the end of life care team provided good clinical leadership and support to the palliative care team.
- Staff worked with local hospices, hospitals, GPs and specialists to seek advice when needed.
- When we talked with patients and staff and observed care, we found that staff were passionate and committed to providing good end of life care.
- Staff were observed providing care to patients with kindness, compassion and dignity.

# Summary of findings

## Background to the service

### Information about the service

The Pennine Acute Hospitals NHS Trust provides 24-hour end of life care services for adults over the age of 18 years and children between 17 and 18 years, including patients with individual and complex nursing needs in the community. The service is provided for people who live across the North Manchester area.

End of life care is provided in a variety of organisational settings by a range of health care professionals. The range of services includes facilitation of discharge from the acute hospital and co-ordination of care provision in the community.

Teams of district nurses provide end of life care as part of their caseloads and additional support is provided by the specialist palliative care Macmillan team. The specialist palliative care Macmillan team are based at a community clinic location and worked from a hub system. This hub accommodates the specialist palliative care team, a community nursing team, allied health professionals and other non-clinical staff.

There are no inpatient services for patients with end of life care needs using community health services provided by the trust.

The Out of Hours (OOHs) service provides professional nursing assessment and advice, management and nursing treatment for patients with palliative care needs and those who are in the terminal phase of their illness. This service also aimed to reduce hospital admissions out of hours and also provided the following services:

- Assistance with the provision of emergency loans and equipment.
- Psychological support and advice.
- Administration of drugs in the out of hour's periods.

During our visit, we spoke with eight patients and 18 members of staff. We looked at a range of policies, procedures and other documents relating to the running of the service. We reviewed 25 sets of care records and 20 medication records.

## Our inspection team

**Chair:**

**Head of inspection:** Ann Ford, Care Quality Commission

**Team Leaders:** Wendy Dixon, Care Quality Commission

The team included CQC inspectors and a variety of specialists:

The team that inspected this core service included one CQC inspector and a specialist advisor who was a specialist nurse.

## Why we carried out this inspection

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

## Good practice

- Staff frequently went the extra mile and were able to give us clear examples where they had acted above and beyond their duty to ensure patients received high quality care.
- The multi-disciplinary hub system used to model the SPCT was innovative and allowed easy multi-disciplinary working to facilitate excellent patient care. Other organisations had visited the service to benchmark against this initiative.

# Summary of findings

- The leadership in the service was strong and encouraged a culture of openness and high quality.
- The service engagement with local faith leaders and funeral directors to break down barriers to patients receiving excellent care was innovative and ensured that all groups within the local population were catered for individually.

## Areas for improvement

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

**Action the provider MUST take to improve**

- **Improve the uptake of mandatory training.**

# The Pennine Acute Hospitals NHS 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 the service as good in relation to safe because:

- Safety was a high priority and there was measurement and monitoring of safety and performance within the service.
- Risks were appropriately managed and identified.
- We saw evidence in patient records that risks were identified on an individual patient basis and appropriate action was taken by staff in response to these risks.
- Staff understood the importance of reporting and learning from incidents.
- Staff within the palliative care Macmillan team told us that they felt well staffed they felt that they had enough time to care for patients.
- Staff worked together to cover unexpected absences and holiday periods.
- The training for staff involved with the delivery of end of life care was appropriate and provided on a regular basis.
- Safeguarding was well managed in the service, training was up to date and staff felt confident to report issues when raised.

However

- The uptake for mandatory training in some subjects was variable and below the trusts 90% uptake target in one service.

### Safety performance

- We observed safety goals and targets in use and the District Nursing teams monitored these.
- One example of this was a key performance indicator in relation to the development and care of pressure ulcers. The indicator was monitored at divisional and executive level. If a patient developed a pressure ulcer at a grade 3 or above the team responsible for the patients care was required to attend a learning and scrutiny panel to examine why the ulcer had occurred.
- Senior managers within the service routinely reviewed incidents and identified themes in relation to the end of life care service.

