

Walsall Healthcare NHS Trust

Community end of life care

Quality Report

Date of inspection visit: 31 May & 21 June 2017

Date of publication: 20/12/2017

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)
RBK		Walsall Palliative Care Centre	

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

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

Where applicable, we have reported on each core service provided by Walsall Healthcare NHS Trust and these are brought together to inform our overall judgement of Walsall Healthcare NHS Trust

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?	Outstanding	☆

Summary of findings

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Summary of findings

Overall summary

Following the last inspection in September 2015, we rated this service as good across all five domains resulting in an overall rating of good. However, during this inspection we saw the service had built on their good work within all areas and made significant improvements across the board. This resulted in an outstanding rating for the caring, responsive and well led domains and good for safe and effective domains, achieving an outstanding rating overall.

Overall rating for this core service Outstanding

- In order to assess the level of service provided to patients at the end of their life, their families and carers we visited the Walsall Palliative Care Centre, we spoke with nursing staff, doctors and managers about their work and how they were supported. We accompanied nursing and therapy staff on home visits to patients, which enabled us to assess the service provided and to talk with patients and their families and friends in their home environment.
- We completed a short notice announced visit on 31 May 2017 having informed the trust on the previous evening. During that visit, we announced a further visit which we undertook on 21 June 2017.
- We spoke with a total of 24 staff and 26 patients/carers. We looked at seven patient health records and we reviewed other records and documents about the provision of the service including training, management of staff and provision and maintenance of equipment.
- We compared what we found against national guidance and best practice. The World Health Organisation (WHO) define End of Life Care as: ‘an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.’
- Our judgement of the service provided in the community by the trust, fulfilled the WHO definition and met the NICE guidance.
- We found the Individualised End of Life Care Plan which the trust had ratified since our last visit to be an exemplary document. The plan ensured that patients received individualised care based on their own personal needs and wishes. The plan had been recognised nationally and had been awarded the Royal College of Physicians – Excellence in Patient Care award.
- Accompanying documentation in the form of guides for staff and health professionals and guides for patients and family members in relation to End of Life Care and planning had also received national recognition and awards. ‘Thinking about End of Life Care’ had received a BMA Patient Information award for user involvement.
- The services palliative care multi-disciplinary team procedures had been recognised by the International Journal of Palliative Nursing and had won the ‘Palliative Care Team of the Year’ award for Specialist Palliative Care MDT 2017.
- Incidents were reviewed and learning shared within and across teams.
- Staff received regular clinical supervision and were encouraged to develop personal skills that would complement or enhance the team’s ability to provide holistic care to patients and support to their families.
- Local audits were used to identify where services could be improved and learning was widely shared across the teams.
- The departments approach to risk assessments was outstanding. Patient’s health and their environment were assessed regularly to ensure that they and staff attending them were safe. Patients attending the Day Hospice were assessed each time they attended. Risk assessments were completed in respect of activities to ensure that they were safe and appropriate for the patients concerned.
- Staff displayed empathy with patients and their families.
- Patients were at the centre of their own care, they and their family members were able influence how,

Summary of findings

when and where they were treated. They were encouraged to retain their independence helped with their dignity and provided with the support and symptom control, which enabled them to remain with their families and continue to make the most of their time.

- Nurses, doctors and support staff all used the mantra 'Every moment counts'.
- Transition services were tailored to meet the needs of young people and introduce them to the services available as they entered adulthood.
- Clear management structures were in place for teams based upon geographical areas of work.
- Staff had confidence in their managers and believed they provided appropriate support and guidance; this was evidenced by training records, annual reviews and clinical supervisions.
- Audits were completed on all aspects of the service and learning was shared within teams.

Summary of findings

Background to the service

Information about the service

Walsall Community Healthcare Trust was last inspected in September 2015. The service had continued to provide End of Life Care both in the community and in the acute Walsall Manor Hospital. The End of Life Care service is provided by two teams the acute team based at the hospital and the community team based at the Walsall Palliative Care Centre, Goscote Lane.

The same senior managers managed both teams and the services operated so that patients moving between community and acute services were identified and received appropriate care.

This report refers to the community-based services only. There may be references to the hospital-based services where these have had a direct impact on the community-based services.

The Walsall Community Specialist Palliative Care team provide a range of services for patients both at the end of life and those with long-term conditions. The Walsall Palliative Care Centre also houses an independent hospice in addition to a number of clinic-based services.

An independent provider operated the hospice, the other services including the day hospice (Fair Oaks) were provided by the trust. These services worked closely to ensure patients who were eligible and required hospice services were able to move between hospital, community and hospice services with the minimum of disruption.

End of Life Care is available to all patients who were assessed as being in their last twelve months of life. In common with many areas of the country, cancer patients form a high proportion of the trust's End of Life Care patients. Between April 2015 and May 2016 the trust's specialist palliative care team received 1,549 referrals. Around 65% of these patients were cancer patients and 35% had other life limiting conditions.

Complementary therapies patients consisted of 84% cancer 16% non-cancer, Specialist therapies 87% cancer, 13% non-cancer. The day hospice 82% cancer 18% non-cancer and the Lymphoedema service 40% cancer 60% non-cancer.

The community specialist palliative care team specialised in assisting patients with long-term conditions or terminal illness, but in many instances, with appropriate care and interventions patients could continue to live with their condition for many years. As a result, the team had often built up close relationships with patients and their families by the time they had been identified as end of life.

The service supported between 40 and 60 patients per month to die in community settings, either at home, in care homes or hospice settings.

Staff in all disciplines and at all levels of the community service were described by patients and family members in very glowing terms.

During our previous inspection, we saw how the complementary therapy team at the Walsall Palliative Care Centre had produced outstanding results using a form of auricular acupuncture. During this inspection, we saw that in addition to continuing this work staff had sourced additional training and whereas previously they were qualified to provide treatments using five acupuncture points, they were now able to use up to seven, increasing the number of conditions, which they were able to assist with. Assessment of the benefits of these services was an on-going process; and patient satisfaction with the services was very high.

The multidisciplinary approach to treatments was still evident with excellent liaison between specialist, therapists, community resources, and external healthcare professionals.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Tim Cooper Care Quality Commission

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Chair: Martin Cooper, retired MD, Royal Devon and Exeter NHS Foundation Trust

Team Leader: Angie Martin Care Quality Commission

The team included a CQC inspector, a Palliative Care Nurse specialist and district nurse with end of life care experience.

Why we carried out this inspection

The trust is currently in special measures, following an announced comprehensive inspection on 8 to 10 September 2015. We also carried out three unannounced inspection visits after the announced visit on 13, 20 and 24 September 2015.

Following the 2015 inspection, we rated this trust as 'inadequate'. We made judgements about 11 services across the trust as well as making judgements about the five key questions we ask. We rated the key questions for safety, effective and well led as 'inadequate'. We rated the key questions, for caring and responsive as 'requires improvement'.

After the inspection period ended, the Care Quality Commission issued the trust with a warning notice served

under Section 29A of the Health and Social Care Act 2008. This outlined the quality of healthcare provided by Walsall healthcare NHS Trust for the following regulated activities required significant improvement:

- Diagnostic and screening procedures
- Maternity and midwifery services
- Surgical procedures
- Treatment of disease, disorder or injury

Due to the special measures status of the trust, we inspected all services at the main acute site, Manor Hospital. We also inspected community services: adult services, children and young people and end of life care.

How we carried out this inspection

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

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

For example:

'Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. In order to assess the level of service provided to End of Life Care patients, their families and carers we visited the Walsall Palliative Care Centre, we spoke with nursing staff, doctors and

managers about their work and how they were supported. We accompanied nursing and therapies staff on home visits to patients which enable us to assess the service provided and to talk with patients and their families and friends in their home environment.

We completed a short notice announced visit on 31 May 2017 having informed the trust on the previous evening. During that visit, we announced a further visit which we undertook on 21 June 2017.

We spoke with a total of 24 staff and 26 patients/carers. We looked at seven patient health records and we reviewed other records and documents about the provision of the service including training, management of staff and provision and maintenance of equipment.

We compared what we found against national guidance and best practice.

Summary of findings

What people who use the provider say

Patients who used the services of the palliative care team, the wider healthcare teams within the trust and the facilities at the Walsall Palliative Care Centre were extremely complementary of the service they received. They described staff in the most glowing terms, “brilliant”, “I don’t know how we would cope without them”, and “Like family” were just some of the expressions used.

