

Nottingham Citycare Partnership CIC

1-186610815

Community end of life care

Quality Report

1 Standard Court

Park Row

Nottingham

Nottinghamshire

NG1 6GN

Tel: 0115 8839600

Website: tracy.tyrrell@nottinghamcitycare.nhs.uk

Date of inspection visit: 28, 29, 30 November 2016,
01 December 2016

Date of publication: 08/03/2017

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)
1-298791257	Headquarters	Community end of life care	NG1 6GN

This report describes our judgement of the quality of care provided within this core service by Nottingham Citycare Partnership CIC. 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 Nottingham Citycare Partnership CIC and these are brought together to inform our overall judgement of Nottingham Citycare Partnership CIC

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

We rated end of life care service as outstanding overall.

We rated caring and responsive as outstanding and safe, effective and well led as good because:

- Openness and transparency about safety was encouraged.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses and where incidents had been raised actions were taken to improve processes.
- Safeguarding was given sufficient priority. Staff had an understanding of how to protect patients from abuse. Staff described what safeguarding was and the process to follow if they suspected a patient was at risk of avoidable harm or abuse.
- Arrangements to minimise risks to patients were in place with measures to prevent falls, malnutrition and pressure ulcers. We observed staff followed good infection and prevention control practices.
- Staff recognised and responded to the changing needs of patients with anticipatory medications readily available and care needs assessed and reviewed appropriately.
- Specialist equipment needed to provide care and treatment to patients in their home was appropriate and fit for purpose so that patients were safe. Syringe drivers were maintained and used in accordance with professional recommendations.
- End of Life care was planned and delivered in line with best practice guidance. Care and treatment was planned and delivered in a personalised and holistic way and care plans took into account people's health and social care needs.
- All staff involved in providing end of life care had access to current guidance through the Nottinghamshire guideline for care in the last year of life.
- Staff had access to relevant training and support. All the teams we spoke with valued the expert knowledge of the end of life care team and the Macmillan specialist palliative care team (SPCT) and used this service often as a learning resource and for referrals where patients had complex symptoms that were difficult to manage.
- Our observation of practice, review of records and discussion with staff confirmed there were effective multidisciplinary team (MDT) working practices. Staff worked collaboratively to understand and meet the range and complexity of people's needs
- Outcomes for patients using the service was collected and monitored on a monthly basis by the end of life care service. For example, the service collected data on the number of patients who achieved death in their preferred place. Between April 2016 and October 2016, 100% of patients who died, achieved death in their preferred place of care.
- The provider used an electronic palliative care coordination system (EPaCCS). This is an electronic computerised information system which contains essential information about patients who had been identified as being in the last year of life. All health care professionals involved in the patient's care could access the information. The local emergency ambulance service could also access this information.
- Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- We observed a holistic person-centred approach to patient care. Patients were treated with compassion, kindness, dignity and respect.
- Without exception, feedback from patients was positive. Staff were not only committed to providing sensitive care to patients, but also for the well-being of their families.
- Patients were supported to maintain their independence. Where possible, staff promoted self-care, self-management and independence. They were empowered to be partners in their care.
- Staff provided emotional support for patients and their families, but appropriately signposted them to other sources of support where appropriate.
- Services were developed in such a way as to meet the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care.
- The provider engaged with external organisations and the local community to ensure the services met the needs of patients and those close to them who required end of life care.

Summary of findings

- The provider was proactive in its approach to understanding the needs of different groups of people and to deliver care in a way that promoted equality. Patients who were vulnerable or had complex needs could access the service.
- Patients could access the service in a timely manner and services that suited their individual needs.
- There had been very few complaints in relation to end of life care services.
- The leadership, governance and culture mostly promoted the delivery of high quality person-centred care.
- Although there was no published strategy, there was a vision and a work plan for the future of the service, and throughout our inspection, we could see that much of the work plan had already been implemented. We could see that the work plan had been developed in line with the provider's vision and values.
- The locality leads, clinical nurse specialists and general district and community staff were able to articulate the purpose of their service, to provide care and support for patients in their last year of life, and their role within the integrated locality team. All staff, including very senior managers understood the importance of end of life care.
- There were good governance structures in place for end of life care through the integrated governance structure.
- The lead for end of life care was visible, and there was good local support and leadership for end of life care.

Staff had confidence in their managers to ensure training and expert knowledge was available to improve end of life care experiences for patients and those who were close to them.

- There was good public and staff engagement throughout end of life care services.

However, we also found:

- There was no safety performance dashboard related to end of life care.
- There was no programme of audit in place for 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms. We were therefore not assured that decisions surrounding DNACPR orders were being appropriately monitored. During our inspection, we reviewed nine DNACPR forms. Our review showed eight forms had been appropriately completed in line with national guidance.
- The strategy and strategic objectives for end of life services were still in development. The service lead was working with all stakeholders to develop the service strategy but it had not been completed and published.
- There was no service level agreement in place between the provider and the specialist palliative care unit that was providing specialist out of hours advice and guidance about symptom control. This meant the provider had no protection from this service being withdrawn.

Summary of findings

Background to the service

Nottingham CityCare Partnership CIC is a community social enterprise that provides end of life care services for patients across a wide range of locations within the City of Nottingham. A social enterprise is a business that trades to tackle social problems, improve communities, people's life chances, or the environment. Social enterprises reinvest their profits back into the business or the local community.

End of life care is undertaken by community nurses, district nurses, end of life care nurses, Macmillan specialist nurses, Macmillan support nurses as well as

other members of the community multidisciplinary team and is provided across the community for all patients registered with a Nottingham City GP. Care is provided in patient's own homes, a care home or in a virtual hospice bed located at the provider's care home.

The end of life care team works closely with all staff working in the community to provide support and advice regarding end of life and palliative care. The team also ran educational courses throughout the year for community staff, including GPs.

Our inspection team

Our inspection team was led by: Carolyn Jenkinson, Head of Hospital Inspection.

Team Leader: Michelle Dunna, Inspector, Care Quality Commission

The team included CQC inspectors, members of the CQC medicines team and a variety of specialists including:

A Resuscitation and Clinical Skills Manager, Physiotherapist, Community Matron, Equality and Diversity Lead, Health Visitor and Director of Nursing.

Why we carried out this inspection

We carried out an announced inspection of Nottingham CityCare Partnership CIC as part of our programme of comprehensive inspections of independent community health services.