### Incident reporting, learning and improvement

- Staff were aware of the reporting systems for incidents and staff had access to the trust-wide electronic reporting system.. Staff said they found the system user friendly and demonstrated to us how they would access and submit an incident report.
- There were 29 incidents reported within the service between December 2014 and December 2015. Of these



## Are services safe?

25 were categorised as low and no harm incidents and four were categorised as 'moderate' harm. All four incidents in the moderate harm category were reports of pressure ulcer development. The service had identified a theme of pressure ulcer development and as a result had implemented monthly scrutiny panels to review all pressure ulcers reported as grade 3 or above. We reviewed minutes from one of these scrutiny panels and noted that the review process was robust and included realistic key actions to reduce the risk of a reoccurrence.

- Learning from incidents was shared with staff at regular team meetings and de brief sessions and we saw evidence of this in the form of minutes of meetings and memos.
- Staff gave recent examples of incidents which they had recently learned from and improved practice as a result. We also saw evidence of incidents being discussed at team meetings and the district nursing forum in the form of minutes of meetings and agendas of meetings.
- Lessons learned were also readily available for staff to view in all areas on a shared, secure computer drive.
- Staff said that they received timely and appropriate feedback when they submitted an incident form or raised a concern.

### Safeguarding

- Policies and procedures for safeguarding vulnerable adults and children were accessible to staff electronically.
- Staff received mandatory training in safeguarding vulnerable adults that included aspects of the Mental Capacity Act 2005 and Deprivation of Liberty safeguards. All district nursing teams had a high uptake of level 2 safeguarding adults training and in all teams, the uptake rate of this training for nursing staff was above the trusts target of 90%. The specialist palliative care Macmillan team (SPCT) had an uptake rate of 100% in this training for nursing staff.
- Staff received mandatory training in safeguarding children at level 2 and the uptake levels within the community nursing teams were high in most areas and 100% in the SPCT.
- We found that staff were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults and were aware of the process for reporting safeguarding concerns and allegations of abuse within the trust.

- Staff confirmed safeguarding was always raised at multi-disciplinary meetings and told us that they received meaningful feedback on any safeguarding concerns they raised.
- Staff told us that they felt confident dealing with matters of a safeguarding nature and were able to give us recent examples of cases they had dealt with.

### Medicines

- We found that the trust had an up to date policy on the management of controlled drugs. This policy reflected current guidance and was easy to understand and accessible to staff electronically.
- The staff we spoke to who were involved with the management of controlled drugs were aware of the policy and how to access it.
- We reviewed 20 medication records across team areas and these were noted to be up to date, clear and unambiguous.
- The process for the destruction of controlled drugs was clearly set out in the trust's policy on the management of controlled drugs. Staff followed this process and ensured that these medications were destroyed following the death of patients in their own home.
- We found that medications were being administered and managed safely in the delivery of the end of life care service.

### Environment and equipment

- We found that staff were aware of how to safely maintain and use equipment used in end of life care such as syringe drivers.
- Staff told us they received training and updates as needed in relation to the use of syringe drivers.
- There were clear and robust processes for the maintenance and checking of equipment provided to patients in their own home. Staff were able to describe the processes and how they followed them.
- We observed the storage equipment at team bases and found that this storage was appropriate and well maintained.
- All electronic equipment had portable appliance testing (PAT) stickers and maintenance records, which would identify when it was last checked. We reviewed the maintenance records for all syringe drivers used within the community services and these showed that all drivers had an up to date testing in place.

# Are services safe?

## Quality of records

- The trust had developed a comprehensive care document, which was used when patients were receiving end of life care. We found this document was comprehensive and patient centred. This document was easy to understand and follow.
- We reviewed eight records relating to patients who had a do not attempt cardio pulmonary resuscitation (DNACPR) forms present.
- In all eight cases, we found that the DNACPR records were completed fully and correctly. They all contained sufficient detail regarding the decision to complete the form and in all eight cases there was evidence that the decision had been discussed with the patient and their relatives.
- The community nursing teams were using a paper based notes system.

## Cleanliness, infection control and hygiene

- Personal protective equipment (gloves and aprons) and hand cleansing products were available to all staff undertaking patient care. A trust audit undertaken in October 2015 showed that 98% of staff audited had adequate access to supplies for cleansing their hands. This audit also showed that 100% of staff audited correctly identified how they would access additional supplies if required.
- Staff were aware of when personal protective equipment should be used.
- Each community nursing team undertook quarterly hand hygiene audits. To undertake these audits the auditor would accompany staff out on home visits and observe their practice in relation to hand hygiene. If any issues of practice were identified, these would be addressed on an individual basis and additional training would be offered when appropriate. The results of these audits were circulated to the team through team meetings.
- There was a twice yearly audit of hand hygiene practice across the community service and this was undertaken in October 2015. This showed that eight out of 13 teams scored above the 90% target for compliance with hand hygiene standards. Two out of 13 teams scored below the 90% target. SPCT team scored 100%.The service had

taken steps to address areas of low compliance at the time of the audit. 98% of staff audited during this audit were noted to be 'bare below the elbows' which can help reduce the risk of infections being spread.