We asked patients including those attending the day hospice, “what staff could do for you, in addition to what they already do”; they unanimously told us, “Nothing”.

Good practice

- Community engagement by the Walsall Palliative Care Centre was exemplary. A panel of patients and patient relatives had reviewed all the content and style of documentation such as the Advanced Care Plan and the Individualised Care Plan. This meant that in addition to following national guidelines on end of life care the documents also reflected the needs and wishes of the local population. It also meant that people in the community were able to understand the documents. As outlined in the report a number of documents produced by the senior managers had won national recognition and awards.
- Ongoing development of the transition service for young people was based on the experiences of those young people. An information film following the real-time transition of patients had been produced. This

was in post-production before being made available to young people, their families and external healthcare professionals. The information included an insight into the medical, physical and social support provided in adult services based around the Walsall Palliative Care Centre.

- Audit of patient records was conducted on a monthly basis, feedback was provided to teams on their performance. Where improvements were required teams were asked to reflect on their own practice and report back to quality assurance meetings how they intended to improve. This had resulted in raising the profile of end of life care throughout the service. Innovative practice from teams was highlighted and circulated to all.

Walsall Healthcare NHS Trust

Community end of life care

Detailed findings from this inspection

Good 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated this domain as good. This was because:

- End of Life Care plans had been created in consultation with the community and external healthcare professionals, which not only met individuals' needs but also ensured that the care provided was of the highest standard and prevented staff using a one-process fits all approach to care.
- Staff had received appropriate training and were managed in a way which ensured they understood how to keep people safe from abuse and how to report or escalate concerns.
- Anticipatory drugs were discussed with GPs so suitably qualified staff could administer the drugs to prevent delay in reducing pain or other symptoms as they arose. We saw advice was provided to GPs regarding potentially beneficial drugs and how these were then prescribed to prevent delay.
- Equipment was readily available for patients who required them. We were told that most equipment could be provided within 24 hours of request. In some instances, smaller items were collected by staff and delivered the same day.
- Syringe drivers were stored locally and were always available when required.

- The specialist palliative care nurse team had over 50% of their staff trained to assess patients' needs for specialist equipment. This meant that patients rarely had to wait for occupational or physiotherapists to complete assessments before equipment could be ordered.
- Clear records were maintained in relation to all aspects of the service including patient health records.
- We saw that staff completed all records whilst still in people's homes, this not only allowed them to leave a copy in the home, but also ensured that information was recorded accurately before moving onto other patients.
- Continuous assessment of care provided and feedback to teams who worked with the specialist palliative care team meant that learning continued in an open and honest forum.

Detailed findings

Incident reporting, learning and improvement

- The trust had an incident reporting policy. Staff we spoke with saw incidents as an opportunity to improve and learn. We saw records which showed that incidents were reviewed, validated and themes or trends were

Are services safe?

identified and discussed at divisional quality meetings. Serious incidents were reported on the Strategic Executive information System (STEIS) and directly to the CCG.

- The community nursing teams held meetings every morning to discuss patient needs and staff workloads. We were told how issues, including any learning from incidents were also discussed. An example of this was the increase in incidents relating to the use and delivery of drugs via the T34 McKinley Syringe Pump showing user error as a recurrent issue and pump availability. The staff implemented a new policy for the use of syringe pumps in palliative care patients, along with regular audits.
- Incidents were reported at divisional level with community end of life patients sitting under the medicine and long term conditions divisional reporting figures. Between March 2016 and April 2017 180 incidents were recorded for the division.
- During this period 71 incidents were reported in relation to patients in the community, of these 22 incidents were reported by the community specialist palliative care team, Fair Oaks Day Hospice and the Walsall Palliative Care Centre; nine incidents were classified as minor harm and 13 were classed as no harm.
- Weekly Combined Specialist Palliative Care MDT meetings and Monthly Specialist Quality Palliative and End of Life Care Group meetings took place during which information from around the trust, including learning from incidents, was shared. We saw minutes of the meetings which confirmed this.
- Monthly performance reports were prepared by senior managers based on record reviews, teams were tasked with reviewing their performance against expected outcomes and providing action plans or responses on proposed improvements, which were shared across the service.

Duty of Candour

- There had been no incidents within the palliative care team or Walsall Palliative Care Centre or Fair Oaks Day Hospice which had required the trust to initiate formal duty of candour procedures. Staff we spoke with were aware of the need to be open and honest with patients and family members.
- 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.

- Senior staff had a clear understanding of the requirements of duty of candour and the trigger points that would impose a legal duty on the trust to follow the procedure.

Safeguarding

- The trust had a safeguarding lead based at Walsall Manor Hospital; Staff in the community were aware of the lead and understood how they could be contacted if advice was required.

Staff understood their role about keeping patient's safe and reporting any issues. Staff were able to describe the different types of abuse and how they would respond if they encountered abuse.

All staff who delivered palliative and end of life care received safeguarding training in line with their role. 100% of nursing staff had received both adult and children's safeguarding training to level 2. One of the two bereavement counsellors dealt directly with the children of deceased or seriously ill patients. They had received additional training to level 3.

- Patients and their relatives were encouraged to tell staff if they had concerns and we saw safeguarding posters displayed in prominent areas in clinics and bases with up to date contact details.
- All staff employed by the trust including the volunteers had been subject to disclosure and barring service (DBS) checks. DBS checks help to ensure only people of good character were employed in certain occupations.
- Patients attending the Fair Oaks Day Hospice told us that they felt safe at the centre. They said they trusted the staff and would be happy to discuss any concerns with staff including any concerns unconnected with the service.
- We asked for information about the number of adult and child safeguarding referrals made between March 2016 and April 2017; the services made four referrals to adult safeguarding services and no referrals to children's safeguarding services. One of the referrals was on two

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separate occasions for the same person. Two of the patients referred were being cared for at home the second patient with two separate referrals was being cared for in a nursing home.

- We saw minutes of trust Safeguarding Committee meetings which showed how cases were discussed and interventions identified.

Medicines

- The specialist palliative care team and community nurses worked closely with primary care services. Ninety per cent of the local GPs implemented Gold Standard Framework (GSF) and held regular GSF multi-disciplinary meetings. The GSF is a model that enables good practice to be available to all people nearing the end of their lives, irrespective of diagnosis. It is a way of raising the level of care to the best possible standard. Patients in the community received their medication on prescription from their GP. The GSF and close liaison between the trust and individual GP surgeries meant that GPs were able to speak with specialist nurses or doctors to ensure that appropriate medication and dosage levels were prescribed to meet patients' needs.
- Most patients self-administered their medication or were assisted by their carers. District nurses and palliative care nurses undertook medication administration and maintained syringe pumps where this was required. Where nurses administered medication we saw they had completed medication records appropriately and had received up-to-date medication training. Where appropriate patients and their relatives told us that staff had explained the procedure for medication administration and they were confident that they understood and could follow the instructions given.
- Patients who received end of life care were prescribed anticipatory drugs where this was appropriate to their care. This could include patients who it was anticipated could deteriorate at short notice. Having anticipatory drugs available in the home allowed qualified staff to attend and administer drugs that may stabilise a patient or reduce pain and anxiety and prevent the need for an emergency admission to hospital. In the absence of anticipatory drugs, doctors were usually called which may involve a delay during which patients may be in pain or discomfort or may deteriorate to the point where they need to be admitted to hospital.

- An audit of anticipatory drugs in community patients was undertaken in relation to patients who had been prescribed anticipatory drugs between October 2016 and January 2017, the audit identified that in most instances correct procedures had been followed; however, two instances of incorrect dosage of symptom control drugs were identified. This resulted in the information being shared with staff to increase understanding and improve compliance.
- Lockable medicine boxes were available and on loan to patients who needed to keep controlled drugs in their home, this meant that children and other vulnerable people in the home were kept safe.
- Monthly Non-Medical Prescribing meetings took place that enabled review of current practice. External speakers were invited to attend and present examples of best practice. Non-medical prescribing involves the prescribing of medication that is allowed by practitioners who were not qualified doctors. Suitably qualified specialist nurses use the system.