How we carried out this inspection

We inspected this service in November and December 2016 as part of the comprehensive inspection programme.

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 our inspection, we reviewed performance information from and about this service. We also held focus groups with a number of staff groups.

During our inspection, we visited and observed care interactions between staff and patients in their own homes as well as nursing homes. We also visited the home where the three virtual hospice beds were located. We spoke with members of staff including, community nurses, district nurses, assistant practitioners, health care support workers, nurses from the end of life care team, the Macmillan specialist palliative care team (SPCT) and the Macmillan support team. We also spoke with allied

Summary of findings

health care professionals. We spoke with nine patients and in some circumstance, their relatives, 22 members of staff and reviewed eight patient care records and nine 'do not attempt cardiopulmonary resuscitation (DNACPR) forms.

What people who use the provider say

People were positive about their experience of the community end of life service. They told us, "The staff are brilliant" and "They [the staff] are marvellous, you can't fault them".

Good practice

- In addition to the Macmillan specialist palliative care team (SPCT), there was a Macmillan support team. The Macmillan support team was part of a two year pilot which had been brought about because of a lack of provision for patients whose needs were not complex enough to warrant support from the Macmillan SPCT. This enabled patients with cancer to access Macmillan support.
- The service had three virtual hospice beds within the provider's nursing home. This enabled patients to access respite care 24 hours a day, seven days a week.
- Teams were supportive of each other and aware of the emotional stress of working in end of life care. The Macmillan support team had a 'sparkling moments' book, in which they recorded their positive experiences of palliative and end of life care. Although they used this to evidence where they had met their key evaluation points set by the clinical commissioning group (CCG) they also found this a useful exercise to provide positive reflection for the team.

Areas for improvement

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

- The provider should consider the use of a safety performance dashboard related to end of life care in order to capture safety outcomes for patients receiving end of life care.
- The provider should ensure community 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms are audited in order to provide assurance they are being appropriately completed and monitored.
- The provider should continue the development and publication of the strategy and strategic objectives for end of life services.
- The provider should ensure minutes are maintained to provide an audit trail of the discussions and outcomes of strategic meetings.
- The provider should consider the risks associated with the lack of service level agreement between the provider and the specialist palliative care unit for providing specialist out of hours advice and guidance about symptom control.

Nottingham Citycare Partnership CIC

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 patients were protected from avoidable harm and abuse.

We found:

- Openness and transparency about safety was encouraged.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses and where incidents had been raised actions were taken to improve processes.
- Safeguarding was given sufficient priority. Staff had an understanding of how to protect patients from abuse. Staff described what safeguarding was and the process to follow if they suspected a patient was at risk of avoidable harm or abuse.
- Arrangements to minimise risks to patients were in place with measures to prevent falls, malnutrition and pressure ulcers. We observed staff followed good infection and prevention control practices.
- Staff recognised and responded to the changing needs of patients with anticipatory medications readily available and care needs assessed and reviewed appropriately.

- Specialist equipment needed to provide care and treatment to patients in their home was appropriate and fit for purpose so that patients were safe. Syringe drivers were maintained and used in accordance with professional recommendations.

Safety performance

- End of life care was provided as part of an integrated care programme. Integrated care aims to 'join up' health and social care to meet the needs of a given population. End of life care was therefore provided alongside other community services, and, as such did not have a high number of incidents.
- There was no safety performance dashboard related to end of life care. There was therefore a risk that the local team may not have full oversight of issues related to safety performance throughout the service.

Incident reporting, learning and improvement

- The provider had an incident reporting policy in place. It provided guidance for staff on how to report incidents.
- There was a good incident reporting culture. Incidents were reported through the provider's electronic reporting system. All staff we spoke with were familiar with the process for reporting incidents, near misses and accidents using the provider's electronic reporting

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system. In addition, all staff we spoke with understood their responsibilities around the reporting of incidents, near misses and accidents. Staff had access to the electronic reporting system when they were delivering care in patient's own homes.

- We saw that a serious incident relating to end of life care had also been appropriately reported to the Clinical Commissioning Group (CCG).
- In addition to the serious incident, there had been three other incidents reported between October 2015 and November 2016 for end of life care services. All three had been graded as a low risk both on reporting and following investigation. We saw that an investigation had taken place for all three incidents; however, we did not see any evidence that the incidents had been shared across teams to enable learning to prevent similar incidents occurring in the future.
- There were no never events in this service between October 2015 and November 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- All staff we spoke with told us they received feedback from incidents they had reported.
- Although information relating to incidents was shared with the immediate team, we were not assured that incidents were more widely shared in order that learning could take place throughout the organisation.

Duty of candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with from all teams had a good understanding about duty of candour. Staff talked of being open and honest when things went wrong. Staff were able to give example of where duty of candour had been applied, and some staff told us that it had recently been applied to a serious incident that was being investigated at the time of our inspection.

Safeguarding

- Arrangements were in place to safeguard adults and children from abuse. Safeguarding policies were available for staff.
- All staff we spoke with had an understanding of how to protect patients from avoidable harm. We spoke with staff who could describe what safeguarding was and the process for referring concerns. Staff were able to give examples of where they would raise safeguarding concerns and were able to tell us about concerns they had raised in the past.
- Patients who were believed to be a safeguarding risk could be admitted to one of the virtual hospice beds to enable the patient to be safeguarded.
- There was a safeguarding lead within the organisation and staff were able to tell us who this person was.
- All staff we spoke with told us they had received safeguarding training. Safeguarding adults level two training was mandatory. Following our inspection, we reviewed training information, which demonstrated 93% of the end of life care team had completed safeguarding adults level two training and 91% had completed children's safeguarding level two training against the provider's target of 90%.
- There had been no safeguarding serious case reviews in the end of life care service.

Medicines

- The provider's policy for the anticipatory supply of palliative care medications for adults was in line with national guidance. Anticipatory medicines are used to control key symptoms such as pain, agitation, excessive respiratory secretions, nausea, vomiting and breathlessness, which may occur as a patient reaches the end of their life. These medicines are prescribed in advance so they can be administered when required, without unnecessary delay.
- All staff had access to procedures for the prescribing of anticipatory medicines and we saw that end of life care nurses and the Macmillan specialist and Macmillan support palliative care nurses worked closely with GPs and district nurses to ensure the timely prescribing of anticipatory medicines. Where required, patients had anticipatory medicines available to them in their own home.

