

South West Yorkshire Partnership NHS Foundation Trust

RXG

Community end of life care

Quality Report

Fieldhead
Ouchthorpe Lane
Wakefield
WF1 3SP
Tel: 01924 327000
<http://www.southwestyorkshire.nhs.uk>

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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)
RXGX5	Kendray Hospital		S70 3RD
RXG82	Mount Vernon Hospital		S70 4DP

This report describes our judgement of the quality of care provided within this core service by South West Yorkshire Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by South West Yorkshire Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of South West Yorkshire Partnership NHS Foundation Trust

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall we rated the trust as good for community end of life care services because:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Lessons were learned and communicated widely to support improvements.
- High performance within the service was recognised by credible external bodies.
- Staff in the community and on the wards of the community hospitals demonstrated a consistently good level of knowledge of end of life care issues.
- The palliative care team was multi-disciplinary with medical, nursing, social work, occupational therapy, physiotherapy and dietetic membership.
- The end of life care lead for the trust was also the end of life care lead for the locality and the trust had a significant role in contributing to the shaping of end of life care services.
- We saw that staff would find ways of making the experience of care as easy as possible for people and that there was a commitment to end of life care at all levels of the community service.
- 84% of patients known to the Specialist Palliative Care Team achieved their preferred place of care at the end of life.
- The integrated multidisciplinary model adopted by the palliative care service supported the development of responsive care packages in the community, including the management of a supportive care at home service.
- There was a clear vision, strategy and values for end of life care with well-defined objectives that were reviewed as part of a district end of life care steering group.
- We observed strong leadership from the Specialist Palliative Care Team (SPCT) and senior staff in the community.
- There was a commitment and culture for providing high quality end of life care that was patient focused.
- Innovation was apparent across the SPCT as a whole.
- The service proactively engaged staff and patients to ensure their views were heard and acted upon, including the use of volunteers to obtain patient and family feedback.

Summary of findings

Background to the service

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) provides end of life care services to a population of approximately 235,000 across Barnsley. End of life care is provided in the community in people's own homes, care homes and in two inpatient facilities located at Mount Vernon Hospital and Kendray Hospital. The trust's community inpatient units at Mount Vernon and Kendray hospitals provided a total of 70 inpatient beds. An end of life care team was operating within the trust, with a remit for promoting end of life care across the locality with specific regard to community and primary care teams. The team was led by the end of life care lead who had responsibility for end of life care within the trust and across the locality and day to day management responsibility for the specialist palliative care service within SWYPFT. In addition there was a practice educator with a remit for end of life care education across the Barnsley borough with two end of life care facilitators. One facilitator was based within the acute trust, the other in the community with a focus on care homes. There was a discharge liaison nurse employed by the trust as part of the team who was based in the acute trust with a remit for coordinating the rapid discharge of patients at the end of life who wished to die in the community.

The community specialist palliative care team consisted of 5.6 whole time equivalent (WTE) Macmillan nurse specialists (CNSs) who provided a seven day service. In addition the team included a 0.64 WTE dietitian, a 0.7 WTE physiotherapist, a 0.74 WTE occupational therapist and one WTE specialist social worker. A consultant in palliative medicine from the local hospice provided 2.5 sessions per week in the community on a flexible basis. The specialist palliative care team (SPCT) provided support and advice for patients with complex needs and

symptom management issues at the end of life. The trust run Marie Curie Supportive Care at Home service provided care and support to people at home with a life limiting illness who were in the last days of life. The team consisted of a WTE co-ordinator, 2.6 WTE staff nurses and 7.6 WTE healthcare assistants. A range of administrative support was also incorporated into the structure of the teams. Between April 2014 and March 2015 there had been 36 deaths across the community hospital sites. Between April 2014 and March 2015 there had been 875 referrals to the specialist palliative care team of which 84% were for patients with a cancer diagnosis. There had been 367 referrals to the supportive care at home team, of which 74% were for patients with a cancer diagnosis with the remaining 26% for patients with heart failure, respiratory conditions and dementia.

During our inspection we met with the specialist palliative care team, members of the end of life care team and members of the supportive care at home team. We visited both Mount Vernon and Kendray hospitals and went on home visits with district nurses and specialist nurses. We visited nine patients in their own homes where we observed care being delivered by district nurse's specialist nurses. We spoke with one patient being cared for in one of the community hospitals and in total we spoke with ten relatives. We spoke with the end of life care lead, the end of life educator, specialist palliative care nurses, a dietitian, occupational therapist, a social worker, the supportive care at home coordinator, district nurses, ward managers, ward nurses, healthcare assistants, service managers, matrons, porters, consultants and other medical staff. In total we spoke with 40 staff members. We looked at the records of eleven patients identified as receiving end of life care and 23 'do not attempt resuscitation' (DNACPR) forms.

Our inspection team

Chair: Peter Jarrett, Retired Medical Director

Head of Hospital Inspection: Jenny Wilkes, CQC

Team Leaders: Chris Watson, Inspection Manager, mental health services, CQC

Berry Rose, Inspection Manager, community health services, CQC

Summary of findings

The community end of life sub team included a CQC inspector and specialist advisers including a retired specialist palliative care nurse and a specialist adviser with a community matron and district nursing background.

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of patients' experiences 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?

The inspection team visited the specialist palliative care team, members of the end of life care team and members of the supportive care at home team. We also visited Mount Vernon and Kendray hospitals and went on home visits with district nurses and specialist nurses.

Prior to the inspection we reviewed a range of information that we held and asked other organisations to share what they knew about the trust. These included the clinical commissioning group, Health Education England, the General Medical Council, Local Authorities and local Healthwatch organisations.

During our inspection of end of life care services we spoke with 40 members of staff. We reviewed the records of 11 patients and reviewed 23 'do not attempt resuscitation' forms. We spoke with 10 patients and 10 relatives. We also interviewed key members of staff and held focus groups with various staff groups.

We undertook the announced inspection visit between 7 and 11 March 2016.

What people who use the provider say

We spoke with a total of ten patients, nine in the community and one in a community inpatient ward. In addition we spoke with ten relatives in the community. People who used the service and their families said;

- "I'm very happy. I don't know what I would have done without them".
- "Nothing is too much trouble".
- "I'm thrilled to have their support."
- "I am in a really good place and feel confident caring for him with the support I am getting."
- "Staff are wonderful. Nothing is too much trouble."