Environment and equipment

- Equipment such as bariatric beds, specialist mattresses and syringe pumps were readily available for patients who required them. We were told that most equipment could be provided within 24 hours of request. In some instances, smaller items were collected by staff and delivered the same day.
- Syringe pumps were stored at the Walsall Palliative Care Centre and additional stocks were kept at the district nurse locality hubs, this meant that supplies were always available when required.
- Staff confirmed that equipment was serviced regularly and well maintained. The trust provided a list of syringe pumps and maintenance dates.
- The specialist palliative care nurse team had over 50% of their staff trained to assess patients' needs for specialist equipment. This meant that patients rarely had to wait for occupational or physiotherapists to complete assessments before equipment could be ordered.
- The Walsall Palliative Care Centre was the base for a number of clinics and specialist services. We saw that equipment required for these specialities was available and had been maintained in accordance with the manufacturer's recommendations. Equipment included

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specialist beds, bathing equipment and hoists to assist patients with limited mobility, and piped oxygen for use by patients attending the Chronic Obstructive Pulmonary Disease (COPD) clinics.

- The centre had one resuscitation trolley; the trolley was properly stocked and was checked regularly to ensure it was ready for use. We saw notices on the walls of treatment rooms around the building to remind staff of the location of the trolley.
- The Walsall Palliative Care Centre shared facilities with the St Giles Hospice. There were no mortuary facilities on site, however a cold room was available as a temporary resting place should the need arise. This facility was within the hospice area of the building but Walsall staff could access the facility if they needed to.

Quality of records

- The trust used paper records for patient care records and clinical notes. Staff used duplicated record sheets, which enabled them to leave a copy at the patient's home and retain a copy for the patient's main records, which were maintained at the Walsall Palliative Care Centre. This meant that an up to date record was available in the patient's home for the information of any visiting health professional.
- We reviewed seven sets of patient records; we did this as we wanted to see what patients and staff had told us was reflected in the records. We saw that records contained details of symptom control, pain relief, and risk assessments appropriate to the patients concerned.
- The trust had developed an advance care plan document for end of life patients and their families. The document was designed to allow families or patients to complete information that was important to them as an individual. Details of likes and dislikes, preferences and information about their history, which helped staff, understand the patient and provide care in a way which met their needs. This was complimented by information booklets and guides for patients and families to understand what to expect and the support, which was available.
- During our previous inspection in 2015, we found that the trust were still working with the local community on a replacement to the Liverpool Care Pathway. During this inspection we saw that the new documentation; the individualised end of life care plan, had been ratified by

the trust and brought into use. The documentation was based on the latest national guidance and provides comprehensive guidance for staff in relation to end of life care.

- We saw that staff completed records whilst still in people's homes, this not only allowed them to leave a copy in the home, but also ensured that information was recorded accurately before moving onto other patients.
- We saw that records regarding the general running of the service and maintenance of equipment were maintained either electronically or in paper form. Paper records were securely stored and electronic records were protected by secure individual login procedures.

Cleanliness, infection control and hygiene

- The trust had an infection control policy and all nursing and medical staff received training in infection control. An infection prevention and control lead was available in the trust for advice. We spoke with staff in the clinics and in home settings and we saw all the staff had a good understanding of infection control practices.
- We saw that all areas of the Walsall Palliative Care Centre, including public areas and treatment rooms, were clean tidy, and free from clutter.
- We observed staff in patients' homes as they used personal protective equipment such as aprons and gloves. We saw nurses washing their hand prior to and following patient contact. In patients' homes, we saw how nurses prepared clean areas before opening sterile dressings or medication.
- Staff followed good practice guidance of being 'arms bare below the elbow' when providing care.
- Sharps bins were used for the disposal of contaminated dressings and sharps we saw that these were readily available. Nursing staff visiting people's homes carried spare bins for use by patients.
- Cleaning schedules were kept which outlined daily, weekly and monthly cleaning tasks and we saw evidence of these being audited. Cleaning schedules of clinics within the Walsall Palliative Care Centre was the responsibility of the trust.

Mandatory training

- The trust target for mandatory training was set at 90%. We saw mandatory training rates in community services varied between teams and disciplines.

Are services safe?

- Mandatory training was made up of a number of subjects, these included conflict resolution, clinical update, equality and diversity, fire safety, patient handling, information governance and safeguarding children. Percentages were aggregated, such that individual members of staff might have completed some subjects and not others, so the figures for each discipline were added together to provide an overall level of compliance. This meant that it was difficult to assess the overall level of compliance at any one time. However, end of year figures showed that other than staff on long-term absence such as sickness or maternity leave all had achieved the trust target during previous years.
- Figures provided by the trust showed that at the time of our inspection staff involved in end of life care services had achieved 100% completion rates in dementia training, patient handling and clinical update. They achieved rates in excess of 90% for infection control, corporate update which included major incident awareness, and mental capacity training. We saw that other subjects fell below the trust target of 90% however, senior staff were confident that all staff in work would complete their training by the year end. We saw that fire safety training stood at 47%. We were advised that this was because standard fire safety training was based at and centred round the Manor Hospital. Trainers had recently attended the Walsall Palliative Care Centre and provided site-specific training to staff based there, the attendance on the course had yet to be updated into the trust figures.
- Staff were able to book themselves onto mandatory training courses using the trust computers. Training was available as a combination of computer based e-learning and face-to-face courses.
- End of life care training had consisted of a two-day mandatory training course for all staff that provided end of life care.

Assessing and responding to patient risk

- Risk assessments were completed in relation to both patients and their environment. We saw information was recorded which would assist staff or other health professionals to understand the patients' needs and provide care, treatment to identify, monitor and mitigate risks.
- Patients who used the Fair Oaks Day Hospice received an additional assessment to ensure that they could be

safely accommodated and basic health assessments were completed on each visit. Reassessments were completed if there were changes to health or wellbeing or at three monthly intervals; staff took the opportunity to discuss peoples advance care plans at these assessments and assisted patients to complete the forms.

- If a patient was expected to attend the day hospice and failed to arrive, staff took pro-active steps to contact the patient or their families to ensure they were safe and establish why they had not attended.
- Protocols were in place that enabled staff to arrange transfers to hospital, return people home, or admit to the hospice at Walsall Palliative Care Centre Hospice if patients were taken ill whilst attending the centre.
- Risk assessments were also completed in people's homes in order to keep staff and patients safe and ensure equipment could be accommodated and used without it presenting a risk to the patients their families or medical staff. Patient assessments included malnutrition universal screening tool (MUST) scores, falls and mobility assessments, patient handling (sometimes referred to as manual handling) assessments and pain assessments.
- Any changes in a patient's health or vulnerability was recorded and any additional interventions were put in place for example, pressure relieving mattresses to reduce the risk of pressure ulcer development and mobility aids to reduce the risk of falls, or fluid and nutrition balance charts if patients were not eating or drinking as expected.

Staffing levels and caseload

- The specialist palliative care nursing team consisted of nine specialist nurses who worked a variety of full and part time hours and an operational manager who also managed other teams within the service.
- The team worked collaboratively with the occupational therapy, physiotherapy and complementary therapies teams and other health care professionals at the centre and with the seven locality nurse teams. During our previous inspection in 2015, the trust had area locality nurse teams; these were in the process of evolving into integrated place teams. Each of the seven teams had a palliative/end of life care link nurse. Link nurses had received additional training and liaised closely with the palliative care team.

Are services safe?

- District nurses provided a range of care and treatment to people in their homes and we saw a proportion of their caseload involved the provision of end of life care. The community palliative medicine consultant based at the Walsall Palliative Care Centre provided medical oversight.
- We saw recognised tools were used to assess staff levels and skill mix in all the locations we inspected. Staff in all areas we visited during the inspection told us they were busy, but they felt they had sufficient time to provide a meaningful and quality experience for their patients. They did say that they felt they were now working to their capacity and that any increase in patients or reduction in staffing levels would affect the quality of care they could provide.

Managing anticipated risks

- End of life patients and vulnerable patients were identified to out-of-hours services and to ambulance services, so appropriate advice or treatments could be given if patients deteriorated. Information relating to patients' wishes such as not being admitted to hospital were also communicated.
- Anticipatory drugs were discussed with GPs in relation to patients in their care and these were kept in people's home if prescribed so suitably qualified staff could administer the drugs to prevent delay in reducing pain or other symptoms as they arose. We saw advice was

provided to GPs regarding potentially beneficial drugs and how these were then prescribed to prevent delay. The trust had an anticipatory prescribing policy available to staff on the intranet.

- Nurses we spoke with told us that they did not have preselected anticipatory drugs. Drugs were prescribed based on a patient's individual needs. There were several drugs which had proved to be effective in symptom control and were often used but only where this was appropriate to the individual patient. They also confirmed that allergies were always considered when deciding how best to support patients.
- Risk registers were maintained in relation to issues, which were or had the potential to interfere with services. Examples of entries included capacity and demand for the lymphoedema service and potential impact on the trust bereavement services caused by the closure of a local authority service in Walsall. We saw that risks were assessed rated and mitigation was put in place where possible.