Are services safe?

- Patients were provided with a grey box in which they could store anticipatory medicines, including the equipment required to administer them.
- Staff from the end of life care team and the Macmillan specialist palliative care team (SPCT) did not hold a supply of medicines. However, they had a system for checking controlled drugs (CDs) that were prescribed and issued through the patient's GP. CDs include strong painkillers such as morphine, which require additional checks to make sure they are used safely.
- The community nursing teams had a system in place to check that CDs were being administered to patients appropriately.
- The provider had a pre-printed palliative care (end of life) medicines administration chart for use in patient's own homes. This contained the prescription and administration record. The chart included stock recording for CDs.
- On one home visit we observed a district nurse completing medication checks in the patient's home. The patient had been prescribed anticipatory medicines. The district nurse checked the medicines against the prescription, counted the medicines and reviewed the expiry dates; this occurred on a monthly basis. A risk assessment had been undertaken to determine how often the checks were required and if circumstances changed, the checks would be done fortnightly.
- One nurse had qualified as a non-medical prescriber within the end of life care team. However, this nurse told us they had undertaken their training some time ago and did not currently undertake prescribing. This meant there were no nurses in the end of life care team who could immediately prescribe medication for a patient should they require it. However, the service had Macmillan nurses who were non-medical prescribers and could therefore prescribe medication for patients should they require it.
- Medicines management training was mandatory and community nurses told us they were up to date with this training. Following our inspection, we reviewed training information, which demonstrated 100% of the end of life care team had completed medicines management training against the provider's target of 90%.

Environment and equipment

- Nursing teams based in the community who provided end of life care for patients were able to order

equipment such as profiling beds, pressure relieving mattresses and cushions and commodes in a timely manner. CityCare had a contract with an external provider for the ordering and provision of equipment and staff told us they were able to arrange for same day and urgent delivery of equipment for patients who were being discharged home for their end of life care.

- The provider used syringe drivers for patients who required a continuous infusion to control their symptoms and those met the current NHS Patient Safety guidance. This meant that patients were protected from harm when a syringe driver was used to administer a continuous infusion of medication because the syringe drivers used were tamperproof and had the recommended alarm features. Syringe drivers were serviced every 12 months to ensure they continued to be safe to use.

Quality of records

- Community nurses maintained individual care records in a way that kept patients safe. Paper based records were kept in each patient's home; these contained essential, but minimal information in order to maintain patient confidentiality. However, community nursing staff also used an electronic system to maintain more detailed records relating to each episode of patient care. Electronic records were password protected. All staff we spoke with were aware of the requirements for ensuring patient's confidentiality was maintained and protected.
- The provider's electronic recording system enabled the community teams to share records with other health care professionals involved in the patient's care, for example, the patient's GP. Most local GPs also used the same system and this enabled information about patients' current care and treatment plans to be shared with other health care professionals.
- Electronic records were contemporaneous. This meant they were maintained in date order and at the time of the visit. Where staff did not update the records in the patient's own home, these were updated when the nurse returned to the office.
- We reviewed the care records of eight patients who were receiving end of life care. The records were accurate, complete and legible. When care plans had been updated, these were printed off and placed in the paper

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records within patient's own homes. This meant the paper records were up-to-date should any other health care professionals need to access them whilst providing care.

- The provider had undertaken an end of life care record keeping audit in 2015. The audit looked at 30 sets of records and information was collected on three separate days in November 2015. The audit identified that abbreviations were being used without being written in full at the first entry. This meant that abbreviations could potentially be misinterpreted. The audit was scheduled to be repeated throughout 2016 and 2017; however, the results were not available at the time of our inspection.
- Information governance training was mandatory and community nurses told us they were up to date with this training. Following our inspection, we reviewed training information, which demonstrated 89% of the end of life care team had completed information governance training against the provider's target of 90%.

Cleanliness, infection control and hygiene

- The provider had an up-to-date infection control policy, which provided guidance for staff on the prevention and control of infection. Risks associated with the prevention and control of infection following the death of a patient were contained in the provider's verification of death policy.
- Throughout community end of life care services, we observed staff to be compliant with best practice guidelines to prevent and reduce the risk of spreading infection. This included appropriate hand washing and use of personal protective equipment (PPE) such as gloves and aprons. We observed staff during home visits. Staff demonstrated a good understanding of infection prevention and control. We observed staff cleaning their hands prior to and following the provision of care. We saw that staff used gloves and aprons where this was appropriate. Community staff were provided with hand sanitising gel to use when providing care in patient's own homes.
- We observed two district nurses whilst they changed patient's wound dressings, one within a patient's own home and one within a care home. Both nurses followed best practice in adhering to best practice for using aseptic non-touch techniques when changing the wound dressings.

- All staff were compliant with the provider's dress code, with 'arms bare below the elbow' when providing direct patient care.
- Infection control training was mandatory and community nurses told us they had undertaken this training. Following our inspection, we reviewed training information, which demonstrated 100% of the end of life care team had completed infection control training against the provider's target of 90%.

Mandatory training

- End of life care training was not mandatory but the end of life care team were rolling out an end of life care training programme to all community nurses. All of the community nurses we spoke with told us they had attended the training and had found it beneficial.
- The community Macmillan SPCT were 100% compliant with some of their mandatory training, such as fire safety, health and safety, equality and diversity, information governance, safeguarding adults and children level one, mental capacity act, medicines management, conflict resolution, infection control, and moving and handling. Compliance levels for safeguarding children level two was 91% and safeguarding adults level two was 93% against the provider's target of 90%.

Assessing and responding to patient risk

- Community end of life and palliative care took place in patients own homes or where appropriate, patients could be admitted to a virtual hospice bed within a care home that was managed by the provider.
- Community nurses and other members of the multidisciplinary team (MDT) had regular meetings to discuss patients, their requirements and any risk that had been identified.
- Within patient's own homes, the community and district nurses provided end of life care from day-to-day. Specialist end of life and palliative care support was available Monday to Friday between 8.30am and 5pm from the Macmillan team or the end of life care team. At weekends and between the hours of 5pm to 8.30am, specialist out of hours advice and guidance about symptom control was provided by staff at a local specialist palliative care unit.
- We looked at the care records for eight patients receiving end of life care in the community. Risks to patients were assessed using nationally recognised risk

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assessment tools. For example, the provider used the Braden risk assessment tool to assess each patient's risk of developing pressure ulcers and a malnutrition universal screening tool (MUST) was used to assess patients' risk of malnutrition. We also saw risk assessments were completed for moving and handling. Risk assessments were tailored to each patient and were completed appropriately. They were updated and evaluated within their required timeframe on the provider's electronic recording system to ensure risks were minimised as much as possible.