Good practice

The trust were found to be outstanding in providing effective end of life care services because;

Summary of findings

- The palliative care team were runners up in the 2015 International Journal of Palliative Nursing Multidisciplinary Teamwork Award for their oral hygiene steering group.
 - The continuing development of staff skills, competence and knowledge was seen as a priority and the service had developed a range of comprehensive training courses for staff at all levels.
 - Staff we spoke with in the community and on the wards of the community hospitals demonstrated a consistently high knowledge of end of life care issues.
 - The palliative care team was multi-disciplinary with medical, nursing, social work, occupational therapy, physiotherapy and dietetic membership. Staff, teams and services were committed to working collaboratively and found innovative and efficient ways to deliver more joined up care to people who use the service.
 - The end of life care lead for the trust was also the end of life care lead for the Barnsley District locality.” This meant that the trust had a significant role in contributing to the strategic shaping of end of life care services. We saw evidence of this in representative membership on locality groups including co-chair for the end of life commissioner steering group.
- Other areas of outstanding practice included;
- The supportive care at home service which was managed by the trust recorded the preferred place of care on the end of life care plan and 84% of patients achieved their preferred place of care at the end of life. Where preferred place of care was not achieved the reasons for this were explored and lessons were learnt.
 - The end of life/specialist palliative care team had worked with learning disability services to develop a more creative approach to communication with patients around advance care planning at the end of life.
 - A volunteer service had been developed in 2015 and based with the team to support the community palliative care service to obtain independent service user feedback in the form of telephone surveys.

Areas for improvement

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

- The trust should ensure measurable improvements are demonstrated in relation to improving specialist support for patients with long term conditions at the end of life.

South West Yorkshire Partnership NHS Foundation Trust

Community end of life care

Detailed findings from this inspection

Good 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as good because;

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Incidents involving patients at the end of life were reported and reviewed by the end of life care clinical lead. Lessons were learned and communicated widely to support improvements.
- Medicines were generally managed safely in relation to end of life care, including the use of “just in case” anticipatory medication to support the management of symptoms quickly and effectively in the community.
- Equipment used in end of life care was monitored and maintained, including the use of syringe drivers. Nursing staff attended annual syringe driver training updates.
- Systems were in place to protect people in vulnerable circumstances from abuse. Staff were knowledgeable about their roles and responsibilities in relation to ensuring vulnerable adults and children were safeguarded.

- Staff were aware of their responsibility in relation to duty of candour and being open with patients and their relatives when incidents occurred.
- We found that the standard of record keeping was high.

Safety performance

- A range of safety performance was being monitored over time. For example we saw that safety thermometer information was reported by each inpatient ward and community nursing services every month. The trust used the NHS Safety Thermometer to measure harm free care delivered to patients. The overall rate of harm free care across the trust between October 2014 and October 2015 was 97.4%.
- Safety performance data included information relating to urinary tract infections, falls and pressure ulcer prevention.
- There had been no never events between November 2014 and December 2015. Never Events are serious incidents that are wholly preventable.

Are services safe?

Incident reporting, learning and improvement

- There were no serious incidents reported for these services between 30 June 2014 and 19 September 2015.
- Staff delivering end of life care understood their responsibilities with regard to reporting incidents. Staff told us that when an incident occurred it would be recorded on an electronic system for reporting incidents.
- In total we viewed 19 incidents relating to patients at the end of life between February 2015 and February 2016. In all cases we saw that these had been investigated and that lessons learned had been communicated and cascaded appropriately.
- The end of life lead told us they were informed of all end of life care related incidents and involved in the analysis and review. Examples of incidents we were informed of included medicine or prescribing errors, incomplete documentation and safeguarding concerns. We reviewed an incident report where a patient with an industrial disease had died and there were confusions about verification of death and the need for a post mortem. Action taken following the incident included a full investigation and resulted in changes to policies and procedures and improvements in sharing information in the patient records kept at home. Information was also shared at relevant training sessions and staff meetings to ensure changes to the way staff worked was cascaded and lessons learnt were shared.
- Incidents were investigated with the involvement of relevant staff and we saw that they were given time to reflect and learn. Staff told us they were involved in discussions about incidents, risks and complaints were discussed and they were encouraged to reflect and learn.
- In particular staff told us they were given the opportunity to discuss and reflect as a team on the care of patients following death.

Duty of candour

- The duty of candour regulation was introduced in November 2014. This regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm.

- Staff were aware of their responsibility in relation to duty of candour and being open with patients and their relatives when incidents occurred. We saw that the incident reporting forms used included a section on the duty of candour and staff consistently told us that patients/relatives were kept informed when incidents occurred.

Safeguarding

- Systems were in place to protect people in vulnerable circumstances from abuse. Staff were knowledgeable about their roles and responsibilities in relation to ensuring vulnerable adults and children were safeguarded. Staff understood what constituted a safeguarding concern and we observed staff discussing safeguarding in handovers.
- 100% of the members of the palliative and end of life care teams for the community had attended safeguarding training relevant to their role in relation to both adult and children's safeguarding (level one and two).
- There have been no safeguarding alerts or concerns raised with the CQC for these services.
- We viewed records of safeguarding concerns being recorded using the electronic reporting procedure and saw that concerns were discussed with the safeguarding lead within the trust. Examples included where staff had reported issues relating to family concerns or where a patient's lack of mental capacity had caused concern.

Medicines

- Medicines in the community hospitals were stored safely.
- Inpatients and community patients who were identified as requiring end of life care were prescribed anticipatory medicines. Anticipatory medicines are 'as required' medicines that are prescribed in advance to ensure prompt management of increases in pain and other symptoms.
- We visited nine patients in the community who had anticipatory medicines prescribed and these were available and stored safely in their home for when they were required.
- The trust had produced guidelines for medical staff to follow when prescribing anticipatory medicines

Are services safe?

together with the local hospice and acute NHS trust and these were incorporated into end of life care documentation. The 2014 – 2017 Palliative Care Formulary included pain and symptom management guidance, pre-emptive prescribing, the use of syringe drivers and guidance on core medicines stocked in local pharmacies for use at the end of life.

- Prescriptions and administration records we looked at in the community were completed accurately and clearly.
- Controlled drugs (medicines controlled under the Misuse of Drugs legislation and subsequent amendments) were stored securely with appropriate records kept.

