

Norfolk Community Health and Care NHS Trust

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Community end of life care

Quality Report

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Date of inspection visit: 16-18 September 2014
Date of publication: 19/12/2014

This report describes our judgement of the quality of care provided within this core service by Norfolk Community Health and Care 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 Norfolk Community Health and Care NHS Trust and these are brought together to inform our overall judgement of Norfolk Community Health and Care NHS Trust

Summary of findings

Ratings

Overall rating for End of life care		Good	●
Are End of life care safe?		Good	●
Are End of life care effective?		Good	●
Are End of life care caring?		Good	●
Are End of life care responsive?		Good	●
Are End of life care well-led?		Good	●

Summary of findings

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Summary of findings

Overall summary

Staff were aware of and had access to the trust's online incident reporting system. We saw evidence of learning from incidents to improve practice. Overall the standards of cleanliness and hygiene were good and staff demonstrated a good knowledge of procedures for the management, storage and disposal of clinical waste, environmental cleanliness and prevention of healthcare acquired infection guidance. Procedures were in place to ensure equipment was regularly maintained and fit for purpose.

There were appropriate systems in place to protect patients against the risks associated with the unsafe use and management of medicines. The trust had replaced all of its syringe drivers in accordance with national guidance.

There were effective safeguarding policies and procedures which were understood and implemented by staff. Staff were aware of the trusts' whistleblowing procedures and what action to take. The trust could not be assured that all of the faith leaders who visited patients had been subject to a DBS check.

We looked at eleven sets of patient medical notes and reviewed the DNACPR (do not resuscitate in the event of a cardiac arrest) documentation. Generally we found these were completed in accordance with best practice, however there were some gaps on some forms.

Throughout the community end of life services we were told of concerns regarding the number of staff available to enable the effective delivery of care and treatment. Community nursing staff reviewed their caseloads according to patient need and end of life patients took priority. Relatives and patients we spoke with spoke positively about access to staff and we did not find evidence to suggest that community nurse staffing levels were adversely affecting the quality of patient care.

Staff told us that there were delays admitting patients to the Ogden Court unit because of the staffing levels. Whilst we were at Ogden Court an afternoon admission was refused because of the staffing levels and the risk this posed.

There was a trust wide safe staffing reporting mechanism in place. This was reported to the Quality Risk and Audit Committee (QRAC) on a monthly basis.

Most staff we spoke with demonstrated little or no understanding of their responsibilities regarding the Mental Capacity Act 2005 and did not know what to do when patients were unable to give informed consent.

Patients were triaged and assessed accurately so that safe treatment and care was provided to guard against risks associated with their condition. Risk assessments in areas such as falls, pressure care and nutrition were complete and updated as patient's needs changed.

The trust had removed the use of the Liverpool Care Pathway and implemented interim guidance called "Caring for people in the last days and hours of life." Training concerning the replacement was still being undertaken by the trust. Patients within end of life services had their pain control reviewed daily. Regular pain medication was prescribed in addition to 'when required medication', which was prescribed to manage any breakthrough pain. We saw that care followed the national Institute for Health and Care Excellence (NICE) Quality Standard CG140. The care records we reviewed showed staff supported and advised patients who were identified as being at nutritional risk.

The care and treatment provided achieved positive outcomes for patients. Patients receiving end of life care received support from a multi-disciplinary end of life care team, which included a specialist palliative care team, consultants, GP's, district nurses. In addition there was a full time social worker at Priscilla Bacon Lodge. In accordance with the Gold Standards Framework, multi-disciplinary team meetings took place weekly to ensure any changes to patients' needs could be addressed promptly.

We saw evidence that end of life services monitored the performance of their treatment and care. Records were completed to a good standard and contained a clear pathway of care which described what the patient should expect at each stage of their treatment.

Community end of life services were caring. We observed positive interactions between staff and patients in their

Summary of findings

homes and in every unit we inspected Patients were treated with compassion and empathy. Throughout our inspection staff spoke with compassion, dignity and respect regarding the patients they cared for. We noted there was an apparent mutual respect amongst the staff.

All of the patients and relatives we spoke with told us that care was good. They were treated with respect and dignity and felt involved in their care and treatment. The specialist palliative care team supported people emotionally. The team had received training to enable them to support patients and families; they also delivered training to community staff.

The trusts palliative care service provided care for 652 patients during 2013/14. We found the service had a good understanding of the different needs of people it served. Services were planned, designed and delivered to meet those needs. We saw through advanced care planning, patients were able to dictate both their preferred place of care and preferred place of death. The trust monitored the performance of their end of life treatment and care service.

We saw numerous letters and cards expressing positive feedback from patients and relatives. Staff were aware of the trust's policy for handling complaints and had received training in this area.

Staff told us there was active reflective practice and learning following complaints, for example, improvements had been made in facilitating timely patient discharge from hospital as a result of learning from a complaint.

The end of life service had a clear local vision to improve and develop high-quality end of life care. The increase in investment to support the implementation of seven day service supported this vision. Most staff were aware of the trust's vision and strategy however this was not fully embedded amongst all the staff.

There was good leadership and support from local managers and most staff felt engaged with senior management. There was a positive culture in the service.

Risk management and quality assurance processes were in place at a local level. The end of life service held governance and patient safety meetings and records showed risks were escalated and included on risk registers and monitored each month. Local quality dashboards were also completed which showed how the service was performing against key quality indicators. We found managers were aware of the quality issues affecting their service and shared them with the staff.

