Hounslow and Richmond Community Healthcare NHS Trust

RY9

End of life care

Quality Report

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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)
RY9X1	Thames House	End of life care team	TW11 8HU
RY9X2	Teddington Memorial Hospital	Grace Anderson and Pamela Bryant wards	TW11 0JL

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

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

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

Summary of findings

Ratings

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

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

- Patients were protected from abuse and avoidable harm. When something went wrong, people received a sincere and timely apology and were told about any actions taken to improve hospital processes to prevent the same event reoccurring. Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses; they said they had been fully supported when they did so. Monitoring and reviewing activities enabled staff to understand risks and gave a clear, accurate and current picture of safety.
- The senior nurses regularly reviewed incidents and shared the findings with individual staff and at team meetings. We were, however, unable to find evidence of this learning being shared trust wide other than at team meetings at the clinics where the incident occurred.
- Nursing staff completed risks assessments and we noted that the shared care record was being used appropriately by the EOLC clinical nurse specialist (CNS) and the district nursing teams. The shared care record (Palliative Care Plan) was a document used when patients were identified as being in the last few days of their life. There was good access to out of hours support and advice for nursing staff from the local hospices.
- The feedback from people who used the service and their families were positive about the care received by patients nearing the end of life. Staff always took patients personal, cultural, social and religious needs into consideration when delivering care. Patients' emotional and social needs were valued by staff and were an important part of their care and treatment. Families were very positive about staff and the service they received. The service demonstrated a high level of compassionate care to patients and their families.
- Patients' needs were assessed appropriately and care and treatment planned and delivered accordingly, however this was not in line with current legislation. There was a multi-disciplinary collaborative approach to care and treatment within community services as they worked closely with Princess Alice and Meadow House Hospices.

However;

- Some of the DNACPR forms we reviewed did not contain discussions held around Mental Capacity Act (MCA) and best interest decisions. It was unclear how patients' mental capacity had been assessed particularly in relation to documenting best interest decisions.
- There was no plan in place for the end of life service to be accredited to best practice in alignment with the gold standards framework (The National Gold Standards Framework Centre (GSF) help doctors, nurses and care assistants provide the highest possible standard of care for all patients who may be in the last years of life. It's a model that enables good practice to be available to all people nearing the end of their lives, irrespective of diagnosis. It is a way of raising the level of care to the standard of the best). There was no recognition of this work having been commissioned and undertaken by the lead director for end of life care. There was very little evidence of audit to support some of the work been undertaken. This meant there was a lack of systems and processes to help identify people entering the last 12 months of life.

Summary of findings

Background to the service

Hounslow and Richmond Community Healthcare NHS Trust is responsible for providing community health services to over 500,000 people living in the London borough of Hounslow and Richmond. The trust was not commissioned by the two Clinical Commissioning Group's (CCG's) it serves to provide specialist end of life care. The CCG's commissioned Princess Alice and Meadow House Hospices to provide specialist end of life care to end of life patients in the boroughs of Richmond and Hounslow respectively.

End of life care (EOLC) services for people living in the London boroughs of Hounslow and Richmond was provided by the trust in conjunction with Princess Alice Hospice and Meadow House Hospice. The trust does not have any dedicated end of life specialist nurses, district nurses provided end of life care in the community. The trust had six continuing care beds at the Teddington Memorial Hospital (TMH) which can be used for end of life patients.

The end of life strategy of the trust was to provide fully integrated end of life care, in coordination with care provided by hospices. We saw in place a vision and strategy for end of life care. This is centred on care that is available at the point of need at any time during the patient's care journey.

End of life care is provided to patients who have been identified and assessed as having entered the last twelve months of their lives. In common with many areas of the country, cancer patients formed a high proportion of the trust's end of life care patients. We did not have the actual figures for cancer and non-cancer patients receiving end of life care from the trust. (Waiting for data for cancer & non cancer death).

During our inspection, we visited the district nursing team in Whitton Corner, Bedfont and Feltham Clinic and Teddington Memorial Hospital (TMH), we observed care being provided by the district nurses and by the general, nurses at the TMH. We spoke with 16 members of staff including the EOLC CNS. We spoke with eight patients and eight relatives and visited patients in their own homes and in community settings. We looked at the records of three patients receiving end of life care.

Our inspection team

Our inspection team was led by:

Chair: Professor Iqbal Singh

Team Leader: Nick Mulholland, CQC Head of Hospital Inspection

The team included CQC inspectors and a variety of specialists including specialist nurse practitioner and a clinical oncologist.

Why we carried out this inspection

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

How we carried out this inspection

During our inspection, we reviewed information from a wide range of sources that included data supplied by the trust both prior to the inspection and data requested at the time of the inspection.

We observed how people were being cared for in their own homes and reviewed care or treatment records of people who use services. We visited district nursing

Summary of findings

services across both boroughs. We spoke with 12 people who use services and their carers. We spoke with 16 members of staff including, district nurses, service managers, senior professionals and senior managers.

As part of the inspection, the CQC held a number of focus groups and drop-in sessions where staff from across the trust could speak with inspectors and share their experiences of working at the trust. We also received information from members of the public who contacted us to tell us about their experiences both prior to and during the inspection and looked at patient feedback about the service over the past year.

What people who use the provider say

The overall patient rating for the service was good. We saw the comments received, which were positive. One person said, "I cannot praise the staff too highly, from first contact the staff were caring and to my wife and I." Another person said there had been "lots of contact and discussion with the staff and any assistance required had been provided on time".

The people who use the service thought it was very good. Most said they could not fault the care they received and that the, "the nurses go the extra mile" to make sure our need was met. Relatives described the end of life services received as 'excellent' and said that nothing could have been made any better for them.

We visited four people in their homes during this inspection. Due to the nature of their illnesses we were not able to speak with two of them, however we spoke with their relatives and they were happy with the services received from the nursing team. One person told us that they thought the service was prompt and thought that the care provided was very good.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve:

- Ensure the current tools used to benchmark and monitor treatment are consistently implemented and used.
- Have a clear audit of monitoring and management of end of life care practices as their current practices was varied and was not consistent across the trust locations.
- Ensure the roll out of the Five Priorities of Care of the Dying is implemented swiftly. Delays in roll out were evident since the withdrawal of the Liverpool Care Pathway in July 2014.

Hounslow and Richmond Community Healthcare NHS Trust

End of life care

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

Staff understood their responsibilities to raise concerns and to report and record safety incidents. There were systems in place to report incidents and learn from them to reduce the chances of them happening again.

The senior nurses regularly reviewed incidents and shared the findings with individual staff and at team meetings. We were, however, unable to find evidence of this learning being shared trust wide.

