

Sirona Care & Health C.I.C.

1-290660061

Community end of life care

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
1-333619227	Thornbury Hospital	Henderson Ward	BS35 1DN
1-297412938	Paulton Memorial Hospital	John Stacey Ward	BS39 7SB
1-297411781	St Martins Hospital	Sulis Unit	BA2 5RP
1-1663905943	Keynsham Health Centre	Keynsham Health Centre	BS31 1AF

This report describes our judgement of the quality of care provided within this core service by Sirona Care & Health C.I.C. 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 Sirona Care & Health C.I.C and these are brought together to inform our overall judgement of Sirona Care & Health C.I.C

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	5
Background to the service	6
Our inspection team	6
Why we carried out this inspection	6
How we carried out this inspection	7
What people who use the provider say	7
Good practice	7
Areas for improvement	7

Detailed findings from this inspection

The five questions we ask about core services and what we found	9
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Summary of findings

Overall summary

Overall, end of life care and treatment was rated as outstanding because:

High quality, effective and responsive treatment and care was evidenced as established in practice and provided to patients and those people close to them. National guidance and best practice was seen to be understood and followed. Staff at all levels were well supported and encouraged to develop their knowledge and clinical skills.

The majority of Sirona end of life care was provided in patients' homes by district nursing teams, most of who were based with GP surgeries. End of life care was also provided within the three community hospitals located in Bath (St Martin's Hospital), Paulton and Thornbury.

There was a truly holistic approach to care and support to patients and those people close to them. Pain and symptoms were regularly reviewed and management plans put in place. Staff proactively and consistently looked for ways to ensure wherever possible, that patients and families hopes and wishes were achieved. Across the services we observed numerous examples of staff who worked in partnership with patients and collaboratively, flexibly and effectively with other professionals, teams and services to provide coordinated care.

Processes were in place to promote equality of access to end of life treatment and care regardless of each patient's

individual differences or personal circumstances. This included the development of end of life care plans for patients with particularly complex or vulnerable needs, and staff training to provide this.

There was a clear end of life strategy in place which was based on service user feedback, national strategy and with local commissioners input. Identified goals and action plans were seen to be kept under regular review. The service was well led and staff were proud of the end of life treatment and care they provided.

Care was safe. Patients had risks assessed, reviewed and actions put in place. Medicines to manage pain and other symptoms were prescribed and provided in advance of requirement. Staff had access to a range of end of life training and were well supported in their roles.

The culture was 'can do' and positive. Patients and those people close to them were consistently highly satisfied, with reports that the level of care and attention to detail far exceeded expectations. Practice was truly holistic, patient centred, compassionate and sensitive at all times.

Some improvements were required to the detail recorded on treatment escalation plans and to systems and processes used to monitor and evaluate risks and quality information specific to end of life patients. Improvements were required to the compliance level of staff with safeguarding children and vulnerable adults training.

Summary of findings

Background to the service

End of life services were nurse led and facilitated through Sirona's adult health and social care directorate. There was one locality manager end of life care lead for Sirona and a vacant (advertised) end of life facilitator post. The majority of end of life treatment and care was provided to patients and their families in their own homes by district nurses. There were 40 district nurse teams aligned to 53 GP practices across the South Gloucestershire and Bath and North East Somerset localities. At the time of our inspection, Sirona told us 300 adult patient's had been identified as in the last year of life and were being supported by the district nursing teams.

End of life patient care was also provided on the Sulis Unit at St Martin's Hospital, John Stacey ward at Paulton Memorial Hospital and Henderson ward at Thornbury Hospital by nurse led teams. Sirona provided a 'Lifetime' service to support children with life limiting conditions and their families. The service typically worked long term with families and where required, transferred care to adult services. All children's end of life care involved other professionals and services such as acute hospitals, children's hospice and GP. The lifetime service was led by a consultant clinical psychologist. At the time of our inspection the Lifetime service was supporting 253 children and young people, none of whom were receiving

end of life care. Records showed the last child death had occurred between July 2015 and September 2015. The Lifetime service has been reported upon within the Children and Young People's report.

During this inspection we visited 10 district nurse teams, the Sulis Unit at St Martin's Hospital, John Stacey ward at Paulton Memorial Hospital, Henderson ward at Thornbury Hospital and the end of life care coordination centre in Kingswood. We met 10 patients and spoke with one other patient on the telephone; we met 13 relatives and spoke with three other relatives on the telephone. We reviewed 18 patients' care plans and attended two district nurse shift handover meetings. We facilitated two focus groups which were attended by a total of 14 district nurses, four community matrons and two locality managers. We spoke with a range of other staff including: 27 additional district and community nurses, three doctors, six nurses on inpatient wards, the end of life lead locality manager, four other locality or assistant locality managers, two health care support workers, two staff from the care coordination centre, a pharmacist and one administrator.

We observed care being provided to patients and relatives. Before and during our inspection we reviewed Sirona's performance information in relation to end of life care.

Our inspection team

Chair: Julie Blumgart, invited independent chair

Team Leader: Amanda Eddington, inspection manager

The team included a CQC inspector, one specialist consultant and one specialist nurse as professional advisors with experience in end of life services

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

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

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

Before visiting the services, we reviewed a range of information we hold about the organisation, asked the provider to send us a wide-range of evidence, and asked other stakeholder organisations to share what they knew.

We carried out announced visits on 19 and 20 October 2016 and returned for an unannounced visit on 1 November 2016. During the visits we met with a range of staff who worked within the services, such as doctors, nurses, healthcare assistants, and managerial staff.

We talked with people who use services. Our experts by experience telephoned a group of patients and carers who were receiving, or who had received care and support. During our visits, we took time to observe how patients were being cared for, and we talked with carers and/or family members. We reviewed treatment records and other information about people's care.

What people who use the provider say

Good practice

- We saw evidence that care provided to end of life patients and those people close to them across the Sirona services was outstanding. Holistic and person centred support was embedded in practice and patients and family were fully involved and informed about all aspects of treatment and care. Relationships were highly valued by both patients and families and staff. The attention to detail and level of care, treatment and support provided by staff far exceeded patients' expectations.
- Patients with end of life care needs were prioritised at all times and care and support was provided 24 hours

a day, seven days per week. Partnership working with patients, families and other professionals and services was evident throughout the service, and this enabled coordinated and responsive care to be provided.

- Staff at all levels were actively supported to develop their end of life knowledge, skills and practice in order to deliver a high quality service.
- Staff positively looked for ways to engage patients and those people close to them with the planning and delivery of services and a range of resources had been developed to promote equality of access to the service. Staff worked above and beyond their roles to ensure wherever possible that patients and families achieved their hopes and wishes.

Areas for improvement

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

Action the provider **SHOULD** take to improve:

- Ensure treatment escalation plans (TEP) contain a written summary of the rationale/decision discussion with the patient, carers or legal representative, or the reasons why this discussion had not been possible.