- An audit undertaken in October 2015 looked at staff's compliance with the trusts uniform policy which stipulates that staff should not wear nail polish or rings with stones to reduce the risk of infection. This audit showed that 98% of staff were compliant with this areas.
- All of the clinic areas we visited were visibly clean and tidy and the equipment was also noted to be visibly clean.
- There were adequate arrangements in place for the handling, storage and disposal of clinical waste, including sharps and an audit undertaken in October 2015 showed 100% compliance in relation to the disposal of waste and sharps.
- The trust had an Infection Prevention and Control policy in place which was accessible to staff on the trusts intranet site.

## Mandatory training

- There were areas of low and high uptake in different mandatory training subjects, which varied between district nursing teams and the specialist palliative Macmillan team. The uptake levels for infection control training varied from 50% to 100% against the trusts target of 90%. There was no action plan in place to address this issue.
- The uptake rate for the mandatory moving and handling patients training varied between teams. In three out of five teams, the uptake rate was below 90% and in two teams; the rate was above the trusts target of 90%.
- The trust provided mandatory training on equality and human rights and required 100% of staff to undertake this training. All of the five teams achieved 100% of staff undertaking this training meeting the trusts target.
- Staff told us that they were encouraged to undertake mandatory training and that their managers monitored this.
- Staff told us that the mandatory training was often more appropriate for hospital based staff and not community specific. Staff had raised this with senior managers and as a result, some training courses had been adapted to meet the needs of the community-based staff.

## Assessing and responding to patient risk

## Are services safe?

- We reviewed 25 care records of patients who received end of life care and found that in 11 of these cases risk assessments such as nutritional assessment, pressure ulcer risk assessments and bed rails assessments were required. We found that in all cases these had been undertaken and were documented fully.
- We saw evidence in patient records that risks were identified on an individual patient basis and appropriate action was taken by staff in response to these risks.
- Where there were significant risks identified, we found that staff responded appropriately such as involving other multi-disciplinary teams to seek advice and ensure a joined up multi-disciplinary approach was taken to mitigate risk. We found one example where staff had arranged a meeting and worked with external agencies to minimise a safeguarding risk to a patient.
- A daily multi-disciplinary team meeting was held at the Cornerstones centre. During these meetings, staff were able to highlight any patients they felt were at risk.
- The specialist palliative care nursing team had 4.0 whole time equivalent band 7 specialist nurses plus 3.0 band 6 nurses and an additional one band nurse facilitator, which was in line with their current establishment.
- Staff within the palliative care improvement team told us that they felt well staffed and that they felt that they had enough time to care for patients.
- Staff told us that they felt they were well staffed within the community teams and they worked together to cover unexpected absences and holiday periods.
- The staffing rotas reflected the number of staff who were on duty.
- There was a low rate of staff turnover, which meant staff had good relationships and knowledge of end of life care processes within the team.

### Managing anticipated risks

#### Staffing levels and caseload

- A consultant with a responsibility for end of life care was based within the palliative care improvement programme team. They provided strong clinical leadership, guidance and support to both staff and patients. Patients were also supported by their GP's.
- We found that there was a local risk register for end of life care services. This contained risks and was appropriately updated on a regular basis.
- Staff told us of ways they had dealt with adverse weather conditions in the past, such as walking to patient's homes and attending their nearest base.
- Staff were aware of how to access the policy to follow regarding adverse weather conditions to ensure patient care would be delivered in these circumstances.
- The lone worker policy was implemented fully and staff were aware of how the policy was to be used.

