

Provide Community Interest Company

1-168055209

Community 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)
1-283687220	Braintree Community Hospital Ward		
1-223332623	Halstead Community Hospital Ward		
1-223517978	St. Peter's Community Hospital Ward		







This report describes our judgement of the quality of care provided within this core service by Provide Community Interest Company. 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 Provide Community Interest Company and these are brought together to inform our overall judgement of Provide Community Interest Company

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

We rated end of life care as good overall because:

- Openness and transparency about safety was encouraged.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses and where incidents had been raised actions were taken to improve processes.
- Safeguarding was given sufficient priority. Staff had a good understanding of how to protect patients from abuse. Staff described what safeguarding was and the process to follow if they suspected a patient was at risk of avoidable harm or abuse.
- Arrangements to minimise risks to patients were in place with measures to prevent falls, malnutrition and pressure ulcers. We observed staff followed good infection and prevention control practices.
- Staff recognised and responded to the changing needs of patients with anticipatory medications readily available and care needs assessed and reviewed appropriately.
- Specialist equipment needed to provide care and treatment to patients in their home was appropriate and fit for purpose so that patients were safe. Syringe drivers were mostly maintained and used in accordance with professional recommendations.
- End of life care was planned and delivered in line with best practice guidance. Care and treatment was planned and delivered in a personalised and holistic way and care plans took into account patients health and social care needs.
- Our observation of practice, review of records and discussion with staff confirmed there were effective multidisciplinary team (MDT) working practices. Staff worked collaboratively to understand and meet the range and complexity of patients' needs.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- We observed a holistic person-centred approach to patient care. Patients were treated with compassion, kindness, dignity and respect.
- Without exception, feedback from patients and relatives was positive.
- Without exception, staff were not only committed to providing sensitive care to patients, but also for the well-being of their families.
- Staff provided emotional support for patients and their families, and signposted them to other sources of support where appropriate.
- As part of the care provision for children with palliative care needs, the provider delivered respite care services for Essex Palliative Integrated Care Children's Respite Service (EPIC). EPIC was part of Provides children's specialist services business unit and sat within the children's specialists services.
- The provider engaged with external organisations and the local community to ensure the services met the needs of patients and those close to them who required end of life care.
- Patients could access the service in a timely manner that suited their individual needs.
- Data provided by the trust showed the end of life care service received one complaint between November 2015 and November 2016 specific to the service.
- The leadership, governance and culture mostly promoted the delivery of high quality person-centred care.
- The locality leads, clinical nurse specialists and community staff were able to articulate the purpose of their service, to provide care and support for patients in their last year of life, and their role within the integrated locality team. All staff, including very senior managers understood the importance of end of life care.
- There were good governance structures in place for end of life care through the integrated governance structure.
- The lead for end of life care was visible, and there was good local support and leadership for end of life care. Staff had confidence in their managers to ensure training and expertise knowledge was available to improve end of life care experiences for patients and those who were close to them.
- There was good public and staff engagement throughout end of life care services.

However;

Summary of findings

- There was no safety performance dashboard related to end of life care. This meant there was no visual aid to advise staff. A dashboard is a toolset developed by the National Health Service (NHS) to provide clinicians with relevant and timely information they need to

inform daily decisions that improve the quality of patient care. The toolset gives clinicians access to data that is being captured locally, in a visual and usable format. The safety dashboard displays local relevant safety information alongside relevant national data.

Summary of findings

Background to the service

Provide is a community social enterprise that provides end of life care services for patients across a wide range of locations within Mid Essex. A social enterprise is a business that trades to challenge social problems improve communities, people's life chances, or the environment. Social enterprises reinvest their profits back into the business or the local community. There are two end of life care facilitators employed by Provide whose remit is to support generalist staff in the delivery of end of life care. The facilitators provide both formal and informal teaching for all staff employed by Provide. The facilitators 'shadow' staff in practice, working alongside them. This may include helping implement the use of Provider's documentation and upskilling staff's knowledge to deliver evidence based end of life care. In addition, each community nurse team has a named end of life care champion. The ends of life care champions attend regular meetings with the end of life care facilitators to impart their knowledge and any end of life care updates.

