Care Quality Commission

Coventry and Warwickshire Partnership NHS Trust

RYG

Community end of life care

Quality Report

Coventry and Warwickshire Partnership NHS Trust
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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RYGCR	Wayside House		

This report describes our judgement of the quality of care provided within this core service by Coventry and Warwickshire Partnership 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 Coventry and Warwickshire Partnership NHS Trust and these are brought together to inform our overall judgement of <Coventry and Warwickshire Partnership NHS Trust

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of findings

Overall summary

Overall rating for this core service Good ●

Overall, we rated community end of life care as good because:

- The feedback from people who used the service and those who were close to them was extremely positive about the care received by patients nearing the end of life. We saw that staff were motivated to go the 'extra mile' to meet patient's needs and the care patients received exceeded their expectations.
- 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.
- There was an open culture in reporting incidents and there were systems in place to learn from incidents and reduce the chances of them happening again.
- Community end of life services enabled rapid discharge of patients from the acute hospital, providing support to meet patient's individual needs and wishes.
- Clear records were maintained in relation to all aspects of the service including patient health records.
- There was evidence of multidisciplinary working across the community teams who provided end of life care and there were good links with the local GP practices.

- There was a good provision of equipment, including syringe drivers and mattresses for patient use in the community. We saw pre-emptive prescribing of anticipatory medicines and availability of the 'just in case' medicines.
- End of life care was delivered through evidence based research and guidance. Education programmes had been developed and delivered; new documentation had been successfully introduced to the trust improving the care for patients.
- Policies and guidelines were all evidence based and we saw excellent examples of multi-disciplinary and multi-agency working and collaboration.
- There was a clear vision that focused on the early identification of patients at the end of life, patients being cared for in their preferred place of care and the use of partnership working to develop services.
- We saw strong leadership, commitment and support from the senior team within the specialist palliative care team.

However, we found that:

The specialist palliative care team did not have a clear strategy in place for delivering end of life care services.

Summary of findings

Background to the service

Information about the service

Care for patients approaching the end of life was provided by the trust's specialist palliative care team. Specialist palliative care nurses supported community nurses who worked in integrated teams to provide end-of-life care services to patients in their own homes, care homes and nursing homes. The trust also had community care staff trained to support people at the end of life. These were a team of health care assistants who had undertaken additional training in caring for patients with advanced illness in their home environment.

End of life care was 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 March 2016, the trust's specialist palliative care team received 980 referrals. 79% of these patients were cancer patients and 21% had other life limiting conditions.

Our inspection team

Our inspection team was led by:

Chair: Paul Jenkins, Chief Executive, Tavistock and Portman NHS Foundation Trust

Team Leader: Julie Meikle, Head of Hospital Inspection (mental health) CQC

The team included one CQC inspector and two specialist advisers with knowledge of community end of life services.

The team would like to thank all those who met and spoke to the team during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Why we carried out this inspection

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

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?

In order to assess the level of service provided to end of life care patients, their families and carers we visited the team base and spoke with nursing staff, doctors and managers about their work and how they were supported.

We accompanied staff on home visits to enable us to assess the service provided and to talk with patient's families and friends in their home environment.

We spoke with a total of 14 staff and nine patients/carers.

Summary of findings

We looked at 12 patient health records and other records and documents about the provision of the service. We reviewed training and management of staff.

Prior to and following our inspection we analysed information sent to us by the trust and a number of other organisations such as local commissioners and Healthwatch.

What people who use the provider say

Patients we spoke with were positive about the staff that provided their care and treatment. They told us they had confidence in the staff they saw and the advice they received, Their comments included:

"They go the extra mile."

"Can't do enough for you."

"I can phone up anytime for advice."

Good practice

• The attention and consideration of peoples' individual needs and a commitment to provide person centred care was evidenced across the specialist palliative care team. Staff were passionate about their work and the difference it made to patients. They displayed caring and compassionate attitudes and said they were supported by their managers to provide excellent care and services.

• The specialist palliative care team had been accepted to participate in a clinical research study by the NHS

National Institute of Health Research. The objectives of the Prognosis in Palliative Care Study II (PiPS2) was to identify the best method to accurately predict survival in patients with incurable cancer. This will be the first clinical trial undertaken by the SPCT. The team members were enthusiastic and looked forward to starting the study once ethical approval had been obtained.

Areas for improvement

Action the provider MUST or SHOULD take to improve
Action the trust should take to improve:

• Develop a strategy and vision for end of life care services focused on achieving priorities identified by the team and delivering good, quality care.

Action the provider COULD take to improve

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Coventry and Warwickshire Partnership 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

Overall, we rated safe as good because:

- Staff understood their responsibilities to raise concerns and to record safety incidents.
- 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.
- Management of medicines was safe and there was guidance available for staff on prescribing palliative medicines and the use of anticipatory medicines at the end of life.
- Clear records were maintained in relation to all aspects of the service including patient health records.
- Patients had access to equipment or aids they required. Community staff were able to arrange delivery of the equipment for patients who were returning home for their end of life care, on the same or the following day.
- Nurse staffing levels met patients' needs at the time of the inspection. Staffing shortages were acted upon appropriately with the use of temporary staff and an effective induction process was in place.