- Ensure systems are in place to evidence the full range of risk and quality management issues specific to end of life patients. This would enable: improved oversight, risk management, review of potential trends and provide increased assurance at board level.
- Ensure all staff has in date mandatory safeguarding children and vulnerable adults training.

Summary of findings

- Ensure all staff has in date training identified by the organisation as mandatory.

Action the provider COULD take to improve

Sirona Care & Health C.I.C.

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

Overall we have rated safety as good because:

- Systems were in place to report incidents. All the staff we spoke with understood what types of issues required reporting and confirmed they received feedback as a result. Incidents identified as serious were investigated and learning from these was shared with staff.
- Patients were prescribed medicines to manage symptoms and pain in advance of requiring them to minimise delay and distress. Information on medicines and access to specialist advice regarding medicines to manage end of life symptoms were available at all times.
- Most patients received end of life care in their own home. District nursing teams followed processes to minimise the risk and spread of infections. There were no issues with the supply of equipment to support patients' treatment and care at home.
- End of life care plans used were based on national guidance. Patients were actively encouraged to participate with their plans of care, which were clear and detailed.
- Patients had risk assessment completed. These were kept under regular review and appropriate actions were documented as taken.

However:

- Improvements were required in records to show how treatment plans had been had been discussed with patients, carers or their legal representatives or why these discussions had not been possible.
- Improvements were required to ensure all staff working with end of life patients had completed all mandatory training. This was due to the level of staff non-compliance with safeguarding and other compulsory training service wide.

Incident reporting, learning and improvement

- There had been no Never Events related to end of life services (a serious, largely preventable patient safety incident which should not occur if the available preventative measures have been implemented).
- Between April 2015 and September 2016, CQC had been notified of one serious incident requiring investigation. We reviewed the investigation report and further discussed this with two locality managers. A range of actions were put in place to reduce patient risks and other similar incidents occurring. For example; increased stocks of equipment were put in place and

Are services safe?

staff were shown how to more effectively refer and work with other services. Records identified when all actions had been completed and by whom and learning was shared with relevant staff teams.

- All the staff we spoke with about incidents demonstrated an understanding of their responsibilities to report incidents and near misses and what type of issues to report such as pressure ulcers, falls and medicine errors. Staff told us they received feedback regarding all incidents they had reported and incident information which was required to be shared more widely was highlighted during shift handovers and during team and other meetings. We observed two shift handovers and saw safety briefing information was discussed.
- The severity of incidents and impact on the patient was graded between one (no harm or near miss) to five (catastrophic) by the person reporting it. This was reviewed by the reporter's line manager and amended if required. Based on the type of incident reported, the most relevant clinical lead within Sirona was also emailed a copy of the incidents. This enabled clinical leads to maintain oversight of incidents and take any necessary actions to mitigate against them. More serious incidents graded as four or five were automatically escalated, monitored and reviewed by Sirona's health and safety team and the majority of the board of directors

Safeguarding

- Staff we spoke with were knowledgeable about safeguarding processes for vulnerable adults and children and were clear about their responsibilities. Staff demonstrated an understanding of what kind of issues might alert them to consider possible safeguarding issues, and what they could do to respond to the patient in a safe and supportive manner.
- Staff attended mandatory safeguarding vulnerable adults and safeguarding children's training and refresher courses. The level of safeguarding training completed ranged from one to three and which course staff attended was dependent upon their roles and level of interaction with patients.
- Improvements were required to the number of staff who had up to date safeguarding training. Records were provided by the organisation confirming compliance levels on 30 September 2016. These figures were variable. The percentage of hospital staff compliant with

level one training ranged from 50% to 100% and with level two ranged from 36% to 91%. Compliance for level three training was zero. The percentage of community staff compliant with level one safeguarding training ranged from 42% to 44%, and with level two ranged from 47% to 51%. Compliance for level three training was 64%. We were not made aware of any plans to address this.

Medicines

- Patients identified as requiring end of life care were prescribed anticipatory medicines. These 'when required' medicines were prescribed in advance in order to promptly manage any changes in patients' pain or symptoms. The medicine chart gave flexibility to individual patient needs by including a treatment range, with the ability to prescribe from a starting dose to a maximum dose and anywhere in-between. This enabled medicine doses to be increased or decreased as required in response to changeable symptoms with the minimum of delay to the patient.
- All patients receiving end of life care and support at home were provided with a 'just in case box'. This contained at least 10 loading (start) doses of oral medicines to treat or manage a range of end of life symptoms. The district nurses told us the 'just in case box' could also be customised in anticipation of specific individual patient's needs.
- Systems were in place to ensure anticipatory medicines were available and transferred from Sirona's inpatient wards to the patient's home. The anticipatory medicines prescription sheet could be used on the inpatient wards or by the district nurses providing care in the patient's home. This supported the continual and smooth transition of medicine management to ease symptoms and pain.
- Clear guidance on medicines was available to assess, manage and review a range of end of life symptoms. Medicine information was printed on the back of the 'community palliative care drug chart' which was kept in each patient's care record.
- We saw medicines being safely dispensed and administered in patient's homes.

Environment and equipment

- Most patients were receiving end of life care in their own home. The district nurses told us they all had access to

Are services safe?

stocks of personal protective equipment such as aprons, antiseptic hand gels and disposable gloves and other equipment such as syringes, sterile packs and wound dressings.

- Sharps bins were taken to and used in patients' homes and we observed district nurses safely disposing of sharps.
- The district nurses confirmed there were enough syringe drivers (a device used to deliver medicines just beneath the skin) to meet patients' needs. The syringe drivers were maintained through contracts with local acute trusts. Staff told us if they reported any operational issues with equipment, these were promptly addressed by surgeries.
- Larger equipment required by patients in their home such as hospital beds and electric bath seats was requested by the district nurses and provided free of charge. The district nurses confirmed most equipment was delivered within 24 hours of ordering and was well maintained.

Quality of records

- Patients' end of life care records were kept in paper form at patients' homes and also completed electronically. Sirona had recently launched three end of life care plans which covered assessment, treatment and care during the early stages, last weeks and days of life and to support care after death. These had been based on patient, carer and district nursing team feedback and followed national guidance (DH 2015, NICE (31) 2015). Each care plan was in three parts and prompted an on-going review of the patient and carer's psychological, physical and emotional needs. The regular care plan (part three) prompted an overview of each contact using a patient reported outcome tool. This actively engaged each patient to score any symptoms as well as adding any goals or activities they wished to be supported to undertake. All staff spoke positively about these care plans, and were able to demonstrate how they were used to support and coordinate care. The care plans had not been audited but there were plans in place to complete this during 2017.
- We reviewed a combination of 18 paper and electronic end of life patient records. We saw detailed discussions between clinical staff, patients and relatives were recorded sensitively. Records were legible and illustrated clear plans of current and planned care which was regularly reviewed.