Environment and equipment

- Inpatient and community services had access to appropriate equipment to keep people safe and comfortable.
- District nurses told us they were able to access equipment for patients at the end of life in the community. This included syringe drivers as well as other types of equipment to enable them to care for people safely in their homes.
- There was an occupational therapist (OT) as part of the specialist palliative care team who carried out assessments for equipment for patients at the end of life in the community. The OT told us there was no waiting list and that all patients would be seen within a week and within 24 hours if they were in the last days of life. There was a community equipment store available and staff consistently told us they could access equipment within hours for patients at the end of life.
- Staff told us that equipment was accessible within a few hours for patients at the end of life who were being discharged from hospital via the fast track route.
- There was a body store at Mount Vernon community hospital but no body store at Kendray hospital. The body store was temperature controlled and monitored with an alarm that would alert staff to temperature changes. We saw that appropriate equipment was available including a hydraulic trolley. Porters were responsible for transferring the deceased during the day and a contracted funeral director was available out of

hours. The deceased from Kendray hospital would be transferred to the body store at Mount Vernon. Staff told us this system worked efficiently and they had not experienced delays in collecting deceased patients.

Quality of records

- Community nurses used an electronic record system that enabled sharing of patient information within the team and with other health care professionals. Staff told us that the majority of GPs in the locality also used the same system but that where they did not, regular recorded updates were shared.
- We viewed 11 care records of patients considered to be at the end of life. We found that the standard of record keeping was high. Risk assessments and individual care plans were in place.
- When a patient was identified as nearing the end of life, a care record known as 'my care plan' was commenced. All of the 11 care records we viewed were completed appropriately, accurately and legibly.
- We viewed 23 'do not attempt cardiopulmonary resuscitation' (DNACPR) records. Twenty two of these records were completed appropriately. For example, they contained clearly documented decisions with reasoning and clinical information, were dated and signed, and included a record of discussions with the patient and their family as appropriate.
- Syringe driver monitoring forms were completed where patients were receiving medicines via a syringe driver. These forms included a record of the amount of medicine being administered and also a check of the pump and the site of the infusion.
- We viewed a mortuary register in use in the body store at Mount Vernon hospital. This included clear records of the patients who had died and there were measures in place to distinguish patients with similar names, although staff told us this had not happened.
- The specialist palliative care team used an electronic patient record which required staff to complete records at the end of the working day back at their base. The team had consistently achieved a 24 hour contemporaneous record keeping standard of 90 – 100% during 2014/15. Staff had been involved in planning for a new agile working approach and there

Are services safe?

were training sessions planned to begin this process. This included the use of agile devices so that staff would not have to return to a single base to complete their records at the end of the day.

Cleanliness, infection control and hygiene

- Infection control information was visible in all ward and patient areas. Hand washing and sanitising facilities were available and well signposted.
- Wards and patient areas were visibly clean. We observed staff wash their hands, use hand gel between patients and comply with 'bare below the elbows' policies.
- We saw staff use person protective equipment (PPE) when caring for patients and we observed the use of 'I am clean stickers' on equipment.
- We observed good infection prevention and control practices carried out in the body store at Mount Vernon hospital.

Mandatory training

- The average mandatory training rate for this core service was 96%. This was above the trust target of 80%.
- Mandatory training was provided for all staff and the type and level of training was identified as part of individual job roles. Members of the end of life and specialist palliative care teams had undertaken training in areas such as infection control, resuscitation, infection control, and fire safety and information governance.
- Syringe driver training was mandatory for nursing staff in the community and working in the community hospitals.
- The end of life care team had produced a training DVD that was available for staff in local care homes, instructing them on how to set up and effectively monitor a syringe driver.

Assessing and responding to patient risk

- Staff assessed and managed patient risk as part of an on-going holistic assessment process. We observed good use of general risk assessments for patients receiving end of life care. This included the assessment of risk in relation to nutrition and hydration, falls and the potential for pressure area damage.

- Changes to a patient's condition were recorded in their daily notes by nursing, medical and therapy staff. Advice and support from the SPCT regarding deteriorating patients was available.
- Specialist palliative care was provided from 9am to 5pm seven days a week. Out of hours, and at the weekend, end of life care was provided by general community and inpatient staff who could access specialist support from the hospice including consultant input. Staff could also access a specialist palliative care telephone advice line for health care professionals via the local hospice.
- We observed a handover in the community where patient risk was discussed, in particular around safeguarding issues and deteriorating conditions. Staff told us that discussions around risk and safety were held at all handovers and we saw that this included when handing over to out of hours teams.
- National Early Warning System (NEWS) scores (assessment of respiratory rate, oxygen saturations, temperature, blood pressure, pulse rate, and level of consciousness) and pain assessments were documented.
- We spoke with relatives who were aware of how to access help and support should a patient's condition deteriorate in situations where they were being cared for at home. This included access out of hours. One family we spoke with told us they had called staff when the patient was in pain and the staff had responded quickly and efficiently.

Staffing levels and caseload

- The total number of substantive staff for specialist palliative and end of life care was 27.8 with the total number of substantive staff leavers in the last 12 months being 2.2. The total percentage vacancies overall (excluding seconded staff) was 2.3% with a total of 5.1% permanent staff sickness overall. There were 15.09 whole time equivalent (WTE) qualified nurses and 10.86 (WTE) nursing assistants. There were no qualified nurse vacancies and 1.06 WTE nursing assistants between 1 November 2014 and 31 October 2015.

Are services safe?

- There were 10.5 WTE staff as part of the specialist palliative care team. This included 5.6 WTE Clinical Nurse Specialists (CNS) for the community and 1.6 CNS covering care homes and SWYPFT Barnsley inpatient areas.
- Allied healthcare professionals within the specialist palliative care team included a specialist dietitian (0.64 WTE), a specialist physiotherapist (0.7 WTE), a specialist occupational therapist (0.74 WTE) and a specialist social worker (1.0 WTE).
- Palliative medicine consultant sessions were provided on a flexible basis which totalled 2.5 sessions per week via the local hospice. Each consultant session equated to a half day.
- The end of life care team was commissioned to work with all health and social care providers in Barnsley; to lead and support the development of high quality end of life care irrespective of diagnosis. This involved developing and supporting care pathways across the whole system and providing education and clinically based support to staff. The team consisted of an end of

life care lead (who was also lead for the specialist palliative care service), a practice educator, 1.4 WTE end of life care facilitator and an end of life care discharge liaison sister based at the acute trust.

- The supportive care at home service provided care and support to those with advanced life limiting illness and who were in the last days of life and also gave respite support when difficulties were being experienced and caused an extra strain on patients' home situation. Staff consisted of one WTE co-ordinator, 2.6 WTE registered nurses, 7.6 healthcare assistants and 1.6 WTE administrators.

Managing anticipated risks

- Patient risk assessment and screening tools were in use including those to assess nutritional risk, falls risk and risks to deteriorating health.
- Staff told us that major incident and winter management plans were in place.
- Emergency equipment was available on the community inpatient units at all of the community hospitals we visited.



Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

We rated effective as outstanding because;

- Staff were actively engaged in activities to monitor and improve quality and outcomes. High performance was recognised by credible external bodies. For example, the palliative care team were runners up in the 2015 International Journal of Palliative Nursing Multidisciplinary Teamwork Award for their oral hygiene steering group.
- The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high quality care and the end of life care team had worked to develop a range of comprehensive training courses for staff at all levels.
- Staff we spoke with in the community and on the wards of the community hospitals demonstrated a consistently good level of knowledge of end of life care issues.
- The palliative care team was multi-disciplinary with medical, nursing, social work, occupational therapy, physiotherapy and dietetic membership. Staff, teams and services were committed to working collaboratively and found innovative and efficient ways to deliver more joined up care to people who use the service.
- There was a dedicated dietician as part of the specialist palliative care multi-disciplinary team. The dietician provided awareness and support to families and patients about nutritional needs at the end of life. Between April 2014 and March 2015, 84% of patients died in their preferred place of care.
- The end of life care lead for the trust was also the end of life care lead for the Barnsley locality. This meant that the trust had a significant role in contributing to the shaping of end of life care services. Between April 2014 and March 2015, 84% of patients died in their preferred place of care.
- The end of life care lead for the trust was also the end of life care lead for the locality. This meant that the trust had a significant role in contributing to the shaping of end of life care services

Evidence based care and treatment

- End of life care was delivered in the community using guidance based on the Leadership Alliance's Five Priorities of Care for the Dying Person (June 2014).
- The end of life care team had developed, and was using, an end of life care plan titled 'My Care Plan' for patients at the end of life. This had been implemented in response to the national withdrawal of the Liverpool Care Pathway (LCP) in July 2014.
- The end of life care plan was based on national guidance including the Five Priorities of Care (Leadership Alliance) and NICE QS13 Quality Standards for End of Life Care for Adults (2011).
- The Gold Standards Framework (GSF) was in use to support the development of good quality end of life care in the community. The GSF is a model that enables good practice in the care of patients at the end of life. Specialist palliative care nurses would attend regular palliative care meetings with GPs and community nursing teams. The framework was used to help staff identify the needs of patients at each stage of their care through detailed assessment. We observed the GSF in use throughout the community and saw that this was used as a tool to assess and identify where patients were in relation to the last year or the last days of life.
- We viewed end of life and palliative care meeting minutes, which showed that updated NICE (National Institute for Health and Care Excellence) guidance was discussed.
- Audits carried out included advance care planning, declined referrals, caseload audits and audits of telephone advice given by the specialist palliative care team.

Pain relief

- There were tools available to assess and monitor pain and we saw these consistently in use both in patient's homes and in the community hospitals.



Are services effective?

- Patients told us their pain was well managed and that staff were quick to respond to requests for additional medicines when pain occurred.
- We observed nursing staff assessing patients' pain levels in the community and saw that they assessed the type and duration of pain as well as factors that made the pain better or worse.
- Where appropriate patients had syringe drivers which delivered measured doses of medicines at pre-set times. All qualified nursing staff were trained in the use of syringe drivers.
- Staff told us there were adequate stocks of appropriate medicines for end of life care and that these were available as needed both during the day and out of hours.
- Anticipatory medicines were available in community hospitals and in patients homes where it had been identified they may require medicines to manage their symptoms quickly in the near future. Community staff told us getting anticipatory medicines prescribed was relatively straightforward and advice was available from the specialist palliative care team where five of the CNS were trained non-medical prescribers.

Nutrition and hydration

- Nutrition and hydration needs at the end of life were identified as part of the last days of life 'My Care Plan'. Assessments incorporated patient choice and comfort and we saw that guidance was based on an individual's ability to tolerate food and drink.
- Patients and family told us they had access to food and drink in community hospitals as and when they wanted it. Staff were able to speak with catering staff and request food that patients wanted.
- We observed community nurses asking patients about their food and drink intake as part of their daily assessment when attending to renew a patient's syringe driver. This included asking the patient and their family about their appetite and any symptoms they were experiencing that may impact on their ability to tolerate food and fluids.
- There was a dedicated dietician as part of the specialist palliative care multi-disciplinary team. They told us they would regularly meet with patients, relatives and staff to

discuss nutritional needs at the end of life and we saw evidence of this in the patient records we viewed. One example of this was a patient whose family were concerned about them not eating in the last days of life. The dietician told us they had been able to provide education for the family around the nutritional needs changing as the patient's condition deteriorated.

- Speech and language therapy (SALT) input was observed for patients experiencing difficulties swallowing and we saw that while there was no dedicated SALT within the specialist palliative care team there were contracted hours included. This meant that patients in the last months or weeks of life could be prioritised. We saw one patient being assessed within 48 hours of a referral.
- Staff told us that all nursing and healthcare staff on the inpatient wards in the community hospitals would attend training in oral care at the end of life delivered by the specialist palliative/end of life care team. On ward five at Mount Vernon we saw that 84% of staff had attended this training and that further sessions were planned for the remaining staff.

Patient outcomes

- The end of life care team had undertaken a community snapshot audit of caseloads and care homes around Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and advance care planning. The results of this had led to an increased roll out of advance care planning education and the development of a 'planning my future' template on the electronic record system both in the community and in care homes.
- A baseline audit of oral hygiene at the end of life, carried out in 2012 demonstrated inconsistencies in how this was being managed. The specialist palliative care team developed educational tools as a result, using picture guides for use by healthcare workers and also guides for families caring for a loved one at home. This work had resulted in the trust being recognised for their work as runners up in the 2015 International Journal of Palliative Nursing Multidisciplinary Teamwork Award. The team was in the process of applying for research funding to extend this work at the time of our inspection.
- Key outcomes for the specialist palliative care and end of life care service were; optimising a person's quality of life when they have an advancing life limiting illness; to



Are services effective?

help the person and their family to adapt to and live with their illness and treatment; to support a person to die in their preferred place of care; to provide highest possible quality of care; to provide support and education to the wider generalist team both formally and informally. Specific examples of performance against these targets was the delivery of 'priorities of care' training to generalist staff where 77% of district nurses had attended, 62% of registered nurses at Mount Vernon Hospital and 100% of doctors at Mount Vernon Hospital. In addition, the team were performing well in supporting patients to die in their preferred place of care with 84% of patients achieving this. The service was working to improve how it measured performance against key outcomes.

- The trust was working with other services in the locality to develop outcome measures based on phase of illness. This project was about to be piloted within the local hospice and staff told us there were plans to roll this out across the community end of life care services in the summer of 2016.
- The service worked with volunteers to gain feedback from carers in the community about the specialist palliative care service. This was compiled into an annual report that was then cascaded to the team and improvements made. Specific action taken in the last year included improving information available on how to access services out of hours.