Detailed findings

Safety performance

- The NHS Safety Thermometer is a monthly audit of avoidable harms which included new pressure ulcers, catheter urinary tract infections (UTIs) and falls. Management and Specialist Palliative Care (SPC) staff said they did not collect safety performance data as this would fall under the remit of the community nursing service. Community nurses are senior nurses who manage care within the community by visiting housebound patients to provide advice and care.
- The service collected safety information and performance which was reported at the trust's monthly safety and quality forum meetings. Safety data collected included safeguarding, incidents, complaints and health and safety and risk assessments. We viewed the report for March 2016 and noted there had been no safeguarding referrals or incidents reported for the previous month.

Incident reporting, learning and improvement

- End of life care (EoLC) community services, had not reported any never events or serious incidents in the last 12 months. Serious incidents known as 'never events' are defined as: "Wholly preventable incidents,

Are services safe?

where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers."

- The trust reported patient safety incidents to the National Reporting and Learning System (NRLS). During the period February 2015 to February 2016, there were no reported incidents relating to EoLC in the community.
- The trust had an incident reporting and investigation policy and this was embedded within the EoLC community service. The trust used an electronic reporting system to record all incidents.
- The end of life service was delivered by community nurses across a number of teams. We did not identify incidents specifically relating to end of life care during our inspection.
- We found staff, in all roles, who delivered end of life care services were aware of the incident reporting systems and told us they had access to them.
- The trust's safety and quality team circulated monthly 'Learning Alerts' bulletins to staff. The bulletin detailed any serious incidents that had recently occurred in the trust. The investigation and learning were shared with staff through the bulletin. Staff also confirmed that they were updated on incidents at their weekly team meetings.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- Staff were aware of their responsibilities in relation to duty of candour and being open with patients when incidents occur, however, as there had been no recent incidents, staff were unable to give us examples which specifically related to end of life care.

Safeguarding

- Systems were in place to protect patients in vulnerable circumstances from abuse. Staff understood their roles and responsibilities in relation to ensuring vulnerable adults and children were safeguarded.

- Staff we spoke with demonstrated an understanding of safeguarding and understood the types of abuse that might be found. Staff knew where to access information about safeguarding through the intranet and where they could get advice about potential safeguarding concerns.
- 100% of medical, nursing and support staff had received both adult and children's safeguarding training to level two. The trust advised that each directorate had identified link clinicians who were required to be trained to level three in both adults and children's safeguarding. These clinicians acted as a point of contact for staff within the directorate. A link staff member was available to the SPC team.

Medicines

- Medicines were well managed. Community patients who were identified as requiring end of life care were prescribed anticipatory medicines. Anticipatory medicines refer to those prescribed in anticipation of managing symptoms, such as pain and nausea, which are common near the end of a patient's life; these medicines can then be given if required, without unnecessary delay.
- The end of life care teams worked in liaison with primary care services which meant medicines were prescribed by the patient's GP.
- Most patients self-administered their medicines or were assisted by their carer's. Community nurses and Specialist Palliative Care (SPC) nurses undertook medicine administration and maintained syringe pumps where this was required. Where nurses administered medicines we saw they had completed medicine records appropriately and had received up-to-date training.
- Some SPC nurses within the community Specialist Palliative Care Team (SPCT) had completed the relevant training to become non-medical prescribers and could independently prescribe medicines and adjust prescriptions.
- Community SPC nurses and community nurses said the management and ordering of medicines were given priority by the teams and that there was good liaison with GPs. This was to ensure that patients who required anticipatory drugs received these. Patients we spoke with confirmed this.

Are services safe?

- The five prescriptions and administration records we looked at in the community were completed clearly; including the administration of medicines prescribed 'as required'.
- We saw in practice that patients at the end of life would routinely have their medicines reviewed during each visit in the community. Reviews included a full assessment of patient's condition, including any changes. We also saw that the SPC nurses worked closely with general community nurses to review patient's symptoms and liaise with medical staff to make changes to medicines as necessary.
- The trust used one model of syringe driver. The syringe driver was used in end of life care to deliver medicines to control pain and other symptoms continuously over a 24-hour period. The trust had guidelines in place for the use of the syringe driver, to reduce the risk of medicine errors.

Environment and equipment

- Staff told us they did not experience any issues with obtaining or maintaining equipment for end of life care patients. Syringe drivers were obtained from the trust wide equipment library and these were accessible to community staff out of hours.
- Patients had access to equipment or aids. Types of equipment that were required to help end of life patients at home included hoists, electric profiling beds, commodes and special mattresses to prevent pressure ulcers. These were ordered by the community nurses. Staff told us the system worked well and did not lead to unnecessary delays. The community staff were able to arrange delivery on the same or next day, for patients who were returning home for their end of life care. Patients we spoke with told us that equipment arrived quickly.
- Patients, carers and staff told us the service had provided beds, mattresses and other equipment for example to help people shower or have a bath. A relative said the equipment they needed had all been delivered to their home before the person was discharged from hospital. Everyone we spoke with said the equipment service was good.
- Equipment was maintained and checked to ensure it was safe to use. All non-medical equipment

maintenance was carried out by the community nursing services. Medical devices were maintained by the trust's estates and facilities department. Staff contacted the department regarding any maintenance issues.