End of life care (EOLC) is undertaken by community nurses, in collaboration with the local hospice(s), the local NHS trust and other members of the community multidisciplinary team. This is then provided across the community for all patients registered with a Mid Essex GP. Care is provided in patient's own homes, or in the organisations in-patient wards.

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

Inpatient, community and community nurses and allied health professionals provide palliative and EOLC services for adults. Patients at the end of life are cared for across three wards in the three-community hospitals.

Specialist palliative care services are provided by partner organisations for example, local hospices or NHS trusts.

Community nurses and allied health professionals in the community provide palliative and EOLC services for children.

The Hospice at Home service is available to all patients who meet the referral criteria, which is to be registered with a GP within Mid Essex and for patients aged 18 years and over approaching the end of life or in an acute palliative care crisis.

During our inspection, we visited three community hospitals and accompanied specialist nurses making visits to patients in their own homes. We spoke with 11 patients, seven relatives and 28 staff across inpatient and community settings, including doctors, staff nurses, community nurses, health care assistants, ward sisters, student nurses, advanced nurse practitioners and community matrons.

We attended two multi-disciplinary meetings, observed interactions between patients, their relatives and staff, considered the environment in inpatient areas, looked at seven 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders, 13 medical and nursing care records and nine medication charts. Before our inspection, we reviewed performance information from, and about, the provider.

Our inspection team

Our inspection team was led by: Carolyn Jenkinson, Head of Hospital Inspection, Care Quality Commission

Team Leader: Simon Brown, Interim inspection manager, Care Quality Commission

The team included CQC inspectors, inspection managers, an inspection planner and a variety of specialists

including: paediatrics and child health professionals, specialist nurses, community matron, safeguarding lead, director of nursing, physiotherapist and a strategic lead for equality and diversity.

The team also included three experts called Experts by Experience. These were people who had experience as patients or users of some of the types of services provided by the organisation

Summary of findings

Why we carried out this inspection

We inspected this core service as part of our comprehensive independent community health services inspection programme.

How we carried out this inspection

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

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

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

Before visiting, we reviewed a range of information we hold about the service provider and asked other organisations to share what they knew. We carried out an announced between 12 to 15 December 2016. During the visit, we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people who use services. We observed how people were being cared for, 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.

What people who use the provider say

During our inspection, we spoke with 11 patients and seven relatives. All spoke positively about the services they received and told us how caring staff were and how much commitment they showed to their work.

Good practice

- There was a sensory room at Moulsham Grange clinic, which provided a stimulating environment for children with a palliative care diagnosis and complex needs.

Parents could reserve a time for their child to use at the families convenience. Parking was directly outside of the clinic to enable easy access to the external ramped entrance.

Provide Community Interest Company Community end of life care

Detailed findings from this inspection

Good 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as good because:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses and where incidents had been raised actions were taken to improve processes.
- Staff had an understanding of how to protect patients from abuse. Staff described what safeguarding was and the process to follow if they suspected a patient was at risk of avoidable harm or abuse.
- Arrangements to minimise risks to patients were in place with measures to prevent falls, malnutrition and pressure ulcers. We observed staff followed good infection and prevention control practices.
- Staff recognised and responded to the changing needs of patients with anticipatory medications readily available and care needs assessed and reviewed appropriately.
- Specialist equipment needed to provide care and treatment to patients in their home was appropriate and fit for purpose so that patients were safe. Syringe drivers were mostly maintained and used in accordance with professional recommendations.

However we also found;

- There was no safety performance dashboard related to end of life care.
- There was no service level agreement in place between the provider and the local hospice that was providing out of hours advice and guidance about symptom control. This meant that there may be a delay to accessing advice and guidance if the service was withdrawn.