Competent staff

- The percentage of non-medical staff that have had an appraisal in the last 12 months was 100%.
- Seven of the Eight CNS in the specialist palliative care team had a degree in supportive and palliative care and five were non-medical prescribers. The team aimed for all CNS to be non-medical prescribers. All were trained in advanced communication skills.
- Members of the end of life care team were trained in leadership and management or education and they had a remit to support end of life care across all service providers in Barnsley including acute NHS and care home providers.
- End of life care training and education was available to staff in line with the guidance from the National End of Life Care Strategy.
- Registered staff were able to access a one day 'making a difference' end of life care course and a one day

'symptom management' course. Evaluation reports of these courses included comments stating that they had helped to improve planning at the end of life and that staff were more confident and less likely to shy away from conversations at the end of life.

- Non registered staff were able to access a two day 'foundations in end of life care' course. Evaluation reports of this course included comments stating that staff felt more confident in talking to patients and families and that their knowledge and skills had increased.
- The end of life care team also provided training for staff on the use of 'my care plan' for patients in the last days of life. We saw that 86% of registered nurses on ward five at Mount Vernon community hospital had attended the 'making a difference' course and that 86% had also been trained in the use of 'my care plan'. In addition 57% of registered nurses on ward five had attended symptom management training. 70% of non-registered staff on ward five at Mount Vernon had attended the 'foundations in end of life care' course. Overall 31% of district nursing staff had attended end of life/symptom management training in addition to the 'my care plan' priorities of care training that 77% of district nurses had attended. 27% of registered nurses and 19% of non-registered care staff at Mount Vernon Hospital had attended end of life/symptom management training in addition to the priorities of care training that 62% of registered nurses had attended. 50% of doctors at Mount Vernon Hospital had attended end of life care/symptom management training.
- Each ward in the community hospitals had a link nurse specifically for end of life care. Bi-monthly meetings were held and attended by the specialist palliative care consultant and CNS and hospital based medical staff. We viewed minutes of meetings and saw that current issues were discussed, including issues around symptom management, advance care planning, oral hygiene and DNACPR.
- Staff we spoke with in the community and on the wards of the community hospitals demonstrated a consistently high knowledge of end of life care issues. For example all had a good awareness of the five priorities of care at the end of life and the use of 'my care plan'. In addition, many staff we spoke with



Are services effective?

confirmed they had attended end of life care training and had developed their knowledge and confidence as a result. This included staff nurses, ward managers and healthcare assistants.

Multi-disciplinary working and coordinated care pathways

- We observed excellent multi-disciplinary team (MDT) working between all staff we met. There was a high standard of collaborative working between community, acute and multi-disciplinary services.
- The end of life care lead was responsible for the management of both the end of life and palliative care services and had the end of life leadership role across the district in the form of managing the end of life care team across a variety of services and chairing the district clinical steering group and involvement in the CCG clinical transformation group.
- The end of life care team included a practice educator, end of life care facilitators and a discharge liaison nurse who was based in the local acute NHS trust. The end of life team worked across all services in the Barnsley region and had a remit to improve end of life care service provision beyond their own organisation.
- The end of life care lead told us that the palliative care MDT working had been established for over 10 years and this was enhanced following the 2009 strategy by the development of the EOLC team. As such this was a multidisciplinary team that included nursing, medical, physiotherapy, social work, occupational therapy and dietetic members. We were told that a speech and language therapist (SALT) had also been included in the team until recently but that these hours were now contracted with the SALT service due to the small number of hours required.
- The specialist palliative care team met on a daily basis to discuss caseloads and individual patients where there were concerns. They would undertake joint visits where appropriate. Members of the team told us that the multi-disciplinary model worked well and they were able to provide a 'seamless and person centred service'. The allied healthcare professionals told us they worked in tandem with palliative nursing colleagues and were able to ensure the most appropriate professional was

available for the patient and their family. One member of the team told us they thought the service had grown from strength to strength over the ten years since the MDT model had been developed.

- From January 2010 the specialist palliative care team provided a seven day specialist nursing service.
- The MDT met across the locality on a weekly basis across both community and acute services.. There was a bi-monthly community hospital MDT held at Mount Vernon hospital with representation from the specialist palliative care team.
- The end of life care steering group included members from other services within the trust; for example senior staff and specialists from elderly care and respiratory services.
- There was a clear pathway for transfer from hospital to community and evidence that the MDT approach to coordinating care was robust. For example, the team used a single assessment proforma that could be completed by any member of the team. New patients were allocated to team members on a daily basis following referral so that the most appropriate team member could carry out the assessment based on the patient need.

Referral, transfer, discharge and transition

- Patients were referred and transferred appropriately for end of life care and to their preferred place of death.
- There was a clear pathway for referral to the specialist palliative care service and the team monitored and audited referrals to identify how patients were being referred, the appropriateness of referral and the outcome of referral.
- We saw evidence of good multi-disciplinary working between services to ensure appropriate and timely transfer, discharge and transition. Staff we spoke with consistently told us that patients could be supported at home very quickly in the last days of life where they wanted to be transferred from hospital.
- As part of the trust's end of life care team there was a discharge liaison nurse based at the local acute trust. This post was managed and coordinated by the end of life care lead. Their role was to coordinate the discharge of patients wishing to leave hospital and die at home.



Are services effective?

Figures from the trust showed that only 16% of patients being supported by the specialist palliative/end of life care teams died in an acute hospital between April 2014 and March 2015.

- Between April 2014 and March 2015, 84% of patients died in their preferred place of care.
- The Supportive Care at Home service was set up with charitable funds twenty years ago but now managed by the trust. The service was fully integrated as part of the end of life/specialist palliative care service and staff consistently told us that patients wishing to go home to die could access this service quickly and as an addition to social care packages at home.

Access to information

- We saw that risk assessments and care plans were in place for patients at the end of life. Patients were cared for using relevant plans of care to meet their individual needs.
- Once a patient had been identified as being in the last days of life staff would use the 'my care plan' document. This guidance incorporated prompts for staff to assess patient symptoms, identify advance decisions, discuss spiritual needs and agree options regarding hydration and feeding.
- In the community paper records were kept in patient's homes and these were kept up to date during the visits we observed.
- A local, Barnsley wide website for end of life care had been developed with the CCG. This provided information and advice for patients, carers and professionals on end of life care issues. Content included bereavement support, benefits advice and an education element that professionals could log onto.