## 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 the service as good in relation to effective because:

- Staff were delivering care in line with key documents such as NICE guidance and priorities of the dying person.
- The service had developed a comprehensive advanced care plan, based on best practice guidance from NICE and other documents, to replace the Liverpool Care Pathway which was withdrawn in July 2014.
- Anticipatory medications were routinely prescribed and pain was being assessed and managed effectively and patients spoke positively about the pain management they received.
- We found that patients nutritional and hydration needs were being assessed and recognised assessment tools were being used to assess these needs.
- There were close working relationships between the palliative care team, district nursing teams and the dietetics team.
- The staff we spoke with appeared to be competent and committed to delivering high quality end of life care.
- Although the service did not participate in the care of the dying audit they did routinely monitor patient outcomes which were mirrored to this national audit and data showed that these outcomes were better than the national standards in most cases.
- The teams involved in the delivery of end of life care worked closely and effectively together to facilitate high quality patient care.
- Patients had easy access to leaflets about the services available specifically in relation to end of life care services.
- Staff were aware of the Mental Capacity Act (MCA) (2005) and were able to describe how they would apply this in practice.

### Evidence based care and treatment

- We found that the care delivered to patients was evidence-based and in line with key documents such as National Institute of Clinical Effectiveness guidance and priorities of the dying person, particularly personalised care.
- The trust had designed and implemented an advanced care plan for patients receiving end of life care. This record was based on NICE guidance and principles set out in the Priorities for Care of the Dying document. The care plan was comprehensive and contained all appropriate areas for consideration.
- Staff had easy access to evidence based guidelines used to plan patient care, including specialised end of life care medication formularies.

### Pain relief

- There was evidence in patients records that pain relief had been prescribed appropriately and was administered when they required pain relief.
- All patients we spoke with spoke positively about the way in which their pain was managed.
- Staff told us that they had 24 hour access to syringe drivers to deliver pain relief and other medications as needed.
- There was evidence within records of patients receiving end of life care that pain was being assessed regularly.

### Nutrition and hydration

- In all records we reviewed, there was evidence that nutrition and hydration had been assessed and a MUST risk assessment tool completed where appropriate.
- Community nursing staff and the palliative care improvement team were aware of how to refer patients to dietetics if needed. Staff talked us through the process of referral and showed us evidence in care records of patients who had been referred.
- The dietetics service had developed a fast track service for patients with upper gastrointestinal cancers. This service was developed as this group of patients are particularly likely to require additional nutritional support

### Patient outcomes

## Are services effective?

- The service routinely monitored patients outcomes and the findings were reviewed on a monthly basis in a variety of meetings.
- The service was monitoring the number of patients who died in hospital while receiving community palliative care services on a monthly basis. The national standard is that 80% of patients should die either at home or in the community setting. Data provided by the service showed that for the 2015/2016 period 85.7% receiving palliative care services died in the community setting and not in a hospital setting, which shows a better performance compared to the national average.
- The service was also recording data in relation to the number of patients who died in their preferred place of care. The national standard is that 80% of patients should die in their preferred place of care. For the 2015/2016 period the service performed better than this target and data showed that 86.7% of patients accessing community palliative care services died in their preferred place of care.
- There were regular meetings where after death analysis and mortality reviews were completed in relation to patients who had received end of life care. These analyses were robust and thorough and were reported and reviewed at service level meetings and escalated to board meeting if required.

### Competent staff

- The specialist nurses within the palliative care team either had undertaken or were planning to undertake specialist degree level training in end of life care. They were all very experienced and competent in their roles.
- Appraisal rates were high within both the district nursing teams and 100% of staff employed within the palliative care Macmillan team had received their annual appraisal last year.
- Staff told us that they were actively encouraged to undertake training additional to their mandatory requirements and were supported to improve their knowledge if they identified areas of improvement.
- There was a culture of debrief and supervision with daily debriefing meetings and clinical supervision provided by senior staff, who also then received their own supervision.
- The community nursing staff we spoke with were knowledgeable about end of life care and specific areas of end of life care such as anticipatory medicines and rapid discharge.

- Staff told us that they regularly received formal and informal clinical supervision.