Across all of community end of life services, staff consistently told us of their commitment to provide safe and caring services, and spoke positively about the care they delivered. At a local level all staff felt listened to and involved in changes within their team and spoke of regular involvement in staff meetings.

Summary of findings

Background to the service

The Norfolk Community Health and Care NHS Trust (NCH&C) delivers community end of life care services to adults and children throughout Norfolk, offering a wide range of NHS healthcare services, such as district nursing, health visiting and speech and language therapy and covers a population of 882,000 people, providing services for West Norfolk, North Norfolk, South Norfolk and Norwich clinical commissioning Groups and Norfolk County Council

Palliative care aims to achieve the best quality of life for patients and their families who are affected by life limiting illnesses. End of life care is an important part of palliative care and refers to the care of patients and their families throughout the last phase of their life. This could be a period of months, weeks, days or hours.

Palliative and end of life care services were delivered within people's own homes with access to services provided by other acute NHS trusts and hospices. Care was delivered by community GPs, hospital doctors, nurses, community nurses, specialist palliative care nurses, health care assistants and allied health professionals. The teams worked closely with other health professionals in the hospital and community to ensure that all appropriate patients, including those with non-malignant disease, achieved the best possible quality of life.

Our inspection team

Our inspection team was led by:

Chair: Dorian Williams Executive Nurse/director of Governance, Bridgewater Community Healthcare NHS Trust.

Team Leader: Carolyn Jenkinson, Head of Hospital Inspection, Care Quality Commission

The team included CQC inspectors and a variety of specialists: health visitor, school nurse, GP, medical consultant, nurses, specialist palliative care nurse, university lecturer, therapists, social worker, dentist, senior managers and experts by experience. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

Why we carried out this inspection

Norfolk Community Health and Care NHS Trust was inspected as part of the second pilot phase of the new inspection process we are introducing for community

health services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

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?

The inspection team always looks at the following core services at each inspection

Summary of findings

1. Community services for children and families – this includes universal services such as health visiting and school nursing, and more specialist community children's services.
2. Community services for adults with long-term conditions – this includes district nursing services, specialist community long-term conditions services and community rehabilitation services.
3. Services for adults requiring community inpatient services
4. Community services for people receiving end-of-life care.

In addition, the inspection team also looked at community dental services.

Before visiting, we reviewed a range of information we held about Norfolk Community health and Care NHS Trust and asked other organisations to share what they knew. We carried out an announced visit on 16, 17 and 18 September. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, and therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service. We carried out an unannounced visit on 2 October 2014 to three of the inpatient hospitals.

What people who use the provider say

We received a range of comments from patients and their relatives, both through comment cards as well as those we spoke with during the inspection. The comments were overwhelmingly positive, with patients commenting on the quality of staff, high standards of care they had received and timeliness of accessing the right care at the right time.

There is no current requirement for community trusts to adopt the Family and Friends Test (FFT), but Norfolk implemented the FFT in community services in July 2013. The FFT is a national initiative and aims to ensure patient experience remains at the heart of the NHS, so members of the public can see what patients think of local services, and that service quality is transparent to all. A simple score is generated by taking the proportion of respondents who would be 'extremely likely' to recommend the service, minus the proportion of those

who say they are 'neither likely nor unlikely', 'unlikely' or 'extremely unlikely' to recommend it. Patients are then encouraged to comment on why they gave that score, enabling services to understand what really matters to them.

The national target is for 75% positive response and 15% sample size. The trust has not yet supplied sample size. Between July 2013 and March 2014 the trust reported an overall score of 79% positive responses, the lowest result being 72% in July 2013 and the highest being 86% in March 2014.

There have been 140 comments on the trust on the patient opinion website, with 128 of these being positive in nature. Of the negative reports, six were regarding staffing levels and waiting times, three were around staff attitude and three regarding poor care.

Good practice

- The service used an Electronic Palliative Care Coordination System to support the co-ordination of care so that people's choices about where they die, and the nature of the care and support they received was respected and achieved wherever possible.
- 92% of patients died in their preferred place of care.
- Throughout our inspection staff spoke with compassion, dignity and respect regarding the patients they cared for.
- The level of multi-disciplinary team working within the service.
- The trusts mortality review process which was led by the medical director was a proactive initiative for a community service.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- Carry out a risk assessment of faith leaders who have not been subject to DBS checks.
- Review the deployment of volunteers working in the day unit to ensure they know what to do in the event of an emergency.
- Increase the number of nursing staff who participate in clinical supervision.
- Review the need for training for staff on advanced decision making.

Norfolk Community Health and Care NHS Trust

Community end of life care

Detailed findings from this inspection

The five questions we ask about core services and what we found

Good 

Are End of life care safe?

By safe, we mean that people are protected from abuse

Summary

Staff were aware of and had access to the trust's online incident reporting system. We saw evidence of learning from incidents to improve practice. Overall the standards of cleanliness and hygiene were good and staff demonstrated a good knowledge of procedures for the management, storage and disposal of clinical waste, environmental cleanliness and prevention of healthcare acquired infection guidance. Procedures were in place to ensure equipment was regularly maintained and fit for purpose.

There were appropriate systems in place to protect patients against the risks associated with the unsafe use and management of medicines. The trust had replaced all of its syringe drivers in accordance with national guidance.