- GPs were kept informed about end of life care issues relating to individual patients by the use of phone calls and a shared electronic record system. Where a GP did not have access to the same electronic record system information was sent in the form of letters. Plans were in progress to develop the EPaCCS electronic system across the locality.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We saw that mental capacity act and deprivation of liberty safeguards information was incorporated into the documentation for use when caring for patients at the end of life. This included prompts for staff to remind them of the need to presume mental capacity or undertake an assessment if capacity was in doubt.
- We saw evidence of mental capacity assessments and deprivation of liberty safeguards in place.
- Members of the specialist palliative care team confirmed they had attended training in the mental capacity act and they told us that the social worker on the team was a best interest assessor and a good resource for support should they need it.
- We viewed the do not attempt cardiopulmonary resuscitation (DNACPR) records of seven patients who had been identified as lacking mental capacity. In all cases we saw that assessments had been undertaken and that there was evidence of decisions having been made in the patients' best interests and with involvement of those close to them.

Are services caring?

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

Summary

We rated caring as good because;

- Patients and their relatives spoke positively about the care they received in the community.
- We observed interactions between staff and patients and saw that these were kind, caring and compassionate.
- Relatives we spoke with told us staff would spend time supporting them alongside the patient and that they demonstrated a good deal of care and compassion.
- Staff were seen to treat patients and relatives with dignity and respect in all interactions.
- We saw that staff would find ways of making the experience of care as easy as possible for people and that there was a commitment to end of life care at all levels of the community service.

Compassionate care

- Patients were treated with dignity, kindness and compassion. Patients and relatives we spoke with told us that staff were professional, supportive and kind. We observed care being provided and saw that patients were treated with compassion, dignity and respect.
- We observed staff caring for patients in a way that respected their individual choices and beliefs and we saw that records included sections to record patient choices and beliefs so that these were widely communicated between the teams.
- All patients and relatives told us they were highly satisfied with the quality of care they received and that staff treated them with respect and maintained their dignity.
- We heard stories of situations where staff had gone the extra mile to support patients. For example, one member of the supportive care at home service told us that a patient had asked them to pray with them. The staff member told us that when they got home they downloaded some hymns so that when they visited the patient at home the following day they could play the hymns while praying with them.

- Specific feedback included a relative who told us that the support they had received from staff ensured they were in a good place and better able to care for their loved one at home. A patient told us did not know what they would have done without the support given to them and how nothing was too much trouble for the staff.

Understanding and involvement of patients and those close to them

- All patients and family members told us they felt involved with the care delivered.
- We saw that staff discussed care issues with patients and relatives and these were clearly documented in patient's notes.
- The 'my care plan' last days of life document used by the trust included prompts for discussing issues of care with patients and relatives.
- The Gold Standards Framework (GSF) model was widely used in the community for patients in the last year of life. The GSF was designed to help involve people in the planning of their care.

Emotional support

- Staff told us they felt they generally had the time to spend with patients and provide the emotional support to meet their needs.
- We observed community nurses assessing people's emotional needs as a matter of routine when visiting them at home.
- Support was available from chaplaincy and psychology teams and staff told us this was readily available to patients and their relatives at the end of life.
- Bereavement support was provided to patients by nursing staff in the community and inpatient wards. Specialist palliative care nurses had all been trained in advanced communication and could also provide bereavement support. The specialist palliative care social worker on the team was available to provide psychological support to patients and their relatives at the end of life.

Are services caring?

- In addition we were given examples of where the social worker had worked with families to prepare them for the end of life. For example, with children undertaking pre-bereavement work.

Are services responsive to people's needs?

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

Summary

We rated responsive as good because;

- Staff we spoke with consistently told us that end of life and palliative care specialists were responsive to their needs in the community, including being quickly available to provide support to community nursing staff around complex care management.
- Preferred place of care was recorded on the end of life care plan and 84% of patients achieved their preferred place of care at the end of life. Where preferred place of care was not achieved the reasons for this were explored and lessons were learnt.
- The integrated multidisciplinary model adopted by the palliative care service supported the development of responsive care packages in the community, including the management of a supportive care at home service.
- There was evidence of planning and delivering services which meet people's needs, including patients at the end of life with conditions other than cancer. However, the data showed that referrals to the specialist palliative care service for patients with long term conditions was low (16%).

Planning and delivering services which meet people's needs

- Services were planned and delivered to meet the needs of patients and their relatives. Staff told us a priority was to ensure that patients were cared for in their preferred place of death wherever possible.
- The end of life and palliative care services were designed to meet the needs of a local population of 235,000 people. Demographic data was taken account of in the development of a local end of life care strategy.
- There was a local end of life care steering group which was chaired by the trust's end of life care lead. Involvement in the steering group included representatives from other specialist areas including elderly care and respiratory specialities.

- Key priorities included the development of end of life care services for people with different conditions and working to promote preferred place of care at the end of life.
- We saw that the end of life team were involved in specific projects to improve the care of patients with conditions other than cancer, including an involvement in local research around the care of patients with COPD (chronic obstructive pulmonary disease).
- Of the 875 referrals to the specialist palliative care service between April 2014 and March 2015, 84% were for patients with a cancer diagnosis. The end of life care lead and consultant in palliative medicine told us they thought this figure did not fully capture the work they did with patients with a non-cancer diagnosis as they would not necessarily case manage patients in that situation. For example, if a patient with a respiratory diagnosis had a complex symptom management issue they would support the respiratory team to manage their care rather than taking it on. This would involve telephone advice and one off visits to assess needs.
- Of the 367 referrals to the supportive care at home team 74% were referrals for patients with cancer. Of the remaining 26% the three main conditions of those referred were respiratory, heart failure and dementia.
- The end of life care service had undertaken a snap shot audit of patients' preferred place of care at the end of life. Of 194 deaths, 110 had a recorded preferred place of care. Of these 84% had achieved their preferred place of care at the end of life. The end of life care team had analysed the data of the remaining 16% to review the reasons for them not having achieved their preferred place of care. Staff told us they were looking at ways of monitoring the data in an ongoing way.
- We were told of a number of situations where staff had been able to ensure patients were cared for in their preferred place and where staff continued to monitor patient's preferences in relation to this. CCG data collated as part of the end of life care strategy for the locality demonstrated that more people were dying at home and that less people were dying in hospital in the Barnsley district.

Are services responsive to people's needs?