### Multi-disciplinary working and coordinated care pathways

- There was a multi-disciplinary team approach to the planning and delivery of all aspects of end of life care.
- The specialist palliative care improvement programme team held daily meetings at their base. These meetings were attended by representatives from all community nursing team, allied health professionals, the specialist Macmillan team and the consultant with a responsibility for end of life care. These meetings were structured and comprehensive. They allowed staff to discuss any patients who required additional support and ensured that all services worked cohesively to deliver coordinated, patient centred care.
- We observed excellent multi-disciplinary team working during this meeting with advice being sought and provided to improve patient care.
- We saw extensive evidence of multi-disciplinary team working to facilitate the best possible care for patients and their families. One example of this was related to a patient who was experiencing issues with nutrition. We observed the community nursing staff, consultant, occupational therapist and dietician work together to support this patient and their family and minimise their distress.
- There was also a weekly multi-disciplinary team meeting held at the North Manchester General Hospital. This was attended by both the community and acute end of life care teams. We attended this meeting, found that it was comprehensive, and functioned well. All new referrals for patients with end of life care needs were discussed at this meeting and this allowed an MDT approach to their care. The presence of allied health professionals and the acute team helped to ensure that patients care was planned effectively and met their needs.
- We found that all teams involved in the delivery of end of life care worked closely and effectively with GP's. One example of this was when a GP visited a patient and found that they required end of life care support. This GP and the community nursing team arranged a joint visit to the patient. Within a few hours, the patient had a comprehensive care plan in place to ensure their needs were met.

## Are services effective?

- Community nursing staff told us that the specialist palliative care team were accessible and supportive.
- The consultant responsible for end of life care in the community provided robust clinical leadership and worked in an integrated way with all teams delivering end of life care. Staff told us that they found this consultant supportive and that they were able to approach them for advice and support.

### Referral, transfer, discharge and transition

- Community nursing staff told us that referrals were responded to by the palliative care team quickly and appropriately. The service was monitoring how quickly they responded to urgent palliative care referrals and data showed that for a twelve month period the service consistently responded to 100% of referrals within two hours of referral.
- The trust had a rapid discharge policy to guide staff on how quickly patients should be discharged to their place of preferred care.
- We reviewed three patient records where a rapid discharge was either requested or required. In all three cases these discharges had been completed within 24 hours of the initial decision.

### Access to information

- A daily handover sheet was completed for each community nursing team. This sheet contained all relevant information pertaining to patients with end of life care needs on the team's caseload. This ensured that all staff had ready access to the information they required about patients.
- Patients had home held notes, which could be accessed by different professionals attending their homes.
- Records relating to the care patients received from the specialist Macmillan team were also stored at the team's base for easy access.
- We observed leaflets and contact sheets, which were given out to patients in relation to end of life care services.

### Consent, Mental Capacity act and Deprivation of Liberty Safeguards (just 'Consent' for CYP core service)

- Staff received mandatory training in safeguarding children and vulnerable adults, which included aspects of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberties Safeguards (DoLS).
- All staff displayed an understanding of the requirements of the MCA 2005 and were able to give us examples of how they would apply this in their practice.



## Are services caring?

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

### Summary

We have rated the service as outstanding in relation to caring because:

- Staff were passionate and committed to providing compassionate, holistic care to patients and their relatives.
- Patients were truly valued and were treated as partners in their care and treatment.
- All patients and their relatives gave positive feedback about the care they received.
- We saw a number of examples of staff going the extra mile to provide person centred, compassionate care. Staff had gone above and beyond to ensure that patients final wishes were met. One example of this was helping to arrange a holiday for a patient at the end of their life. Another member of staff was known as the wedding planner within a community team as they frequently helped arrange weddings for patients at the end of their life.
- The culture within the service was strongly patient centred and motivated staff to provide a high standard of compassionate and dignified care.
- Staff had strong relationships with patients and their relatives and these were highly valued by staff.
- Staff considered the totality of the needs of patients and their loved ones. One patient told us that they were able to die in peace as the staff had helped them achieve their final wish.
- Staff encouraged patients and their relatives to be partners in their care and ensured that they were consulted on all decisions relating to their journey.
- Staff went the extra mile to ensure that patients and their relatives received the emotional support they need.
- This included support for patient's relatives after patients had passed away. One example of this was that staff attended a memorial one year after a patients death.

### Compassionate care

- Staff respected patients and their relatives and truly valued them as individuals. The care provided by the end

of life care service was person centred and the culture within the team reflected this. All interactions between staff that we witnessed were patient centred and displayed compassion and respect.