- However, national guidance was not fully followed with regard to patient treatment escalation plans (TEP). These were completed by doctors in the community hospitals to document planned treatment and limits to treatment in the event of deterioration. These were based on each patient's individual circumstances. We reviewed 11 TEP forms used on the Sulis Unit at St Martin's Hospital and the John Stacey ward at Paulton Memorial Hospital. At the time of our inspection, there were no patients at Thornbury hospital who had a TEP in place. The TEP required a written summary of the rationale and decisions regarding treatments that had been discussed with the patient, their carers or legal representative. If discussions had not been possible, a written summary was required by a doctor to explain why not.
- We reviewed 11 TEP forms and found not all the TEP forms had been fully completed by a doctor. Eight had been ticked to indicate discussion had or had not taken place. Of these, two discussion boxes had been left blank and six had limited statements such as; 'patient's wishes', 'patient's choice' and 'best interests' rather than a summary of what was discussed. We also reviewed the patient's care records and saw only an entry had been made to confirm the TEP form had been completed. National guidance; 'Treatment and care towards the end of life: good practice in decision making' (p66 General Medical Council, 2010) states doctors must make a record of the decisions made about a patient's treatment and care.

Cleanliness, infection control and hygiene

- Most patients were receiving end of life care in their own home. We observed district nurses used personal protective clothing before providing any patient treatment or care. We saw district nurses wash their hands and use antiseptic hand gels before and after providing any patient care. Antiseptic hand gels were also used in between patient visits.
- We observed the district nurses used sterile packs and appropriate techniques to minimise the risks of infection or the spread of infection when providing care in patients' homes.
- We observed appropriate processes were followed to dispose of clinical and other waste from patients' homes. This included how equipment was cleaned after use and how waste was handled and disposed of.

Are services safe?

- Procedures were in place and followed by district nursing teams to minimise infection control risks if these were an issue when a patient died at home. This included notifying the coroner if the patient had a notifiable disease.

Mandatory training

- There was no specific compulsory end of life training. However staff working with end of life patients attended a range of mandatory training every year. This included: health and safety awareness, equality, diversity and human rights, information governance, infection control, fire safety, moving and handling, life support, dementia awareness and safeguarding vulnerable adults and children. Staff told us the quality of training was good and supported them in their roles.
- Sirona calculated the compliance levels of mandatory training by directorate. Records were provided by the organisation dated 30 September 2016 for the community hospitals and community staff. These showed compliance for mandatory training ranged between 67% to 75%. Therefore not all staff working in the district nursing teams and community hospitals who provided end of life care and support had in date mandatory training.

Assessing and responding to patient risk

- We reviewed 18 care plans and saw patients had risk assessments completed and appropriate actions put in place. Risks assessed included: pressure care, nutrition and hydration, infection risks and adverse effects from medicines. Patient risks were reassessed during each contact, care plans were updated accordingly, and any necessary actions completed promptly.
- Patients receiving end of life care in community hospitals or at home had treatment escalation plans (TEP) which were combined with the resuscitation decision record. TEP forms identified which treatment and actions were appropriate to take in the event of deterioration based on each patient's unique circumstances. For example: decisions regarding the use of oral or intravenous antibiotics, referral for dialysis or transfer to critical care.
- We observed district nurses sensitively discussed with patients and their relatives what issues might occur as a consequence of the progression of illness and

deterioration in health, and what options were available. Patients' and families choices and wishes were fully documented and reviewed at every subsequent contact.

- We were shown on Sirona's IT system how patients' care plans were kept under constant review. This was done with reminders on calendars and alerts on the systems to prompt staff to repeat risk assessments and reviews of treatment and care.

Staffing levels and caseload

- There was one identified end of life lead locality manager for Sirona. This person worked full time and told us a minimum of 50 per cent of the role was focused on end of life care. There was an end of life facilitator role of 15 hours per week. This post was being recruited into at the time of our inspection. The end of life lead told us other staff, such as the district nurse team leaders and assistant locality managers completed specific end of life work linked to the service improvement or policy development as required.
- There were sufficient staffing levels to ensure that patients received safe care and treatment 24 hours day, seven days per week. The majority of end of life care was provided within a patient's own home as required and within the three community hospitals. The district nursing teams consisted of district nurses in team leader roles, community nurses, assistant practitioners and health care support workers. The team skill mix enabled a range of end of life treatment and care skills to be appropriately responded to, with the most complex work being managed by the most experienced staff.
- Palliative support from specialist nurses and consultants was available at all times from two hospices, one based in South Gloucestershire and one based in Wiltshire.

Managing anticipated risks

- Each day the district nurse teams reviewed patient treatment and care needs including how best to manage and support both anticipated and potential risks. The district nurses worked in small cluster teams covering three or four GP practices. The cluster teams worked across surgeries and geographical boundaries to fill any gaps based on increased patient risks and needs or lack of staffing. Staff told us the needs of end of

Are services safe?

life patients and their families were always given priority over other routine clinical work. This ensured end of life patient care risks were managed and care provided was consistent.

- Winter and other system pressures were continually monitored by senior staff. Home visits were reallocated as necessary to ensure priority patients were visited.
- We observed in several of the district nursing team offices a safety board on identified end of life patients. This included information related to safeguarding, pressure area care, the use of syringe drivers (to deliver

medicines under the skin) and visits that required two staff at a time to attend. We saw the safety information was referred to during staff shift handovers to discuss anticipated and ongoing risks.

- Staff we spoke with demonstrated a clear understanding of the organisation's lone working policy. Patients' care plans included the risk assessment of issues associated with pets and challenging relatives or carers. Staff told us they ensured colleagues knew where they were intending to go and regularly contacted each other to provide updates.