- Where possible patients at the end of life in community hospitals were cared for in side rooms.
- Facilities were in place for families, including quiet rooms, reclining chairs and comfort packs. At Mount Vernon hospital there was a family room that provided a peaceful, relaxing space for the families of patients at the end of life.
- The end of life care team had published end of life care advice and guidance for relatives and carers. In addition there was a bereavement support leaflet available as a hard copy and on the trust website.
- Staff told us they could access support and advice from the trust's learning disability nurse or the community dementia services. We were told of one example where the specialist palliative care nurse did a joint visit with the specialist learning disability practitioner.
- We viewed case studies relating to preferred priorities for care project that the end of life care team were involved in. This project was specifically designed to improve communication around end of life care issues for people with sensory and physical disabilities, learning disabilities and poor cognitive function. The end of life care team worked with other specialist services to develop an approach using creative communication to enable patients to influence their care in relation to what matters to them at the end of their life.

Equality and diversity

- All members of the palliative and end of life care teams had attended equality and diversity training and the team were 100% compliant in this area.
- Patients receiving end of life and palliative care were treated as individuals.
- The trust's chaplaincy team provided comfort and support to people in hospitals across the trust. The chaplains visited patients on hospital wards and in quiet spaces away from clinical areas. The chaplaincy team had strong links with the leaders of local churches and faith communities and churches.
- The chapel at Mount Vernon Hospital had mainly Christian symbols which reflected the local population. There was access to Muslim prayer mats and a quiet room for those not wishing to use the chapel at Mount Vernon hospital.
- Advance care planning was a key part of end of life care and we saw that this was prioritised in terms of training delivered to generalist staff and also in terms of the development of tools and templates that were available as part of the team's electronic record system.
- Staff told us they were able to access translation and interpreting services if required.
- Comfort care packs which contained toiletries were given to families and carers staying overnight with patients at the community hospitals. The palliative care team also had access to packs that could be taken into patients' homes in the community.

Meeting the needs of people in vulnerable circumstances

- Personalised care plans were used to plan care for patients at the end of life. A priority for the trust was to develop good quality end of life care based on the wishes and preferences of the individual and to improve care for patients in the community. This included support to people in vulnerable circumstances. For example, the end of life care team worked to improve end of life care education in local care homes for patients living in supported environments. This included patients with dementia.
- All specialist palliative care team referrals were assessed in the morning referral meeting and were prioritised from the information provided and response requested. The specialist palliative care team aimed to respond to all urgent referrals within 24 hours and all non-urgent referrals within 48 hours (excluding weekends). Data showed that 92% of patients were seen within the allotted time.
- Referrals were prioritised based on assessed patient need. Staff on the community in-patient wards and district nurses in the community told us that if a patient required urgent review the community palliative care team would respond very quickly.
- Patients we spoke with told us staff were responsive to their needs. One family told us that when their loved

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one had been in pain while at home they had called the district nursing team and staff had been with them very quickly. Patients on the community wards told us that staff were quick to provide support.

- The specialist palliative care service had commenced as a seven day service in January 2010. General nursing staff we spoke with were aware of this and knew how to contact the team at weekends.
- The end of life care team included a discharge liaison nurse and end of life care facilitator who were based at the acute NHS trust but managed within the SWYPFT team under the management of the end of life care lead. Staff told us this enabled more collaborative working around ensuring patients could be cared for in the most appropriate place in relation to their needs and their wishes and enabled staff to communicate more effectively.
- The supportive care at home service operated over twenty four hours a day, seven days a week, providing day time and overnight stays. The team included three qualified nurses, eleven health care assistants and a secretary and worked closely with other health and social care professionals.
- The supportive care at home team worked annualised hours. This meant that staff were available to work at short notice and be more flexible in order to meet the needs of patients requiring additional support at home at the end of life.
- There had been 289 referrals to the supportive care at home team between April 2015 and February 2016. The provision of a registered nurse to provide overnight stays was particularly useful when caring for patients at home with complex symptom management concerns.
- During 2014/2015 the supportive care at home service received additional funding and participated in a pilot working with Long Term Conditions patients and specialist services. The aim was to provide care to those

suffering from a life limiting illness and who required some care at home, regardless of diagnosis. The service continued to work with Long Term Conditions Teams and support these patients at the time of our inspection.

Learning from complaints and concerns

- Thirty-four compliments were received relating to the specialist palliative care team in the last 12 months (1 February 2015 – 31 January 2016).
- There had been no complaints directly relating to the specialist palliative care service; however the end of life care lead would be involved in general complaints where a patient was identified to be at the end of life.
- Complaints and concerns were listened to and learning was used to improve services. The trust had a comprehensive complaints management system that included a format for reviewing contributing factors.
- We did not see specific complaints relating to end of life care during our inspection.
- Staff we spoke with told us that patients and family members would sometimes talk to them about concerns relating to treatment or care. Staff told us they saw it as part of their role to support people in this area, including signposting them to raise formal complaints if they wished to do so. However all staff we spoke with said this was a rare occurrence.
- One staff member told us about a situation where a relative raised a concern about another relative and potential financial abuse of the patient. The staff member told us this had been raised with the safeguarding team and we viewed records that confirmed this.
- Staff told us that complaints, concerns and compliments would be taken back to the monthly team meetings and we saw evidence of this in meeting minutes.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We rated well led as good because;

- There was a clear vision, strategy and values for end of life care with well-defined objectives that were reviewed as part of a district end of life care steering group.
- We observed strong leadership from the SPCT and senior staff in the community.
- There was a commitment and culture for providing high quality end of life care that was patient focused.
- Innovation was apparent across the SPCT as a whole. In particular we saw evidence that the team worked proactively with care homes in the community to develop end of life care. They also worked to develop comprehensive training in a number of relevant areas for a range of staff across the trust.
- The service proactively engaged staff and patients to ensure their views were heard and acted upon. For example, the palliative care service engaged volunteers to proactively call patients and their families to gain feedback about the services.
- Staff spoke about a vision for high quality end of life care. Comments included one staff member on an inpatient ward who told us that they have to make end of life care count for the sake of the patient and for their family.
- There were five clear aims of the strategy. These were the development of an end of life clinical steering group; the creation and monitoring of consistent quality standards; the development of an education and training plan for clinicians; the review and implementation of an Electronic Palliative Care Coordination System (EPaCCS); and, the review of service specifications to ensure they continue to meet local need.
- Progress against the delivery of the strategy was monitored. We viewed a steering group action plan with clear action points, individuals responsible and dates for completion recorded.
- The business unit that the end of life care team reported within contributed to the annual planning process and the development of the annual plan through engagement with clinical and specialty based teams and key stakeholders. A key objective included to promote delivery of the highest standards of end of life care.