- We observed interactions between patients and staff. Staff were courteous and caring towards patients at all times. Staff displayed a high level of compassion and understanding when communicating and supporting patients.
- We observed handover and spent time in the team office listening to staff talk to patients on the telephone and to each other. Staff spoke respectfully and compassionately to patients and about patients and appeared to have their best interests at the centre of their decisions.
- All relatives and patients told us that staff were always kind, caring and compassionate. All patients told us that staff went beyond their duty to provide compassionate care.
- All staff in all the teams we visited displayed that they were passionate about providing a caring and compassionate approach to their work.

### Understanding and involvement of patients and those close to them

- Staff displayed a person centred approach and went beyond their duty to provide care to patients, which met their needs. Staff valued patients and their relatives as partners in their care.
- All patients told us that they had been involved with decisions about their care and had been actively involved in their care plan.
- The staff within all teams involved in delivering end of life care worked together to ensure that all the patients' needs were identified and met in a holistic way. One example of this was the presence of speech and language therapists, dieticians, occupational therapists and nursing staff within a designated specialist palliative care team. This team was located in one base that ensured a truly holistic approach was taken to patients care.
- Patients cultural, religious and social needs were always given due consideration and staff went beyond what would be expected to meet these needs. One example



## Are services caring?

of this was staff arranging a specific piece of equipment which was not routinely available; to ensure that a patient's partner could continue to sleep next to them. The patient told us that this had provided them comfort and reassurance. Another example was the close working relationships between the team, local faith leaders and international funeral directors; to ensure patient's cultural needs were met.

- Staff showed determination to overcome obstacles and challenges to delivering the holistic care patients needed. One example of this was when a patient's relative had conveyed to them community nursing team that a patient's last wish was to visit a certain place. The patient and their family did not have the financial means to pay for this last wish. The staff worked outside their usual working hours with the specialist Macmillan team and a charity to procure the funding for the patient to take this trip. The team then arranged for the patient to receive end of life care during their holiday. The patient went on their holiday and passed away a short time afterwards and told the staff that they had granted them with their wish so they felt they could die peacefully.
- There were specific sections within the advance care plan and in the integrated care pathway for patients and their relatives to record their preferences.
- There was a section within the integrated care pathway that was specifically designed for patient's relatives. This section contained a card that could be completed by the patient's relatives to record a personal message and this would travel with the patient when they had passed away to the funeral director. A recently deceased patient's relative told us that this brought them great comfort; as they felt that they had been able to send a part of their heart and love with them when they left with the funeral director.
- There was also a small kit contained in this pack that was designed to hold a lock of hair from a deceased patient for their loved ones to keep.

### Emotional support

- We observed patients and their relatives being offered and provided with emotional support on the telephone and we saw evidence of this in patient's records.
- The staff involved with the delivery of end of life care worked hard to continue to support patient's relatives after their loved ones had died. An example of this was

the close relationship between a number of charitable organisations and the end of life care team. Staff would signpost patient's relatives to these services for additional support and counselling. Staff would then follow up by checking back in with these relatives to ensure that they had been able to access the services.

- Staff involved in the delivery of end of life care also conducted after death visits to support the relatives of patients who had passed away.
- We saw that sympathy cards were routinely sent to patients' relatives following the death of their loved ones.
- The dates of patient's funerals were noted in a book and a confidential board. During the daily meetings, staff would ensure that a representative from one of the community nursing or specialist palliative care team was allocated to attend all funerals. Staff told us that this was important to them as a team as they felt their role did not end when a patient passed away, but continued in providing emotional support to the patient's relatives.
- All patients and relatives we spoke with were very positive about the emotional support they received from all professionals delivering end of life care.
- One patient's relative told us that they found the support following their partner's death excellent. They told us that they had felt depressed and the team had arranged for them to see a GP and put them in touch with a counsellor. Staff also attended a memorial for the patient on the one-year anniversary of their death to support their relative.
- A patient who was receiving end of life care at the time of the inspection told us that the staff had helped them come to terms with and accept their diagnosis through their emotional support. This patient also told us that they felt that the staff went beyond their duty to support them with all aspects of their condition holistically. This included assistance with applying for benefits and signposting them to free will writing support. They told us that this had helped them enjoy the last months of their lives in a worry free way and had given them more time to spend quality time with their loved ones.
- We were told by one community nursing team that a specific member of staff was named the wedding planner due to their commitment to helping organise weddings for patients at the end of their life.