Quality of records

- The trust used a combination of electronic and paper healthcare records. Staff attending to patients in the community completed paper records, which were held at the patient's home. This meant that when healthcare staff visited they had an up-to-date record of the patients' care and treatment. Community nurses would also update their patients' records electronically. The SPC team did not have access to electronic notes and would update the records that were held at their base. Staff were aware of the importance of ensuring the paper or electronic notes, also reflected the records in patients' homes.
- We looked at 12 patient records kept by the community SPC Nurses and found they were completed accurately. Records contained information about the individual patients which was designed to keep them safe and monitor their health over time. We saw the assessment documentation identified the patients' wishes, patient's symptoms were scored and details of medicines and symptom control were recorded.
- We observed staff complete records during their time with patients and this often included an explanation to the patient of what the nurse had recorded.
- We reviewed three do not attempt cardiopulmonary resuscitation (DNACPR) forms which were visible in the front of patient's notes. We found there were clear reasons recorded in the DNACPR documentation and evidence that patients and / or their families had been involved in the discussion. Community staff told us that GPs would visit patients if they had discussed a DNACPR with them.
- We saw there had been regular audits of patient records undertaken by the team. We viewed the results of the audit completed in February 2016. We noted there were three actions for follow up following the audit. A further audit was planned in June 2016.

Cleanliness, infection control and hygiene

- Infection control was part of the staff mandatory training. The trust's target was 95% of clinical staff having completed the training. The community SPCT

Are services safe?

were below the trust target with 92% of the team having completed infection control training. We were told that the reason for the shortfall was due to staff long term sickness.

- The service demonstrated high levels of compliance in relation to infection control. We spoke with staff about infection control; all staff had a good understanding of infection control practices.
- We noted that staff undertaking community visits had adequate stocks of hand gel and personal protective equipment (PPE) to take out with them.

Mandatory training

- Staff were aware of the mandatory training they were required to undertake. We were told that some training was mainly available electronically.
- The trust's mandatory and statutory training programme covered fire, conflict resolution, health and safety, infection prevention control, manual handling, information governance, basic life support, safeguarding adults, safeguarding children (levels one and two), Mental Capacity Act and Deprivation of Liberties Safeguarding (DoLS) and equality and diversity. The trust target completion rate for each course was 95%.
- We examined the training records for the community SPCT and found mandatory training compliance was just below the trust target for fire training (92%), health and safety (92%), infection control (92%) and life support level one (92%). We were told that the reason for the shortfall was due to staff long term sickness. All other training courses met or exceeded the trust target.
- Information governance training was part of the annual mandatory requirement for all staff and 92% of the SPCT were up to date with this against a target of 95%.
- The SPC team provided education on a formal and informal basis which included staff from external organisations, including those working in local nursing homes, for example, syringe driver training.

Assessing and responding to patient risk

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

- SPC nurses attended weekly consultant-led multidisciplinary meetings to discuss their patients' level of need and any risks that had been identified.
- Community SPC nurses, community nurses and GPs had regular meetings to discuss their patients and their level of need. The community SPC team discussed complex cases every morning.
- Changes to patient's condition were recorded in their daily notes by nursing, medical and therapy staff. Advice and support from the SPC team regarding deteriorating patients were available in the community. We observed a community nurse contact the SPC team regarding the deterioration of a patient. We also visited a patient with a member of the SPC team and saw that specialist advice was sought appropriately and in a timely way.
- We spoke with relatives who were aware of how to access help and support should a patient's condition deteriorate in situations where they were cared for at home. We met a family who had called on the community nurses, the night before our visit, due to the deterioration in the patient's condition. The family told us they had been clear about the process to follow in the circumstances and that staff had responded quickly and compassionately to their needs.
- The community SPCT worked five days a week and was available between 8:30 am and 4:30 pm. Out of hours and medical cover was provided by GP services that could access specialist support from a consultant on-call rota and the local hospice.

Staffing levels and caseload

- Staffing levels, skill mix and caseloads were planned and reviewed so that people received safe care and treatment at all times to meet their needs.
- Caseloads were discussed each morning by the SPC team, which included medical, nursing and therapy staff. The needs of each patient, details of new patients, changes both expected and unexpected to the patient's health or circumstances were discussed which allowed an appropriate response to be planned from the most suitable member of staff. The average caseload for a community SPC nurse was 20 to 30 patients.
- The SPC nursing team consisted of eight specialist nurses and the acting head of palliative care, who also managed other teams within the SPC service, for

Are services safe?

example support and therapy staff. The team worked collaboratively with the occupational therapy and physiotherapy teams and the community nursing teams located across Coventry.

- A consultant in palliative care medicine (WTE 0.9) was supported by a registrar specialising in palliative care medicine.
- The community SPCT had access to two clinical psychologists working across the trust in community services. They offered psychological support to staff.
- Staff in all areas we visited during the inspection told us they were busy. They ensured us they had sufficient time to provide a meaningful and quality experience for their patients. Patients told us that, with very few exceptions, staff were unhurried and willing to spend time explaining procedures and health issues with them.
- Care for end of life patients in the community was provided jointly by the specialist palliative care team and the community nursing service. Each area community nursing team had a palliative care link nurse. The link nurses had received additional training

and liaised closely with the specialist palliative care team. We saw community nurses had good relationships with the palliative care team. This was demonstrated when we saw how the two teams worked together, discussing a patient's needs during a home visit.