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

Overall we have rated effective as outstanding because:

- End of life care was consistently demonstrated to follow the best available evidence and national guidance and promoted a good quality of life for each patient.
 - Patients and those people close to them were kept central to all clinical care planned and provided. Care was effective because it achieved good outcomes by being tailored to individual needs and circumstances.
 - Staff were committed to partnership and collaborative working and there was an embedded culture focussed on the delivery of a holistic care. This was achieved through continual multidisciplinary and multiagency working when assessing, planning and delivering care. This included regular multidisciplinary meetings to identify early on those patients approaching the last year of life and ensure extra care and support was planned for in advance of needs.
 - Patients' nutrition and hydration needs were documented as routinely assessed and appropriate actions were taken to maintain comfort.
 - The management of pain and other symptoms was shown to be continually assessed and effectively responded to.
 - A skilled workforce was recognised as integral to the delivery of high quality effective patient care. Staff in all positions were actively encouraged and supported to develop their skills and knowledge of the treatment and care of end of life patients.
 - Patient outcomes were routinely monitored and reported to commissioners. This included the percentage of patients who received care in their preferred place of choice. This was evidenced as achieved for the majority of patients.
 - Consent, mental capacity and deprivation of liberty safeguards were demonstrated to be well understood by staff and fully documented in care records.
- strategy action plan and all of the end of life care planning and assessment tools. This included The National Council for Palliative Care (2008, 20013), the Department of Health (DH 2008), The Leadership Alliance for the Care of Dying People (2014) and the National Institute for Health and Care Excellence (NICE, 2014, 2015).
- Staff we spoke with understood end of life care was focused on the approximate last year of a person's life and was not just cancer specific but related to any illness or condition. Throughout the inspection, community and inpatient staff demonstrated in practice how they supported end of life patients and those people close to them with evidence based treatment and care. This included: holistic, person centred treatment and care, the provision of adaptable and flexible care in order to respect the wishes and needs of the patient and those close to them, multidisciplinary and team working, including with others employed external to Sirona.
 - The majority of GP practices held Gold Standard Framework (GSF, RCGP, 2011) meetings and registers. These multidisciplinary meetings, attended by the district nurses were used to discuss any potential patients nearing the end of their life, and to assess and plan in advance who may need additional support. We saw GSF notice boards in some of the district nurses' base rooms with patient details colour coded to show at a glance where patients were on the end of life pathway and what support was in place or required setting up. At surgeries where Gold Standard Framework meetings were not held, district nurses attended other multidisciplinary meetings to help identify patients approaching end of life.
 - The end of life audit plan included measures to review clinical practice and the delivery of the service against the identified strategy which was based on six national standards (Leadership Alliance, 2014). We looked at the audit plan covering the period between October 2016 and August 2017. Actions completed included the development of bereavement standards including for children and adults with learning disabilities. Other

Evidence based care and treatment

- End of life care was delivered by Sirona staff based on the best available evidence and in line with national guidance. This was embodied within the end of life



Are services effective?

actions planned included planned audit of the effectiveness of end of life care plans, review of standards of care to support with bereavement, and audit of carer experience and staff morale.

Pain relief

- Pain and symptom relief was prioritised in the treatment and care of end of life patients. Anticipatory or 'just in case medicines' were prescribed to all end of life patients and stored in patients' homes so they were readily available when required. Patients and their relatives told us the district nurses always discussed pain and other symptoms with them and ensured there were adequate supplies of medicines available.
- Pain and symptoms were reviewed during each contact and documented in care records. We saw patients were encouraged to describe and rate their pain and symptoms and where appropriate those people close to the patient were also asked their opinions. The patient's GP or specialist was referred to regarding pain and symptom control when required, and this was documented in records. We observed that when required, the district nurses completed joint visits with a specialist hospice nurse to review complex pain and symptom control.
- When patients were not able to communicate, symptoms were kept under regular review and observation and recorded in care plans. Syringe drivers (used to deliver medicines under the skin) were available to all patients who required them. The district nurses demonstrated they were observant of patients' body language and took time to thoroughly check all issues.
- The district nurses told us GPs were prompt to respond to medicine reviews or queries when requested. Expert advice regarding end of life medicines was also accessible to the district nurses 24 hours a day, seven days per week from specialist nurses and consultants at two local hospices.

Nutrition and hydration

- We observed patients had their nutrition and hydration needs assessed using a Malnutrition Universal Screening Tool (MUST) which identified nutritional risks. Records showed appropriate nutrition and hydration actions were taken when required by staff.
- Care records showed patients were asked about nutrition and hydration during home visits. Each

patient's weight was monitored as part of an ongoing review of nutrition. Patients were given advice such as the use of high energy meal replacement drinks. We observed during one home visit that a recording tool had been created specifically to meet one patient's needs in order to more effectively monitor hydration needs.

- The district nurses described how each patient's needs were evaluated and supported at the end stages of life. Patients were supported to be as comfortable as possible. Mouth care kits were kept within the comfort boxes maintained in patients' homes and used when required

Patient outcomes

- Patient outcomes were routinely monitored and reported back to the two clinical commissioning groups (CCGs). We looked at the reports dated April 2016. These evidenced how actions and improvements had been made against key areas agreed with the CCGs. These included: communication and coordination of care, pain and symptom management, providing access to respite for carers, increasing patient and carer engagement with the service delivery and improving knowledge and confidence to recognise patients approaching the end of their lives. The reports documented a range of actions taken to demonstrate improvements in the identified areas. For example: using feedback from a range of services and professionals, the community palliative care medicine chart was devised and piloted and subsequently disseminated across services in South Gloucestershire. This has supported consistency of pain and symptom management between hospital and community services.
- The end of life services also had an audit plan in place which was used to monitor and benchmark the quality of the services provided and patient outcomes not specifically included in the CCG reports. The majority of the audits were planned for completion during 2017. For example: the effectiveness of care plans by the review of 20 sets of nursing records and a staff questionnaire.
- Supporting patients to be in their preferred place of care at the end of life is part of national strategy (DH, 2008, Leadership Alliance for the Care of Dying People, 2014). This was monitored by Sirona and reported back to the local CCGs. We looked at records dated April 2016 to September 2016. During this time there had been 240



Are services effective?

patients who had received end of life care by Sirona staff at the time of death. Of these, 89% of the patients living in South Gloucestershire, and 96% of patients living in Bath and North East Somerset had received care in their preferred place of choice. This was higher (much better than) the national average of 82% (Office of National Statistics, Preferred priorities for care, (last three months), 2016).

- Staff had been supported to follow good practice guidance and the early identification of potential patients approaching the end of their life. Information was available and accessible on the organisations intranet to all staff working with end of life patients on the use of the Gold Standards Framework Prognostic Indicator (GMC, 2011). We saw use of this guidance was also included in the end of life staff training.

Competent staff

- All of the district and community nurses were trained to use syringe drivers and attended an annual skills update. New staff were supervised until they were assessed as competent and confident to use syringe drivers independently with patients, as it was not always possible to have two staff visit together.
- District nurses in team leader roles were expected to have, or to be working towards completion of a district nurse qualification at a local university. This was fully supported by the organisation, and senior staff recognised this was integral to ensuring high quality care. We spoke to several nurses attending the course and were told the content was both stimulating and challenging. The course included: nurse prescribing, care of older people and management and leadership modules. Staff told us learning from any course was shared and disseminated with colleagues during team meetings.
- Band five community nurses and band six district nurses were all encouraged and supported to attend the 'End of Life Care, Practitioner Development' course. The course lasted six months and developed knowledge and skills in relation to all aspects of end of life treatment and care, national policy and bereavement. At the start of the course, participants were given the option to complete the course to either degree or master's level, with credits given that could be applied to other qualifications at a local university. Staff we spoke with who were or had attended this course reported it was excellent and had supported clinical roles in practice.