# 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 the service as good in relation to responsive because:

- The needs of the local population were taken into account when planning the delivery of services in relation to end of life care and the service routinely sought patient feedback when planning or changing services.
- Patients reported that they received a good service in relation to end of life care.
- Patients living with a disability were supported and signposted to appropriate support.
- Patients could access care and treatment 24 hours a day.
- We observed the service delivering care to a range of patients with different conditions.
- The trusts were actively working to remove barriers to patients from different groups to access services. This included work with local faith leaders and community figures from minority groups.

## Planning and delivering services which meet people's needs

- The service was adapted and tailored to meet the needs of the diverse local population. One example of this was the recognition that outcome for patients with cancer in the local area were consistently poor for a number of years. This was recognised by the trust and a national charity. As a result, the palliative care improvement programme was designed and implemented in 2014.
- This programme has a number of different strands. The first was to improve the early recognition of patients with cancer. The team had a facilitator who worked specifically with local GP's to improve the rates of timely referrals for patients with suspected cancer. This facilitator met with all GP's in the local area on a regular basis and worked collaboratively to meet key goals in eight specific areas of practice. These areas included the completion of DNACPR forms, progress towards the gold standard framework for end of life care, cancer

screening rates and timely referrals for suspected cancer. This facilitator did not meet with patients and was in post to improve the recognition of suspected cancers with GP's.

- Another strand of this programme was the introduction of a truly multi-disciplinary team co located in one base to facilitate a holistic approach to patients care. The team was based in one office in a local health centre. This allowed all members of the team to share their knowledge and respond quickly to patients changing needs. This team worked closely with all community-nursing teams, charities, support groups and GP practices. This close working relationship between multiple organisations allowed the service to be flexible
- We found that patient's needs were central to the planning and delivery of local services.
- The specialist palliative care team delivered a training programme to community staff on aspects of end of life care. Community nursing staff told us that they could request training subjects from the specialist team in relation to specific patient needs.
- We were told by senior staff that they routinely sought patient feedback when planning or changing services. This was completed through local consultation with service user groups and was supported by third party organisations including charities.

## Equality and diversity

- The community nursing teams gave us examples of when they had referred patients living with a disability to support groups.
- The team had recognised that there was a low uptake by patients of bowel cancer screening in some areas. GP's advised that this was due to the patients not speaking English as their first language and being unable to order the screening kits. As a result of this the team facilitator had worked with the GP's and the national screening programme to allow GP's to order the kits on behalf of patients.
- We saw that all leaflets provided to patients by the service could be provided to patients if their first

## Are services responsive to people's needs?

language was not English. On the reverse of these leaflets a message guiding patients on how to request material was displayed in a number of languages including Arabic and Chinese.

- Staff were able to tell us how they would access a translator if they needed to. These materials could also be provided in braille and audio formats.

### Meeting the needs of people in vulnerable circumstances

- End of life care services were available and were being provided to patients with a variety of conditions including dementia and patient with disabilities, and we saw examples of this in case records and when talking to patients. This showed us that staff were providing these services to all groups of patients regardless of condition or disability.
- The service worked with support groups and charities to engage with people in vulnerable circumstances. They would collaboratively to remove barriers for these patients to access services.
- One example of this was their work with local faith leaders and community leaders from minority communities. The service had worked closely with a specific religious group in relation to the cultures and practices after death. They had imparted this information to staff and had a close link with a local funeral director from this community.

### Access to the right care at the right time

- Patients had access to 24-hour care through the community nursing and palliative care team during the day time and the out of hour's service at night.

- Staff members involved in all areas of delivering end of life care told us that they made every effort to ensure patients reaching the end of their life received timely care.
- A triage helpline was available seven days a week from 9am until 8pm. This line was staffed by a support worker or nurse whose designated duty was to take calls from patients, their relatives and other health care professionals in relation to end of life care services.
- The out of hours district nursing service was based at North Manchester General Hospital
- All patients we spoke with told us that the service was excellent and that they felt supported including during out of hour's periods.

### Learning from complaints and concerns

- Staff told us that they did not often receive complaints for end of life care specifically.
- Information on how to raise a complaint was available in leaflet form and staff told us that they provided these to patients as needed.
- Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint from a patient.
- The trust recorded complaints on the trust-wide system. The community team leaders were responsible for investigating complaints and undertook these investigations with staff involvement.
- Information about complaints when they were received; was discussed during staff meetings to facilitate learning. Senior staff also told us that they worked with staff individually to address any issues of performance highlighted as a result of a complaint.