There was appropriate equipment available in patients' homes and at various clinics, and we saw that equipment for patients at the end of life had appropriate safety checks completed.

We noted that Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) documentations were completed consistently. However Some of the DNACPR forms we reviewed did not contain discussions held around Mental Capacity Act (MCA) and best interest decisions.It was unclear how patients' mental capacity had been assessed particularly in relation to documenting best interest decisions.

Medicines were prescribed in line with national guidance and we saw good practice in prescribing anticipatory drugs for patient's at the end of life. We noted that anticipatory drugs were prescribed for patients at the end of life and that these drugs were available in patients' homes in the community. We were told there were stock of anticipatory drugs were also kept in some selective clinics for use in an emergency.

Cleanliness and infection control procedures were adhered to and potential risks to the service were anticipated and responsive actions planned. Appropriate major incident plans were mostly in place. Clinical staff had appropriate safeguarding awareness training and people were safeguarded from abuse. There were adult safeguarding policies and procedures in place, supported by mandatory staff training.

Safety performance

- The service had not reported any never events in the end of life care service. Service managers ensured incidents met the correct classification criteria, including those considered a serious incident (SI) or Never Event. Never Events are serious incidents that are wholly preventable as 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.

Incident reporting, learning and improvement

- Staff told us they knew how to report an incident through the electronic incident management system. Two staff described the incident reporting process and demonstrated this to us through the electronic reporting system.
- A formal process was used for reporting, investigating and learning from incidents, errors or near miss situations. Nursing and other clinical staff described to us the system they used and the investigating process.
- Clinical governance meetings provided staff with the opportunity to discuss incidents. All incidents were investigated using the root cause analysis tool, taking into account the factors which may have contributed to the incident. The managers we spoke with confirmed information relating to reported incidents was collated and discussed by the management team at clinical governance meetings, and minutes we saw confirmed this.
- District nurses told us they were confident to report incidents and were encouraged to do so. Most incidents were reported on the day they occurred and the incident was discussed at lunch time handover meetings as a form of shared learning. The locality team managers and staff told us they reviewed incidents at team meetings. We saw minutes of the meetings which confirmed this was the case.
- The community specialist palliative care services from the hospices were provided with reports which enabled them to analyse the reported incidents. We saw this service had reviewed incidents to identify and share information in order to reduce the likelihood of similar incidents recurring.

Duty of candour

- The Duty of candour regulation, which came into force in November 2014, explains what providers must do to make sure they are open, transparent and honest with patients and their families when something goes wrong with their care and treatment. Staff were aware of this new regulation and understood its implementation.
- The staff we spoke with understood their role and responsibility in informing patients of incidents that could or have affected them. They told us they would apologise and explain what actions had been taken as a result of the situation.
- Senior nurses were able to describe how the Duty of candour formed part of their working practices. The process they followed was a verbal apology and explanation followed by a written apology and explanation of the incident and what was done by the trust. The patients were also invited to a face to face meeting with the trust.

Safeguarding

- Staff were trained to recognise and act upon abuse or suspicions of abuse of vulnerable people and were aware of their responsibilities in relation to raising safeguarding concerned. A district nurse we spoke with was aware of the safeguarding reporting process and they recognised the potential vulnerability of the patients in their care.
- Safeguarding adults level one and two training was part of the trust's mandatory training and was routinely provided to all staff. All the clinical staff working in the community had attended safeguarding training relevant to their roles. Staff The trust monitored compliance regarding training attendance and for safeguarding this was 96% (safeguarding children level 2), 98% (safeguarding children level 1) and 96% (safeguarding adult's level 1).

Medicines

- Anticipatory drugs were delivered to the patient's home; these drugs were recorded on a drug stock record sheet by a registered nurse and the drugs were checked and signed during all visits by the nurses. All drugs including controlled drug (CD) and anticipatory drugs were recorded in this way. Records we reviewed were fully completed and showed the drugs were checked during each visit. The record was kept in the patient's home with the prescription sheet and the drugs. The patient kept these out of sight, usually in a storage container by their bed or in a secure place.
- A district nurse explained how controlled drugs were stored in a secured cupboard in patient's homes to prevent risks to vulnerable people such as any children living in or visiting the patient's home.

Good

Are services safe?

- We found that medicines were stored securely and appropriate emergency medicines were available at the TMH. Controlled drugs were stored, recorded and audited appropriately. No routine medicines were kept in the district nurses bases we visited except emergency medicines.
- Prescriptions and administration records we checked were completed clearly and legibly, detailing the times of administration of medicines prescribed 'as required' and checks to ensure the safety and suitability of controlled drugs kept at patients homes.
- On a home visit with a district nurse in Hounslow, we witnessed a patient received the appropriate palliative medicine and saw an improvement of the patient's symptoms. The nurse reacted quickly to the patients' needs and explained clearly what she proposed to do and obtained the patients consent beforehand.

Environment and equipment

- The trust had appropriate equipment's for use by patients in the hospital and at their own homes to support their care. Nursing staff in the community told us there were no issues with ordering or obtaining equipment promptly for patients who were receiving end of life care. This included pressure relieving mattresses for patients at risk of developing pressure ulcers.
- District nursing team leaders told us they maintain a small stock of equipment including continence products to be supplied to patients at short notice, including weekends and bank holidays. Relatives we spoke with told us equipment was delivered quickly when it was needed, but the service was slow to retrieve it when no longer needed. One relative told us "there is a lot of hassle to chase things; they had lots of inappropriate incontinence pads that were delivered and waiting to be collected."
- Emergency syringe drivers were kept at each district nursing base and in patient's homes ready for use when needed. The syringe drivers were all of a standardised type that conformed to national safety standard guidance on the use of syringe drivers for continuous subcutaneous infusions of medication for symptom control during the end of life.
- District nursing staff were able to access a syringe driver and other equipment whenever it was needed. The trust had a guidelines and policy on the use of syringe drivers. The homes we visited in the community had syringe drivers and sharps containers to allow for the safe disposal of objects such as needles, syringes and glass ampules. All the sharps containers were correctly labelled and signed.
- District nurses had rapid access to equipment by ringing the equipment library, either during normal working hours or out of hours (OOH). District nurses had no issues with the supply of extra equipment when required. Syringe drivers were stored at district nursing clinics, and the hospices had their own supply of syringe drivers if needed. The community palliative care CNS provided informal on the job training on the use of syringe drivers and symptom management to district nurses when required.