- The health care support workers based with the district nursing teams were encouraged and supported to attend an end of life training course. At the start of the course, participants were given the opportunity to achieve City and Guilds accreditation for the course at level 2 or 3. In addition, a booklet had been developed to support and increase health care support workers understanding of palliative care. This included: mouth care, spirituality, positioning of patients and care after death.
- Specialist nurses from one of the hospices facilitated end of life training sessions for the district nurses. These were provided every two months and 10 district nurses attended from different teams. Session topics were based on requests made by the district nurses. The last teaching session had been during September 2016 and was on pain and symptom control in renal failure. District nurses told us they often used current or recent clinical work to link the theory to practice and shared learning through team and other meetings.
- Other specialist end of life training was regularly facilitated by Sirona or through the two local hospices. Records showed training topics had included: how to recognise people nearing the end of their lives and initiating difficult conversations. Staff attending training completed a questionnaire before and after to assess for changes in staff confidence. Comparison of this data showed the confidence and knowledge of different staff groups (nurses, allied health professionals and health care support workers) increased as a result of the training provided.
- All the staff we spoke with told us they felt well supported in their roles by managers who were approachable and accessible. The compliance level for staff who had received an annual appraisal was collated by whole service areas. The percentage of staff with an in date annual appraisal for the South Gloucestershire region was recorded as 84% (Performance Report, August 2016)

Multi-disciplinary working and coordinated care pathways

- Multidisciplinary working was seen to be embedded in practice across Sirona services and with other professionals or services external to the organisation. This was evident in patients' records, and through discussions with staff and observations. Staff had positive relationships with other professionals and



Are services effective?

services. This included: GPs and consultants, allied health professionals, hospital and hospice staff, care agencies and pharmacists. Sirona staff demonstrated a thorough understanding that good end of life care in the community could not be provided without partnership working with others in order to coordinate patients' treatment and care.

- There was excellent communication between the GPs and district nurses who also regularly attended practice meetings and other clinical meetings. The district nurses had access to the GPs IT systems which enabled communication and care to be coordinated. We spoke to one relative about their experience of multidisciplinary care. This person told us they knew the district nurses kept everyone updated. They gave the example of a recent district nurse visit during which the patient had shown signs of deterioration. Later that day the GP had telephoned and went straight to the details, later a night sitter from the hospice arrived and also demonstrated full understanding of the issues. This person said they found this comforting not to have to repeat information and reassuring as she could see all the professionals working together.
- End of life patients who had been assessed as requiring fast track treatment and care were supported through two dedicated care coordination services covering both local clinical commissioning areas. The role of the coordination centres was to arrange rapid access to care and support directly with external services. We observed how individual care packages of support were organised for patients based on individual needs. The coordination service acted as a link between the patient and their family, professionals and agencies. Staff told us that when a patient's care package had been sourced they kept this under review to ensure the services provided were satisfactory and dealt directly with any issues or concerns.

Referral, transfer, discharge and transition

- We spoke with 11 patients and 16 relatives who received end of life care and support at home. We asked if they felt care was coordinated between the GP and all other professionals who needed to be involved. Feedback was positive, we were told: "If you ever want to see a team work well, this was the team to watch. The flow of information was constant and always with my father's

care at its centre" and "The nurses have been great, they bring things together, make sense of things and coordinate". Another person told us: "We didn't realise they are all working together. They are so coordinated".

- Equipment and care packages were put in place promptly through a 'fast track' (Continuing Health Care) system for end of life patients. We were shown current patient records, assessments and action plans. Fast track assessments had been completed quickly and promptly passed to the care coordination centres.
- District nursing teams actively supported end of life patients who chose to receive care at home. Staff confirmed that a lack of care agency staff (external) could delay the start of a patient's discharge and care package, and this was particularly problematic during holiday seasons and within rural areas. However, in practice the district nursing teams, working in partnership with local hospices frequently filled care gaps until care packages could be sourced in order to ensure patients were in their preferred place of care. We were told Sirona and commissioners were actively in the process of reviewing the provision of care services and looking for alternative solutions to prevent fast track discharge delays.

Access to information

- Primary care and the district nursing teams had systems in place to share and have immediate access to information. Sirona's IT system was compatible with the systems used in the majority of GP practices and with the hospice based in Wiltshire. The district nurses had passwords for the surgery they were linked to and could access the IT system remotely.
- The district nursing teams updated patient contact information onto the IT system promptly and we observed when a GP was not available to talk with in person, this was achieved with IT messages to relay clinical updates. Staff told us this meant information was shared promptly at all times.
- A range of end of life care planning tools based on best practice was available as part of the end of life strategy. These also aimed to improve continuity and coordination of care between the community and inpatient services. These were available to staff through Sirona IT system.



Are services effective?

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Consent was sought before each episode of treatment and care, and documented in patients' care records. Patients and relatives told us staff always explained what they wanted to do and asked for permission before proceeding. We observed this in practice and staff checked if patients understood or had any questions.
- We reviewed 18 patient care plans and saw consent was fully documented on treatment escalation plans (TEP) and resuscitation decision records. Mental capacity assessment followed national policy (Mental Capacity Act, 2015) and the process to follow was printed on the reverse of the combined TEP and resuscitation form. All the staff we spoke with about capacity demonstrated a thorough understanding of assessment of capacity and of the associated principles of best interests' decision making.
- Additional consent procedures and resources were available and followed by staff where appropriate with end of life patients. These included guidance on: the process for making decisions with adult patients with serious medical conditions, and an advance decision to refuse treatment policy. We saw these also followed national policy and guidance (NHS improving Quality Team, 2008, NHS End of life care programme, 2013).
- Staff attended mandatory mental capacity and deprivation of liberty safeguards training. Sirona calculated the compliance levels by directorate. End of life services were part of the community directorate. Records were provided by the organisation dated 30 September 2016 for the community hospitals and community staff. These showed compliance ranged between 67% and 75%.



Are services caring?

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

Summary

Overall, we have rated caring as outstanding because:

- Patients and relatives had nothing but the highest of praise and thanks for the treatment and care provided. We were told care had exceeded all expectations and consequently patients and families felt safe, able to cope and very well supported.
- Holistic, person centred care was seen to be central to end of life care services provided. Partnership working, led at all times by the patient and family was observed to be embedded, and routinely applied in practice.
- People told us they felt truly respected and valued and care provided was how and what care was wanted by patients and those people close to them. The words used most by patients and others to describe how they were supported by staff were; “exceptional” and “truly outstanding”.
- Patients and those people close to them told us they were fully included in all care treatment and care plans and that information was presented honestly and sensitively.
- End of life patient care was prioritised at all times and staff nurtured positive, compassionate and respectful relationships with patients and those people close to them. These relationships were highly valued by both users of the service and by staff.
- We observed numerous examples of compassionate, thoughtful, respectful and sensitive care provided to patients and those people close throughout Sirona’s end of life services.