Major incident awareness and training

- The trust had major incident plans that included strategies to relieve pressure on acute services by increasing early discharge and care at home for patients. Community based staff were aware of the plans and how their role supported the trust.
- The plans had been used during periods of high demand due to winter pressures. Major incident awareness training was incorporated into the corporate update training which staff received annually.

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 have rated this service as good for effective. This was because:

- Comprehensive guidelines had been introduced in consultation with the CCGs; whilst consultation with other healthcare professionals, patient advisory bodies, and community groups continued.
- We saw that the trust had Individualised End of Life Care Plans.
- The service published guidance in pamphlet form for other healthcare professionals (e.g. GPs and community nurses) to ensure they had sufficient knowledge to support the patient during their care.
- Local audits were used to identify where services could be improved and learning was widely shared across the teams.
- The team responded to issues in the community which affected their patients. An example being the review of support for patients requiring the service of Citizens Advice Bureau following changes to the provision by external agencies.
- The latest end of life care audit showed evidence that 93% of cases had received multidisciplinary discussion about the expectation of death.
- Services were provided in people's homes and specialist services such as palliative care nurses and specialist therapies teams were supported by locality nurse clinics in health centres, which people could access in their local area. Staff were actively engaged in monitoring people's health and encouraged other health professionals in the wider health community to do so.
- Staff were consistent in supporting people to live healthier lives, including identifying those who need extra support, through a targeted and proactive approach to health promotion and prevention of ill-health, and they used every contact with people to do so.
- Specialist support was available for patients for whom conventional drugs were ineffective in reducing their pain. A consultant from a neighbouring trust was employed by Walsall Community to provide this specialist support and knowledge.

- Staff received regular clinical supervision and were encouraged to develop personal skills that would complement or enhance the team's ability to provide holistic care to patients and support to their families.
- We saw that there was a focus on nutrition and hydration which is key in patients with end of life care needs.
- The facilities of the Walsall Palliative Care Centre were also available for patients on an outpatient or drop in basis. Patients concerns, anxieties, or questions were addressed quickly and honestly.

Detailed findings

Evidence based care and treatment

- Walsall Healthcare NHS Trust completed a comprehensive patient and family's consultation process over a number of years. This followed the abolition of the Liverpool Care Pathway (LCP) in 2013. The LPC was withdrawn nationally as it had not always been seen to deliver appropriate care. Trusts were required to produce their own approach to end of life care.
- When we inspected the trust in 2015, we found that a replacement for the Liverpool Care Pathway had not been introduced since the abolition of the LPC. We did see that comprehensive guidelines had been introduced in consultation with the CCGs whilst consultation with other healthcare professionals, patient advisory bodies, and community groups continued. During this inspection, we saw that the trusts Individualised End of Life Care Plan had been introduced. The plan was very comprehensive and followed the latest guidance from NHS England, NICE and the National Council for Palliative Care.
- Senior staff involved in the consultation process told us that although the CQC had been critical of the time taken to ratify a formal replacement for the Liverpool Care Pathway; they would not have done anything differently; they felt that for Walsall the protracted consultation process was exactly what was required. It produced excellent relationships with external health professionals and with patients and their families. They

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told us that the establishment of the Individualised End of Life Care Group had been invaluable to helping understand and reflect the needs of patients into the final care plan. The group still meet to discuss end of life issues.

- During the consultation process the trust had introduced an advance care plan (ACP) which we saw during the previous inspection. The ACP assisted patients to express their wishes. It also enabled family members and staff to understand what that individual wanted and enabled them to provide targeted personalised care. The trust had continued to review its processes following feedback from patient groups. Feedback had suggested that the ACP was lengthy and time consuming to complete. This meant that patients and families often did not have time to consider the intimate questions and difficult conversations particularly where patients reached the end of life unexpectedly or faster than had been expected. The trust responded by introducing a short one page version of the plan which covered the areas patients and families had identified were the most important to address. The short form enabled an increase in engagement from staff and families. This demonstrated how the trust continued to take account of patients and their families when planning care.
- The trust also recognised through their close liaison with healthcare professionals both in the trust and in other community healthcare settings such as GP surgeries and clinics; that not all staff had the same level of knowledge and expertise in using the ACP as the dedicated palliative care teams; in order to provide guidance and following consultation they published a guidance pamphlet 'ACP Pro Guide'. This was made available in both printed and electronic format.
- To assist patients and family members understand the system and to assist them with the difficult decisions and conversations they might face the trust produced their 'ACP Patient Guide' and their 'Thinking About End of Life' booklet.

These publications were written by trust staff following consultation with healthcare professionals, patients and family members. These booklets and guides had received national recognition; the British Medical Association awards 2016; the 'Thinking About End of Life' booklet was

awarded a Highly Commended certificate in the patient information category. Staff were particularly proud of this, as other entries had included publications produced by professional publishing houses.

Pain relief

- Pain relief formed an important part of the service's function. Patients in the community who received end of life care remained under the care of their GP. GPs and some specialist nurses who had completed prescribing training were responsible for prescribing medication for community patients. However, consultants were available at the Walsall Palliative Care Centre and within the acute trust to provide advice and guidance to GPs on the most effective treatments for patients on end of life care.
- The Specialist Palliative Care team supported patients by liaising with GPs and district nurses regarding best practice in relation to care and treatment, including pain management. We reviewed seven sets of patient records. Patients had all received pain assessments that was evidenced in their notes. Patients or family members confirmed that staff had asked them about pain relief and discussed options and with them. They confirmed their pain had been managed well.
- Where appropriate patients had syringe pumps to deliver medication. A syringe pump is a small, battery powered pump that delivers medication through a soft plastic tube, into a syringe with a needle that is placed just under the skin of the patient's arm, leg or abdomen. The continuous dose of medication is used to treat symptoms such as pain, vomiting, seizures, and agitation. Where syringe pumps were in use, we saw staff checked the operation, delivery and site of the pumps.
- We saw qualified nursing staff on the community teams were trained in the use of syringe pumps. Staff explained that syringe pumps were readily available within the trust. It was also noted that all pumps in use were T34 McKinley pumps that met national requirements.
- Staff described how specialist support could be obtained for patients who did not respond to the usual interventions for pain relief. A consultant specialising in complex pain issues attends the trust on Friday of each week to assess and review complex pain issues. The consultant works at an external trust but had practising

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privileges with the trust; advice was also available between visits for urgent cases. This enabled the team to provide effective pain relief to patients who might otherwise experience intense pain and discomfort.

Nutrition and hydration

- Patients were encouraged by staff to maintain a healthy lifestyle, this included advice on diet and drinking. During their interaction with patients we saw staff discussing diets and reminding patients to drink plenty of fluids to stay hydrated. This included speaking with family members so that they could encourage patients to eat and drink. General health issues were also discussed and where staff had concerns for patients they discussed these with them and arranged appropriate referral to GP's or other services.
- During home care assessments, malnutrition universal screening tool (MUST) scores were completed which helped staff identify patients at risk of malnutrition. For patients who were assessed as being 'at risk' of malnutrition, food and liquid intake was recorded and patient weight was monitored more regularly. Fluid and nutrition balance charts were used to help monitor patients.
- Pain management drugs can have the side effect of making patients feel nauseous. Some patients received medication to reduce nausea and enable them to eat and drink without feeling ill.
- We observed staff in the Fair Oaks Day Hospice interacting with patients and providing hot and cold drinks. One patient said, "You no sooner finished one drink and them here with another one".

Technology and telemedicine

- At the time of our inspection, the trust did not use telemedicine for community palliative care patients. Managers told us that telemedicine may be something the trust could use for some palliative patients. It was not appropriate for end of life patients where first class face-to-face care was preferable.
- Funding was being sought from commissioners in relation to mobile computing solutions for palliative care nurses that would enable them to update care records and instantly update central records for the patients. The technology would also include access to

guidance and best practice. This would enhance the excellent service already provided, and free up time for staff to spend more time with patients or see more patients.

Patient outcomes

- On 5 July 2016, the Department of Health published plans to reform and standardise end of life care. The plans set out six priorities which healthcare providers were expected to achieve by 2020. These were:

Honest discussions between care professionals and dying people

Dying people making informed choices about their care

Personalised care plans for all

Discussion of personalised care plans with care professionals

Involvement of family and carers in dying people's care

A main contact so dying people know who to contact at any time of day

We found that these plans were already incorporated into the trust's individualised end of life care plan and the advance care planning documents.