Quality of records

- Patients were risk assessed and their records well completed in relation to their end of life care. End of life patients' documentation was designed to promote best possible clinical care and make documentation easy for nursing staff in order to improve care delivery and communication with other health and social care providers.
- In a completed care record we reviewed, we found clear and concise documentation and a recorded discussion with family members about the end of life wishes of their relative.
- We received a report of the notes audit completed by the trust. The audit was undertaken to determine the quality of end of life care using 14 indicators which reflect the standards and aspiration on One Chance to Get it Right. The results of the audit were variable between the two local areas the trust served. The audits were on correct diagnosis, prognosis, and preferred place of death, advance care planning, palliative care support, and end of life care plan. The trust had developed an action plan through the End of Life Steering Group to implement the findings of the audit.
- During an accompanied home visit with district nurses, we observed the nurses completing appropriate care records for end of life patients, they documented the visit appropriately on patient's care records.
- We looked at four sets of patient records and two of these had Do Not Attempt Cardio Pulmonary Resuscitate orders (DNACPR) in place. We saw evidence that staff had discussed these with patients and their families.

Good

Are services safe?

Cleanliness, infection control and hygiene

- The inpatient unit at the Teddington Memorial Hospital was visibly clean and tidy and so were the patient rooms. Patients told us that their rooms were cleaned daily.
- Staff used personal protective equipment such as gloves and aprons when carrying personal and invasive care, and we noted the availability of spillage kit and guidance. There were guidelines for dealing with blood and bodily fluids available and accessible for all staff when needed. Hand sanitizer gels were always available and used by the nurses we were with during the onsite inspection visits to patients home.
- Sanitising hand gel was available and was used by staff before entering clinical areas. Patients told us they observed nurses and consultants using hand washing facilities before and after administering care.
- During visits with the district nurses to patients' home we witnessed good hand hygiene and the use of personal protective equipment, such as disposable gloves and aprons, when administering care to a patient.

Mandatory training

- Nursing staff we spoke with confirmed they had undertaken the trust mandatory training. We saw data showing evidence of attendance to mandatory and statutory training for nurses and health care assistants.
- Evidence provided by the trust confirmed that 97% staff had attended mandatory training. The trust mandatory training could be accessed through the online "Wired System". Mandatory training covered various topics including, incident reporting, mental capacity act, safeguarding, manual handling, and infection control among others. The training target for mandatory training was 95%. The trust had achieved this for the year 2014/2015.
- Most of the mandatory training courses were completed every three years. Corporate induction training was provided for all staff and was compulsory for all new staff to attend. All the nursing staff we spoke with confirmed that they had received their mandatory training in line with the trust's policy. Staff we spoke with were positive about the training provided and were confident they would be supported to attend additional training if requested.
- District nursing staff we spoke with told us they were up to date with their mandatory training. They gave examples of the training they had attended which included; basic life support, moving and handling of patients, safeguarding, information governance, prevention of falls and dementia awareness.

Assessing and responding to patient risk

- Patients were reviewed daily in their homes by their assigned district nurse, and in some cases home visits were undertaken jointly with the EOLC CNS from the local hospices the service was aligned with.
- Risks to end of life patients' were assessed and responded to by the nurses. The care record in the last days of life incorporated regular reassessments of patients' needs to minimise their risks of uncontrolled pain and maximise their symptom control. The trust had a system in place to alert the out of hours services where a patient's condition was deteriorating.
- Most of the district nursing staff we spoke with were aware they could access advice and request specialist support from the EOLC CNS if their patient had been identified as requiring end of life care support.
- We observed a lunch time handover between nursing staff. It was effective and relevant safety information was passed between staff members. The handover was structured so each nurse gave clinical information about the patients they had visited, the purpose of the visit and the outcome. End of life care patients were discussed first during the handover.

Staffing levels and caseload

- End of life care was provided by district nurses who worked in their designated locality area of the two London boroughs served by the trust. The EOLC CNS from the local hospices provided specialist end of life care to patients through a referral system across the boroughs of Hounslow and Richmond.
- At the two in-patients wards at Teddington Memorial Hospital (TMH), staffing had been problematic due to recruitment problems. Evidence available to the inspection team suggested that, there were no trained end of life specialist nurse recruited at the hospital. End of life care was provided by generalist nurses and they were supported by the EOLC CNS from the hospices. Almost 50% of the nursing shifts were covered by

Good

Are services safe?

agency or bank nurses for the year ending 2014/2015. Managers told us they tried to ensure continuity of cover as much as possible by requesting agency nurses for block periods of time.

- The specialist palliative care team (SPCT) from the two local hospices worked across their local boroughs (Princess Alice Hospice covered Richmond and Meadow House Hospice covered Hounslow borough). Each of the specialist team were being managed by a clinical team leader from the hospice. Staff we spoke with in the specialist palliative care team told us they were able to manage their caseloads and offered specialist advice and teaching session to the district nurses when required.
- Caseloads, staffing levels and skills mix were reviewed regularly at ward level to ensure patients received safe care and treatment at all times. There was a multidisciplinary approach to discussing patients on a daily basis. The EOLC CNS caseload was allocated according to geographical area and the size of existing caseload. All staff told us their caseloads were manageable. Please refer to our reports on the provision of care at Teddington Memorial hospital and community district nursing services for additional information.
- The district nurses held daily handovers meetings in the afternoon to discuss patients care; the nursing staff discussed each patient, their condition, medication and any concerns and agreed actions and follow up.

Managing anticipated risks

- We were told the trust had systems in place to make sure end of life care was provided irrespective of the weather condition. Caseloads were prioritised and those that do not need to be seen were informed and their visits re-scheduled in the event of severe weather condition.
- The trust had a lone worker policy, which give good guidance to staff on how to protect themselves whilst on duty. Staff told us risk assessments were completed on the first visit to a patient's home to ensure compliance with the trust policies, guidelines and procedures.

Requires improvement

Are services effective?

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

Summary

We judged the effectiveness of end of life care as requiring improvement.

We found end of life care and treatment was not provided in line with appropriate professional guidance of the National Institute of Health and Care Excellence (NICE). Regular and meaningful clinical audits and benchmarking were not carried out consistently across the end of life care services.

End of life care was delivered by a range of generalist nursing staff that participated in annual appraisals and had access to further generalist training as required. Whilst the trust does not provide specialist end of life care, the service model is for district nurses and community matrons to work closely with the clinical nurse specialists from the local hospices. The trust had an end of life care expertise and had invested in training and development for senior staff. A multi-disciplinary team (MDT) approach was evident across the end of life care services provided by the trust and the two hospices within the boroughs of Hounslow and Richmond.

We observed a shared responsibility for care and treatment delivery by the district nurses employed by the trust and EOLC CNS employed by the hospices.