Compassionate care

- Feedback from patients and those people close to them overwhelmingly reported end of life treatment and care was provided sensitively, compassionately and with dignity and respect. We spoke with 11 patients and 16 relatives. When asked to describe the level of satisfaction with end of life care provided by the district nursing team, the most commonly used words were “exceptional” and “truly outstanding”.

- Patients and relatives told us: “Exceptional care. It made me feel I was lucky to live in this country and have this wonderful service provided” and “Timely, caring, and respectful, it was absolutely personal. He wasn’t a patient he was a person. Thank you so much”.
- All staff we spoke with told us end of life care patients and their families were always given priority. Patients and relatives repeatedly expressed how grateful they were for the staff supporting them during what was often the most sensitive, difficult and personal of experiences.
- Other professionals external to Sirona told us they had been greatly impressed with the standard and level of compassion of care provided to end of life patients. GPs and other medical staff told us they would want their own care or care of their relatives’ to be supported by Sirona staff. One person told us they had specifically applied for a job in the area because of the reputation of excellent standards of end of life care.

Understanding and involvement of patients and those close to them

- Patients and family were fully involved and informed about all aspects of treatment and care. All the patients who were or had received end of life care and other people close to them spoke very positively. Comments included: “I know and trust the staff, they are interested in us and our lives” and “I have nothing to say other than praise. I feel I have been provided bespoke care, it has been made to fit around what me and my family want and need”. Other people told us: “They always explained what they were doing and always asked if it was ok to do things” and “We were kept fully informed as things progressed, but in a careful and kindly way” and “They were ready to answer any questions we had. They were very professional. I don’t think things could have been any better than the way they were handled”.
- Other comments, repeated by several patients and family related to how much they valued the relationships with staff and the care received. This was felt to have far exceeded expectations and to be integral



Are services caring?

to patients fulfilling their hopes and plans for how they were cared for and supported. One person said: “They were exceptional. We were extremely lucky and happy to have such a team”.

- There was a visibly strong person centred culture of working with end of life patients. Using regular discussions and open ended questions, patients were sensitively supported to identify their own needs. We observed how treatment and care was delivered and how staff spoke with, and about patients and their relatives. Staff had been seen to be striving to provide care in personalised ways suited to individual circumstances. This was achieved and demonstrated with a real understanding of what was important to patients and families and by respecting choices, views and feelings. One person told us: “The care plans took into account all information given by my family. This reflected the level of all round care given”.
- In the community hospitals family and other people close to end of life patients were treated with kindness and compassion. Comfort cards were given to visitors during the last days and hours which conveyed a sense of kindness and respect. The cards suggested visitors could lie on the bed with the patient, sit close and hold hands and to stay as long as required. We were told whenever possible patients were offered side rooms which provided increased privacy.
- We observed staff adapted how they provided care to fit around people, so that at all times, patients were as involved as much as they wanted to be and treated with dignity and respect. Staff skilfully balanced humour, honesty and compassion with each situation. One person told us: “we were all included from the word go. Everything was out on the table and could be discussed”. Another person said: “My father was able to make his own choices and we were all listened to”.

Emotional support

- We were told by all the patients and people close to them that emotional support was offered and provided

whenever required. For example, one person said: “I feel safe and looked after and all the district nurses have been superb”, “I know if I ring the district nurses will be here. The consistency is just amazing, they remember us and our situation, it feels personal, like they are genuinely invested in our family” and, “We want him to stay at home. The nurses have always come quickly when we needed them. I really feel like the nurses are listening to what I’m saying. It’s given us the confidence to believe as a family we can do this.”

- We observed staff recognised feelings of anxiety and offered additional support. This ranged from extending and/or additional visits with patients and families to discuss concerns and referrals to others such as counsellors, chaplains and GPs.
- We saw in records that spiritual needs were routinely assessed and discussed as part of patients’ care plans. Where required, appropriate actions were taken.
- Nothing was viewed as too much trouble by staff when trying to support the hopes and wishes of patients and families, regardless of lack of time, workload or obstacles. We observed and were told of numerous examples of this which staff viewed as standard rather than exceptional care. For example: the partner of one patient wished to attend a family wedding. Staff at one of the care coordination centres worked diligently with commissioners and care agencies to promote the provision of increased care and support for an extended period. This meant the patient’s partner was able to attend not only the wedding but also the reception without having to worry. Another end of life patient (in hospital) talked about their love of fish and chips. Staff promptly purchased these for the patient (and others on the ward) in recognition that although the patient could no longer eat, the smell was evocative of past positive memories.



Are services responsive to people's needs?

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

Summary

Overall we have rated responsive as outstanding because:

- Patient care and needs were kept central at all times to end of life care provided by Sirona. Staff worked proactively and in partnership with patients', other professionals and services in order to provide individualised, responsive, flexible and coordinated patient treatment and care.
- Staff responded positively to feedback from patients and those people close to them in order to make end of life service improvements. This included the development of a range of end of life booklets and information to support with decision making and choices. Patient and family feedback regarding these service improvements had been consistently positive
- Staff proactively and positively looked for ways to engage with patients and those people close to them. Sirona provided end of life care 24 hours a day, seven days a week and people were seen at times that suited them.
- Processes were in place and followed to ensure people were supported by staff who were familiar with their personal circumstances in order to provide continuity of care. This extended to ensuring other services providing support were kept apprised of each patient's most current care needs.
- Staff understood the needs of the local population and worked collaboratively and positively with other organisations and services to provide patient led care in a timely and consistent way. We observed this in practice across the locality.
- The majority of patients achieved their preferred place of care goals. Records showed this had been achieved for 89% of South Gloucestershire patients and 96% of patients living in Bath and North East Somerset.
- Processes were in place to promote and ensure equality of access to end of life treatment and care regardless of each patient's individual differences or circumstances. This included specific end of life care plans to promote engagement with patients with particularly complex or vulnerable needs.