- All patients receiving end of life care had access to emergency contact telephone numbers should they need them. These were stored at the front of their nursing care records. The provider could access urgent medical attention for patients where appropriate by contacting emergency services such as the ambulance service.
- As patient's needs increased, or where community and district nurses felt they were unable to meet the needs of patients at the end of their life, they could refer patients to the end of life care team or where appropriate they could seek guidance from the Macmillan SPCT.

Staffing levels and caseload

- End of life and palliative care was provided in patient's own homes and the three virtual hospice beds located at a care home managed by the provider. End of life and palliative care was undertaken by the end of life care team, the Macmillan Specialist Palliative Care team (SPCT), the Macmillan support team and the community and district nurses. There was also a care homes team of district and community nurses, who provided end of life care to patients living in care homes.
- The end of life care team consisted of a band seven 0.5 full time equivalent manager, four band six 3.6 full time equivalent end of life care nurses, a 0.2 full time

equivalent Macmillan GP facilitator, one full time equivalent electronic palliative care coordination system (EPaCCS) project assistant and a 0.5 full time equivalent administrator.

- The Macmillan specialist palliative care team (SPCT) consisted of six (4.8 full time equivalent) SPCT nurses, and one full time equivalent administrator.
- The Macmillan support team consisted of two full time equivalent Macmillan nurses and two full time equivalent assistant practitioners.
- Although members of these teams told us they could be very busy, and one member of staff was going on maternity leave, another member of staff retiring and a further member of staff was due to be leaving, none reported any concerns relating to vacancies, staffing levels or workloads.

Managing anticipated risks

- Potential risks were taken into account when planning services, for example seasonal fluctuations in demand, the impact of adverse weather and disruption to staffing.
- Lone working guidance was available to those staff providing end of life care in the community. All staff we spoke with were aware of the guidance.
- There was a lone worker risk assessment which detailed potential hazards and control measures that were essential to reducing risks associated with lone working.
- Each lone worker had a personal profile, which described distinguishing features that could be used to identify the person.
- Conflict resolution training was mandatory and community nurses told us they were up to date with this training. Following our inspection, we reviewed training information, which demonstrated 100% of the end of life care team had completed conflict resolution training against the provider's target of 90%.

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 good because patients received effective care and treatment that met their needs.

We found:

- End of Life care was planned and delivered in line with best practice guidance. Care and treatment was planned and delivered in a personalised and holistic way and care plans took into account people's health and social care needs.
- All staff involved in providing end of life care had access to current guidance through the Nottinghamshire guidelines for care in the last year of life.
- Staff had access to relevant training and support. All the teams we spoke with valued the expert knowledge of the end of life care team and the Macmillan specialist palliative care team (SPCT) and used this service often as a learning resource and for referrals where patients had complex symptoms that were difficult to manage.
- Our observation of practice, review of records and discussion with staff confirmed there were effective multidisciplinary team (MDT) working practices. Staff worked collaboratively to understand and meet the range and complexity of people's needs
- Outcomes for patients using the service was collected and monitored on a monthly basis by the end of life care service. For example, the service collected data on the number of patients who achieved death in their preferred place. Between April 2016 and October 2016, 100% of patients who died, achieved death in their preferred place of care.
- The provider used an electronic palliative care coordination system (EPaCCS). This is an electronic computerised information system which contains essential information about patients who had been identified as being in the last year of life. All health care professionals involved in the patient's care could access the information. The local emergency ambulance service could also access this information.
- Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005.

However, we also found:

- There was no programme of audit in place for 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms. We were therefore not assured that decisions surrounding DNACPR orders were being appropriately monitored. During our inspection, we reviewed nine DNACPR forms. Our review showed eight forms had been appropriately completed in line with national guidance.

Evidence based care and treatment

- Nottingham CityCare Partnership had been involved in the development of the Nottinghamshire guidelines for care in the last year of life and this provided guidance for professionals employed by them. The guidance was based on national guidance such as the Leadership Alliance for the Care of Dying People (LACDP), which set out the five priorities for care which should be applied irrespective of where a person is dying. The guidance was also aligned to regulatory guidance and legal requirements, including the Mental Capacity Act (MCA) 2005.
- End of life care was managed and delivered in line with the National Institute for Health and Care Excellence (NICE) guidelines. For example, symptom control for patients receiving end of life care was managed in accordance with the relevant NICE Quality Standard (NICE CG140). This defines clinical best practice for the safe and effective prescribing of strong opioids for pain in palliative care for adults.
- End of life care was also aligned, managed and delivered in line with NICE guidance NG31. There was an emphasis on the early identification of people approaching the end of their life in order that discussions around end of life could take place.
- The provider completed an individualised care plan, to plan care for patients who were in the last days of their life. The personalised plan of care for the last days of life was based on the Priorities for Care of the Dying Person set out by the LACDP.

Are services effective?

- Care and treatment was planned and delivered in a personalised and holistic way and care plans took into account people's health and social care needs.
- All staff involved in providing end of life care had access to current guidance through the Nottinghamshire guideline for care in the last year of life.
- Relevant end of life care policies, guidance and support were available to all community staff via the provider's intranet.
- Within all the care records we reviewed, we saw that patients had their needs assessed, their care goals identified and their care planned and delivered in line with evidence-based, guidance, standards and best practice.
- Each community nursing team, the community end of life care team and the community Macmillan specialist palliative care team was aligned with a number of GP Practices. Each of the practices were registered with the Gold Standards Framework (GSF). The GSF is the national training and coordinating centre for all GSF programmes, with the aim of equipping non-specialist frontline staff to provide a gold standard of care for patients nearing the end of their life.