There were effective safeguarding policies and procedures which were understood and implemented by staff. Staff were aware of the trusts' whistleblowing procedures and what action to take. The trust could not be assured that all of the faith leaders who visited patients had been subject to a DBS check.

We looked at eleven sets of patient medical notes and reviewed the DNACPR (do not resuscitate in the event of a cardiac arrest) documentation. Generally we found these were completed in accordance with best practice, however there were some gaps on some forms.

Community nursing staff reviewed their caseloads according to patient need and end of life patients took priority. Relatives and patients we spoke with spoke positively about access to staff and we did not find evidence to suggest that community nurse staffing levels were adversely affecting the quality of patient care. Staff told us that there were delays admitting patients to the Ogden Court unit because of the staffing levels. Whilst we were at Ogden Court an afternoon admission was refused because of the staffing levels and the risk this posed.

Patients were triaged and assessed accurately so that safe treatment and care was provided to guard against risks associated with their condition. Risk assessments in areas such as falls, pressure care and nutrition were complete and updated as patient's needs changed. Volunteers working in the day unit did not feel confident about what they should do in an emergency situation.

Are End of life care safe?

Incidents, reporting and learning

Staff were aware of and had access to the trust's online incident reporting system. This allowed staff to report all incidents and near misses where patient safety may have been compromised. Staff were aware of what should be reported and were encouraged to do so.

We saw an example of an incident that had been classified as serious which had occurred in one of the day units. We saw evidence that the incident had been discussed at the clinical governance meeting and a root cause analysis (RCA) investigation took place. There were actions for learning and development and training was implemented as a result of this. Staff told us trends in incident reporting were analysed and training was organised where necessary. This meant steps to learn from incidents were being taken.

Cleanliness, infection control and hygiene

Overall the standards of cleanliness and hygiene were good and staff demonstrated a good knowledge of procedures for the management, storage and disposal of clinical waste, environmental cleanliness and prevention of healthcare acquired infection guidance. During a visit to a patient's home we observed the nurse sanitising their hands before and after patient contact and wearing aprons and gloves when delivering personal care to the patient.

We saw that the wards we visited were clean, bright and well maintained. Surfaces and floors in patient areas were covered in easy to clean materials which allowed high levels of hygiene to be maintained throughout the working day. We saw throughout the clinical areas the general and clinical waste bins were covered with foot opening controls and the appropriate signage was used. 'I am Clean' stickers were placed on equipment including toilet seats, the resuscitation trolley and the fire evacuation trolley. This indicated they had been cleaned and were ready to be used.

We saw that wards and departmental staff wore clean uniforms with arms bare below the elbow and personal protective equipment (PPE) was available for use by staff in all clinical areas.

Separate hand washing basins, hand wash and sanitizer were available in the ward bays. At Priscilla Bacon Lodge that staff sanitised their hands between patient contacts and wore aprons and gloves when delivering personal care

to patients. We saw audits were carried out for hand hygiene which reported compliance of over 90%. We also saw cleaning audits which showed compliance of over 90%.

Medicines management

At Priscilla Bacon Lodge, there were appropriate systems in place to protect patients against the risks associated with the unsafe use and management of medicines. Staff followed clear guidelines for prescribing medicines for patients receiving end of life care. Records showed anticipatory planning was undertaken to reduce the risk of escalating symptoms. Appropriate systems for the safe custody and checking of controlled drugs and syringe drivers were in place which reduced the risk of inappropriate use.

In 2011, the National Patient Safety Agency recommended that all Graseby syringe drivers should be removed by the end of 2015. The trust had undertaken this and the McKinley syringe driver was now used throughout the service. We observed a community nurse administering medicines through a syringe pump to a patient in their home. We saw the completed records which had been signed and dated following administration.

Staff at Ogden court received support from the staff at Priscilla Bacon Lodge in relation to medicines management for patients at the end of life. For example, the ward manager told us that that staff had spoken to the pharmacist at Priscilla Bacon Lodge concerning a drug combination in a syringe driver and would always contact them if there were any concerns.

Safeguarding

There were effective safeguarding policies and procedures which were understood and implemented by staff. Staff were aware of the trusts' whistleblowing procedures and what action to take. Trust data showed the majority of staff providing end of life care services had received mandatory training in the safeguarding of vulnerable adults. Staff we spoke with demonstrated a good understanding of the different types of abuse and how to detect these.

The trust had a chaplaincy service which was provided by the Norfolk partnership and covered all of the NHS trusts in Norfolk. The Chaplains had been subject to Disclosure and

Are End of life care safe?

Baring Service checks (DBS) as part of the recruitment process. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

The chaplains were supported by multi-faith leaders who provided spiritual support as required by patients. There were four faith leaders who were regularly called upon to provide spiritual support; these include the Rabbi, Imam, and a Catholic priest. These religious leaders had been DBS checked with their employing organisations. There could be requests for support from 30 multi-faith leaders who could be called on but the trust could not be assured these faith leaders had been subject to DBS checks.

The Norfolk chaplaincy planned to ensure all multi faith contacts had a DBS check in place by December 2014. Until this time the Norfolk chaplaincy had a procedure in place to ensure that a member of staff oversaw visits by faith leaders when they were in direct contact with patients. If the patient requested a private meeting with the faith lead this would occur in a room with a glass observation panel in the door and a member of staff would be within calling distance. If the patient was seen on the ward they would have their call bell to hand. We did not find evidence of this risk on the trust risk register.