Managing anticipated risks

- Potential risks were taken into account when planning services, for example, the impact of adverse weather, or disruption to staffing. We saw that the community management team attended monthly management meetings where they reviewed all potential risks, lessons learnt, and outstanding action plans. These meetings included any end of life care issues.
- There was a clear lone working policy and staff were aware of this and how to mitigate risks of lone working. There were systems in place with staff checking in with each other. Staff we spoke with described the system they used, which reflected the lone working procedures that were in place.

Are services effective?

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

Summary

Overall, we rated the service as good for effectiveness because:

- People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- The trust had introduced an Individualised Plan for Care for the Dying Person for patients with end of life needs.
- Education was delivered for clinical staff to update their skills and knowledge in caring for end of life patients. Staff were also encouraged to develop personal skills which would complement or enhance the team's ability to provide effective palliative care to patients and support to their families.
- Resources were readily available for staff to access.
- We observed good practice in terms of pain assessment and management and all patients we spoke with told us their pain was well managed.
- There was evidence of multidisciplinary working across the community team, who provided end of life care.
- Staff had the appropriate skills and knowledge to seek consent from patients. Staff were able to tell us clearly about how they sought informed verbal and written consent before providing care or treatment.

Detailed findings

Evidence based care and treatment

- The Priorities of Care for the Dying Person were published in June 2014 by the Leadership Alliance for the Care of Dying People. Taking the five priorities to; recognise, communicate, involve, support, plan and do, the SPC team, in partnership the local acute trusts, had developed a personalised care plan for each patient in the last days of life with guidance for staff on how to best meet the five priorities of care.
- The personalised care plan, called the Individual Plan of Care for the Dying Person, had been shared with other healthcare professionals, patient advisory bodies and groups in the area. This ensured all interested parties had an opportunity to comment and suggest amendments or alternatives.

- We examined the Individual Plan of Care for the Dying Person and we saw it followed the National Institute for Health and Care Excellence (NICE) guidance, was patient focused, and ensured patient's physical, mental and spiritual needs were all considered. The care plan included the consent and involvement of families, friends and interested parties in making decisions for patients who could no longer communicate their own preferences.
- We saw evidence that care was based on the NICE Quality Standard QS13, including the identification, assessment and communication of all patients approaching the end of life.
- The SPC team used the West Midlands Palliative Care Physicians Guidelines which were available on the intranet. These guidelines were used for patients who were receiving care at home.
- The SPC team worked closely with GPs, the majority of who used the National Gold Standards Framework (GSF) for Palliative Care. The framework was used to help staff identify the needs of patients at each stage of their care through detailed assessment.
- Staff had access to the trust's policies and procedures via the intranet and we saw these were based on national guidance and had been reviewed regularly.

Pain relief

- Pain relief formed an important part of the service's function. Patients in the community who receiving end of life care remained under the care of their GP who was responsible for prescribing their medicines. There were consultants available within the end of life care teams to provide advice and guidance to GPs on the most effective treatments.
- The SPC team supported patients by liaising with GPs and community nurses regarding best practice in relation to care and treatment, including pain management. We reviewed 12 patient records. Patients had all received pain assessments which was evidenced in their notes.

Are services effective?

- SPC nurses told us they reviewed the patient's medicines and make recommendations to the GPs, who would issue the prescription. Six of the SPC nurses were non-medical prescribers, which meant that they could prescribe medicines where appropriate.
- The team had set up prescribing forum which met monthly. The purpose of the forum was to provide support by the consultant in palliative care medicine for nurse prescribers. Prescribing records are kept for each nurse prescriber and are reviewed at each meeting. Education on specific aspects of prescribing is delivered by the consultant as the need is identified.

- We observed medical and nursing staff on community visits assessing patients' pain levels and saw they assessed the type and duration of pain as well as factors that made the pain better or worse.
- Where appropriate, patients had syringe pumps. A syringe driver is a small, battery powered pump that delivers medicines through a soft plastic tube, into a syringe with a needle which is placed just under the skin of the patient's arm, leg or abdomen. The continuous dose of medicine was used to treat symptoms such as: pain, vomiting, seizures and agitation.
- We saw qualified nursing staff within the community teams were trained in the use of syringe pumps. Staff explained that syringe pumps were readily available within the trust.
- Patients we spoke with told us their pain was well managed and that staff were quick to respond to requests for additional medicines when pain occurred.
- Support services such as occupational therapists or physiotherapists were available to patients in all areas. Complementary therapies, specifically with massage treatments were used to help reduce pain.

Nutrition and hydration

- Patients were encouraged by staff to maintain a healthy lifestyle which 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.
- We observed patients in the community who were assessed for swallowing difficulties. We saw that community nurses were aware of the issues relating to nutrition and hydration at the end of life.
- During home care assessments we saw that malnutrition universal screening tool (MUST) risk

assessments were undertaken to identify patients at risk of malnutrition. The care planning document included an assessment of patient's nutrition and hydration status.
- Some patients were given medicines to reduce nausea which enabled them to eat without feeling ill.