## 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 the service as good in relation to responsive because:

- The service had a comprehensive strategy and framework for the delivery of services within end of life care.
- Staff were aware of the trust and service strategy, values and vision.
- Progress towards key aspects of the end of life care strategy was monitored at a local and trust level.
- There were local risk register for end of life care and robust arrangements for identifying, recording and managing risks were in place.
- The risks identified on the risk register reflected the risks staff on the front line told us about. Progress against these risks was regularly updated.
- The service had robust governance arrangements in place including review of complaints data and incident data within the community nursing teams and also within the palliative care improvement team.
- Clinical audit was used to monitor quality and drive improvements.
- There was an open culture centred on patients and the delivery of high quality care.
- Staff told us that they felt that their leaders were approachable and visible and they felt comfortable and able to raise issues of concern.
- Staff felt supported and spoke positively about their leaders.
- Staff told us that they felt their workload was manageable and was regularly reviewed by their managers.
- The service regularly engaged the public in how the trust planned their services.
- The service was innovative in its approach to the delivery of end of life care and other organisations had visited the service to benchmark their practice and take ideas away.

### Service vision and strategy

- The service had a clear strategy and framework for the delivery of services within end of life care .

- Progress against key aspects of this strategy was monitored on a regular basis through a number of meetings and forums.
- All staff we spoke with were able to articulate key points of the strategy and describe work streams in line with this.

### Governance, risk management and quality measurement

- Senior managers within the service told us how they reviewed and brought together different streams of governance to inform risk management, including review of incident and complaints across community and end of life care services.
- The board assurance framework made reference to end of life care and there was a board appointed lead for end of life care. Staff told us that they were visible and all staff knew who they were.
- There were local risk registers for end of life care and community teams which provided robust arrangements for identifying, recording and managing risks. The risks on these registers reflected the risks staff working on the frontline told us about.
- The end of life care service integrated into the overall trust governance framework and there were appropriate methods of escalating risks and concerns.
- The service used internal audit to monitor quality and drive improvements.

### Leadership of this service

- Staff spoke positively about their leaders. Staff felt supported by their managers and felt able to approach senior leaders.
- Staff spoke very positively about the head of service and the consultant lead for the palliative care improvement team. We observed the head of service and the consultant lead providing excellent day to day leadership and support for staff in meetings and one to one interactions.
- Staff felt their leaders supported them to form supportive relationships between their team members and other teams.

# Are services well-led?

## Culture within this service

- Staff told us that they felt respected and valued.
- There was a strong patient centred culture within the community nursing and end of life care services in relation to the delivery of end of life care.
- All staff we spoke with said they felt supported by their immediate line managers and they would feel comfortable raising any concerns.
- Staff told us they had an open culture and were not afraid of speaking up if they made an error or had a concern.
- Senior managers within the service told us they felt supported by the trust senior management and board.

## Public engagement

- Patient feedback and opinion was routinely sought through regular service user forums and meetings. Their opinions were taken into account when planning the delivery of services in relation to end of life care.
- All patients we spoke with were aware of who the service lead was and told us that they felt able to provide feedback on their opinions of their care and treatment.

## Staff engagement

- Staff told us that they had regular team meetings and we reviewed minutes from these meetings.

- There was a district nurse and Macmillan review group, who reviewed the EOLC and particularly the hub model of working on a regular basis. We reviewed minutes from these meetings which showed that staff at all levels were involved and their feedback was taken on board and used to develop the service further.
- Staff also told us that they were actively encouraged to feedback any issues they have to their leaders. They outlined to us how they would do this either by email or using the incident reporting system.
- Staff told us that they received timely feedback when they raised a concern or an incident.
- Staff told us that they felt that their managers engaged with them in a one to one and team setting.

## Innovation, improvement and sustainability

- The staff involved with the delivery of end of life care worked effectively as a team. They engaged with other professionals to ensure patients received the required level of care and support.
- The multi disciplinary approach taken by the service in the delivery of end of life care ensured patients received excellent care from the right professionals.
- The service had comprehensive plans for the future and these outlined how the service would be sustained in the future.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

This section is primarily information for the provider

## Enforcement actions

### Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.