Records systems and management

The End of life Care Service had an electronic care record system called 'Systmone'. The community end of life service staff told us of the problems they had encountered such as access due to connectivity problems in the community. This problem was not unique to this trust and it was reliant on internet coverage. The trust were actively trying to improve the problems staff faced.

We were told by the senior managers that an electronic care record system was being rolled out across the trust which would facilitate the sharing of information between professional groups and out of hours services.

We looked at eleven sets of patient medical notes and reviewed the DNACPR (do not resuscitate in the event of a cardiac arrest) documentation. Of the eleven sets of notes nine had DNACPR documentation in place; the other two sets of notes did not contain any DNACPR documentation. We raised this with the staff responsible for the patient's care who were unsure why the DNACPR form was not readily available

Of the nine documents we found all were located in the front of the notes so they could be easily seen. They were legible and had been completed by a senior doctor. We saw four of the nine forms had been discussed with the patient as well as with family members. One had been discussed with family only as the patient was said to 'lack capacity', however, we could not find the patients mental capacity assessment in the medical notes. We raised this with the staff responsible for the patient's care who were unsure why the mental capacity form was not readily available

The trust's audit of DNACPR's in patients' medical notes for May 2013 showed that at Priscilla Bacon Lodge, 100% of patient's notes had a DNACPR in them.

Lone and remote working

We asked about the lone worker policy and were told that at present the trust were piloting a lone worker device. There was a centrally held diary for the Palliative Specialist Nurses and the teams were to telephone into base at the end of each day.

We spoke with a community nurse who often worked in isolation said she knew there was a lone worker policy but stated that this was not always followed in the community. We also spoke with another community nurse about the lone working policy, she said that she was aware there was a policy. The nurses had informal arrangements to check on each other but there did not appear to be a structured arrangement as per the trust policy.

Community nursing staff had access to a work mobile phone.

Assessing and responding to patient risk

We spoke with two volunteers at the Priscilla Bacon Lodge Day Hospital known as The Rowan Centre Day Unit who had been volunteering at the unit for the past 12 years. The volunteers expressed concern that they were left alone with the patients for about an hour while the staff all attended a staff meeting. They were unsure what to do in case of an emergency, although one volunteer was aware there were panic buttons and another volunteer told us they would run to the office where the meeting was being held to get help.

Are End of life care safe?

Risk assessments for patients receiving end of life care were completed. These included assessments for the risk of pressure ulcer development and falls. We saw these risk assessments had been completed and care had been planned to address the identified risks.

Staffing levels and caseload

Like many NHS trusts, Norfolk Community Health and Care NHS Trust had nurse staffing vacancies and at times it struggled to recruit the required number of nurses. There was on-going recruitment of nursing staff. Where staffing levels were low staff told us they would raise this as an incident through the trust online incident reporting system.

Staff reviewed their caseloads according to patient need and end of life patients took priority. To ensure safe levels of staffing, staff worked extra shifts through the trust bank. Relatives and patients we spoke with spoke positively about access to staff and we did not find evidence to suggest that community nurse staffing levels were adversely affecting the quality of patient care. We spoke to a senior nurse at Ogden Court about staffing, she told us they had five registered nurse vacancies at the time of our inspection. Two of these vacancies were because of long terms sickness and they were in the process of recruiting to three posts. Staff told us they didn't think they had enough

staff and although they were using bank and agency staff, this was not ideal. The director of nursing was aware that there had been concerns about staffing levels at Ogden Court and monitored this regularly. The staffing concerns were placed on the risk register in April 2014.

Staff told us that there were delays admitting patients to the unit because of the staffing levels. This meant that although patients were not able to be admitted to the unit, steps were being taken to ensure staff could safely care for the patients who were on the ward. Whilst we were at Ogden Court an afternoon admission was refused because of the staffing levels and the risk this posed.

Deprivation of Liberty safeguards

There were no patients with deprivation of liberty safeguards in place within community end of life services at the time of our inspection.

Most staff we spoke with demonstrated little or no understanding of their responsibilities regarding the Mental Capacity Act 2005 and did not know what to do when patients were unable to give informed consent. Not all staff understood the concept of Deprivation of Liberty Safeguards and Best Interest decisions.

Are End of life care 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

The trusts had removed the use of the Liverpool Care Pathway and implemented interim guidance called "Caring for people in the last days and hours of life." Training concerning the replacement was still being undertaken by the trust. Patients within end of life services had their pain control reviewed daily. Regular pain medication was prescribed in addition to 'when required medication', which was prescribed to manage any breakthrough pain. We saw that care followed the national Institute for health and Care Excellence (NICE) Quality Standard CG140. The care records we reviewed showed staff supported and advised patients who were identified as being at nutritional risk.

The care and treatment provided achieved positive outcomes for people who used the service. Patients receiving end of life care received support from a multi-disciplinary end of life care team, which included a specialist palliative care team, consultants, GP's, district nurses. In addition there was a full time social worker at Priscilla Bacon Lodge. In accordance with the Gold Standards Framework, multi-disciplinary team meetings took place weekly to ensure any changes to patients' needs could be addressed promptly.

We saw evidence that end of life services monitored the performance of their treatment and care. Data showed that between April and July 2014, there were 494 deaths of patients within the care of the community nursing and therapy teams. Of these 494, 266 had indicated their preferred place of care, and of these 245 (92%) died in this preferred place. This meant that for the majority of patients, services were being provided to meet people's individual wishes.