The trust reviewed the National Care of the Dying audit but did not participate as it was acute focussed. As a community provider, the trust was not eligible to contribute to the national minimum data set for end of life care. The trust undertook its own internal notes audit in 2015/16 and has implemented a full audit plan for 2016/17.

The end of life care service depended clinically on specialist palliative care input from the two hospices (Princess Alice and Meadow House Hospices) and there was a good support and supervision in place for the district nursing team from the specialist community palliative care team.

Evidence based care and treatment

- Evidence based care, in line with National Institute of Health and Care Excellence (NICE) guidance (QS13 End of Life Care for Adults), had not been implemented or provided by the trust for all patients who were in the last year of their life.
- End of life care was not consistently managed in accordance with national guidelines. Patient's needs were regularly assessed, their preferences identified and holistic care planned and delivered, however the delivery was not in line with best practice as demonstrated in the notes audit completed by the trust in March 2016.
- The trust had carried out baseline audits of case notes to monitor the quality of end of life care during 2014/15. The results of the audit were presented to the End of Life Care Steering Group meeting in March 2016. The audit findings suggested that the trust should develop an end of life information sheet as a brief aide memoire, and to ensure all elements of end of life care were recorded appropriately and consistently. The trust should also to review training and development for staff around advance care planning, having difficult conversations, giving emotional support and record keeping.
- Staff told us that the Liverpool Care Pathway (LCP) had never been used by the trust. Even though it was phased out in July 2014, we did not see a replacement for the LCP in operation. The trust was currently piloting an end of life care plan called "palliative care plan" as their end of life document. At the time of our inspection, the pilot was ongoing, hence the care plan was yet to be used widely across the trust, and yet to be audited to determine if it was effective.
- The trust had not fully implemented the five core recommendations for care of patients in the last few days and hours of life in the Department of Health's End of Life Care Strategy 2008. It had also not implemented recommendations of 'One chance to Get it Right'

document published by the Leadership Alliance for Care of the Dying People 2014. Most of the trust documentation for end of life care was in draft and yet to be embedded in the trust's end of life care services.

- The trust was not currently working towards accreditation of provision of end of life care using the Gold Standard's Framework. Many acute trusts and hospices are currently working towards the Gold Standards Framework as this is considered to be best practice. The Gold Standards Framework (GSF) is a model that enables good practice to be available to all people nearing the end of their lives, irrespective of diagnosis. It is a way of raising the level of care to the standard of the best. Through the GSF, palliative care skills for cancer patients can now be used to meet the needs of people with other life-limiting conditions. The GSF provides a framework for a planned system of care in consultation with the patient and family. It promotes better coordination and collaboration between healthcare professionals.
- Staff were aware of the Advanced Care Plan (ACP) but we did not see any evidence of its use. ACP is a key part of the Gold Standards Framework Programmes. It should be included consistently and systematically so that every appropriate person is offered the chance to have an advance care planning discussion with the most suitable person caring for them.
- Advance Care planning is a vital tool for improving care for people nearing the end of life and of enabling better planning and provision of care. It helps patients to live and die in the place and the manner of their choice. The main goal in delivering good end of life care is to be able to clarify peoples' wishes, needs, aspirations and preferences and deliver care to meet these needs.
- We were told the trust meets regularly with the local hospices to network within end of life care. Staff attending these meetings learns latest evidenced based practice and news relating to end of life care and share it with the multidisciplinary team to improve practice.

Pain relief

- Patients who were considered to be in the last days/ weeks of life were appropriately prescribed anticipatory drugs for symptoms experienced by patients at the end of life, including pain, nausea, agitation and anxiety.These anticipatory drugs were prescribed in advance to be given to allow management of any sudden changes in patients' pain and other symptoms, and these drugs were available at all times. Nursing staff told us there were adequate stocks of appropriate medicines for end of life care and these were available as needed both during the day and out of hours.
- Where appropriate patients had syringe drivers (devices for delivering pain medicines continuously under the skin) which delivered measured doses of drugs at pre-set times. District nurses and the in-patient unit at TMH had adequate supplies of syringe drivers and the medicines to be used with them. Staff were trained to set up syringe drivers when needed by the patients. Most of the nurses we spoke with at the TMH and in the community have told us they were trained in the use of syringe drivers.
- We observed staff assessing patients' pain levels and responding quickly and appropriately, to provide pain relief if they identified the patient was feeling pain or discomfort. Patients and relatives we spoke with told us their pain was "well managed" and that staff were "very responsive".

Nutrition and hydration

- Nutrition and hydration was well managed. We observed a district nurse visited a patient on Total Parenteral Nutrition (TPN) and took blood samples to be tested to ensure that appropriate TPN was made for the needs of the patient. The patient was was unable to eat orally and was fed TPN through the Hickman line (a line inserted centrally through the chest).
- We saw evidence of daily fluid charts in use and recorded appropriately on a patient on gastrostomy feeding regime at home. If patients at home were recognised as in need of rehydration they could either be managed at home or taken to TMH or the local hospices to have their hydration needs managed. Some of the district nursing staff were trained to provide subcutaneous fluids to help a patient absorb fluids if needed in their own homes.
- We were told by the nursing leadership that screening tools were used to determine how best to support patients in need of nutrition and hydration. A patient in receipt of end of life care, for example, will be assessed using the Malnutrition Universal Screening Tool (MUST). The assessment will then determine the nutrition and hydration intervention needed by the patient.

Requires improvement

Are services effective?

Patient outcomes

- At the time of the onsite inspection visit, we did not see measures of patient outcomes specific to specialist end of life care. District nursing staff told us the specialist palliative care team will measure patient's outcomes.
- Managers told us clinical outcomes on end of life care were not being measured by the trust, however they had plans to implement monitoring of patients outcomes in line with the Priorities of Care set out in One Chance to Get it Right (June 2014) and the NICE Guidance (December 2015) through the End of Life Strategy Group.
- We were told the trust had not participated in the National Bereavement Survey 2014. Even though they didn't participate in the survey, the expectation was to use the survey results to inform their end of life care service development, which they didn't do. 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 was 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 trust leads for end of life care told us they noted gaps in the use of audits and the monitoring of patient outcomes and that was an area they were intended to address in line with the implementation of the end of life care strategy which was ratified and launched in December 2015. The end of life care steering group had started working to address the gaps in terms of auditing of patient outcome.
- Preferred place of death information for 2014/15 confirmed that preferred place of death was recorded in only 47% of records audited. Out of 30 patients records audited, 11 patients died in the preferred place of death, two patients were not, and medical records was unclear about the 17 patients on whether they died in their preferred place of death or not.
- We asked nurses in all the locations we visited what care planning tool they were using in replacement of the Liverpool Care Pathway (LCP) which was withdrawn from use in June 2014. The trust never used the LCP for their end of life care patients and used normal care plans instead.
- We were told the trust had a developed patient centred care plan; however this had not been implemented widely across the trust. We were shown a document called "Pilot of end of life care planning – Palliative care plan" which was designed to prompt nurses to think about and document patient's care and wishes and plan for care at an early stage. This meant that patients who used the service had information and an opportunity to consider their wishes and to enable staff to plan the care pathway from an early stage in the person's illness. This care plan is yet to be rolled out across the trust, and we were advised that the roll out was planned for June 2016.