- In April 2017, the Walsall end of life care service lead completed a review of 480 deaths that had occurred in the trust between April 2016 and March 2017. The review included 240 patients from the acute sector and 240 from the community.

We saw that the review identified that end of life care services were already incorporating the six priorities into their work and that overall compliance was good. For example that the trust achieved a higher rate of home deaths during the period than other trusts in the region and also higher than the national average for the period.

- The main causes of death across the whole cohort of 480 patients was neoplasms (196) (neoplasms are abnormal growths such as cancers), circulatory disease (125) and respiratory disease (64).
- We saw that care plans were written and reviewed to meet people's individual and changing needs.
- Walsall Palliative Care Centre had two bereavement counsellors, one of whom had received specialist training in counselling children whose parent had or was near to passing away. We saw this member of staff

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had also received level 3 child safeguarding training. Bereavement services support was available to patients and their families prior to death and continued with support for family members following a death. We were told that there was no time limit applied to the service, people could attend whenever they needed to. Some relatives of patients had continued to have counselling many years after their relatives death.

- The annual end of life care audit showed that of the 240 community patients reviewed 222 (92.5%) died in their preferred place of death and 227 (94.6%) had received care in their preferred place of care. The review also showed that 223 (93%) had evidence of multidisciplinary discussion about the expectation of death.
- Senior palliative care managers had recognised how the ongoing auditing of end of life records could be used as a tool to improve services throughout the trust. Each month a review was conducted of 20 sets of patient records. The information from these was provided back to the ward or community team involved. A list of expected outcomes was provided and the teams actual outcomes were compared both in written and graphical form. Teams were asked to reflect on the results and where required consider how they could improve their own performance. There was no prescribed method of response but teams were asked to present their responses to the next End of Life Strategic Delivery Group meeting. We reviewed how three teams had responded with action plans and interventions to improve compliance and performance. Some had written formal action plans whilst others used PowerPoint presentations to explain their proposed actions.
- The innovative way the information was shared and teams were encouraged to respond had resulted in good practice being shared throughout the service.
- Managers explained that they had now completed the process for all areas and were commencing a second round, which would not only continue to identify improvements but would also allow the different departments to review their own progress and the effectiveness of their actions.

Competent staff

- Specialist palliative care medicine consultants were available for advice to trust staff and to other healthcare professionals. Home visits were completed in support of district nurses and GPs to advise on practice.
- We saw evidence at all locations we visited regarding training for nursing and healthcare workers. Specialist palliative care training included medicines training, syringe pump training and tissue viability training, many of the specialist palliative care nurses had also received training in assessing the needs of patients in their homes that reduced the time for patients waiting for specialist equipment as they did not have to wait for a trained therapist to attend.
- Specialist nurses worked with specialist therapy teams and complementary therapists based at the Walsall Palliative Care Centre and were also able to make home visits. Additional support was also available from a range of services, including psychologists.
- Specialist palliative care nurses were aligned to GP practices to increase communication and give external healthcare professionals known points of contact. End of life care link nurses were re-aligned to meet the new district areas introduced by the trust as integrated care hubs; and a competency framework was introduced to give structure to the role. Link nurses were also provided with badges in recognition of the role and to make them easily identifiable to colleagues and other healthcare professionals.
- At the time of our inspection all the community specialist palliative care nurses, palliative care therapies team, self-care management team and volunteering and membership staff had a current personal development plan (100%), however complementary therapy and Fair Oaks Day Hospice staff had 86% and 88% respectively against a trust target of 90%.
- Staff received regular one to one meetings with their managers, clinical supervisions and regular team meetings where each month a different case was discussed.

Multi-disciplinary working (MDT) and coordinated care pathways

- The specialist palliative care team held daily team meetings. The awareness of patients and their individual needs were discussed each day together with details and needs of any new patients who required visits. The team identified on a daily basis who was best

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able to support each patient and how care and support might best be delivered. The team liaised closely with the place nurse teams and the link nurses on each team and with therapy staff.

A different team chaired MDT meetings each quarter. We were told how this had improved engagement as some disciplines had previously felt excluded from the process and rarely had their opinions included. The new system ensured that all disciplines were engaged and had been universally hailed as best practice.

- Psychologists, occupational therapists and physiotherapists were all based at the Walsall Palliative Care Centre and provided clinics at the centre. They also provided home visits where required, and were available to staff and external healthcare professionals for advice and guidance.
- The Citizens Advice Bureau (CAB) provided advice and guidance to patients and family members. Staff described how many patients often became anxious about how their condition would affect their income and how they or their families would cope. The CAB advice service helped people understand what assistance was available and enabled people to concentrate on their health without having to worry about other issues.

We were told that because of funding changes the CAB service were reducing their availability at the centre. The exact changes had yet to be finalised but staff believed the service provision would be shared between the hospital and the Walsall Palliative Care Centre.

- We saw a number of instances of shared care between community specialist palliative care nurses, allied health professionals such as physiotherapists, district nurses and doctors. Staff explained how they were involved providing guidance and information to GP practices and external agencies, increasing their knowledge and skills in the area of palliative and end of life care. Consultants explained how they regularly discussed complex cases with GP's particularly in relation to medication and pain relief.
- Patient records showed how effective care was managed through interaction between these different disciplines. Information in records enabled all those involved in care to understand any changes in health or wellbeing and respond accordingly.

- The community specialist palliative care team had been nominated for and won the International Journal of Palliative Nursing; Nurse/Team of the year 2017 for their MDT working. The annual review of end of life services in the trust showed that 93% of community patients had been subject of MDT discussions.
- The trust had a number of teams and individuals involved in end of life MDT working with surrounding hospices. Two palliative care consultants also worked with other NHS trusts in the region, as part of the on-call rota, which helped increase understanding across the region. The consultants were also members of the West Midlands Physicians Group.

Staff attended the region wide audit guidance group across a range of disciplines.

Weekly specialist palliative care MDT takes place within a local hub of which the Walsall Healthcare Trust (WHT) community Specialist Palliative Care staff were core members. The main aim of this MDT was to discuss the most complex patients on the caseloads of any services including community nursing, matrons, GP's, long term condition (LTC) specialist nurses It also included ward teams where patients had a palliative diagnosis. A recent addition to this meeting was to include palliative patients with a lymphoedema diagnosis enabling access to practice nurses, GP's and community nurses also require specialist palliative care advice from the lymphoedema team.

The operational managers and consultants meet monthly with a local hospice to discuss any issues across nursing, medical & facilities issues.

A specialist advisor was provided from another local hospice weekly.

- Training delivered across the organisation by specialist palliative care team was also offered to staff from local hospices, for example, Advance Care Planning Training. Palliative care teams worked closely with local GPs. Because of this close liaison, 90% of the local GP practices were signed up to the National Gold Standards Framework for Palliative Care. In addition, staff used other tools to assess and monitor patients, such as the Macmillan care support guide.

Referral, transfer, discharge and transition

- We saw that overall 85% of patients who had expressed a desire to die at home, which included care homes,

Are services effective?

had been facilitated to do so. Staff we spoke with told us they did everything they could to facilitate peoples wishes but the provision of suitable equipment and community care packages delayed some discharges which in some cases meant patients had to be supported in the hospital or hospice setting which had not been their first wish.

- District nurses, specialist palliative care nurses and community-based consultants all understood their role in the process of enabling patients to receive end of life care that met their needs and wishes.
- The trust's specialist palliative care team and the support services shared a building with a local hospice. Clear protocols existed between the trust and the hospice that enabled patients to move between the trust and hospice services as their needs changed. Whilst the two were separate organisations, they provided a seamless transition for patients.
- End of life care patients were able to attend the Fair Oaks Day Hospice, where they could take advantage of all the facilities and services in the centre. Where patients were too ill to attend the centre, referrals could be made and staff such as therapists, psychologists, and counsellors visited patients in their homes.
- District nurses and palliative care nurses worked closely with GP services and care home staff to ensure end of life patients received appropriate medication and support.
- The Fair Oaks Day Hospice was working with young people who were in the process of transitioning from children's services to adult services. An information film was in the process of being produced that followed the transition process from the perspective of a young patient. We were shown draft version of the film. We saw how visits to the hospice were incorporated into the transition process including a review of the facilities and activities that were offered. This would enable young people to understand what the service offered and how they would be supported in the future.
- We were fortunate to meet one of the young people who featured in the film during a home visit with staff. They confirmed how they had been supported in the transition process, they had engaged in joint meetings with paediatric and adult teams, they had been told about the day hospice and invited to visit and view the facilities. They told us the experience had exceeded their expectations.