Patient outcomes

- The trust had submitted data to the FAMCARE 2 Project by The Association for Palliative Medicine of Great Britain and Ireland. This is a post bereavement survey of relatives about the care and support they and their relative received. Data was submitted for deaths known to the palliative care team for the period June to August 2015. The results indicated that bereaved carers were satisfied with the end of life care provided to their family member by the SPC team. For example, 84% of respondents to the survey were very satisfied, or satisfied with the way in which the patient's condition had been explained by the SPC team.
- The Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. The trust did not have any CQUINs associated with end of life care.

Competent staff

- The SPC consultant and registrar were available to provide advice to trust staff and other healthcare professionals. Home visits were completed in support of community nurses and GPs to provide advice on practice.
- Doctors told us they were supported to complete their revalidation. Revalidation for doctors was introduced in 2012; in order to maintain their licence to practice, doctors were required to demonstrate on a regular basis they were up-to-date and fit to practice. Study leave was provided and the service had a robust appraisal system which helped to support the revalidation process.
- Information provided by the trust shows that 94% of all nursing staff in the trust had had an appraisal for the twelve months to November 2015.

Are services effective?

- The community SPC team received monthly clinical supervision by a clinical psychologist. Without exception, all staff told us this was excellent and they were very positive about the trust supporting them to attend.
- The consultant in palliative care medicine delivered weekly one hour protected learning sessions to the team before each Multidisciplinary Team meeting. We saw from records that topics included, Level 2 psychology training, prescribing forum, palliative care drugs update, advance decision to refuse treatment and a mental capacity act update.
- Healthcare support workers attended specific training courses on end of life care. For example, six of the 10 support workers have completed phlebotomy training in order to be able to undertake blood tests requested by the SPC nurse. Four support workers also explained they had a support worker 'away day' in November 2015 which they described as "brilliant" as it made them feel part of the SPC team. Other training completed included bereavement training and communication skills.
- Community nursing staff we spoke with confirmed they had received training in the use of syringe drivers.

Multi-disciplinary working and coordinated care pathways

- The specialist palliative care held daily multi-disciplinary team (MDT) meetings. The awareness of patients and their individual needs were discussed each day together with details of any new patients who required visits. The team identified on a daily basis who was best able to support each patient and how care and support might best be delivered.
- The SPC Team worked closely with the community nurses, all of whom supported people to remain in their homes rather than being admitted to hospital. The care was coordinated through the team leader who ensured appropriate services attended, this reduced duplication and unnecessary repetition of assessments.
- The SPC team said they had a good rapport with GP surgeries and had regular contact with them. GP's held a Gold Standards (GSF) meeting monthly with community nurses and a SPC nurse to discuss the early contact for newly referred patients as well as reviewing on-going patients and their required facilities.
- The team worked closely with Coventry Myton Hospice and a member of the nursing team attended the weekly MDT meeting at the hospice.

- Records held in patient's homes were multidisciplinary and ensured there was good communication between the community nurses and the community PCNSs, this meant that patients care was co-ordinated.

Referral, transfer, discharge and transition

- Patients were referred to the community SPC team through hospitals, community nurses and GPs. The SPC team provided care and support for more complex patients. If patients' needs changed over time, they may be discharged from the service, with their continued care and support being provided through community nurses and GPs.
- There was a process in place to rapidly discharge patients to their preferred place of death in the final days or hours of life. Support was provided following discharge by community nurses and the SPC support workers.
- The SPC team allocated new referrals on a daily basis and followed up non-urgent referrals within five days and urgent referrals within 2 working days. We viewed the referral pathway for patients. The team had introduced a red, amber, green (RAG) rating for referrals with red being the most urgent. As this system had only recently been introduced there were no audits available to demonstrate how the team were meeting their own targets. During the period April 2015 to March 2016, a total of 980 patients were referred to the team.

Access to information

- 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. This meant that all health care professionals involved in the patients' care had up to date information and knew of any changes or developments in the patients' health.
- A new Electronic Palliative Care Co-ordination system (EPaCCS) was due to be introduced across the community with access for GPs and community staff allowing improved access of information sharing. EPaCCS is designed to enable the recording and sharing of people's care preferences and key details about their care at the end of life. We were told the trust hope to pilot the system later in 2016.
- Do not attempt cardio pulmonary resuscitation (DNACPR) forms were held at the patient's home. In

Are services effective?

order to direct emergency services to the DNACPR form they were stored at the front of the patients' notes in a green plastic envelope (green sleeve). This meant they were easily identifiable.

- Guidance, policies, procedures and general information to assist staff were available through the trust intranet and internet systems.

- Staff had access to CASTLE website (Care and Support Towards Life's End - the palliative care website of the clinical implementation group of Coventry and Warwickshire). This website was primarily for health and social care professionals working in the fields of palliative and end of life care within Coventry and Warwickshire. It provided up-to-date information, local contact details (including primary care, care homes, hospitals and hospices), clinical tools, guidelines and information about education events.

- 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.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- SPC staff used a national mental capacity assessment tool to assess the capacity of patients. We did not meet any patients who did not have capacity during our inspection.

- We reviewed three DNACPR forms and found they had been completed appropriately. For example, patients had signed their consent, or where appropriate best interest meetings had been held with relatives or carers and medical staff. The DNACPR forms had been signed by GPs or hospital consultants.

- The specialist palliative care team had completed consent and mental capacity act training and this was repeated annually in mandatory training. We observed that the staff would check patients' consent whilst discussing treatment and ongoing support.

Are services caring?