Safety performance

- End of life care was provided as part of an integrated care programme. Integrated care aims to connect health and social care to meet the needs of the local population.
- End of life care did not have a specific dashboard, this was included as part of the inpatient and community provision.
- During our inspection, we found there were arrangements in place to minimise risks to adults, children and young people receiving end of life care.
- Community nursing teams and hospitals took part in the national safety thermometer scheme. Data was collected on an identified day each month to indicate performance in key safety issues. However, this data was for all community patients and was not specific to end of life care.

Are services safe?

Incident reporting, learning and improvement

- Between December 2015 and November 2016 there had been no never events occurring within community end of life services. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Between December 2015 and November 2016 there had been one serious incident reported in relation to end of life care, this was reported in the mortuary at St Peters Hospital. We saw following this incident a thorough investigation had taken place and an action plan implemented.
- Systems were in place to ensure that incidents were reported, investigated and learned from. Staff told us and we saw meeting minutes, which showed that incidents and significant events were, discussed at team meetings, training sessions and clinical governance meetings.
- Incidents were reported through an electronic reporting system. Discussions with staff demonstrated a good awareness of the incident reporting policy and how to use the reporting system.
- All the staff were able to explain how they would identify and report incidents using the electronic reporting systems. This meant the provider was able to identify, investigate and learn from incidents.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- All staff we spoke with had a good understanding about duty of candour. Staff talked of being open and honest when things went wrong. We reviewed the serious incident report for an event in 2015 in which duty of candour requirements would have been required. We found that the organisation had complied fully with these requirements.

Safeguarding

- There were up-to-date provider wide safeguarding policies and procedures in place, which were accessible to staff through the trust's intranet site.
- Staff demonstrated a good understanding of the safeguarding policies, procedures and what to do should a safeguarding situation arise.
- Staff providing end of life care to both adults and children had received mandatory training in safeguarding children and vulnerable adults. Data supplied by the provider showed 96% of the community children and young people's nursing team had completed level three children's safeguarding training, with 100% of the team completing level two children's safeguarding training. For the community adult's end of life care nursing team, data showed 100% compliance with safeguarding level three training.
- Halstead Hospital, data showed 96% compliance with safeguarding level two training for adults and 93% for level two children's training against the provider target of 95%. At Braintree Community Hospital, and St-Peters Hospital data showed 100% compliance with safeguarding adults and children level two.

Medicines

- We found controlled drugs were managed in accordance with the Controlled Drugs Regulations 2013. Controlled Drugs are prescription medications controlled under the Misuse of Drugs legislation. They are classified by law based on their benefit when used in medical treatment and their harm if misused.
- We observed nursing staff were following the provider's policy on checking and administration of controlled drugs. The provider had a palliative care (end of life) medicines administration chart for use in patient's own homes, this contained the prescription and administration record.
- Pharmacies delivered controlled drugs to patient's homes and administered by community nurses.
- We reviewed medication charts for nine patients who were nearing the end of life. All patients had anticipatory medicines prescribed appropriately.
- District nursing teams were led by Band seven Community Matrons, 17 of these were non-medical prescribers, working within the end of life care adult services.
- The provider did not have any non-medical prescribers within the children and young people's service. Service

Are services safe?

leads told us the prescribing of medication was the responsibility of the patient's consultant or a GP. There was no evidence of any delay to prescribing for children who were end of life.

- Anticipatory medicines for patients were prescribed for the five key symptoms in the last days and hours of life, these symptoms are pain, agitation, excessive respiratory secretions, nausea and vomiting, and breathlessness. Prescribing medicines, before the patient has any symptoms, allows patients to receive effective symptom control in a timely way.
- 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. We looked at nine risk assessments for palliative care patients and found all had been completed appropriately.
- We saw documentation and observed care that followed the Nursing and Midwifery Council standards for medicine management. This meant that patients were protected against the risks associated with the unsafe use and management of medicines.
- Staff were knowledgeable about the providers controlled drug policy, which was available on the intranet.
- Data showed that 95% of the community qualified nursing team were competent to use syringe drivers. For the community children's nurses, the figure was 40%. We did not see any evidence to suggest that this number was not sufficient, given the number of children accessing the service.
- Advice regarding medication was available to nursing teams through the specialist palliative care teams based in the local hospice. Staff also told us that they would contact the patient's GP if needed.