Pain relief

- Patients who had been identified for end of life care were prescribed anticipatory medicines. These 'as required' medicines were prescribed in advance to properly manage any changes in patients' pain or symptoms.
- Pain relief was available to patients at end of life. The nursing staff in the community teams were skilled at ensuring that patients were using their pain relief medicines, and monitoring their effectiveness.
- The community teams used a pain tool to assess patients' level of pain. We also heard staff ask patients whether they were experiencing any pain as well as exploring the type of pain.
- Staff used the World Health Organisation (WHO) pain ladder to ensure patients were receiving the right sorts of pain medication for their pain.
- We undertook home visits with the district nurses, community nurses and the Macmillan nurses and we observed all of them undertaking pain assessments whilst communicating with patients and prior to undertaking any care interventions with patients.
- Specialist advice about pain control was available from the Macmillan specialist palliative care team (SPCT) or

end of life care team Monday to Friday between 8.30am and 5pm. At weekends and between the hours of 5pm to 8.30am, specialist out of hours advice and guidance about pain control was provided by staff at a local specialist palliative care unit.

Nutrition and hydration

- Throughout community services, a national assessment tool was used to assess patient's nutritional status and identify when interventions were required.
- Community staff could access support from a speech and language therapist (SALT) if a swallow assessment was required. Staff could also access the support of a dietitian if required.
- We undertook a home visit with one of the district nurses and we observed the nurse took the patient's milk into the house from the doorstep. With permission from the patient, the nurse put the bottles of milk in the refrigerator. The nurse used this as an opportunity to check the patient had nutritious food in the refrigerator.
- On another home visit we observed the district nurse providing guidance about how to fortify food, for example by adding butter and cream to potatoes and soups to ensure the patient received a higher intake of calories.
- On a home visit with a Macmillan nurse, we observed the nurse checking with the patient about their nutrition. The nurse asked questions to establish whether the patient was managing to eat and drink enough high calorie foods.

Patient outcomes

- The End of Life Care Audit: Dying in Hospital is a national clinical audit commissioned by the Healthcare Quality Improvement Partnership (HQIP) and run by the Royal College of Physicians, with additional funding provided by Marie Curie to assist with the sharing and usage of audit results for quality improvement purposes. It was designed to ensure that the priorities for care of the dying were monitored at a national level. As Nottingham CityCare Partnership was a community provider, it was not required to contribute to the national care of the dying audit.
- The provider did not contribute any data about end of life care to the national minimum data set (MDS) as they were not required to; however, they had just become a member of the National Council for Palliative Care. The National Council for Palliative Care collects the MDS for

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Specialist Palliative Care Services on a yearly basis, with the aim of providing an accurate picture of specialist palliative care service activity. It is the only annual data collection to cover patient activity in specialist services within the voluntary sector and the NHS in England, Wales and Northern Ireland.

- Outcomes for patients using the service was collected and monitored on a monthly basis by the end of life care service. For example, the service collected data on the number of patients who achieved death in their preferred place. Between April 2016 and October 2016, 100% of patients who died, achieved death in their preferred place of care.
- At the time of our inspection, end of life care services had not participated in any national audits or benchmarking exercises.

Competent staff

- Staff were not required as part of their mandatory training to undertake training in subjects specific to their area of practice, such as management of symptoms, dementia care for end of life patients and communication. However, opportunities to undertake the end of life training was available and they were encouraged to attend.
- The end of life care team delivered a comprehensive rolling programme of end of life care training to the generalist district and community nurses. They also delivered training free of charge to general nursing and care staff working in care and nursing homes.
- All new staff undertook a new starter training day on end of life care. There was also a two day course and a five day course aimed at care staff and nursing staff. The course was not accredited but covered essential aspects of end of life care such as achieving priorities of care, advance care planning, pain and symptom control, communication and difficult conversations, loss and bereavement and holistic assessment.
- At the time of our inspection, 60 staff members had undertaken the two-day course, 87 staff members had undertaken the five-day course and 19 new staff members had undertaken the new starter training.
- Staff attending the course evaluated them and we saw the majority of the comments made were extremely positive. All staff we spoke with who had attended one of the end of life care courses told us they found it a resourceful course and had helped to prepare them for their role in supporting patients with end of life care.

- The service had 25 end of life care link clinicians, including nurses, therapists and specialist clinicians across all eight care delivery groups (CDGs) who could provide additional support and advice to the district and community nurses as required.
- At the time of our inspection, 238 members of community staff had undertaken syringe driver training. The company that supplied the syringe drivers provided this. Some staff had undertaken train the trainer training and this enabled them to deliver the training in-house to other members of their team.
- All staff we spoke with told us they were encouraged and given opportunities to develop. Some staff had been supported to undertake higher-level academic learning.
- The provider had suitable provision in place to ensure staff received regular supervisions and one to one support. There were systems in place to ensure nurses could meet the requirements for revalidation.
- At the time of our inspection, 50% of staff in the end of life care team had received an annual appraisal and 88% of staff in the Macmillan nursing team had received an appraisal. The reason for the low rate of appraisal in the end of life care team was due to there being three new members of staff and one member of staff on sick leave.

Multi-disciplinary working and coordinated care pathways

- There was an end of life care rehabilitation team; these had been transferred over from a neighbouring NHS trust at the time of our inspection. The end of life care rehabilitation team included a physiotherapist, an occupational therapist, a dietitian and a support worker.
- All members of staff we spoke with were aware of the roles of other members of the multidisciplinary team and were respectful of the boundaries of their roles.
- Multidisciplinary gold standard framework meetings took place at GP surgery's once a month to discuss all patients in receipt of end of life care and to highlight other patients who would benefit from this care. Nurses from the end of life care team and the Macmillan specialist palliative care team (SPCT) attended these meetings.
- The Macmillan SPCT and the end of life care team had historically not held formal meetings to discuss patients but communicated on a need to know basis. There was



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however a plan for a meeting to take place on 20 December 2016 to discuss the way forward for the end of life and palliative care service throughout the organisation.

- Where necessary, patients received therapy support at home from occupational therapists and physiotherapists. The input of these therapists was seen by the community nursing teams as providing essential elements of end of life care.
- Patients could also receive therapy support through a local day hospice where patients could be referred for day therapy. We spoke with a patient who had been attending his service for five months. The patient told us they enjoyed and benefited from this service.
- Weekly multidisciplinary team meetings were held between the Macmillan SPCT and the local specialist palliative care unit where essential information was handed over in case there were any issues out of hours.