We saw that records were completed to a good standard and contained a clear pathway of care which described what the patient should expect at each stage of their treatment.

End of life care was included on the trusts mandatory training programme and there were several established professional training courses for different professional groups working in end of life care.

Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team (MDT) working practices were in place.

Evidence based care and treatment

The trusts had removed the use of the Liverpool Care Pathway and implemented interim guidance called "Caring for people in the last days and hours of life." Training concerning the replacement was still being undertaken by the trust and not all of the staff we spoke to were aware of the new paperwork in use.

In all the areas we inspected staff followed guidance set by The Gold Standards Framework (GSF). This was a way of working that had been adopted by patients and all the health care professionals involved in their care. We saw staff working together as a team and with other professionals to help to provide the highest standard of end of life care possible for patients and their families. Staff were also following the Leadership Alliance for the Care of Dying People.

Pain relief (optional)

Patients within end of life services had their pain control reviewed daily. Regular pain medication was prescribed in addition to 'when required medication', which was prescribed to manage any breakthrough pain. This is pain that occurs in between regular, planned pain relief. We saw that care followed the national Institute for health and Care Excellence (NICE) Quality Standard CG140. This quality standard defines clinical best practice in the safe and effective prescribing of strong opioids for pain in palliative care of adults.

One patient we spoke to at the day hospital demonstrated a good understanding of their pain medication, and told us the staff had explained everything very well. The patient's relative told us they thought their relative's pain was managed appropriately.

People using the service were supported to alleviate their pain appropriately. We observed a community nurse following the prescribed medicine protocol for pain relief and administering the medicines prescribed through a syringe pump.

Are End of life care effective?

We noted a community matron promptly visited a patient when a call came through to the community centre where the nurses from the Coastal Integrated team (West locality) were based. A syringe pump had become blocked but the problem was resolved promptly.

Nutrition and hydration

The care records we reviewed showed staff supported and advised patients who were identified as being at nutritional risk. The two patients we spoke with confirmed that they had received advice and support from the dietician and were very happy with the food.

Approach to monitoring quality and people's outcomes

We saw evidence that end of life services monitored the performance of their treatment and care. Data showed that between April and July 2014, there were 494 deaths of patients within the care of the community nursing and therapy teams. Of these 494, 266 had indicated their preferred place of care, and of these 245 (92%) died in this preferred place. This meant that for the majority of patients, services were being provided to meet people's individual wishes.

The National Bereavement Survey (VOICES) was conducted by the Office for National Statistics on behalf of the Department of Health. The aims of the survey were to assess the quality of care delivered in the last three months of life for adults who died in England and assess variations in the quality of care delivered in different parts of the country and to different groups of patients. The survey results suggest that the trust is at least in line with the national average in all areas and above average in terms of :

- GPs and hospital doctors providing excellent care,
- Sufficient help and support for family at time of death
- Involvement of families and patients in decisions.

We saw that records were completed to a good standard and contained a clear pathway of care which described what the patient should expect at each stage of their treatment. At Pricilla Bacon Lodge the staff were using end of life pathway rounding documentation. This was completed 2-4 hourly depending on the patient's condition. It covered assessment of the patient's pain and other symptoms, nutrition and drinks and the need for hydration, mouth care, skin integrity, repositioning and syringe driver checking. This was in line with NICE guidance

QS13 2011, which states the emphasis of the pathway is on individual care, daily reassessment by a clinician, offering fluids and nutrition as appropriate, symptom control, engagement and clear communication with the patient and family. Additionally, we saw two communication sheets with the rounding sheets. These were available for families and sometimes patients (depending on their condition) to read and also to document conversations around end of life care. Rounding sheets and communication sheets were kept at the bedside with the intention that patients and families could read them.

The trust had developed a mortality review policy which was approved by the trust board in September 2014. We considered this to be an area of outstanding practice for a community trust. The aim of the policy was to have a consistent approach to review patient mortality across the trust and to provide a clear reporting structure to escalate any concerns. All inpatient deaths were reviewed and included the cause of death, the length of admission, the categorisation of death and any concerns were noted. Further scrutiny was applied where concerns were identified and there was a clear process for escalation in place. The mortality review group was led by the trusts medical director who provided strong leadership for the initiative.

There was a standard operating procedure in place for the management of unexpected deaths. It cited clear roles and responsibilities for identifying an unexpected death and reporting the death in accordance with national and local guidance.

Competent staff

The trust recorded a compliance score of 87.1% for its mandatory training programmes in 2013/14 against a target of 90%. This meant that the majority of staff had undertaken the trusts mandatory training programme. The results of the 2013 NHS Staff Survey are organised into 28 key findings. The trust performed better against questions regarding staff receiving job-relevant training, staff being appraised and staff receiving health and safety training.

Staff that had recently gone through the induction programme were positive about it. Staff told us they were able to access professional training in line with their specialism. We spoke with a senior manager who was responsible for one of the localities and they showed us

Are End of life care effective?

evidence that staff were able to undertake different programmes of non-mandatory study to enhance their practise. We saw they monitored this to ensure access to study was fair and equitable across all staff groups.