Service vision and strategy

- The trust had been actively involved in and were working within the CCG's end of life care strategy for 2015 – 2017. There was an end of life care steering group that was led by the end of life care lead. This group worked closely with a district wide end of life care steering and strategy group where the aim was to provide strategic direction for end of life care services in the area.
- The trust's vision is 'Enabling people to reach their potential and live well in their community'. The six values were honest, open and transparent; respectful, person first and in the centre; improve and be outstanding; relevant today, ready for tomorrow; families and carers matter.

Governance, risk management and quality measurement

- Community end of life care reported within the structure of the Barnsley Business Delivery Unit (BDU) and Long Term Condition business unit in Barnsley general community services, contributing to the local and trustwide annual planning process.
- Governance arrangements were in place to enable the effective identification of risks, monitoring of such risks and the progress of action plans.
- The business unit reviewed the risks on the risk register, and discussed these issues at clinical governance meetings. The end of life care team fed into the clinical

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governance structure of the business unit and we saw evidence of governance issues and processes being discussed at the range of end of life care service meetings held.

- Because the end of life care service worked across the range of service providers in the locality there was close working with the acute hospital end of life/palliative care service and the hospice service. There was representative attendance at end of life care locality meetings.
- Trust policies relating to community end of life care were up to date and based on national and local guidance. We saw that guidance including NICE was discussed at service level meetings and that policies and operating protocols were updated accordingly.
- Annual reports were produced for all end of life care services including the specialist palliative care service, the end of life care team and the supportive care at home team.
- An electronic report was produced following the death of any patient on one of the community inpatient wards. This was then reviewed with input from the end of life care lead so that all deaths were reviewed in order to ensure that care at the end of life was appropriate. Issues raised as a result of this process were addressed as a significant event so that learning could be shared.
- We were told that there were no identified risks relating to end of life care in the community at the time of our inspection.
- Minutes of trust board meetings included some reference to end of life care service monitoring.

Leadership of this service

- There was a trust end of life care lead within the community who had leadership and management responsibility for the end of life care service across community, acute and care home provision.
- Board level leadership for end of life care was unclear; we did not see individual executive or non-executive leads within the trust with a clear role in relation to the implementation or monitoring of the end of life care strategy.
- We observed clear leadership for end of life care from the end of life care lead and their team and from ward

and team managers within community services and community inpatient services. We saw that senior staff prioritised end of life care and that there was a commitment to good quality end of life care. All staff we spoke with in leadership roles had a good understanding of the importance of high quality end of life care and we consistently heard from staff that end of life care was prioritised based on patient need.

- District nurses and staff working within the community inpatient units told us that the end of life and palliative care teams were visible on a day to day basis. All staff we spoke with knew who the end of life and palliative care team staff were by name and knew how to contact them.
- We saw evidence of the end of life care team providing end of life care leadership across all services within the trust, extending to external services including the acute trust, GPs and care homes.

Culture within this service

- Staff we spoke with demonstrated a commitment to the delivery of good quality end of life care. There was evidence that staff felt proud of the care they were able to give and there was positive feedback from nursing and care staff as to the level of support they received from the end of life and palliative care teams.
- There was evidence that the culture of end of life care was centred on the needs and experience of patients and their relatives. We viewed training materials that supported this focus in terms of education and staff consistently told us they felt able to prioritise the needs of people at the end of life in terms of the delivery of care.
- We observed good collaborative team working across community teams. Staff told us there were opportunities to learn and that the delivering of high quality end of life care services within the community was a priority.
- We were told that district nurses would generally double up on visits to patients with complex symptom management needs, particularly where syringe drivers were in use. We observed this in practice. Staff told us that appropriate measures were taken to protect their safety when they worked alone in the community.

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- There was a strong culture in place of enabling people to receive end of life care where they wished and we saw evidence that this was incorporated into the monitoring of the service.

Public engagement

- A volunteer service had been developed and based with the team to support the community palliative care service to obtain independent service user feedback in the form of telephone surveys.
- An independent survey of carers had been undertaken in 2015/16 to identify the overall satisfaction that carers in the community had with the specialist palliative care service. We saw that responses were high with a number of areas achieving 100%. Where issues had been identified we saw that positive action had been taken. For example, where carers did not know how to make a complaint should the need arise or where they were unsure how to access the service out of hours, action was taken to ensure this information was shared.
- We saw that patients and those close to them were actively engaged and involved in decision making and we saw evidence that their views were listened to, for example to the extent of being able to influence change if they were unhappy with certain aspects of care.
- The specialist palliative care results from the Friends and Family Test (November 2014 – September 2015) were very positive, with 90% stating they were extremely likely to recommend the service and 10% stating they were likely to recommend it.
- On the community inpatient wards we saw that the modern matron and deputy would undertake informal walks around the wards and encourage patients to feedback about the service.

Staff engagement

- Staff told us they felt actively engaged with the end of life care team and felt able to share their views with confidence in relation to being listened to.
- Members of the specialist palliative care, end of life care and supportive care at home teams told us they felt engaged with the service and able to express their views with confidence of being listened to.

- There were a number of forums for staff to contribute to the running of the service including a range of multi-disciplinary meetings, team meetings and planning meetings that staff were able to participate in.
- An area of particular relevance at the time of our inspection was the imminent move for the specialist team to more agile working. Staff told us the trust were in the process of providing agile devices which would prevent staff from having to return to a particular office to access the electronic patient record system. Some staff told us they had concerns about the change and the possible impact it may have on their MDT working which was working well. However, they also saw the benefits of the new way of working and felt that the trust and the end of life care lead had provided appropriate support for them to manage the change. They also told us they felt that the management and leadership of the service had listened to their concerns and were working with them to ensure that the current quality of MDT working would not be detrimentally affected.

Innovation, improvement and sustainability

- The end of life care team was focused on continually improving the quality of care and we also observed a commitment to this within the general nursing teams we spoke with.
- The end of life care lead worked closely with other providers to ensure that services across the locality continued to improve in order to meet the end of life care needs of patients and those close to them.
- Examples of innovation within the end of life care service included the development of a range of training to meet the needs of different staff groups both in within the trust and for other service providers across the locality.
- The specialist palliative care and end of life care teams had worked closely to develop innovative ways of working in relation to improving oral hygiene care for patients at the end of life. They were runners up in the 2015 International Journal of Palliative Nursing Multidisciplinary Teamwork Award for their oral hygiene steering group. They had also worked with other providers to share research and learning in relation to the care of patients with chronic obstructive pulmonary disease (COPD) at the end of life.

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- Another particular area of innovation was the team's work with learning disability services to develop a more creative approach to communication with patients around advance care planning at the end of life.