Referral, transfer, discharge and transition

- There was good liaison between the community matrons who looked after patients with long-term conditions and end of life care services. These services worked together to ensure that patients were referred to end of life care services in a timely way.
- There was a clear pathway to refer patients to the community end of life care team, the community Macmillan support team and the community Macmillan SPCT. Referrals to the community end of life care team and the Macmillan SPCT were processed through the provider's health and care point. A specialist nurse who prioritised the referrals in order of urgency then triaged referrals.
- Referral to other disciplines was straightforward and effective, such as speech and language therapists to help patients cope with symptoms such as swallowing difficulties and occupational therapists or physiotherapists to help patients cope with symptoms such as breathlessness.
- The provider worked very closely with the local acute NHS Trust and worked collaboratively to assess and plan ongoing care and treatment in a timely way and to ensure appropriate plans were in place when people were being discharged from hospital to the community.

Access to information

- The provider used an electronic palliative care coordination system (EPaCCS). This is an electronic

computerised information system which contains essential information about patients who had been identified as being in the last year of life. All health care professionals involved in the patient's care could access the information. The local emergency ambulance service could also access this information.

- The EPaCCS provided information regarding the 'do not attempt cardiopulmonary resuscitation' (DNACPR) form, as well as the patient's wishes regarding being admitted to hospital, and this information was available to the local emergency ambulance service.
- The provider could access the electronic information system used to record diagnostic test information by the local acute NHS trust. This gave community staff providing end of life care the ability to be able to access essential diagnostic results in a timely manner.
- Staff also used paper records to record community visits. These records were left in patients' homes.
- 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.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Mental Capacity Act (MCA) 2005 training was delivered as part of the mandatory training programme across the organisation.
- Nursing staff were knowledgeable about the processes to follow if a patient was unable to give informed consent to care and treatment. All staff we spoke with demonstrated a good understanding of consent in relation to the Mental Capacity Act (MCA). We observed community staff as they gained appropriate informed consent from patients prior to carrying out any procedures during our home visit.
- Throughout our inspection, we did not meet with or review any patients that lacked the capacity to make informed decisions.
- During our inspection, we reviewed nine 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms. Our review showed eight forms had been appropriately completed in line with national guidance. All but one DNACPR form had a documented assessment of the patient's capacity to make decisions and where patients had capacity we saw that appropriate discussions had taken place and were documented in patient's care records. Where patients had been assessed as lacking

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capacity, appropriate decisions had been made in the best interest of the patient and discussions had taken place between the leading professional and an appropriate family member.

- The provider told us they did not routinely audit DNACPR forms, some of which were completed by GPs, some were completed by the local trust and some were completed by community nursing staff who had received training and were deemed competent to

complete DNACPR forms. The lead for the service told us that GPs were responsible for the audit of DNACPR forms. We were therefore not assured that decisions surrounding DNACPR orders were being appropriately monitored.

- We noted the DNACPR form being used in the community was not 'version controlled'. This meant we could not be assured the form was the most up-to-date version.



Are services caring?

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

Summary

We rated caring as outstanding because patients were truly respected and valued as individuals and were empowered as partners in their care.

We found:

- We observed a holistic person-centred approach to patient care. Patients were treated with compassion, kindness, dignity and respect.
- Without exception, feedback from patients was positive.
- Without exception, staff were not only committed to providing sensitive care to patients, but also took into account the well-being of their families.
- Patients who were approaching the end of life were offered the opportunity to create an advance care plan, including preferred priorities for care and an advance decision.
- Patients were supported to maintain their independence. Where possible, staff promoted self-care, self-management and independence. They were empowered to be partners in their care.
- Staff provided emotional support for patients and their families, and appropriately signposted them to other sources of support where appropriate.
- Community staff took time to consider the needs of family members who were caring for a dying person. This included assessment of the carer's anxiety, stress and support for arranging additional services or respite care.

Compassionate care

- We observed a holistic person-centred approach to patient care. Patients were treated with compassion, kindness, dignity and respect. Throughout our home visits to patients, we observed nursing staff providing holistic person-centred care. Without exception, we found the care and treatment of patients and support for their families and those important to them to be kind, empathetic and compassionate. On our home visits we saw that staff treated patients with dignity and respect. Nurses were sensitive towards the needs of patients and supported them in a professional manner.

- Patients knew the nurses by name and confirmed that they regularly saw the same team of nurses. Staff took time to listen to patients, give reassurance and took time to ensure patients understood what was happening.
- Community staff took time to consider the needs of family members who were caring for a dying person. This included assessment of the carer's anxiety, stress and support for arranging additional services or respite care.

Understanding and involvement of patients and those close to them

- Without exception, staff were not only committed to providing sensitive care to patients, but also took into account the well-being of their families.
- We saw that staff discussed planned care and treatment with patients and, where necessary, provided information to reinforce understanding. We also observed that community staff explained choices and treatments with patients, family members and carers.
- Patients, and those close to them, told us they felt involved in their care and had an understanding of what was happening. We witnessed good rapport between nursing staff, patients and those who were important to them. Staff took the time to communicate in a sensitive and unhurried way to ensure they could understand the information being given to them.
- Patients were supported to maintain their independence. Where possible, staff promoted self-care, self-management and independence. They were empowered to be partners in their care.
- All staff delivered end of life care in a holistic person-centred manner. They were calm and took account of patients' individual preferences.
- During home visits, we saw that nurses discussed patients' personal and social interests and provided opportunities to discuss how patients and those close to them could plan for their future and continue to engage in social activities, even when the symptoms of their condition may have restricted them.
- Patients who were approaching the end of life were offered the opportunity to create an advance care plan, including preferred priorities for care and an advance



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decision. Advance care planning involves a structured discussion with patients and their families or carers about their wishes and thoughts for the future. Preferred priorities for care include enabling patients to choose where they wish to be cared for and where they wish to die.

- Without exception, feedback from patients was positive.

Emotional support

- All staff we spoke with considered emotional support as part of their role. Staff completing home visits

demonstrated knowledge of patients and their unique situations. Emotional support was tailored to each patient's individual set of circumstances and we saw that appropriate emotional support was provided.

- Emotional support was also provided to patients and their families through a variety of services, such as the end of life care team and in more complex cases, the Macmillan team. Bereavement support was also provided through a local day hospice and the service had the support of organisations from the voluntary sector, such as Cruse.