Staff's experience of clinical supervision was variable across teams and some staff were not accessing regular protected time for facilitated in-depth clinical supervision. Clinical supervision is a way of supporting staff in the development of their practice. The director of nursing told us they were aware that clinical supervision was patchy, particularly amongst nurses. Initiatives were in place to try and improve access to supervision such as group supervision being available.

Most staff we spoke with told us they had had an appraisal within the last 12 months and staff thought it was a supportive and valuable process. Records showed that the trust's appraisal rate dropped below 90% to 66.6% in May 2014. The North locality had the highest level of compliance with a rate of 74.8%, whilst the South locality had the lowest rate at 51.4%.

There were several established professional training courses for different professional groups working in end of life care. The common aim of these courses was to improve palliative care across the trust by empowering staff through education. We saw there had been three workshops for staff on caring for patients who were at the end of life and also had a learning disability.

In 2013, the trust set up a two day mandatory training programme for all staff. One member of staff said, "The two day training is more structured and organised." In addition to the mandatory training, staff were able to access online e-learning and there was a good library service to support staff with professional learning and development. The trust did not monitor compliance with mandatory training within the end of life care service, but within the localities for adult community and inpatients, mandatory training compliance was satisfactory.

Multi-disciplinary working and coordination of care pathways

Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team (MDT) working practices were in place. Staff told us there was effective communication and collaboration between teams who met regularly to identify patients

requiring visits or to discuss any changes to the care of patients. The meetings followed the principles of the Gold Standards Framework. As a minimum the service held a full MDT reassessment of patients led by a named senior medic every three days. There were also on-going daily reviews of all patients.

The service used an Electronic Palliative Care Coordination System to support the co-ordination of care so that people's choices about where they die, and the nature of the care and support they received was respected and achieved wherever possible. This enabled key medical information and conversations about end of life care wishes to be communicated across areas and with external providers and services.

Communication and coordination between all the health care professionals within end of life services was enabled through the use of the electronic palliative care coordination system known as "Systmone." This was accessed by all the professionals who were caring for the patient including the District nurses, specialist nurses, Macmillan nurses, and some hospital services. It enabled staff to record and share information necessary to ensure the on-going needs of the patient, including decisions about their care, could be widely accessed.

Within the integrated care team weekly meetings were held between the nursing staff, social services, the housing department, allied health professionals and members of the voluntary sector. This allowed the opportunity to discuss individual patients who had complex needs and were requiring end of life care.

A physiotherapist described the MDT meetings they attended, which were organised by a GP from a local practice. The team consisted of GPs, social services, Macmillan nurses and the trust community team. They followed a co-ordinated care pathway for patients requiring palliative care using the Gold Standard Framework. At Priscilla Bacon Lodge, MDT meetings followed best practice from NICE Quality Standard 13 and the Leadership Alliance for the Care of Dying people 2013. The team discussed patients' care needs and the support required to assist the patient and their relatives. During the meeting, there would be education sessions by consultants and discussion of lessons learnt from decisions made by the team in caring for their patients.

Are End of life care caring?

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

Summary

Community end of life services were caring. We observed positive interactions between staff and patients in their homes and in every unit we inspected. Patients were treated with compassion and empathy. Throughout our inspection staff spoke with compassion, dignity and respect regarding the patients they cared for. We noted there was an apparent mutual respect amongst the staff.

All of the patients and relatives we spoke with told us that care was good. They were treated with respect and dignity and felt involved in their care and treatment. The specialist palliative care team supported people emotionally. The team had received training to enable them to support patients and families; they also delivered training to community staff.

Due to the complex needs of patients receiving end of life care services, it was not always possible to promote self-care. However, the patient records we looked at included person-centred care plans based on the individual needs and preferences of patients.

Compassionate care

We observed positive interactions between staff and patients in their homes and in every unit we inspected. Patients were treated with compassion and empathy. We observed staff speaking with patients and providing care and support in a kind, calm, friendly and patient manner. The patients we spoke with were very complimentary about staff attitude and engagement. One person told us they could not praise the staff more, they said that 'the staff in the day hospital are fantastic and very caring, they greet you with a hug and a kiss.' Another patients and their relative told us, "The care here is fantastic."

We spoke with seven patients and six relatives. All were consistently positive about their experience within the end of life services.

We attended home visits during our inspection. We saw the community staff treated patients with compassion and cared for the patient as well as their family.

Dignity and respect

We observed throughout our inspection and in accordance with The National End of Life Care Strategy (DH, 2008), staff spoke with compassion, dignity and respect regarding the patients they cared for. Staff were welcoming and friendly.

On two home visits we saw the nurses treated the patients respectfully and with dignity, they were welcoming towards the patient and their relatives and supported them in a professional and sensitive manner. We observed in the inpatient areas staff treated patients and their relatives with dignity and respect. Patient confidentiality was respected when delivering care, in staff discussions with patients and their relatives as well as in any written records or communication.

At Priscilla Bacon Lodge we observed staff speaking to patients in a caring and respectful manner during patient contact. We observed staff were smiling and positive. Staff took time with each individual patient and would make equal eye contact by ensuring they were at the same level as the patient so as not to stand over them.

The National Bereavement Survey (VOICES) was conducted by the Office for National Statistics on behalf of the Department of Health. The aims of the survey were to assess the quality of care delivered in the last three months of life for adults who died in England and to assess variations in the quality of care delivered in different parts of the country and to different groups of patients. The survey results suggest that the trust was average in terms of dignity and respect.