Environment and equipment

- Specialist equipment needed to provide care and treatment to patients in their home was appropriate and fit for purpose, which meant patients were safe. Equipment was accessed through a local community equipment service. None of the staff we spoke with raised any concerns with accessing equipment and told us equipment could arrive in the patient's home within the same day.
- The provider used syringe driver pumps for end of life patients requiring a continuous infusion to control their pain. A continuous infusion is a controlled method of

administering intravenous medicines without interruption. Syringe driver equipment met the requirements of the Medicines & Healthcare Regulatory Agency (MHRA). Patients were protected from avoidable harm when a syringe driver was used to administer a continuous infusion of medication; as the syringe drivers used were tamperproof and had the recommended alarm features.

- Syringe drivers were available in both the inpatients and community settings. We looked at ten syringe drivers across all settings. We found one syringe driver in use on Halstead Ward overdue for service three months prior to our inspection. We saw another syringe driver not being used overdue for a service by 11 months; it was due for service January 2016. We escalated both of these to the ward manager who addressed them immediately.
- We saw a further five syringe drivers which were not switched on and were not in use. The syringe drivers did not have any stickers to indicate the service date. The community matrons told us they had been serviced at correct times and dates. However, the community matrons also said a more robust servicing procedure needed to be introduced and they had already highlighted this within Provide. Managers told us a new contract had recently commenced, and all syringe drivers were in the process of regular annual servicing.

Quality of records

- Community nursing staff used an electronic system to access patient records, this included access to GP records. Electronic records were updated as and when required, either in the patient's home, or back at the office. This meant an accurate record of the patient visit was recorded at the time of the visit or very shortly afterwards.
- We reviewed the care records of 11 patients who were receiving end of life care.
- The records were accurate, complete and legible. When care plans were updated, these were printed off and placed in the paper records within patient's own homes. All end of life care patients had their own paper records. Patients were given a green folder called 'Advance Care Planning Records'. This meant the paper records were up-to-date should any other health care professionals need to access them whilst providing care.

Are services safe?

- During our inspection, we saw the provider was using individualised care plans for end of life care patients. The individualised care plans replaced the Liverpool Care Pathway documentation, which was phased out in July 2015.

Cleanliness, infection control and hygiene

- The provider had an up-to-date infection control policy, which provided guidance for staff on the prevention and control of infection. Risks associated with the prevention and control of infection following the death of a patient was contained in the provider's infection prevention guidelines.
- Throughout end of life care, we observed staff to be complying with best practice with regard to infection prevention and control policies. Staff were observed to wash their hands or use hand-sanitising gel between patient contact. There was access to hand washing facilities on the inpatient wards. Personal protective equipment, which included gloves and aprons, was available both on wards and during home visits.
- All staff were observed to be adhering to the organisation dress code, which was to be 'bare below elbows'. Patients commented that all staff washed their hands before and after treatments.
- Staff undertaking community visits had adequate supplies of gel hand sanitiser and personal protective equipment (PPE).
- Hand hygiene audit data supplied by the provider for the community nursing service between and the community hospitals between April 2016 and June 2016 showed 100% compliance.
- The service audited 13 different infection prevention and control markers. For example Isolation of MRSA on the in-patient wards and commode audit's. Data provided from April to June 2016 showed compliance rates of 100 % across all control markers.

Mandatory training

- There was an annual mandatory programme in place for all staff. The programme was completed through e learning and by classroom based learning. The mandatory training programme included basic life support, safeguarding patients, infection control, medicines management moving and handling, equality and diversity and information governance.

- The compliance rates for all mandatory training for community end of life care staff was 100%. The provider target for mandatory training was 95%.
- There were no end of life care modules on the mandatory training programme.
- The provider did not class end of Life care training as mandatory training for either adults or children's services. However, at the time of our inspection the provider was in the process of rolling out the end of life care training. The ward matron at St Peters Hospital and the end of life care facilitator told us this training would be mandatory for staff.