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 outstanding because services were developed in such a way as to meet the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care.

We found:

- The provider engaged with external organisations and the local community to ensure the services met the needs of patients and those close to them who required end of life care.
- The provider was proactive in its approach to understanding the needs of different groups of people and to deliver care in a way that promoted equality. Patients who were vulnerable or had complex needs could access the service.
- Patients could access the service in a timely manner and access the services that suited their individual needs.
- Between April and October 2016 100% of patients had died in their preferred place of care.
- There had been very few complaints in relation to end of life care services.

Planning and delivering services which meet people's needs

- A number of services had been commissioned in order to ensure the end of life care needs of the local population could be met. These included three virtual hospice beds, a hospice at home service, day therapy services and bereavement support. The services were tailored to meet the needs of patients and were delivered in a way to ensure flexibility, choice and continuity of care.
- The provider worked with other organisations and the local community to plan services that met patient's needs. For example, the provider worked with a local day hospice to ensure a provision of day therapy services, bereavement services and a hospice at home service.
- The provider worked with a local NHS trust and community matrons were instrumental in going into the health care of older people's wards to facilitate rapid discharges, and this included patients who had

expressed a wish to die at home. The creation of three virtual hospice beds in the provider's nursing home also gave patients the flexibility for continuity of care whilst they received respite care. In addition the provider had good links with the specialist palliative care unit at the trust and could refer patients in need of inpatient specialist palliative care.

- We observed care delivered in the community. We saw staff made every effort to ensure that people's needs were met, which included medicines being delivered, equipment being provided and support for relatives being put in place.
- Where appropriate, equipment such as profiling beds and pressure relieving mattresses were provided to support patients who wished to die at home; an external provider delivered this. The service was responsive and staff confirmed equipment was delivered quickly to patients' homes to facilitate hospital discharge or prevent admission to hospital.
- Some community staff and staff in the end of life care team and the Macmillan team had undertaken verification of expected death training to support timely verification and certification of death.
- Community staff and staff in the end of life care team and the Macmillan team carried a mobile telephone. This enabled patients and relatives timely access to telephone advice and the ability to request assistance from the teams. The teams were well connected with other support networks who could be contacted to provide additional support.

Equality and diversity

- All staff received awareness training in equality and diversity as part of their induction to the organisation and on an ongoing basis as part of their essential training. At the time of our inspection, 100% of the end of life care team were up to date with this training.
- End of life care services were planned to take account of the needs of the population of patients who were registered with a Nottingham City GP regardless of their race, ability or gender.



Are services responsive to people's needs?

- Staff could access face-to-face and telephone translation services. Staff were aware of how to access the service and told us that requests for translation services were very responsive.

Meeting the needs of people in vulnerable circumstances

- End of life care services were accessible to all members of the community including patients who were living with dementia.
- The end of life care team had access to Admiral Nurses for support, advice and guidance. Admiral Nurses are dementia specialist nurses who give expert practical, clinical and emotional support to families living with dementia to help them cope. They are registered nurses, and have significant experience of working with people with dementia before becoming an Admiral Nurse. Following our inspection, the provider told us the Admiral Nursing Service was no longer in existence.
- Inevitably, some patients managed by the end of life care team also had a diagnosis of dementia. The needs of patients living with dementia were assessed individually with appropriate involvement from family and carers. Staff had undertaken dementia training and were able to explain when they might need to make adjustments.

Access to the right care at the right time

- The provider shared with us data for the number of patients who died in their preferred place of care. They had achieved a result 100% from April 2016 to October 2016.
- End of life care service provided care for patients with cancer and patients who did not have cancer. Between October 2015 and November 2016, there had been 1268 referrals to the specialist palliative care service. Of these 35% had a diagnosis of cancer, whilst 37% had a non-cancer diagnosis. 13% of patients had a diagnosis of cancer with a long-term condition and the remainder of the patients did not have a diagnosis recorded.
- Staff could obtain support from a local palliative care specialist unit provided by a local NHS Trust. Although staff told us this service was commissioned, we did not

see any evidence that there was a memorandum of understanding or a service level agreement in place. In addition, we did not see any evidence to indicate the provider monitored the provision of out of hours services in order to assure themselves patient's needs were responded to in a timely way.

- A community matron was based in the healthcare of older people's wards at the local NHS trust and could assist in ensuring patients who wished to receive end of life care in their home were discharged as soon as possible.
- There were three virtual hospice beds based at the provider's nursing home. These were staffed by the nursing home staff with input and oversight from the end of life care team.
- There was a hospice at home service that could deliver the same standard of hospice care in patient's own homes if that is where the patient preferred to be. The hospice at home team worked closely with GPs and district nurses to ensure patients could be cared for and die in their own home if that is where they wished to be.

Learning from complaints and concerns

- The provider had an up-to-date management of concerns and complaints policy. The policy was available for staff to access on the provider's intranet. The policy and procedure provided guidance and standards for the handling of complaints.
- Staff told us there were very few complaints relating to end of life care services. Between October 2015 and November 2016 there had been two complaints relating to end of life care. Both complaints had been dealt with appropriately.
- There was a clear explanation about how to make a complaint or compliment by email or telephone about care on the provider's web site. There was also information about independent support and advice as well as links to referring complaints to the parliamentary and health service ombudsman (PHSO). Patients also had access to this information in the form of a leaflet.
- Staff were unable to give us any examples where they had experienced learning and change from complaints and concerns.

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:

- The leadership, governance and culture mostly promoted the delivery of high quality person-centred care.
- The service lead was working with external stakeholders to develop a service strategy. This had not been completed at the time of our inspection.
- Although there was no published strategy, there was a vision and a work plan for the future of the service, and throughout our inspection, we could see that much of the work plan had already been implemented. We could also see that it had been developed in line with the provider's vision and values.
- The locality leads, clinical nurse specialists and general district and community staff were able to tell us the purpose of their service, to provide care and support for patients in their last year of life, and their role within the integrated locality team. All staff, including very senior managers understood the importance of end of life care.
- There were good governance structures in place for end of life care through the integrated governance structure.
- The lead for end of life care was visible, and there was good local support and leadership for end of life care. Staff had confidence in their managers to ensure training and expert knowledge was available to improve end of life care experiences for patients and those who were close to them.
- There was good public and staff engagement throughout end of life care services.