- Staff told us how they liaised with ambulance services regarding end of life patients in order to prevent unnecessary hospital admissions. We were told due to the geographical areas covered by the trust they received support from a number of ambulance trusts.

Access to information

- All nursing and medical staff had access to the trust's computer systems when at their respective base or when visiting other trust sites. However; the trust did not have remote access to electronic systems; staff used duplicated case notes when visiting patients in community settings. This enabled one copy to be left with the patient notes in the home and a second copy to be placed with the main patient records held at the base. The service lead was in discussion with the CCG regarding additional funding to provide tablets or laptops for specialist palliative care nurses who completed home visits.
- Guidance, policies, procedures and general information to assist staff was available through the trust intranet and internet systems.
- Copies of policies and audits were kept by managers and senior nursing staff at the various bases and were available to staff if they needed to view them.
- Staff had individual email accounts where they received information or messages directly affecting them.
- News items appeared on the trust intranet and electronic newsletters were circulated which we saw contained useful information and guidance regarding incidents and medical alerts.
- Specific guidance and information relating to End of Life Care and the associated documentation was available to staff and external healthcare professionals in the form of the Advance Care Plan pro guide and the 'Thinking About End of Life' information booklet.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Community specialist palliative care staff used a national Mental Capacity Assessment tool to assess the capacity of patients. We did not encounter any patients who did not have capacity during our inspection. Staff we spoke with understood the importance of seeking consent from patients and understood how to follow trust guidance in respect of patients who lacked capacity, including recording of best interest decisions and the persons involved in such decisions.

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- The Alzheimer's Society describes deprivation of liberty standards as 'The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aimed to ensure that people in care homes, hospitals and supported living were looked after in a way that does not inappropriately restrict their freedom.'
- Do not attempt cardio pulmonary resuscitation (DNACPR) forms were checked during home visits and were seen to be completed correctly. There had been one incident reported regarding DNACPR documentation. A patient had been discharged from hospital and had been provided with a duplicated copy of the DNACPR form. It had been correctly recognised that it was not lawful for medical staff to rely on copies when making decision about resuscitation. Arrangements were made for the doctor to attend and complete a new DNACPR however the patient's health deteriorated before this could be done which resulted in nursing staff and ambulance staff attempting to resuscitate the patient which had been expressly against their will, causing anxiety for both staff and relatives.
- We saw documents which showed that between April 2016 and March 2017 100% of end of life care staff had completed Mental Capacity Act and Deprivation of Liberty Standards (DoLS) training.



Are services caring?

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

Summary

We judged the caring of end of life care staff to be outstanding.

- End of Life Care in all areas of the trust's community services was centred on the individual patient, this also included support and guidance for carers, family members and healthcare professional both inside and external to the trust.
- Staff displayed genuine empathy with patients and their families.
- Staff were proud of how they cared for and supported people and strove to develop ways to improve the service they provided.
- We observed well-planned, thoughtful and careful interactions by staff both when dealing with patients but also with family members.
- Patients and family members all described how well they had been treated and could not imagine how staff could do better or do more than they did.
- Patients were at the centre of their own care, they and their family members were able influence how when and where they were treated. They were encouraged to retain their independence. Helped with their dignity and provided with the support and symptom control that enabled them to remain with their families and continue to make the most of their time.
- Nurses, doctors and support staff all used the philosophy 'Every moment counts'.
- Staff involved patients in their care, encouraged them to be independent and gave advice to carers or family members to help them assist with care when this was appropriate.
- Emotional support was provided to everyone concerned including staff supporting each other and being supported by their teams and managers.
- Bereavement counselling for families of patients was exemplary. This included support for children who had a parent nearing the end of life or after their death. Trained counsellors met with family members either at the palliative care centre or in their homes. Enabling people to understand and cope with their situation.

Detailed findings

Compassionate Care

- During our previous inspection in September 2015, we identified that the caring domain was very good but we did not see or hear anything that raised the service above other end of life care services in other trusts. During this inspection, we did see examples of care and personal commitment, which were outstanding.
- Following the previous inspection the trust were served with a warning notice regarding the lack of a formal end of life care plan. The implementation of an end of life care plan had been delayed because of the extensive external consultation process, which the trust had undertaken. Senior staff who had been involved in the consultation process explained how they were proud of the process they had used and how remaining patient and committed to providing the best possible outcome for patients had resulted in the Individualised End of Life Care Plan. They explained how this now reflected the needs and wishes of the people who it was designed in consultation with and for whom it would be used. They said, "Although we were criticised for the time it took; I wouldn't change a thing". The version available at the last inspection in 2015 had been version nine. The final ratified version was version 17 which demonstrates the number of changes and consultations undertaken to ensure that the plan which staff now follow catered exactly for the needs of the patients and their loved ones. Patients and carers had been central to the discussions and understood the delays were to ensure that the trust 'got it right'.
- We heard personal accounts from staff about how their own experiences had enabled them to understand better how patients felt about their health and wellbeing and how this had improved the service they provided to patients. It is not possible to expand on this, as it would identify individual members of staff. We were told how these personal experiences had been shared with colleagues and increased understanding for the staff concerned.
- During our previous inspection, we found well trained staff in the Specialist Palliative Care Teams care teams with the skills and personality to enable them to deal with the difficulties associated with the role. During this



Are services caring?

inspection, we saw that staff continued to be an asset to the department, we also saw the excellent levels of compassion and empathy shown to patients and their family members.

- Staff established relationships with the patients and their families; they were not only competent professional clinicians but also became friends and confidants who patients clearly trusted.
- Staff encouraged patients to complete Advance Care Plans so that if they reached a crisis in their health or when their condition deteriorated they and their family members had completed the difficult discussions and made decisions about how they wanted to be treated.
- During our inspection we were able to visit a number of end of life care patients in their homes and we saw how staff interacted with the patients they cared for. Staff were polite and courteous; patients appeared genuinely pleased to see staff. Staff were welcomed into people's homes and treated almost as family by patients and their relatives or carers.
- Staff were seen to be skilled at supporting people with their emotional needs and enabling people to understand and deal with the complexities of approaching the end of their life or that of a loved one. The support and guidance they provided was exemplary.
- We also spoke with patients and staff in the Fair Oaks Day Hospice. The patients described how helpful staff had been, they talked of medical reviews when they attended and advice which staff gave them to help relieve symptoms and improve health, but they also explained how staff supported them to enjoy life and make the most of what they had. They described activities and outings but also simple pleasures such as sitting and talking about their lives, their loved ones, their worries and their pleasures.
- During one home visit, a patient described their visits to the day hospice as the highlight of their week. They could not wait to go back. The patient's wellbeing had been enhanced and staff were trying to find space to enable them to attend on an additional day each week.

Understanding and involvement of patients and those close to them

- When we accompanied staff on home visits, we spoke with patients and family members. They all confirmed that staff were open and honest with them. They told us

that whilst it was difficult to hear some of the information, they felt more informed and empowered than if they had not known what to expect and what could and could not be done.

- They told us that they had been able to explain what was important to them, and felt able to discuss their fears and worries without feeling foolish.
- We saw how staff were friendly and exchanged banter with patients and their relatives but were professional and caring in their practice.
- Patients told us their medication and treatment had been explained to them including any possible side effects and the benefits they might see from taking medication.
- We observed staff provide care and support, and noted how staff took time to explain what they were going to do, how they were going to do it and ensured the patient was happy for the procedure to be undertaken. They confirmed with patients they were still happy for us to be present and where appropriate, they were happy for relatives to be present.

Emotional support

- All end of life care patients were allocated a named nurse so that they had a single point of contact. Patients told us they had found all the staff, either in person or on the telephone, to be equally as helpful and friendly. Some patients did say that having a named nurse was reassuring to them.
- Bereavement counselling was provided by the trust from Walsall Palliative Care Centre. Two bereavement counsellors were employed, one of whom specialised in dealing with children who had a parent who had passed away or was expected to pass away in the near future. Patients described how the service had enabled them to cope during the worst experiences of their lives. We saw that there was no set period during which counselling was provided. Some relatives made periodic visits to the service months and even years after their loss.
- Quiet rooms were available for people to speak with bereavement or nursing staff in a friendly, less clinical environment. A playroom was also used where small children could be engaged with games and activities whilst discussing their feelings.
- A multi faith prayer room was available where patients or family members could meet with chaplains for



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spiritual support or use to collect their thoughts. We were told how weddings and blessing services had been conducted in the room. The room was accessible 24hrs a day.