We noted there was an apparent mutual respect amongst the staff.

Patient understanding and involvement

Patients and relatives we spoke with all indicated they were involved in care decisions. Records contained evidence of consent from patients for treatment. We saw that clinical records contained evidence of consent from patients for treatment. We also saw evidence of clear documentation as to what had been discussed with them concerning their care

Are End of life care caring?

We spoke with six relatives and three patients both during and following our inspection. They all told us they had been fully involved in the care provided and had a clear understanding of what was happening at all times.

Emotional support

The specialist palliative care team supported people emotionally. All the patients and relatives we spoke with valued the support offered by the nursing teams.

The team had received training to enable them to support patients and families; they also delivered training to community staff. Bereavement counselling was also available through the trust Psychological service. The service helped patients who were either living with a life-limiting illness or were at the end-of-life. Support was also available to patients families. We noted that this service was available for families for up to a year after bereavement has occurred.

Counselling and other forms of psychological support were provided by an experienced team with specialist skills in assisting people cope with the emotions and changes faced during illness, end-of-life care and bereavement. The psychological service also provided support, supervision and education for the staff working in the specialist palliative care team. They undertook events and wrote

materials to promote public and professional awareness across Norfolk of the psychological needs of patients and their families during illness, end-of-life care and bereavement.

Referral to the psychological service was by way of either self-referral in conjunction with a referral from a healthcare professional, such as a member of staff at the Priscilla Bacon Centre, a consultant, a community nurse, or a GP. We spoke with two people who were using the psychological service, both were satisfied with the care they received and would recommend counselling to other people in the same position.

During a home visit with the community nurse, we met a specialist nurse from the palliative care team who had been asked by a GP to visit the patient to give support to their partner, who seemed overwhelmed when the patient had been discharged home a few days earlier.

Promotion of self-care

Due to the complex needs of patients receiving end of life care services, it was not always possible to promote self-care. However, the patient records we looked at included person-centred care plans based on the individual needs and preferences of patients. 92% of patients died in their preferred place of care.

Are End of life care responsive to people's needs?

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

Summary

The trusts palliative care service provided care for 652 patients during 2013/14. We found the service had a good understanding of the different needs of people it served. Services were planned, designed and delivered to meet those needs. We saw through advance care planning, patients were able to dictate both their preferred place of care and preferred place of death. The trust monitored the performance of their end of life treatment and care service.

We saw numerous letters and cards expressing positive feedback from patients and relatives about end of life care. Staff were aware of the trust's policy for handling complaints and had received training in this area.

Staff told us there was active reflective practice and learning following complaints, for example, improvements had been made in facilitating timely patient discharge from hospital as a result of learning from a complaint.

Service planning and delivery to meet the needs of different people

The trusts palliative care service provided care for 652 patients during 2013/14. We found the service had a good understanding of the different needs of people it served. Services were planned, designed and delivered to meet those needs. There was evidence that staff actively engaged with local commissioners of services, the local authority, other providers, GP's and patients to co-ordinate and integrate pathways of care that met the health needs of patients. Service specifications were in place which detailed the aims, objectives and expected outcomes for patients nearing the end of their life and were monitored against national and local performance indicators. Outcomes showed patients were receiving a high quality service.

There were referral criteria in place and there were discussions about all patients who were referred to the end of life care service, including those who were waiting for a bed.

Staff showed us leaflets about "Preferred priorities for care" that were given to patients. These provided simple

explanations about advance care planning and the different options available to patients. We visited two patients in their own home and saw the patients had received this leaflet.

There were identified link nurses who worked with the local prisons to provide end of life care support to the prison population.

At Priscilla Bacon Lodge we saw complimentary therapies such as reflexology and massage were offered.

Access to the right care at the right time

We saw through advance care planning, patients were able to dictate both their preferred place of care and preferred place of death. Information received prior to our inspection showed that the trust monitored the performance of their end of life treatment and care service.

Data showed that between April and July 2014, there were 494 deaths of patients within the care of the community nursing and therapy teams. Of these 494, 266 had indicated their preferred place of care. Of these, 245 died in their preferred place of care which equated to 92%. Staff also told us patients were able to change their mind about their preferred place of care and preferred place of death and the electronic care records would be updated to reflect this change.

Patients at the end of life in community settings were able to access the out of hours GP service. Additionally, advice was available from the nursing and medical team at Priscilla Bacon Lodge on a 24 hours a day seven days a week basis. The palliative specialist nurses had plans to extend their service to enable them to provide a seven day service.

Discharge, referral and transition arrangements

Staff told us patients were referred to the end of life care services through a number of routes including via GP or consultant referral, or they could visit local hospices or self-refer. The service actively used the Gold standard Framework to plan the right care for people as they neared the end of their life.

There were effective systems in place to identify patients who had a rapidly deteriorating condition and required access to the fast track pathway for NHS continuing

Are End of life care responsive to people's needs?

healthcare. Records showed patient needs were met without delay following discharge from hospital with all the appropriate equipment and support being available within four to six hours.

The trust told us that during 2013/14, there were 21 palliative care patients on inpatient units who had a delayed transfer of care to other settings. Of these 21 patients, four died on the ward, 4 died on the ward, 2 were transferred to another NHS provider and the remaining 15 were transferred to their usual place of residence or a care home. This meant that 3.2% of patients had some part of their care delayed due to waiting to be discharged into another setting. The trust were actively trying to reduce this further.