Competent staff

- The trust provided evidence of staff training but none of the staff had attended specialist palliative care training module.
- District nurses had access to formal and informal training opportunities from the EOLC CNSs to develop their end of life care skills and knowledge. They told us they worked alongside EOLC CNS from the Meadow House Hospice and Princess Alice Hospice and these had helped them to develop end of life care skills and competencies.
- All the nursing staff we spoke with told us that they had received an informal communication training which taught them how to effectively manage demanding situations, giving them confidence in knowing when it was appropriate to discuss sensitive subjects. They said they had also received monthly supervision from their line managers and the EOLC CNS to support them in developing their confidence in caring for end of life patients'.
- The End of Life Care Strategy launched by the trust in December 2015 included guidance for training requirements and learning objectives for staff involved in delivering end of life care. This was based on End of Life Care for All (e-ELCA – Topic Matrix June 2015). End of Life Care for All (e-ELCA) is an e-learning programme that aims to enhance the training and education of health and social care staff and volunteers involved in delivering end of life care.
- The trust had developed a proposal for end of life care training and development dated March 2016, the proposal recommended the following; the trial of e-learning modules, to develop a plan to roll out the e-

learning to all staff, to earmark some aspects of end of life care training as mandatory for all clinical staff and the development of monitoring tool to accurately record staff training and development.

Multi-disciplinary working and coordinated care pathways

- There was a good approach to multidisciplinary working in end of life care. EOLC CNS worked alongside the trust's district nurses and they participated in Gold Standards Framework meetings at GP practices. However, district nurses told us they do not attend these meetings on their own.
- EOLC CNS spent time with the district nurses to discuss and agree end of life care plans for patients. They liaised and communicated with other specialist services and reviewed end of life care as and when required for their patients.
- Patients requiring end of life care, who needed involvement of the multi-disciplinary team in their care were discussed on a daily basis with the EOLC CNS, as part of the agreed specialist palliative care input to patient care. Patients told us they felt all staff involved in their care worked as a team and communication between EOLC CNS and nursing staff was good. We were told nurses worked closely with EOLC CNS. We were told there was evidence of agreed local pathways, with patients moving between services as and when needed.

Referral, transfer, discharge and transition

- Patients were referred and transferred appropriately between services. Nursing staff told us patients could be referred to the hospices or to the hospital with appropriate support from the district nursing team when they were being transferred from the community for symptom management.
- District nurses were involved in the planning of discharges to an alternative place of care. This process involved the support of the specialist palliative care teams as well as the support of other agencies in providing end of life care to patients at home or in their preferred place of death.
- Access to in-patient beds at Teddington Memorial Hospital (TMH) for all patients was managed by a Single Point of Access (SPA). This contributed to patients at the end of their life being in their preferred place of care when being discharged from an acute hospital or admitted from home via their GP. Even though there were no designated end of life care beds in TMH, the trust managers stated that TMH had seven continuing care beds which was usually used for palliative and end of life care patients.

Access to information

- District nursing staff told us discharge summaries and referral notes from hospitals, GPs, hospices and TMH were available for patients under their care. This enabled them to carry out fully informed assessments of all new end of life patients.
- Patient's medical records were kept at their home for all staff involved in the patient's care to document their actions and outcomes. This meant staff involved in the patient's care had up to date information and knew of any changes or developments in the patient's health, because all the information needed to deliver effective care and treatment was available and accessible to relevant staff at the patient's home.
- There were systems in place for the transfer of patient's medical information between hospitals, GP practices and hospices. This meant nurses and specialist palliative care CNS caring for patients had their patients' full medical history to ensure continuity of care.
- The trust acknowledged that they need to work with their IT team to ensure EOLC care plans are on "System One" and are easy to access by staff. They will develop a flag process on "System One" so staff can clearly identify EOLC patients. "System One" is the IT system that the trust used to manage patient care including care planning.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- The trust reported 95% of nursing staff had attended Mental Capacity Act (MCA) training as part of their mandatory training. District nursing staff told us they were aware of the Act and knew what to do if they suspected someone lacked capacity to consent.
- We looked at four sets of patient records and two of these had Do Not Attempt Cardio Pulmonary Resuscitate orders (DNACPR) in place. We saw evidence that staff had discussed these with patients and their families. We also noted that records kept at patient homes were accurately completed.
- District nurses we spoke with were able to discuss decisions around resuscitation. This included discussion with the patient and family.

Requires improvement

Are services effective?

- We noted verbal consent had been obtained for invasive procedures and was clearly documented by the nurse carrying out the procedure.
- Staff told us that where possible they gained the patient's consent in planning treatment and care. We saw evidence in patient's notes to support this A patient we spoke with told us that staff sought their consent "in sharing information and discussing treatment" and that staff had ensured the patient was fully aware their care and treatment.

Good

Are services caring?

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

Summary

Staff at Hounslow and Richmond Community Healthcare (HRCH) Trust provided a dignified and compassionate end of life care (EOLC) service to patients. A team of palliative care specialist nurses from the Princess Alice and Meadow House Hospices supported nursing staff to provide an EOLC service to patients both in Teddington Memorial Hospital (TMH) and within their own homes in the local community.

Staff at all levels spoke compassionately about patients who were approaching end of life and demonstrated they had considered the emotional needs and well-being of patients and those close to them. Staff were committed to providing good patient care that focussed on meeting patients' holistic needs. Staff were caring, compassionate, and treated patients with kindness, dignity and respect.

End of life care patients we spoke with and those close to them were encouraged to be involved in their care. They told us they were routinely involved in decision-making and felt they had sufficient information to understand their treatment choices. Families and relatives we spoke with told us staff were caring and provided them with emotional support and that staff kept them informed about their loved one's care and treatment.

Nursing staff treated patients, and those close to them, with dignity and respect; they provided personal care in way that protected the patient's privacy and dignity. Feedback from patients and relatives was positive about the care they had received. Relatives and those close to patients told us the staff were "fantastic" and their loved ones had received "excellent care" from staff. They said both doctors and nurses were "always available" when they needed them.