Assessing and responding to patient risk

- Community end of life and palliative care took place in patients own homes or at the providers' community hospital wards.
- Community nurses and other members of the multidisciplinary team (MDT) had regular meetings to discuss patients, their requirements and any risks that had been identified.
- Comprehensive risk assessments were carried out for patients and risk management plans developed in line with national guidance. We saw that risk assessments and care plans were in place for patients at the end of life. Patients were cared for using relevant plans of care to meet their individual needs.
- We reviewed the care records of 11 patients identified as being at the end of life and looked at nine risk assessments for palliative care patients, all had been completed appropriately.
- We identified the following risk assessments being used; a waterlow assessment for pressure ulcers, malnutrition universal screening tool (MUST) and falls assessment. We noted that these risk assessments were regularly reviewed where appropriate.
- The organisation worked collaboratively with another provider who operated a hospice at home service. As patient's needs increased, or where community and district nurses felt they were unable to meet the needs of patients at the end of their life, they could refer patients to this service.
- The provider had a 'Fast Track Tool Referral Pathway'. This pathway helped clinicians make a decision to fast track a patients for NHS Continuing Healthcare, on the

Are services safe?

basis of need, due to a rapidly deteriorating condition which might be entering a terminal phase. We did not see any patients undergoing this fast track system during our inspection.

Staffing levels and caseload

- Specialist nurses from the children's community nursing team cared for children at the end of life. However, staffing numbers were not specific to end of life care as nurses looked after a range of children with long term or complex needs.
- There was no specialist end of life care community team for adults. However, there were two end of life care facilitators who provided support, advice and training to all the community teams for both adults and children. End of life care was delivered within the caseloads of the community nursing teams. Staffing for these caseloads was included as part of the community adults provision.
- Staff within the community nursing teams told us their caseloads were variable depending on the number of referrals received. Staff felt they were able to spend time with their patients and their families to meet their needs.
- The provider had a localised caseload management process each week where the team leaders and community matrons would hold a caseload review meeting to discuss their workloads. This would then determine how the work was allocated and set against the rota's and skill sets. A daily review and handover also took place between shifts.

- Each locality area had a daily triage nurse who allocated incoming referrals to enable the appropriate response times were met.
- Allied health professionals were employed by the local hospice. There was a team of physiotherapists, dieticians, speech and occupational therapists, the team cared for palliative and cancer patients in their home who worked collaboratively with the provider's community nurses.

Managing anticipated risks

- The organisation had provided business continuity plans for each of the community teams. We reviewed the service business continuity plan together with the winter contingency arrangements for one of the integrated care teams. These plans gave clear direction for staff in the event of loss of services such as telephones and IT, and in the event of adverse weather.
- Staff told us, in the event of severe weather, they would contact patients by phone to assess their needs. The service had access to local volunteer drivers with "four by four" vehicles, who were willing to assist with the transportation of staff to essential visits during episodes of severe weather. One of the ward managers told us she had previously used her husband's four by four trucks to go and collect staff and bring them into work.
- Conflict resolution training was mandatory and community nurses told us they were up to date with this training. Following our inspection, we reviewed training information, which demonstrated 100% of the integrated care teams had completed conflict resolution training against the provider's target of 95%.

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.