However, we also found:

- We did not see where patient outcomes or incidents had been discussed for patients receiving end of life care. In addition, there was no safety performance dashboard related to end of life care. There was therefore a risk that the local team may not have full oversight of issues related to safety performance throughout the end of life care service.

Service vision and strategy

- The provider had a well-communicated vision and set of values across all services. The vision was around building healthier communities and concentrated on delivering quality services that put patients at the centre of their care. The vision was underpinned by four fundamental core values, which were based upon integrity and trust, focusing on excellence, working in unity with patients and other providers to ensure integrated care and building sustainable well-being.
- When asked about the vision and strategy for end of life services, without exception, all staff we spoke with, including the service lead told us they were following the Nottinghamshire guideline for care in the last year of life. However, we found the provider's strategy and strategic objectives for end of life services were still in development. The service lead was working with internal and external stakeholders to develop the service strategy but it had not been completed and published. However, there was a vision and a work plan for the future of the service, and throughout our inspection, we could see that much of the work plan had already been implemented. We could see that the work plan had been developed in line with the provider's vision and values.
- All staff we spoke with knew about developments within the service and a meeting was planned for all agencies involved in the service to come together to discuss the strategy and vision going forward.
- The locality leads, clinical nurse specialists and general district and community staff were able to express the purpose of their service, to provide care and support for patients in their last year of life, and their role within the integrated locality team. All staff, including very senior managers understood the importance of end of life care.

Governance, risk management and quality measurement

- Governance for end of life care was integrated with the CityCare integrated governance structure.
- Governance arrangements were in place for risk events and staff told us that they received feedback after

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incidents had been investigated. Staff also felt confident that incidents led to learning and changes being made. We were however concerned that opportunity for learning from incidents was only shared following the completion of incident investigations, this meant patients could be at further risk whilst the investigation was being completed.

- All staff we spoke with were clear about their roles and the roles of others within end of life care services.
- There were clear lines of accountability including a structure for cascading information to the senior management team and back down to staff delivering care.
- Staff and managers were able to describe the governance structure within the service. A review of governance meeting minutes confirmed there was an effective governance structure with topics such as incidents being discussed at the integrated governance meetings. However, we did not see where patient outcomes or incidents had been discussed for patients receiving end of life care. In addition, there was no safety performance dashboard related to end of life care. There was therefore a risk that the local team may not have full oversight of issues related to safety performance throughout the end of life care service.
- As part of our inspection, we attended an end of life care strategic operational group meeting. This involved the lead and manager for end of life care services and the chief executive of a local hospice which had been commissioned to provide day therapy services and a hospice at home service. We could see there were strong working relationships and a collaborative approach to end of life care. The meeting was set to discuss progress and future actions and although there was a plan of action for the future of the service, no formal minutes were taken of the meeting. The team therefore had no audit trail of the discussions that had taken place prior to our inspection. We discussed our concerns with the lead for end of life care who told us they could understand our concerns and would look at this going forward.
- There were team meetings across individual teams. Previous meeting minutes indicated where staff shared good practice and highlighted areas of concern.
- The provider did not undertake mortality reviews for patients that had died within the service.

- There was no risk register for the end of life care service and there was nothing on the provider's risk register relating to the end of life care service. The local leadership team told us they felt there was very little risk within the service.

Leadership of this service

- The locality lead for end of life care had been seconded to the role and had not been in position very long at the time of our inspection. However, all staff we spoke with knew who the lead was for end of life care.
- Although the lead for end of life care was new to the role, they were able to express a clear commitment to the development of end of life care services within the organisation.
- Staff told us the lead for end of life care was visible, and there was good local support and leadership for end of life care. Staff had confidence in their managers to ensure training and expert knowledge was available to improve end of life care experiences for patients and those who were close to them.
- There was representation for end of life care at board level and the lead for end of life care told us that end of life care issues was fed into the board meetings through the governance structure. This meant the provider had a designated person at board level to champion the strategic direction of end of life care within the organisation.

Culture within this service

- Without exception, all of the staff we spoke with throughout all of the teams delivering end of life and palliative care were committed to providing and ensuring patients received a good end of life care experience.
- We found an open, honest and supportive culture in end of life care services with staff being very engaged, open to new ideas and interested in sharing best practice in end of life care.
- Staff reported positive working relationships, and we observed that staff were respectful towards each other, not only in their specialities, but across all disciplines.
- All staff we spoke with said they felt confident to raise concerns with their managers.
- The community nurses we spoke with told us that end of life care was always considered a high priority for

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them. They also stated that end of life care was deep-rooted in their work for patients. They spoke with pride about the importance of helping individuals achieve a comfortable and pain free death.

- Without exception, all staff were committed to ensuring patients received end of life care where they wished.
- There were systems in place to ensure that staff affected by the experience of caring for patient at end of life were supported. There were opportunities for formal debriefings as well as informal support.
- Teams were supportive of each other and aware of the emotional stress of working in end of life care. The Macmillan support team had a 'sparkling moments' book, in which they recorded their positive experiences of palliative and end of life care. Although they used this to evidence where they had met their key evaluation points set by the clinical commissioning group (CCG) they also found this a useful exercise to provide positive reflection for the team.

Public and staff engagement

- The provider had a website that people could use to find out information regarding services offered. There was information about end of life care on the provider's website.
- Patients and those close to them were actively engaged and involved in decision making about their end of life

care. Throughout the delivery of care, staff held open and honest discussions with patients about their end of life care wishes. Patients we spoke with confirmed this and we observed staff interacting with patients.

- Staff recognised the importance of receiving the views of people who used the service and encouraged them to complete feedback forms.
- The provider sought feedback from relatives following the death of their loved one. Feedback shared with us was overwhelmingly positive.
- CityCare Voice encouraged staff engagement through the alignment of its culture and values. It facilitated communication between staff and the senior management team through nominated CityCare Voice Ambassadors.
- Staff told us they felt engaged with and were encouraged to contribute ideas to shape and improve the service.

Innovation, improvement and sustainability

- There were three virtual hospice beds situated in a dedicated nursing facility owned by CityCare. There was an end of life in reach team who provided specialist support. Those beds provided an opportunity for respite care to patients and their families.
- Opportunities with external stakeholders meant that patients could access facilities such as day therapy services, hospice at home services and bereavement support.