Compassionate care

- Nursing staff demonstrated empathy while providing end of life care. The patients' privacy and dignity was maintained at all times with careful consideration given to minimising the patients' distress and pain levels whilst carrying out essential tasks such as changing dressings.
- We observed district nurses and community specialist palliative care nurses providing end of life care to patients in their own homes in a respectful, dignified and considerate manner, for example they asked permission before going upstairs.
- Nursing staff told us that patients who had chosen to receive end of life care in Teddington Memorial Hospital were provided with the option of being moved from the main ward into a side room to provide them and their family with privacy. We spoke with one recently bereaved relative who told us their loved one had been given a side room so she was able to visit and stay at her convenience.
- Patients were encouraged by nursing staff to create a memory box and to think about other considerations regarding their last days and hours of life. For example, we observed a patient having a discussion with a palliative care nurse about creating a "memory box" for their loved ones.
- Feedback from patients and relatives was very positive about the care they received. Relatives and those close to patients said staff were "fantastic" and their loved ones had received "excellent care" from staff. They said that both doctors and nurses were "always available" when they needed them.
- Relatives we spoke with gave us examples of where staff had gone beyond their job role to provide compassionate care to patients. Another nurse on the ward went out of her way to get hot chocolate for a patient when they had asked for it and there was none available on the ward.
- Patients told us they felt their spiritual needs were being met as they were able to see the chaplain on the ward most afternoons and their family and friends were able to pray and sing with them.
- Patients were provided with sufficient information about their treatments and had the opportunity to discuss any concerns they might have about their care and treatment with either the district nurse or the EOLC CNS.

Good

Are services caring?

Understanding and involvement of patients and those close to them

- Staff communicated clearly and sensitively with patients and their families, ensuring that they understood what staff were doing.
- District nursing staff ensured that discussions about end of life priorities were held in a sensitive manner. They made sure the patient and those close to them were provided with all the information they needed to be fully involved in making decisions about the patient's care. We observed a district nurse provided information to a relative about a patient's prognosis in a sensitive and supportive manner. The nurse ensured they were given time to understand new information before any decisions about care were made.
- All patients we spoke with were able to describe conversations they had had with medical and nursing staff about their wishes and priorities for the last days and hours of their life. However, some did not know if they had an individual plan for their end of life care.
- We observed discussions between patients and staff about options for alternative pain medication and other suggestions to make the patient more comfortable. Staff told us that where possible family members were always involved in these discussions.

Emotional support

- Patient records showed that appropriate discussions had taken place with the patient and those close to them to identify their emotional and spiritual needs. We noted that patients and those close to them were involved in discussions about their preferred place of care and preferred place of death.
- Staff at all levels spoke confidently about providing emotional support to patients and their relatives. They were able to provide us with examples of when they had comforted patients and those close to them.
- Patients we spoke with confirmed they had received information about the availability of counselling services offered by the hospice.
- District nursing staff told us they provided a bereavement service and that they visited each family at least once after the patient had died to offer them support, however we did not see any evidence of this during the onsite inspection.
- Nursing staff referred to patients by name and spoke about their care and treatment in a sensitive and caring manner. They provided emotional care and support to patients and their families at the time most needed.
- Patients told us they "could not wish for better support" and that staff were "always responsive" to their needs. A recently bereaved relative described the care provided by the staff as "excellent" and said the staff were "fantastic".
- Where patients have chosen to receive end of life care at home, they and their relatives had access to a "Care Line" telephone number that provided them with access to 24-hour support.

Good

Are services responsive to people's needs?

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

Summary

End of life care (EOLC) services were planned and delivered to meet people's needs, wishes and choices. End of life patient's wishes were met in a timely manner by the trust working in collaboration with other end of life service providers to provide appropriate end of life care package care.

Nursing staff listened to patient's needs and acted quickly to meet them. There were good systems in place to ensure patients had received the right care and treatment including medications and equipment. At the TMH, visiting times were waved or relaxed for relatives and loved ones who visited the end of life care patients.

There were good working relationships between the district nursing teams and the community specialist palliative care CNS from local hospices. District nursing staff were happy with the support received from the community palliative care CNS in relation to the end of life care needs for their patients. The communication between them was open and flowing and together they delivered an EOLC for their patients.

The integration of services and shared working practices between providers allowed for more seamless transfers of care and improved the likelihood that patients' needs were responded to in a timely manner. We found the end of life services to the residents of Hounslow and Richmond to be accessible, timely and patient centred. The service was integrated to provide care to patients in a place of their choice supported by family and other healthcare professionals with the flexibility to allow for changes of preference as the patient's condition worsened.

People's different religious and cultural requirements were taken into account. Staff adapted their approach to be sensitive to the family's needs.

Complaints were being recognised and lessons were being learnt from the concerns. Relatives were being invited to share their experience, to learn and improve the delivery of end of life care. Nursing staff responded to complaints quickly to ensure that it was resolved quickly. Lessons learnt from complaints were shared at staff meetings.

Planning and delivering services which meet people's needs

- The trust used information about the needs of the local population to plan their end of life care services. Other service providers and commissioners were involved in the process.
- The trust's end of life care team worked closely with Meadow House Hospice and Princess Alice Hospice to ensure EOLC needs of their patients were met. District nurses received informal end of life training and advice from the local hospices.
- Each district nurse knew the GPs that served the patients they were caring for and worked closely with them. The GPs and the district nursing team had a good communication flow and working relationship between them. These resulted in a greater understanding of the patients' needs and the community they lived in.
- District nurses held monthly meetings with GPs in their locality to discuss patient's needs, their current diagnosis and prognosis and agreed on the care package needed by the patient. These meetings resulted in a comprehensive end of life care package for patients.
- The trust held end of life care steering group meetings, which looked at key issues regarding end of life care, including the development of new end of life palliative care plans and training needs for nurses.
- Nursing staff at Teddington Memorial Hospital (TMH) worked well with the GPs who visited the in-patients wards five hours a day. The GPs were able to share their wealth of knowledge of the local community with staff.
- We visited the TMH and asked the nurse in charge to identify the patients on the ward who were receiving end of life care, or were nearing the end of their life. All wards could clearly detail who was to receive this level of care, and were aware of what was required of them. TMH provided side rooms for patients nearing the end of life. If family members wished to stay the night, a bed was supplied. Patient's relatives and loved ones were able to visit their relatives at any time when required during their in-patients stay at the TMH.
- The trust was aware that Hounslow and Richmond were demographically and culturally different. Hounslow had some highly deprived areas and had cultural challenges,

which required staff to work thoughtfully with individuals and families. The community nursing team were made up of highly experienced staff that lived locally and understood the needs of the diverse community.