Evidence based care and treatment

- Care and treatment was planned and delivered in a personalised and holistic way and care plans took into account people's health and social care needs.
- We saw where patient's symptoms of pain were suitably managed. Staff underwent training at the local hospice and by the end of life care facilitators on how to identify patients who were at the end of their life.
- The provider followed the end of life care Department of Health strategy (2008). This is a national All staff involved in providing end of life care had access to current guidance through the guidelines for care in the last year of life.
- End of life care was managed and delivered in line with NICE guidance NG31. There was an emphasis on the early identification of people approaching the end of their life in order that discussions around end of life could take place.
- 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 and children.
- Staff were aware of the five priorities for care of the dying person (Leadership Alliance).
- The end of life service provided for children and young people followed the guidance issued by Together for Short Lives; "A Core Care Pathway for Children with Life Limiting and LifeThreatening Conditions", 2013. A holistic approach to care involved the patient, wherepossible, and the whole family in care planning directed at providing the individualised care and support required.
- End of life care was managed and delivered in line with NICE guidance QS13. Documentation showed there was an importance on supporting families and care givers of people who had died to receive timely verification and certification of the death. For bereavement visits were undertaken where discussions took place, and notes and equipment were collected. The provider was also in the process of writing a new Last offices and bereavement guidance in conjunction with the local hospice. however, this had not been completed at the time of our inspection.
- The provider followed recognised and approved national guidance for example the provider used individualised care plans for patients in their last days of life. These care plans were completed electronically; a copy printed off and left in the patient's home in the district nursing notes, which we reviewed.
- At the time of our inspection, the provider had recently developed a new end of life care plan. The care plan was formulated around national guidance and written in line with 'Ambitions for palliative and end of life care', a national framework for local action 2015 to 2020.
- All end of life care patients were offered the opportunity to complete an Advance Care Plan (ACP). We observed this offer was recorded electronically to enable staff to see if an ACP had been declined, was in progress or had been completed.
- Information about me (IAM) forms provided a holistic approach to gathering information, for example, it included questions to establish if the patient had made an Advance Decision to Refuse Treatment (ADRT), or if they had a Lasting Power of Attorney (LPA). Information also included whom they would like to provide their care and their Preferred Place of Care (PPC) at the end of their life. The IAM form also contained consent to share information section to enable patient information sharing with other health and social care professionals as required. Completed alongside the symptom management plan, these were both patient hand held documents and formed part of the electronic Advance Care Planning records.
- We found the use of the IAM care plans were fully embedded with staff. When completing symptom assessments for patients in the last days of life, staff were required to complete care plans for each symptom. We looked at seven symptom management forms and seven IAM forms care plans and found all were completed in line with the provider's guidance.

Are services effective?

- We saw the forms staff used to monitor the use of syringe drivers were completed correctly used appropriately and in accordance with the recommended guidelines.
- New policies and procedures were communicated to staff through staff meetings, emails and weekly updates. All teams had end of life care champions who attended meetings and were able to provide staff with end of life care updates and support. All staff were able to demonstrate they received regular communication from the board, head of service and team leaders. This meant staff were able to keep up to date with current practice and national guidance.
- As part of the care provision for children receiving palliative and end of life care, the provider delivered respite care services for Essex Palliative Integrated Care Children's Respite Service (EPIC). EPIC team used 'Together for short lives. 'This was a core care pathway for children with life limiting and life threatening conditions.

Pain relief

- Patient's symptoms were managed and anticipatory medicines were prescribed (medication that patients may need to take to make them more comfortable). Advice concerning symptom and pain management was available to staff from specialist staff at the Hospice on a 24 hour seven day basis.
- We checked nine medication administration records and found that all the records demonstrated anticipatory prescribing was undertaken to reduce the risk of escalating symptoms.
- Patients within end of life care had their pain control reviewed daily or more often as was needed. Regular analgesia was prescribed in addition to 'when required medication' (PRN), which was prescribed to manage any breakthrough pain. This pain occurs in between regular, planned pain relief.
- Pain relief was reviewed for effectiveness and changes were made as appropriate to meet the needs of individual patients. The community teams used a pain tool to assess patients' level of pain. We also observed staff ask patients whether they were experiencing any pain as well as exploring the type of pain.
- Patients told us staff had discussed pain relief with them and they understood what they were taking and the effect the medicine would have.

- Staff confirmed that syringe drivers were accessible if a patient receiving end of life care required subcutaneous medication for pain relief.