- We saw how staff encouraged patients to complete tasks for themselves to maintain their independence.

We saw nurses encouraged patients to live as independently as possible, monitor their own health and to report any changes rather than wait until a scheduled visit took place.



Are services responsive to people's needs?

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

Summary

- The Specialist Palliative Care (SPC) team were extremely responsive to people's individual and changing needs and we judged the service in this area to be outstanding.
- Staff used all the services available both inside the trust and in the wider health community to enable as many patients as possible to be treated and die in their preferred place of care.
- Care was planned to meet the individual patient's needs and followed national guidance and best practice; most services in the community were available during core hours between 8:30am and 8:30pm seven days per week, with some provision of overnight care following certain procedures such as blood transfusions.
- Patients and relatives told us they had never had problems getting appropriate advice or services, regardless of the time of day they called.
- Community end of life services enabled rapid discharge of patients from the acute hospital, providing support to meet patient's individual needs and wishes.
- Transition services were tailored to meet the needs of young people and introduce them to the services available as they entered adulthood.
- There is a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that meets these needs, which is accessible and promotes equality. This includes people with protected characteristics under the Equality Act, people who may be approaching the end of their life, and people who were in vulnerable circumstances or who had complex needs.
- People who use the service and others were involved in regular reviews of how the service manages and responds to complaints. The service could demonstrate where improvements had been made because of learning from reviews and that learning was shared with other services.
- The community specialist palliative care team were based at the Walsall Palliative Care Centre but travelled throughout the Walsall area. Each specialist palliative care nurse had a number of GP services that they were aligned to. This focused their work with those GP's but did not prevent them being deployed to other areas where the need arose.
- The specialist palliative care team oversaw palliative and end of life care and worked with the locality nurse teams and GP practices. The services worked together to provide a comprehensive service to patients.
- District nurses worked from seven community based locations or hubs, which meant that staff were familiar with the issues for patients in their particular area. Staff were able to understand the cultural and spiritual needs of the people they served. Each district team had a palliative care link nurse who had received additional training and supported the communication between the team and the specialist nurses.
- The trust worked closely with a local hospice which shared the location with the specialist palliative care team. Patients who were admitted to hospital or the hospice with end of life care needs were supported to return home if this was their wish and if it were possible to facilitate based on their needs.
- The trust had a community rapid response team. The team used offices within a local authority care home as a base. They operated between 8.30am and 10pm seven days per week. Part of their role was to respond to and support end of life care patients to prevent unnecessary hospital admissions. They responded within two hours of referral to provide a multidisciplinary approach to stabilise patients until other services such as district nurses or GPs could respond to the patient's needs. Referral to the rapid response team was via healthcare professionals, patients were not able to self-refer.
- Each day, information on new patients, those at risk of deteriorating or those who were particularly vulnerable were shared with the rapid response team and the ambulance services in the area. This enabled staff called to an address to have an initial understanding of the issues and needs of the patient they were attending.
- We saw that overall 85% of patients who had expressed a desire to die at home, which included care homes,

Detailed findings

Planning and delivering services which meet people's needs



Are services responsive to people's needs?

had been facilitated to do so. Staff we spoke with told us they did everything they could to facilitate peoples wishes but the provision of suitable equipment and community care packages delayed some discharges which in some cases meant patients had to be supported in the hospital or hospice setting which had not been their first wish. They described how they liaised with GP's, nursing homes, local authorities and patient families to ensure that safe and effective care could be provided in the location chosen by the patients. This included arranging for specialist equipment, temporary or permanent adaptations or alterations to people's homes through to more simple interventions such as moving beds or furniture to more appropriate rooms.

- We saw how people's social needs were catered for in addition to their medical needs. The Fair Oaks hospice ran a series of events that were open to patients to engage with. One such event had been a canal barge trip. Staff explained how the trip was designed to meet the needs of the patients including those with mobility problems such as those who used wheelchairs. They explained that only one patient had been unable to take advantage of the event due to safety restrictions. In order to ensure that the patient did not feel left out staff had provided a personal pampering session for the patient at the centre.

Equality and diversity

- Staff received training in equality and diversity as part of their mandatory training. All 100% of the community specialist palliative care team had received this training.
- Staff we spoke with understood how to support patients who had particular religious or cultural preferences.
- We saw printed information leaflets provided to families were all written in English. Staff told us even though there was a diverse community with many ethnic minorities; the vast majority of patients spoke English. The main languages after English were Polish and the South Asian languages of Urdu, Hindi and Bengali. Staff assured us information leaflets were available and could be provided in any language required.
- A telephone interpreter service was available and face-to-face interpreters could be arranged if required.
- A 'Black, Minorities, Ethnic' (BME) outreach team operated from the Walsall Palliative Care Centre and led on education too hard to reach sections of the community.

Meeting the needs of people in vulnerable circumstances

- Systems were in place, which were designed to meet patients requests regarding their preferred place of death, these are summarised in the effective domain of this report. However, they also reflect the way the trust met people's emotional needs.
- Patient records were flagged to identify patients with advance care plans, so that staff could consider their wishes when taken to or admitted to hospital.
- The Walsall Palliative Care Centre included the Fair Oaks Day Hospice where palliative and end of life patients could meet socially; patients were very complementary of the day centre and told us how they received health checks when they attended and how they were able to use other facilities at the centre such as therapies or counselling whilst they were there.
- The day centre had its own team of nursing and health care staff who were able to support patients with their complex needs. Transport services were available to collect and return patients to the centre.
- Other facilities at the centre included: the day hospice, community oncology and chemotherapy service specialist, community palliative care service, complementary therapy service, specialist therapies teams, cancer and palliative information and support services and library, specialist lymphoedema services, voluntary services, psychology, bereavement counselling, an outpatients department offering a range of consultation facilities, and citizens advice bureau.
- Home visits were completed for patients who found it difficult to access the clinic facilities; this included screening services such as cervical screening.

Access to the right care at the right time

- The specialist palliative care team provided a range of interventions both in people's homes and in community settings enabling patients to receive treatments, which historically might have only been available in hospital. These included blood and blood product transfusions, scans and medicines management screening services and therapies.
- Supported by the community locality nurse teams and Rapid response team, access to services was available throughout the day and night seven days per week. The community specialist palliative care and district nurses worked between 9am and 5pm seven days a week,



Are services responsive to people's needs?

covering on call until 9pm, including all public holidays. The service also provided out-of-hours sitters who could spend time with patients allowing carers to rest for a few hours or in some circumstances overnight.

Learning from complaints and concerns

- Very few complaints were received by the service. This showed the service understood the benefits of listening to patients and had systems in place to help people raise issues in a non-judgemental way.
- No complaints were recorded during the period April 2016 to March 2017 in relation to end of life care services in the community.
- Managers and staff told us how details of complaints or issues raised were shared amongst teams during handovers and team meetings. We saw minutes of management and team meetings where complaints were seen to be a standing agenda item.



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 judged local management of services was outstanding.

- The commitment of senior managers to ensure that consultation was completed into the individualised end of life care plan before it was taken into use demonstrated how patients were put at the centre of the system. This also fulfilled the trust vision to ensure the right care in the right place at the right time.
- Staff at all levels strived to improve the services offered. This was fuelled by initiatives from senior managers using audit evidence to highlight good practice and identify areas where further improvement could be made.
- Teams were challenged to identify how they could improve their own performance. Outcomes were shared across teams to constantly improve services for patients.
- Staff were complimentary of their managers, they told us they had complete confidence in their managers and believed they provided appropriate support, guidance and direction; this was evidenced by training records, annual reviews and clinical supervision.
- Public engagement was excellent, patient focus groups which had initially been set up to during the reviews of the individualised care plan; had continued and focussed staff on issues from patient's perspective.
- Audits were fully completed across all aspects of the service and learning was shared within teams.
- The service actively engaged community groups to promote the work of the service to patients who may need it, including a local college and the production of short films, which were published on the trust website and distributed on DVDs.
- Managers took account of comments from patients and staff to improve services. Actively seeking engagement with the community in order to shape and influence services.
- Robust governance processes enabled local and trust level monitoring of the service.

- There was a non-hierarchical culture throughout the service, staff at all levels and all disciplines felt comfortable engaging with each other. Staff demonstrated a clear sense of pride in the achievements of the service and their contribution to it.