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

Summary

Overall, we rated caring as outstanding because:

- We observed people's emotional and social needs were highly valued by staff and were embedded in their care and treatment.
- Staff were highly committed to providing care that was of a consistently high standard and focused on meeting the emotional, spiritual and psychological needs of patients as well as their physical needs.
- We found staff involved in end of life care, whether they were managers, administration staff, doctors or nurses, showed great compassion and care.
- All staff interactions and relationships with patients and their families were strong, caring and supportive.
- There was an excellent recognition of the importance of family and friends as the patient neared the end of their life. Feedback from patients and those close to them was consistently positive about the way staff treat people. We were told lots of examples that demonstrated the compassion and kindness of SPC staff. Patients and family members all described how well they had been treated with one patient describing the service as "going the extra mile."
- It was clear that there was a strong, consistent culture of person centred care for patients and those close to them.
- There were robust systems and processes to record the patient's wishes relating to their treatment and care, advance care planning and appropriate escalation of treatment.

Detailed findings Compassionate care

- Throughout 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. We saw all staff providing care and treatment to patients with end of life needs demonstrated a respectful approach when communicating with patients and their carers/families.

- We observed staff caring for patients in a way that respected their individual choices and beliefs. We saw patient records included sections to record their choices and beliefs which were widely communicated between the teams.
- We accompanied a nurse who was meeting a patient for the first time. The nurse asked for permission to enter the patient's home and introduced themselves to the patient and their carers. We observed that the conversation was set at a pace that the patient was comfortable with. The nurse listened to concerns and addressed the issues raised in a professional, caring and compassionate manner. The patient was given information about the role of the community SPCN team and community nurses. This meant that the patient was aware of who was responsible for which aspect of their care.
- Patients and relatives told us they were happy with the quality of care they received. One patient told us specialist palliative care nurses visiting them at home were always courteous, kind and caring in their approach.
- A patient told us of the tremendous support they and their family had received from the team. They told us the team was always available and would respond to any request or get in touch with the right person who could resolve the problem.
- Staff we spoke with were extremely passionate about delivering quality care for patients and their relatives at the end of life. We observed a nurse arranging for a patient to be admitted to the local acute hospital with a suspected fracture. The nurse packed the patient's overnight bag, asking for permission beforehand. They rang the patient's relatives to let them know the patient was being taken to hospital by ambulance. We saw the next day that the nurse checked on the patient's condition at the hospital.
- On another occasion, we saw the nurse arrange for an ambulance to transport a deteriorating patient and their spouse to hospital. The nurse rang ahead to let the clinical decisions unit and the oncology nurse know that

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the patient was being admitted. They also made contact with the oncology department at another trust where the patient was being treated, so they could liaise with the local hospital.

- The level of care was obvious to families and patients alike. We saw the team had received eight thank you cards and letters from bereaved relatives thanking the staff for their kindness and compassion shown towards their family member in the last weeks of their life.

- The trust had submitted data to the FAMCARE Project. This is a post bereavement survey of relatives about the care and support they and their relative received. We saw that 94% of respondents were very satisfied, or satisfied with the way the SPC team respected the patient's dignity.

Understanding and involvement of patients and those close to them

· Staff told us they involved carers and relatives in discussions about care and support and how this involved helping them as well as the patient to understand and come to terms with their condition. We saw evidence of this involvement and support when we observed members of the team during home visits where patients, carers and other family members were present. We spoke with nine patients and/or their carers. Staff were friendly and chatted informally with patients and their relatives but were professional and caring in their practice.

- 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.

- Patients and relatives all told us they had been fully involved in the care provided and had a clear understanding of what was happening at all times

- We observed a discussion with medical staff and a patient and their family about symptom control and future expectations.

· Patients told us their medicines and treatment had been explained to them including any possible side effects and the benefits they might see from taking the medicines.

- Guidance literature was available for patients and their relatives. This included leaflets about loss and bereavement and information about services available. Staff told us they had access to language line and interpreters.

· We saw that patients were asked about their advance wishes when completing the preferred priorities of care document and that these were recorded and accessible to all staff involved in their care.

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 said that having a named nurse was reassuring to them.

- SPC nurses were trained to Level 2 in advanced communication skills in line with NICE Guidelines (GSG4, 2004), which meant they were trained to provide emotional support.

- Staff developed trusting relationships with patients and their relatives by working in an open, honest and supportive way. Throughout our inspection we saw that staff were responsive to the emotional needs of patients and their relatives. Staff also gave us examples, of how they had supported the patients and families with referrals to different services and voluntary sector providers, for example, the local hospice, CRUSE and Citizens Advice Bureau.

- We heard of numerous occasions where staff provided emotional support to patients. For example, a family had concerns about income and additional costs as the patient neared the end of their life. The nurse contacted the benefits agency and completed the necessary paperwork to ensure the family had the financial benefits they were entitled to.

- Psychological support and complementary therapies were available to patients in the community receiving end of life care, through the Coventry Myton Hospice.

- Bereaved children were referred to 'rainbow ripples', a counselling service at Coventry Myton Hospice for children affected by the serious illness or death of a close family member. However, this service was only

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available to relatives of patients who had used the hospice. If a patient did not have a direct connection with the hospice, counsellors would offer telephone support and advice rather than one to one sessions.