Complaints handling (for this service) and learning from feedback

We saw numerous letters and cards expressing positive feedback from patients and relatives about end of life care.

Staff were aware of the trust's policy for handling complaints and had received training in this area. Information was given to patients about how to make a comment, compliment or complaint. There were processes in place for dealing with complaints at service level or through the trusts Patient Advice and Liaison Service.

We found the clinical lead for palliative care was proactive in dealing with complaints before they escalated by visiting patients and their family at home to discuss concerns. We considered this to be good practice.

Staff told us there was active reflective practice and learning following complaints, for example, improvements had been made in facilitating timely patient discharge from hospital as a result of learning from a complaint.

Are End of life care 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

The end of life service had a clear local vision to improve and develop high-quality end of life care across the service. The increase in investment and staff to support the implementation of seven day service supported this vision. Most staff were aware of the trust's vision and strategy however this was not fully embedded amongst all the staff.

There was good leadership and support from local managers and most staff felt engaged with senior management. There was a positive culture in the service.

Risk management and quality assurance processes were in place at a local level. The end of life service held governance and patient safety meetings and records showed risks were escalated and included on risk registers and monitored each month. Local quality dashboards were also completed which showed how the service was performing against key quality indicators. We found managers were aware of the quality issues affecting their service and shared them with the staff.

Across all of community end of life services staff consistently told us of their commitment to provide safe and caring services, and spoke positively about the care they delivered. At a local level all staff felt listened to and involved in changes within their team and spoke of regular involvement in staff meetings.

Vision and strategy for this service

The end of life service had a clear local vision to improve and develop high-quality end of life care across the service. This followed the Department of Health's End of Life strategy (2008) and End of Life Care Strategy: quality markers and measures for end of life care (2009). The increase in investment and staff to support the implementation of seven day service supported this vision. Most staff were aware of the trust's vision and strategy however this was not fully embedded amongst all the staff.

There was an Organisational Development Strategy in place that was developed from engagement of staff across the trust. As part of this work the trust values have been refreshed involving 900 staff members and were formally signed off at an extraordinary Board on in June 2014. The

values were in the process of being rolled out across the trust through promotion materials, training at Induction, mandatory training and leadership training. We found some staff knew about the values.

There was good leadership and support from local managers and most staff felt engaged with senior management. There was a positive culture in the service. Staff felt leadership models encouraged supportive relationships as well as compassion towards people who used the service. Staff were encouraged to raise problems and concerns about patient care without fear of being discriminated against.

Governance, risk management and quality measurement

Risk management and quality assurance processes were in place at a local level. The end of life service held governance and patient safety meetings and records showed risks were escalated and included on risk registers and monitored each month. Local quality dashboards were also completed which showed how the service was performing against key quality indicators. We found managers were aware of the quality issues affecting their service and shared them with the staff.

Leadership of this service

There was an executive director who was responsible at board level for end of life care. We found there was good leadership within the end of life service.

Staff told us they were encouraged to raise concerns about patient care and this was acted on. We found all the staff were dedicated and worked well as a team. We saw data that showed staff sickness levels were in line or lower than expected targets. The majority of staff told us morale was good.

Culture within this service

Across all of community end of life services staff consistently told us of their commitment to provide safe and caring services, and spoke positively about the care they delivered. At a local level all staff felt listened to and involved in changes within their team and spoke of regular

Are End of life care well-led?

involvement in staff meetings. However, most staff we spoke with did not feel part of the trust and commented on the poor visibility of the non-executive directors and members of the wider executive team.

All the staff we spoke with assured us they understood the trust whistleblowing policy and told us they would feel comfortable using it if necessary. This suggested that the trust had an 'open culture' in which staff could raise concerns without fear.

Public and staff engagement

Staff told us staff engagement was good. They spoke positively about being able to raise concerns with their immediate managers and to make suggestions for improvements. We did not find any specific evidence of how the end of life service had engaged with members of the public.

Every month the trust board heard about a patient's experience at the start of their board meeting. A patient or carer is supported by the Patient Experience and Involvement team to share their experiences of their care from the trust and how this connected with other services they may have experienced. Patients and carers can directly tell the board about where care has been good and where improvements can be made. Actions arising are followed up by the Director of Nursing Quality and Operations.

The trust held a Recognition of Excellence and Achievement in Community Health (REACH) ceremony on

an annual basis. This is an awards ceremony to recognise the contribution of staff. In March 2014 the awards included some for staff working in inpatient areas including the specialist neurological rehabilitation inpatient service.

The results of the 2013 NHS Staff Survey showed the trust has performed better than the national average against five questions and worse than the national average against three questions. The trust performed better against questions regarding staff feeling their role made a difference to patients, effective team working, staff receiving job-relevant training, staff being appraised and staff receiving health and safety training. The trust performed worse than average against five questions – the percentage of staff experiencing physical violence from patients, staff experiencing harassment from staff, staff feeling under pressure to work when unwell, staff reporting good communication with management and staff recommending the trust as a place to work. The trust's performance has deteriorated against the first two questions.

Innovation, improvement and sustainability

Evidence showed staff were encouraged to focus on improvement and learning. We saw examples of innovation such as the development of provision of care and treatment for people with learning disabilities and ethnic minorities.

There was good collaboration with local and national palliative care networks including other providers to improve quality of care and people's experiences.