Planning and delivering services which meet people's needs

- The end of life service lead worked proactively with commissioners to plan and deliver services to meet the needs of the local population. This person attended the commissioners' end of life meetings and was fully aware of locally commissioned priorities and expectations. These were incorporated into Sirona's end of life work plan and overall strategy to ensure the service delivered what it was commissioned to do.
- We saw end of life reports were sent to commissioners on a quarterly basis outlining work progress against targets to meet local needs. These included: user engagement activities and resources developed for patients and families to maintain and improve choice and involvement. In addition targets were set (and met) for staff training and resources to drive forward quality and practice standards.
- Sirona staff worked proactively with other services to meet the needs of end of life patients and those close to them. For example, a working group was convened specifically to review discharge processes. This included the Sirona end of life lead and representatives from the hospital, hospice, continuing health care and discharge liaison. The group created a pathway with agreed standards which could be audited. It was agreed the hospital would use the work to further support and develop the end of life discharge processes. Sirona's end of life lead continued to liaise with the hospital to improve and coordinate patient pathways between the hospital and community.
- Sirona worked collaboratively with other end of life services and professionals in order to provide an integrated and consistent approach to care. The end of life lead attended the south west region end of life facilitators' meetings and the Bath and North East Somerset strategic meetings. We reviewed meeting minutes (dated March 2016, and October 2016), and saw these meetings were attended by people from a range of other clinical, commissioning and charitable end of life services. The purpose of these meetings was to share and disseminate good practice and review and



Are services responsive to people's needs?

coordinate actions from national policy with regard to services provided locally. For example: using personal budgets to support end of life care, and NHS improving quality updates.

- In the community hospitals, visitors to end of life patients were permitted on the wards at any time. Snacks and drinks were available and recliner chairs were provided for those who wished to stay for extended periods or overnight.

Equality and diversity

- Sirona had proactively reviewed how end of life care was provided to patients with particularly complex needs by developing specific processes in order to be responsive to the needs of adults with learning disabilities. This was based on evaluation of audit undertaken during March 2015 in consultation with South Gloucestershire commissioners. The subsequent actions promoted inclusion and equality and had included staff education and training. In addition resources were developed to enable adults with learning disabilities to actively participate with choices regarding their end of life care plans. We spoke with senior staff from the learning disability services in Bath and North East Somerset who confirmed they had recently commenced similar work.
- Staff told us they worked in partnership with other services to ensure all patient needs were fully supported. We were told of recent patient case histories which had included partnership working with mental health and learning disability practitioners. This was done to ensure communication and care was provided in ways which maximised each patient's inclusion, understanding and choices.
- Patients' religious and cultural needs were assessed as part of their care plan and we saw appropriate actions were documented. Staff said if they required additional guidance regarding spirituality this was accessible at any time via one of the hospices.
- Staff knew how to access an interpreting service if this was required by patients or those people close to them.

Meeting the needs of people in vulnerable circumstances

- Staff demonstrated an understanding that the very nature of end of life care caused varying degrees of vulnerability to patients and those people close to them. Records showed that all referrals for end of life

care in the community were accepted by the district nursing teams. This was regardless of the person's age, life limiting condition, beliefs or any personal circumstances.

- End of life care to patients and families was prioritised above all other work by staff. We were told this was done in recognition that some end of life physical and emotional needs could not always be anticipated or delayed.
- When staff worked with a patient for the first time they completed joint visits with staff already known to the patient and family first. Staff told us this was a positive way to introduce new staff during a sensitive time and supported continuity of patient care and continuity of support to those people close to the patient.
- Staff showed an understanding of patients' support networks and how this could have a positive or negative for each patient's circumstances. Packages of care were arranged to assist patients and relatives based on individual needs. We saw this documented in care records as regularly reviewed and appropriate actions taken.
- The district nurses worked in a responsive manner to patients. Nurses told us if they needed to spend additional time with patients or their families, other planned work was shared between, and completed by other team members.
- Staff were aware of patient vulnerabilities and took actions to address issues sensitively. District nursing team feedback identified that some staff felt uncomfortable asking patients and relatives for opinions on the end of life services during such a difficult time in their lives. This was proactively addressed. A letter and questionnaire was sent to patients and their families asking how they felt to be asked to give feedback and what types of questions they thought would be beneficial. The results were positive and the information was being used to improve the content and timing of feedback forms and to improve service provision and reassure staff.

Access to the right care at the right time

- End of life care in the community hospitals and within patients' homes provided by district nursing teams was provided 24 hours a day, seven days per week. Specialist end of life advice and support was accessible at all times through two local hospices.



Are services responsive to people's needs?

- Priority was always given to end of life patient treatment and care. We observed during shift handovers how staff worked flexibly to prioritise patients whose needs became urgent. This included how care was planned for during out of hours. Patients and relatives told us staff contacted them if appointments needed to be delayed.
- Partnership working with other services and professions was embedded within end of life practice. This enabled increased ability to access the right care for patients and families when required. We saw care plans were detailed and shared as required between all services involved with the patient. Needs were reviewed and evaluated at every contact and staff used their knowledge and skills in part to anticipate needs in advance. Patients told us they knew information had been shared because staff from other services were always knowledgeable of their current needs and issues.
- End of life patients who had been assessed as requiring fast track treatment and care were supported through two dedicated coordination services covering both local clinical commissioning areas. The coordination centres planned care and support directly with external services based on each patient's individual needs. The assessments were completed promptly and the majority of patients achieved their preferred place of care goals (89% of South Gloucestershire patients and 96% of patients living in Bath and North East Somerset).
- There was a policy and staff were trained to be able to verify an expected death of a patient in a community

setting. This meant essential processes could be completed in a timely way, often by staff already known to the deceased patient and family. When training had been completed, a GP was required to assess and sign off practice. Records showed 48 nurses had completed the training and 16 had been signed off as competent.

Learning from complaints and concerns

- Staff responded positively to concerns raised by looking for ways to make service improvements. Feedback from carers during 2015 suggested on occasions patients and those people close to them were not provided enough information, nor was this always provided at the right time. In response a variety of resources for end of life care were developed and were piloted. These included information on: advance care planning, knowing when to ask for help, understanding what support would be available and how to access it, support for carers and understanding the role of keyworkers. We reviewed the results of subsequent audit which showed the provision and use of the resources had improved awareness and communication between patients, family and staff.
- There had been no formal complaints for end of life care services. However, adverse event information was discussed as a standing agenda item at the monthly district nurse team meetings. We attended a meeting during October 2016. We heard a concern, documented as an adverse event as the family did not wish to pursue further as a complaint. The agreed action was to widely share awareness and learning from the issue.

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

Overall we have rated well-led as good because:

- There was a vision and strategy for end of life care in place which had been based on national policy and local priorities. This was monitored for progress through reviews of action plans.
- Processes were in place to monitor risk management and quality issues which were documented in reports to commissioners and to the board and in service and quality meeting minutes.
- There was good leadership at local and service manager grade for end of life services. Leaders were appropriately skilled, knowledgeable and accessible.
- The culture was nurturing and positive and staff told us they felt supported. Throughout the organisation staff were passionate about providing good quality end of life care for patients and families.
- Patient and staff engagement took place in order share information and gather feedback which was used to inform the development of services.