Nutrition and hydration

- The provider had a nutrition policy for all adult patients.
- Protected meals times were in place on all the wards we visited. We observed end of life care patients had access to drinks, which were within their reach. All of the care records we reviewed showed staff supported and advised patients who were identified as being at nutritional risk.
- We saw the malnutrition universal screening tool (MUST) being used. This is a universal five-step tool to identify adults who are malnourished, at risk of malnutrition or obese. It also included management guidelines, which could be used to develop a care plan. It is for use in hospitals, community and other care settings and can be used by all care workers.
- Staff were proactive in assessing the patient's nutrition and hydration needs.
- We observed nutritional assessments were completed and nursing records, such as nutrition and fluid charts were completed accurately.
- On the wards we visited we saw that a nutrition and hydration white board was clearly visible for patients and displayed information on healthy nutrition and hydration.

Technology and telemedicine

- Care was coordinated through an electronic computerised system that provided clinicians and health professionals with a single shared electronic health record (EHR) available at the point of care.
- Letters and care plans were sent electronically through secure email to patients and families or by post.

Patient outcomes

- There was a clear approach to monitoring, auditing and benchmarking the quality of services, this was reported through the integrated care teams and end of life care facilitators.
- Outcomes for patients using end of life service was collected and monitored on a monthly basis by. For example, the service collected data on the number of

Are services effective?

patients who achieved death in their preferred place. Data showed that between April and June 2016, 91% of patients who died, achieved death in their preferred place of care.

- The provider was actively using the Gold Standard Framework to plan the right care for people as they neared the end of their life. The National Gold Standards Framework (GSF) Centre in End of Life Care is the national training and coordinating centre for all GSF programmes, enabling generalist frontline staff to provide a gold standard of care for people nearing the end of life.
- The provider had just become a member of the National Council for Palliative Care. The National Council for Palliative Care collects the MDS for Specialist Palliative Care Services on a yearly basis, with the aim of providing an accurate picture of specialist palliative care service activity. It is the only annual data collection to cover patient activity in specialist services within the voluntary sector and the NHS in England, Wales and Northern Ireland.
- We saw the end of life care teams also liaised closely with the nurses, who provided night-time care in the community.
- Staff working with end of life care patients worked closely with external services for example social services. This allowed staff to provide holistic care and ensure patients received an effective service.
- The End of Life Care Audit: Dying in Hospital is a national clinical audit commissioned by the Healthcare Quality Improvement Partnership (HQIP) and run by the Royal College of Physicians, with additional funding provided by Marie Curie to assist with the sharing and usage of audit results for quality improvement purposes. It was designed to ensure that the priorities for care of the dying were monitored at a national level. As Provide were a community provider, it was not required to contribute to the national care of the dying audit.
- At the time of our inspection, end of life care services had not participated in any national audits or benchmarking exercises.

Competent staff

- There was no specialist end of life care community team for adults' end of life care. Patients were included within the caseload of the community nurses. However, there were two end of life care community facilitators. The facilitator's role was to provide both educational

sessions for all disciplines of staff and facilitate learning in practice through shadowing and sharing knowledge and expertise. For example, the facilitators provided training on the implementation of the last days of life care plan, advance care planning, and syringe driver training.

- Staff received training through e-learning as well as face-to-face teaching. Staff were positive about the training they received. They demonstrated a good knowledge of safeguarding, infection control and mental capacity assessments. They understood how to support people to make decisions for themselves and how to achieve this.
- Nurses said they had access to electronic learning. We saw the electronic system had highlighted training that was due to be completed for one staff member.
- Community nurses received specialist clinical support from the clinical nurse specialists at the local hospice (non-Provide organisation). There were also two end of life care facilitators employed by Provide who delivered teaching sessions on end of life care, for example, there was recently a session on breaking bad news.
- We saw evidence, on the wards and in the community, of regular training sessions being delivered by the end of life care facilitators. These sessions were delivered to all grades of staff and included Advance Care Planning.
- Appraisal rates for community nurses were 88% against the provider target of 90%. Staff said appraisals were undertaken regularly and were positive about the appraisal system. During our inspection we looked at two staff appraisals, both had been completed correctly and comprehensively.
- The provider had suitable provision in place to ensure staff received regular supervision and one to one support. There were systems in place to ensure nurses could meet the requirements for revalidation. Staff were knowledgeable about the provider's clinical supervision policy and the benefits of regular supervision.
- Staff told us they felt supported to pursue additional training to develop professionally. For example, one staff member told us they had been supported to undergo syringe driver training.
- We observed throughout our inspection and in accordance with the National End of Life Care Strategy (Department of Health 2008), staff speaking about the patients they cared for with compassion, dignity and respect

Are services effective?