- In Teddington Memorial Hospital there was a multi-faith chapel available for patients, staff and visitors to use for prayers or quiet reflection. Staff told us that there was a service held twice a week and everyone was welcome to attend.
- Staff in the Teddington Memorial Hospital told us that all bereaved relatives received a "bereavement pack" after the death of the patient. Staff told us the pack provided a sensitive way to provide the relatives with the patient's death certificate. We saw a copy of this pack which contained helpful information including a leaflet about what actions to take and details of the annual chapel service. However, the pack did not contain any information about counselling services or other bereavement support services. Staff told us that the Princess Alice Hospice provided this information.
- End of life patient's care plans and their individual needs were catered for but not documented well. We reviewed six sets of notes and we did not find any evidence of the patients preferred place of death always documented, and this was also the findings of the notes audit completed in March 2016.
- Ward visiting times were flexible for family and friends when patients were approaching end of life. Relatives were able to stay with patients at the end of life if they wished.

Equality and diversity

- We saw that all patients receiving end of life care were treated as individuals. The leadership team told us equality and diversity training was delivered to all staff during induction and then as part of the trust mandatory training programme.
- The trust through their audit, found that 97% of patients did not have advance care plans. They are in the process of devising new care plan documentation that will supply a clear format for staff to write this down.
- In 93% of cases, no religion was recorded and no evidence in the notes of spiritual care been provided, even though this was an integral part of care that healthcare staff offered for end of life patients.
- Translation services were available from the both Hounslow and Richmond Borough Council for use by the district nursing team if they felt the need to use them. They knew who to contact if they needed to make the arrangements for translation services.
- Staff were open about providing care for patients from different cultures. They said that every individual was different and that they approached situations with sensitivity to their needs.
- At TMH, a chaplain service was available with twice-weekly service in the Chapel. Multi-faith support was available to all persons of all faith and none. We visited the chapel at TMH, and saw that it had information relevant to people from different faiths. The chapel was decorated and configured to provide a space appropriate for the use of people from multiple faiths.

Meeting the needs of people in vulnerable circumstances

- There appeared to be confusion about the verification of a patient's death. In Hounslow, the district nurses were under the impression they were not allowed to verify death, although a nurse was trained to do this. In Richmond, a district nurse trained to verify death was doing so. The end of life care leadership team we spoke with, said district nurses were able to verify death and would ensure this was communicated throughout the trust. The district nurse told us they thought it would be useful to do this as they were often present and knew the family. It would help alleviate the doctor's workload, as it could take up to six hours for the doctor to visit the home. It would allow families to make arrangements with the undertaker promptly.
- End of life care patients living with dementia were assessed early and their treatment planned and supported by CNS from the hospices. Hospital and district nursing staff had support and advice from a link nurse for people living with dementia and those with learning disability.
- There was recognition by the nursing staff that an individualised approach was needed to support patients living with dementia as well as those with learning disability when they approached the end of life. There was also awareness that time was important to ensure patients' needs and choices were identified before there was a loss of capacity and so sensitive discussions were undertaken.

Good

Are services responsive to people's needs?

- TMH offered one to one care if the circumstances of the patient required this. The complex needs of patients were met by the provision of specialist equipment if needed. Wheelchairs were provided to families to help them move individual patients within and outside the hospital with ease.
- A leaflet was supplied to the individual and family members about end of life care and community services that were available and provided by the trust if required. Nursing staff were able to clearly explain the challenges of caring for patients approaching the end of their life who were part of the travelling or homeless communities and what this involved.
- TMH provided a bereavement package for relatives, once the death certificate had been issued. It gave relatives information about the support services available and the annual chaplaincy service that was held in the chapel. Princess Alice Hospice provided information regarding counselling and bereavement support, and patients and their relatives were encouraged to use the service.

Access to the right care at the right time

- The community specialist palliative care team from the local hospices operated a 9am – 5pm service and undertook community visits or joint visits with the district nursing teams. It also provided professionals, patients and carers with an out of hours on-call service for specialist advice seven days per week.
- District nursing staff visited patients in the morning, prioritising patient's appointments to meet their needs. District nurses visited patients who were poorly and needed specialist assistance first. Appointment times were agreed with the patient. If a patient required two visits, these were arranged by the district nurse and agreed time of visit with the patient.
- A rapid response team was available from the hospices. The patient's notes displayed the out of hours and rapid response team numbers on the front page.
- At TMH, a GP visited every working day for five hours. They admit new patients, wrote prescription and attended MDT meetings. They were flexible in their approach. They were on-call between 9am and 6.30pm. The out of hours (OOH) team worked from the hospitals outpatient centre and covered out of hours and overnight calls.
- TMH is a nurse led unit. Nursing staff did not need GP permission to transfer a patient back to the hospital. The nurses can verify death but cannot certify. The GP will either certify death at the hospital or at the undertakers, depending on the time of death. The undertakers collected deceased patients within one hour of death, 24 hours a day, and seven days a week.
- If patients expressed the wish to go home for EOLC, nursing staff at TMH were able arrange a fast track transfer within 24 to 48 hours. The nurses we spoke with said it was an easy process to go through, and were always able to do so for end of life patients.
- The trust recently sampled 10 random patients' notes each from Hounslow, Richmond, and TMH and from children's services. They found that only 37% of patient's notes were clearly documented with their preferred place of death. In two cases, the patient did not die in their preferred place of death, due to rapid deterioration of their condition. The notes of 67% reviewed were unclear about where the patients died, whether at home, hospice or hospital.
- There was a lack of written information about discharge options available for patients receiving end of life care at the Teddington Memorial Hospital. The matron told us this was currently being developed by the EOLC Steering group.

Learning from complaints and concerns

- End of life services received no formal complaints within the last year. We were given a clear explanation of how complaints were handled. All staff preferred to deal with issues immediately and endeavoured to diffuse the situation before it escalated. They spoke to people either over the phone or directly in a face-to-face meeting.
- Information on how to raise concerns or make a formal complaint were displayed at various locations at the TMH. The trust had a policy which set out how complaints should be dealt with and timescales for responding to these.
- The trust had leaflets explaining how to make a complaint. A senior nurse told us most complaints were resolved at ward level. Nursing staff told us that wherever possible, they tried to resolve any issues with patients prior to a written complaint being made. There was an expectation that any concerns raised by patients on the wards or in the community would be immediately addressed by the manager of the service concerned and if possible resolved immediately to the patients' satisfaction.

Good

Are services responsive to people's needs?