Detailed findings

Leadership of this service

- There were clear lines of accountability within the management teams. Teams worked in a well-organised way and were all well-led. They knew what was expected of their role and respected the roles of managers and team leaders.
- Healthcare workers and nurses all told us they were supported by their line managers and department heads in all aspects of their work, including training and supervision of their work.
- We saw evidence at all the locations we visited of learning from incidents and complaints.
- Whilst speaking with one senior manager regarding the skills and abilities of the specialist palliative care team they said, "They are all band 7 staff, all on top of their game and eager to do well".
- We saw that audit processes were followed and used to promote learning and improvement.

Service vision and strategy

- The vision for Walsall Healthcare NHS Trust was 'becoming your partners for first-class integrated care'.
- Staff at all levels of the service understood how their work assisted the trust to fulfil its vision and strategy. Staff we spoke with believed that the vision reflected the priorities of end of life care in so much as they wanted to provide patients with the right care in the place where the patient most wanted at the time they needed it.
- Managers were passionate about the service their teams provided. They were proud of the achievements that had been made and there was a clear wish to continue to improve the service for the benefit of patients. We saw how the introduction of the individualised end of life care plan had been supported by information leaflets and guides which showed how thought had



Are services well-led?

been given to assisting patients, family members, staff and external healthcare professionals understand the processes involved and what was available and what was to be expected.

- Following the consultation and ratification of the individualised end of life care plan, the staff had retained their links with the community and the individualised end of life care group had been retained and was seen as an important advocate and voice for patients and families requiring end of life support.
- Senior managers demonstrated their commitment to the trust vision by ensuring that the individualised end of life care plan put patients at the heart of the process. They ensured that patient groups and the wider health community understood and agreed with the content and processes involved before putting it to the trust board for ratification. This meant the process was long and protracted. They recognised that pressure from regulators and peer pressure from similar organisations who had already produced their own plans; should not be allowed to divert them from their vision.

Governance, risk management and quality measurement

- Quality and risks were managed through a monthly specialist quality group for palliative and end of life care. Minutes from these meetings showed a wide range of issues were covered including reviews of incidents and risks.
- The trust provided us with minutes from End of Life Strategic Delivery Group from February 2017 to April 2017. These showed clear understanding of governance issues.
- The service produced an annual report called “Achievement of 6 key priorities for End of Life Care” for acute and community services for the period April 2016 to March 2017. This report brought together governance, quality and outcomes.
- We saw that the end of life care service identified risks to the service and was seen to be up to date, including review dates for the risks, and an allocated responsible lead person for the risks and completion of any actions.
- There was a risk register for palliative care and end of life care. This was integrated with the community service. One area of concern was finance and the provision of cancer and non-cancer patients.
- We reviewed the risk register for end of life care services and saw that the organisation had no electronic

coordination system (EPPaCs) for the storage and sharing of essential information for those patients at the end of their life. The trusts plan was to engage with the work stream to develop new EPPaCs system for Walsall agreed through the CCG commissioning board for a review in 2018.

- We saw there was an increase incident reporting in relation to use and delivery of drugs via the T34 McKinley Syringe Pump showing user error as a recurrent issue and pump availability. This had been reviewed and an updated syringe pump policy for use in palliative care patients had been implemented along with regular audits.
- We saw minutes from the palliative and end of life care strategic delivery group and saw discussions had taken place around syringe driver pumps, these continued to be held on wards unnecessarily, which led to a lack of pumps for other wards. The team from the EBME department also raised this. We saw discussions around the use of the amber care bundle, the progress was slow and concerns may have been around confusion with other initiatives taking place, such as a safer bundle and red and green days.
- We saw clear clinical oversight and involvement with patients throughout their care. Systems were in place which ensured managers understood their workforce and their workload. Clinical supervisions took place in addition to regular one to one meetings and staff meetings.
- Weekly and monthly team meetings took place. Standing agenda items included incidents, complaints, praise and policy updates. Staff at all levels told us the meetings were a useful source of information and encouraged staff to engage with issues and enabled learning to be passed across the teams and the trust. We looked at minutes of meetings and saw what staff had told us was reflected in the notes.
- Monthly End of Life Care Strategic Delivery Group took place, which included staff from all disciplines involved in end of life care. The group received presentations from teams regarding their action plans following audit responses.
- Monthly caseload reviews were completed with the specialist nurse teams and locality nurse teams.

Culture within this service

- There was a clear sense of pride and belonging amongst staff at all levels within the Specialist Palliative Care



Are services well-led?

teams. Each person's role was seen as being equally as important as the next. Staff appeared to have a genuine respect for each other, which allowed them to concentrate on their role within the team.

- Daily discussions about patients' needs and staff skill mix ensured that patients received the best possible response and staff were supported to provide it.
- Staff received weekly updates via the intranet from the head of the service relating to board level issues.
- Members of the team told us there was no hierarchy within the team and they felt they were able to contribute and influence the team during team meetings and discussions.
- Whilst the trust had not had a ratified end of life care plan in place, they had collaborated with the CCG and the local hospice to develop the 'Dying Well community charter'. This had provided guidance for staff alongside the advance care plan, which enabled the trust to provide good end of life care in the absence of a definitive plan.
- The trust had a lone worker policy; staff told us they understood how to keep themselves safe when working in the community. All staff carried mobile phones provided by the trust and details of all visits were recorded at each base, which meant staff could be traced.

Public engagement

- The trust collated information from patients, families, carers and staff using the friends and families test, we also saw evidence of public engagement at trust level, in relation to changes to services. The public consultation of the trusts individualised end of life care plan had resulted in a permanent panel of patient and family representatives being formed.
- The palliative care teams had worked with the performing arts department of a local college. Students had visited the facilities and been given awareness information about the services provided and the medical conditions supported. The students then produced a 'Flash Mob' singing and dancing routine which they performed in the foyer of the hospital to raise awareness of the department and its work.
- Staff in the Fair Oaks Day Hospice were in the process of producing an information film for young people transitioning from paediatric to adult services. The film involved patients of the hospice explaining their

personal journey through transition and how they were supported. We were able to see a pre-production copy of the film, which was to be made available on the trust website and as DVDs for young people to view.

- Having been identified either in the community or in hospital settings as requiring end of life care, when they returned to the community, patients and their families were encouraged to discuss their treatment and care and could influence their own treatment and care. The managed care document provided an excellent opportunity for patients to provide this information. Patients were provided with a credit card sized card, which identified that they had an advance care plan in place.
- The trust used recognised sources of patient feedback such as complaints, compliments, patient advice and liaison service (PALS) and incident analysis. In addition, they used on-line review sites where patient experiences were posted and the trust was able to respond.

Staff engagement

- Staff engagement was primarily through team meetings, email and intranet services. All staff we spoke with described the service as inclusive and supportive.
- Senior managers made frequent visits to community based locations. Staff we spoke with were able to name senior managers and told us they engaged with them during visits and appeared genuinely interested in their work and issues.

Innovation, improvement and sustainability

Awards:

- British Medical Association Patient Information awards for user Involvement; 'Thinking About End of Life Care', a supportive guide for those caring for someone dying from a life limiting illness.
- International Journal of Palliative Nursing; 'Palliative Care Team of the Year', for Specialist Palliative Care MDT.
- Royal College of Physicians: 'Excellence in Patient Care awards', Individualised End of Life Care Plan.

Innovations:

- Dying Well Community Charter; Principles of Care & Support. Walsall Healthcare trust, and local hospice and Walsall CCG.
- Transition work; Walsall Healthcare Trust, with a local hospice and transition service.



Are services well-led?

- Presentation of Care Group and Locality team action plans to End of Life Strategic Delivery Group
- Local Advance Care Planning 'Just a Thought' Campaign across Walsall
- Monthly clinical supervision support for Specialist Palliative Care and Clinical Nurse Specialists including thematic reflection sessions with Clinical Psychology.
- Monthly Non-Medical Prescribing meetings; review current practice and invite external speakers.
- Monthly caseload reviews & training sessions (Community Specialist Palliative Care and Clinical Nurse Specialists and Community nurses)
- Advance Auricular Acupuncture treatment; expanding the service from five to seven acupuncture points increasing the number of therapies available.
- Palliative Care Research projects: Integrated Specialist Palliative Care Team (Acute & Community) collaboration with the trust Cancer Research Team and the National Cancer Research Network NCRN
- All staff were provided with a Pocket Palliative and End of Life Care Toolkit information booklet.