Are services responsive to people's needs?

Good ●

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

Summary

Overall, we rated responsiveness as good because:

- Community end of life services enabled rapid discharge of patients from the acute hospital, providing support to meet patient's individual needs and wishes.
- The trust supported patients to achieve their preferred place of death either through rapid discharge to home, hospice or nursing home or by ensuring appropriate care for patients who wished to die at home.
- The community SPC team provided services five days per week. Out of hours advice was available from the local hospice and a palliative care consultant on call rota.
- Patients and relatives told us they had never had problems getting appropriate advice or services, regardless of the time or day they called.
- There was an open and transparent approach to handling complaints.
- Services were planned and delivered to meet patient's and relative's needs. Staff were very clear that the key priority was ensuring patients were cared for in their preferred place of death wherever possible. Therapy and nursing teams had good knowledge of how to improve care for those living with dementia/complex needs. The patient's needs were detailed in care plans and were person centred.

Detailed findings

Planning and delivering services which meet people's needs

- Services were planned and delivered to meet patient's and relative's needs. Staff were very clear that the key priority was ensuring patients were cared for in their preferred place of death wherever possible.
- The trust supported patients to achieve their preferred place of death either through rapid discharge to home, hospice or nursing home or by ensuring appropriate care for patients who wished to die at home.
- The community SP team offered end of life care training to community nurses and care staff working in nursing homes in Coventry.

- Equipment was provided to support patients who wished to die at home. This was delivered by an external provider quickly to patients' homes, to facilitate discharge or prevent unnecessary admission to hospital.

Equality and diversity

- Staff received training in equality and diversity as part of their mandatory training. Training figures identified that 96% of staff had up to date training.
- Information leaflets were not routinely available in languages other than English, but were available on request.
- Staff we spoke with understood how to support patients who had particular religious or cultural preferences.

Meeting the needs of people in vulnerable circumstances

- Patients may require a discharge at short notice, usually due to deterioration in their condition and their wish to return home. We saw a fast track discharge procedure was employed by the acute hospital end of life teams.
- We found that wherever possible patients were transferred home if that was their wish, when it became apparent care at home was appropriate, or no further interventions were available in a hospital setting.
- Therapy and nursing teams had good knowledge of how to improve care for those living with dementia/complex needs. The patient's needs were detailed in holistic care plans and were person centred.
- Staff confirmed they could access a nurse who specialised in learning disability when required.
- The team had access to mental health advisers who could provide support, guidance and review patients as required.
- Advance care plans were in place, where appropriate, for individuals to reflect their choices and wishes.

Access to the right care at the right time

- We saw evidence that for the period October 2015 to December 2015, a total of 110 patients had been identified as being end of life patients across the trust. Of those, 94 patients (86%) had died at home or at a hospice. We saw this was their preferred option and a good outcome for the patient and their family.

Are services responsive to people's needs?

- Supported by the community nursing teams, access to services was available throughout the day and night seven days per week. The community palliative care nurses and therapists worked Monday to Friday between 8:30am and 4:30pm. Eight palliative care healthcare support staff worked seven days a week 8am to 10pm with overnight care being available as and when required.

- An on-call consultant in palliative medicine was available to provide telephone advice to professionals in community and acute settings across Coventry 24-hours per day. This was provided jointly by the trust, a local acute NHS trust and local Hospices. The hospice nurses also provided out of hours advice to patients, families, and healthcare professionals.

- The SPC team aimed to respond to all routine referrals in the community within five working days and within two working days if the referral was urgent. All referrals to the team went through an administrator who would immediately pass them onto SPCT nursing staff if the referral was marked as urgent or if the patient's needs were complex.

Learning from complaints and concerns

- The service had a complaints procedure. Patients we spoke with said that they would feel able to raise any issues with staff. Staff told us that if patients or relatives had any complaints they would try to deal with them quickly.

- There had been no complaints received by the service in the 12 months before our inspection. 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.

- Managers and staff told us how details of complaints 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.

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Are services well-led?

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

Summary

Overall, we rated well-led as good because:

- The end of life service had embedded the trust's vision and values in their service.
- There was a clear structure for governance reporting and risks were identified and understood by members of the SPC team.
- Staff had confidence in their managers and believed they provided appropriate support and guidance. This was evidenced by training records, annual reviews and clinical supervision.
- Staff demonstrated a commitment to the delivery of good quality end of life care. They described the trust as a good place to work.
- The SPC team were involved in raising public awareness around end of life care.

However, we found that:

- The specialist palliative care team did not have clear strategy in place for delivering end of life care services.

Detailed findings

Service vision and strategy

- The trust had a vision and values based on 'compassion in action, working together, respect for everyone and seeking excellence'. The end of life service had embedded the trust's vision and values in their service. An example of how this had been done through the value based recruitment and appraisal process. Examples of the staff appraisal paperwork were seen.
- Staff were passionate about the service the team 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.
- There was not an end of life strategy in place. However we were told the team planned to look at the development of a strategy across end of life care services. No date had been set for the implementation of the plan.

- We saw a copy of the team's work plan for end of life care and priorities for 2016. The main priorities were listed as service development, education and surveys.