- We were told that themes for formal and informal complaints were analysed and discussed at weekly team meetings. Action plans and learning from complaints were discussed at those meetings. Staff explained that issues discussed in the weekly team meetings were, firstly to share the complaint and to see if lessons could be learnt and action plans and learning from complaints agreed.

Good

Are services well-led?

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

Summary

We have rated end of life care services as good in how it was led.

We found there was a clear vision and focused strategy to deliver good quality end of life care however this was at a very embryonic stage. The trust had developed a strategy for end of life care, which was launched in December 2015 that incorporated five Priorities for the Care of the Dying Person that included the delivery of end of life care in different settings across the trust.

At the point of inspection, the local leadership was effective and had just put in place a strategy for the service. However, as the strategy was at an embryonic stage, this limited how effective the service could be overall.

The governance framework ensured staff responsibilities were clear and that quality, performance and risks were well understood and managed. The leadership, governance and culture promoted the delivery of high quality person-centred end of life care.

Management and frontline staff in all areas knew and understood the vision, values and strategic goals of the end of life care services. Staff morale was high and the end of life steering group was enthusiastic about the future of end of life care at the trust.

The end of life care leadership, the organisational culture, its vision and values encouraged openness and transparency and promoted good quality care. People who used the service and staff were involved in planning of their care and their input was highly sought and valued.

The trust board lead for end of life care had appointed an interim end of life programme manager to work towards the implementation of end of life strategy and work streams. There was an end of life steering group to take end of life care forward and maintain responsibility for provision of the service for the trust.

The end of life management team and staff we spoke with were aware of the vision and values of the end of life services provided by the trust. All staff were committed to providing safe and good quality end of life care. There was a culture of collective responsibility between the local teams and had many opportunities to discuss patient needs and review caseloads.

Most of the frontline staff and team leaders we interacted with felt engaged at a local level. They were fully aware of the trust's vision and direction of travel for end of life care and they were encouraged to contribute ideas to influence the development of end of life care services.

Service vision and strategy

- There was evidence of an end of life strategy within the trust; this was launched by the trust in December 2015. The end of life care vision and strategy of the trust centred on care that is available at the point of need at any time during the patient's end of life journey. The trust's aim was to provide integrated end of life care in partnership with the local hospices.
- The end of life care programme manager had been appointed as the lead for the development of end of life care policies and strategy and provides input to the trust board about end of life care, however, there was no non-executive director appointed for end of life care.
- District nursing staff we spoke with were not all aware of the end of life strategy.
- EOLC CNSs confirmed they met with the district nursing staff regularly to discuss workload and the strategy of the service going forward.
- The trust had not contributed to the independent review of the Liverpool Care Pathway (LPC), 'More Care, Less Pathway' (2013) and 'One chance to get it right' (2014). The LCP was withdrawn nationally on 30 June 2014 and was replaced with 'Principle of Care and Support for the Adult Dying Patient' in conjunction with the end of life care plan and the '5 priorities of care'. The trust was yet to adopt fully the recommendation of the independent review and to introduce quality markers for use with the end of life care plan to monitor the quality of care across the community and the in-patient unit at TMH.

Good

Are services well-led?

Governance, risk management and quality measurement

- The governance structure showed clear lines of accountability from directors, operational managers and team leaders to the front line staff delivering end of life care services. Meetings were in place for key areas such as clinical governance, health and safety and training and development.
- The end of life risk register was maintained by the head of quality and patients safety. We saw an action plan in place to mitigate risks identified on the risk register with follow up date and realistic expected completion date. Discussions of risks on the risk register was a standing item on the end of life steering group meeting, and we saw end of life risks being discussed at the steering group meeting we attended in March 2016.
- There were systems in place which ensured that managers understood their workforce and their workload. There was clear clinical oversight and involvement with patients and their families throughout their end of life care journey.
- The end of life care leadership team told us they recognised there was a gap in the use of audits and monitoring of patient outcomes and that this was an area they were intending to address in line with the implementation of the end of life care strategy going forward, and we noted this was discussed at the end of life steering group meeting we attended in March 2016.

Leadership and culture of this service

- The end of life care management was divided between administrative management and operational staff which included all staff providing end of life care. District nursing staff were happy to work in the district nursing team in conjunction with the specialist community end of life team from the hospices. They said their line managers were seen to be supportive. They told us the trust was a progressive and proactive place to work, where change was accepted for the benefit of patients and staff.
- The end of life care service leads we met had priorities that were patient focused and based around delivering best practices in end of life care services. They linked well with the local teams in the community. We noted that district nursing teams were well led in terms of the team and management structure. Staff felt they were able to discuss any concerns with their line managers and felt well supported by their team leaders and line managers.
- There was evidence that the culture of end of life care was centred on the needs and experience of patients and their relatives. Nursing staff told us they felt able to prioritise the needs of patients at the end of life in terms of care delivery.
- We observed good joint team working by the district nurses and community specialist palliative care teams. Staff told us there were opportunities to learn and that the delivery of high quality end of life care services within the community was their priority.
- All the staff we met were committed to making a difference, encouraged learning and development, and sharing of their knowledge, skills, experience and expertise in end of life care. The staff felt well supported and valued in their roles.
- The district nursing staff felt involved in the end of life service development and felt very well supported by the end of life care leadership team. The culture within the end of life care service was caring and supportive. Staff were actively engaged and encouraged to provide feedback. Staff spoke positively about the high quality care and services they provided for patients and were proud to work for the trust.
- Staff reported an open culture where they could raise and discuss any concerns with their team and managers. They felt well supported by their managers in all aspects of their work including training and supervision.
- The culture we saw within the service was open and caring. The interactions we saw between staff, families, and people using the service were kind and professional. We received highly positive comments about relationships between staff within teams, across professional boundaries and between organisations involved in delivering end of life services to the people of Hounslow and Richmond.

Public and staff engagement

- We found no evidence of public engagement specific to end of life care, and there were no end of life patient group in place at the trust. The trust told us they carried out Friends & Family Test results; however these were trust wide and not specific to end of life care.

Good

Are services well-led?

- We did not see any evidence of frontline staff involvement in the launch of the end of life strategy. The strategy was launched via information posted on the trust intranet. Some sections of staff were not aware of the launch of the end of life care strategy.
- Staff were positive and focused on how to improve the services for patients and providing a high quality end of life care services.

Innovation, improvement and sustainability

- The associate director for acute care close to home responsible for EOLC told us it was a priority for the trust to provide comprehensive and patient centred driven end of life care for the dying patient. The trust had recently completed a strategic review of their end of life care across the community and the in-patient unit at the Teddington Memorial Hospital. The aim of the trust's end of life strategy was to provide quality end of life care to patients and their families at the end of their life wherever they chose to be, whether at home or in the community hospital.