However:

- There was lack of systems in place to specifically identify, review and monitor end of life quality measures and risks

Service vision and strategy

- Sirona had an end of life vision and strategy which was based on six national ambitions (National Palliative and End of Life Care Partnership, 2015-2020). The framework used originated from an external service and was viewed positively by the south west regional end of life group and local commissioners.
- We reviewed the end of life strategy which included assessment and action plans against the six ambitions. These included: individual care, fair, coordinated and equal access, maximising comfort and wellbeing, with educated and supported staff and communities. We saw ongoing audit was used to evidence progress against these ambitions. For example: the provision of equal access to bereavement resources was identified as a

target. Evidence documented as compliance for this included: the development of bereavement standards including for children and adults with learning disabilities.

- Whilst not all staff were familiar with all the details of the strategy, the principles and overarching core ambitions were demonstrated to be well understood.

Governance, risk management and quality measurement

- Systems and processes were in place to report and monitor risks reported as incidents. These were processed by Sirona's health and safety team. Incidents reported on Sirona's internal IT system automatically generated an alert email to the relevant clinical lead (to the incident reported), and the reporter's line manager. However it was the reporter's manager who was ultimately responsible for completing any necessary actions to mitigate risks and share learning.
- The end of life service lead was responsible for ensuring compliance with the CQC Regulations and overall risk management systems in accordance with Sirona's risk management policy. This included deciding the most appropriate forum for the discussion of risk management issues. This was dependent upon both the issue and the severity of the issue. In addition the service lead developed appropriate action plans and was responsible for escalating risks and other significant information to others and the board as appropriate.
- Improvements were required to some governance processes to maintain oversight of risk management and quality measures specific to end of life patients. This was because Sirona's systems had been set up to review risks relating to the clinical lead roles rather than by patient groups. For example; pressure ulcers were reported as incidents to the lead for pressure ulcers who maintained oversight of these in terms of risks. However, a patient with a pressure ulcer who was also an end of life patient would not be identifiable. Therefore there was no clear data relating to the number of risks or incidents specifically related to end of life patients.
- We saw records which showed end of life risks related to provision of quality standards had been RAG (red,

Are services well-led?

amber, green) rated. Appropriate actions and who was responsible for these were documented. For example: access to domiciliary end of life care (external) was reported as variable for both quality and availability. A meeting had been arranged with commissioners who agreed to review what alternative options might be available.

- The last reported serious incident which involved an end of life patient (January 2016) had related to pressure area care. A range of actions had been taken as a consequence of this incident, including staff training. However, the impact on the patient was potentially more significant than identified. As this had been an end of life patient, the emphasis would have been on control of pain and symptoms and maximising comfort. The addition of a pressure ulcer would have been contrary to this at the end of this patient's life.
- Discussion with two locality managers and one professional lead identified that a percentage of all pressure care risks routinely related to end of life care patients. However, the managers were not aware of the actual number. We were assured there were often justifiable reasons, related to consent and complex symptom management. However, for end of life patients' there was no process in place to capture this information and document the evidence and no governance processes in place to maintain oversight or review.
- Other quality measurement information was more effectively monitored, reviewed and evaluated. This included the quality and innovation targets (CQUINs) agreed with the local clinical commissioning groups. Quarterly reports included governance information related to audit, policy and staff training. Sirona's end of life strategy plans were also regularly reviewed for potential risk and quality issues. These were reported through to Sirona's operations and quality committee meeting and to the board.
- The organisations quality committee was responsible for ratification of guidance and policies regarding end of life and reported this information to the board. The lead for end of life also produced a six monthly update report which they presented at the quality committee. We looked at the report dated October 2016 and saw it provided updates on actions and progress with quality standards set with commissioners and the end of life strategy.

Leadership of this service

- There was good leadership at local and service level for end of life services. There was one lead end of life role at locality manager level. This person demonstrated they had appropriate skills, knowledge and experience of end of life services, commissioning and management to oversee the strategic planning and delivery of the service.
- There was an identified board lead who represented the end of life services. The end of life lead told us they felt listened to by the board and that issues and the strategy were understood.

Culture within this service

- We spoke with 67 staff in various roles and locations across Sirona services. Staff told us they were proud to work with Sirona because they said they knew patients received excellent end of life care. It was evident staff cared passionately that patients received care, wherever possible, on their own terms. We saw this culture and these attitudes were embedded service wide.
- Staff told us they felt supported in their roles, particularly with opportunities to access training in order to develop and advance practice skills.
- Local team managers and deputy and locality managers were reported to fully understand service pressures and were supportive and accessible to staff. We observed managers to be both professional and supportive to staff teams.

Public engagement

- Public opinion was sought and used in the development of services. Sirona worked in partnership with a community group to host an event during May 2016 to encourage more openness regarding end of life issues. More than 80 local people attended and feedback was positive. This event linked with Sirona's end of life strategy to build and support more compassionate communities and encourage end of life discussions. Plans were being discussed to facilitate other similar events.
- Sirona was in discussion with other community services in order to obtain regular feedback from bereaved families to inform judgements on the quality and development of services.
- We saw written information encouraging feedback was provided to patients. This included how to raise

Are services well-led?

concerns or complaints. This information was kept in care plans. There was evidence in district nursing teams and the community hospitals of numerous letters and cards expressing grateful thanks for the care provided.

Staff engagement

- An organisation wide staff survey was completed annually. The last staff feedback was during September 2016. The highest scoring area (78%) was staff feeling they made a difference to service users. The lowest score (61%) was for how staff rated their wellbeing at work.
- One of the roles of the end of life facilitator was to produce an end of life newsletter which was available on Sirona's intranet. We looked at the last newsletter dated May 2016. This contained national and local policy updates and training information. For example; the release of new national guidance for the clinical care of adults who are in last 2 to 3 days of life. Links were provided to direct staff on how to access this.
- Sirona produced a monthly newsletter which was circulated across the organisation. We looked at the newsletter dated October 2016 and saw it contained a range of information. For example: staff awards, health and safety information, staff survey results and learning and development information.

Innovation, improvement and sustainability

- The sustainability of the end of life services provided by the district nurses were monitored. We reviewed performance reports for the areas of South Gloucestershire and Bath and North East Somerset dated August 2016 and October 2016. These identified the district nursing services accepted all work referred and that the number of referrals had been increasing. This was recognised as a potential service risk and was being monitored and reviewed by the district nursing teams.
- We attended a district nursing team leaders' meeting during October 2016. Part of the agenda focused on the ongoing collation and analysis of 'Bridging the Gap' audit. This aimed to identify how and what additional work was being completed by the district nursing teams. This included providing personal care and help with domestic chores. The results of this would be discussed with commissioners.
- There was only one lead end of life post for the organisation and this person was responsible for the effective coordination of services and delivery of the strategy. While staff felt confident others would be able to continue with the end of life plans and strategy, there was no succession planning in place and there was a risk that if the one person left or was absent unexpectedly, the end of life service could become disjointed.