Governance, risk management and quality measurement

- There was a clear structure for governance reporting and risks were identified and understood by members of the SPC team.
- All management and heads of departments across community health and wellbeing services, which included mental health services, attended monthly safety and quality forum meetings. This meant that the same messages were shared across the directorate. We viewed the minutes of the meetings held in March and April 2016 and noted meetings had a standard agenda and some of the topics covered included feedback on incidents, complaints, risk management, service evaluation and team training updates.
- SPC staff confirmed that the acting head of palliative care shared the outcomes of these meetings with staff. Staff knew how to escalate risks to senior managers and were confident in doing so.
- The trust did not have an end of life steering group. They were however part of the local acute NHS trust's steering group which facilitated collaborative working.
- The SPC team attended CASTLE (Care and Support Towards Life's End), which is a clinical implementation group for end of life care providers across Coventry and Warwickshire. CASTLE supports professionals by providing local contact details, clinical tools and guidelines. Four annual palliative and end of life care education events are also held for health and social care professionals across Coventry and Warwickshire to share best practice.
- A small number of audits were undertaken. Recent audits included an evaluation of clinical letters sent to GPs and an internal records audit. Audit results were shared and learnt from where appropriate.
- There was a specific risk register for the specialist palliative care service. One example of a risk identified was the inability to contact a patient or for patients to

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contact the service by phone. Control measures in place included the use of mobile phones. The risk register was actively reviewed and contained all relevant risks within the service at the time of inspection.

Leadership of this service

- There was comprehensive leadership within the palliative care service with clearly defined leadership roles. The SPCT was led by a consultant in palliative medicine and a senior nurse. They were passionate about the service and encouraged staff to deliver high quality care. They demonstrated an understanding of the current issues facing the service.
- The medical director was the executive director with end of life care interest on the trust executive committee. We saw the medical director had recently attended the team's MDT meeting.
- Staff told us that leaders in the service were open and visible.
- Staff told us they generally felt that the trust was committed to the ongoing development of end of life care services. Staff felt well connected to teams across the trust and all commented positively about the effectiveness of the MDT meeting which was held weekly.
- Healthcare support workers, therapists 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.

Culture within this service

- Staff told us they were proud to work for the trust and enjoyed working in the community. They demonstrated a commitment to the delivery of good quality end of life care. They described the trust as a good place to work. Some staff had worked for the trust for a number of years.
- Staff told us they were comfortable reporting incidents and raising concerns. They were aware of the trust's whistleblowing policy and said they would be confident in using it if necessary.
- Patients we spoke with acknowledged a positive and caring culture within the service and were happy with their care provided by the staff.

Public engagement

- Patient stories were used to gain an understanding of the healthcare experience of individuals in order to

provide focus and improve the quality of services. We read one patient's experience which was presented at the board meeting in October 2015. The patient spoke positively about the support they had received from the SPC team and the many ways in which they had been helped.
- The trust collated information from patients, families, carers and staff using the friends and families test. Surveys were only undertaken quarterly, due to the sensitive nature of the service.
- We saw that 8 letters had been received in March 2016 from bereaved relatives thanking the team for their help and support both to themselves as well as the patient.
- The specialist palliative care therapy team had conducted a patient satisfaction survey over an eight week period from March to May 2015. We saw that comments received from patients were positive about the service.
- The SPC team were involved in raising public awareness around end of life care. For example, they participated, in partnership with the local acute hospital trust, in Dying Matters week in May 2015. We saw the team were making arrangements to participate in this event in May 2016.
- Members of the team attended patient forum group meetings to talk about their work, for example the Prostate Cancer Support Group' and the 'Cancer United Support Group'.
- The team had also recently done a presentation for GPs on 'Optimal Palliative Care Medication.' The feedback from the GPs about the presentation was very positive.

Staff engagement

- Staff told us they were encouraged to attend regular meetings and events and to share their experiences and feedback with managers on a regular basis.
- 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.
- Staff felt actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture.
- Feedback from staff was reviewed by the service used to inform improvements and learning.

Innovation, improvement and sustainability

- A fatigue and breathlessness programme has been piloted as a collaborative development between the

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Palliative Care Consultant Lead at the trust and Coventry Myton Hospice. This is a five week course for patients, the aim of which is to enable them to improve confidence in managing their breathlessness and fatigue. It is aimed at those patients who have mild to severe breathlessness as a core symptom and have a life limiting condition. The evaluation of the programme has not yet taken place.

• The team had been accepted to participate in a clinical research study by the NHS National Institute of Health Research. The objectives of the Prognosis in Palliative Care Study II (PiPS2) were to identify the best method to accurately predict survival in patients with incurable cancer. This will be the first clinical trial undertaken by the SPCT. The team members were enthusiastic and looked forward to starting the study once ethical approval had been obtained. All community SPCT nurses were aligned with GPs and district nursing teams and also worked with nursing homes in Coventry by providing training to staff on end of life care.

• Two Band 6 (junior sisters) had been recruited to work with partner organisations across Coventry. The aim was to provide education and development to the health and social care workforce and any voluntary sector teams to ensure they have the necessary skill and knowledge to provide high quality end of life care.

• The team had received approval from the Board to appoint a full time clinical psychologist who specialised in palliative care. The aim was to provide support to family and staff. However, we were told that due to financial constraints the trust may not be able to fund this post at the present time.

Requirement notices

Action we have told the provider to take

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

Enforcement actions

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