- As part of the care provision for children with palliative care need, the provider delivered respite care services for Essex palliative integrated care (EPIC). EPIC was part of Provides specialist children services. Staff working with Provide EPIC Team received bereavement training as part of their job role.

Multi-disciplinary working and coordinated care pathways

- As part of our inspection, we attended two multi-disciplinary meetings, which included discussions about patients at the end of their life.
- 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 and district nurses. 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.
- Patient care was also undertaken by face to face multi-disciplinary meetings and the community matrons attending GP surgeries to discuss patients on the palliative care register held at the different GP practices
- Patients received care and support from a variety of sources such as, consultants, nursing staff; GPs, community nursing teams, dieticians, physiotherapist, occupational therapists and the local hospice at home team.
- Multidisciplinary visits took place, with the consultant paediatrician and the GP visiting the child at home and with the children's community nursing service. Within the children and young people's services, the children's community nursing service were seen daily.
- Staff worked collaboratively with the local hospice, which was regarded as a local centre of excellence for end of life care and care in the last days of life.

Referral, transfer, discharge and transition

- Staff were able to refer patients to a hospice at home service provided by another organisation if the criteria were met. Referrals to the hospice at home service were sent from community nurses, GPs or through the single point of access system and was available to all patients who met the referral criteria, which was to be registered with a GP within Mid Essex and for patients aged 18 years and over approaching the end of life or in an acute palliative care crisis.

- Patients were referred to the end of life care services through a number of routes including through GP or consultant referral, or they could visit local hospices or self-refer.
- Staff at the Essex Palliative Integrated Care Children's Respite Service (EPIC) told us that children could be referred to them by a healthcare professional, or by the child's parents. Senior nurses then triage the referrals. The oversight and of acceptance of each patient to the service came from a monthly multi-agency panel. The panel was chaired by a Provide assistant director and was attended by EPIC staff, nurses from other organisations, and service managers from children with disabilities

Access to information

- Patients and relatives told us they were provided with all the necessary information required to make decisions about their care and treatment. We saw this was recorded in their IAM form.
- On discharge from the hospital, staff sent a discharge letter either electronically or by fax to the end of life care patient's GP and to the community services. Staff also gave a copy of the discharge letter to the patient to be included as part of their IAM hand held documentation
- Each patient was given an advance care planning folder the 'do not attempt cardiopulmonary resuscitation (DNACPR) form as well as the patient's wishes regarding being admitted to hospital, and this information was available to the local emergency ambulance service and other health and social care providers.
- We saw examples of where patients had been discharged from hospital, we reviewed records, which confirmed information to support their care was available to staff in a timely way.
- The provider used an electronic patient record system, which meant staff could access patient records flexibly within the community and in the community hospitals.
- Staff could access information in the office or remotely using a laptop computer in the family's home.
- Staff working within end of life care in both community and inpatient settings had access to a 24-hour advice line from specialists at the local hospice.
- Paper based medical notes and nursing notes were easily accessible within the community hospitals when required. We observed that ward based nursing staff were able to locate specific information within patient records.

Are services effective?

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- The provider did not report any Deprivation of Liberty Safeguards applications and we did not see any end of life or palliative care patients deprived of their liberty during this inspection.
 - Patients and relatives told us that staff did not provide any care without first asking their permission. During a home visit, we observed staff asking for verbal consent before undertaking personal care.
 - Signed consent forms were evident in all the patient records we examined. This demonstrated that staff obtained consent to treatment appropriately.
 - Mental Capacity Act (MCA) 2005 training was not delivered as part of the mandatory training programme across the organisation. However, nursing staff were knowledgeable about the processes to follow if a patient was unable to give informed consent to care and treatment. All staff demonstrated a good understanding of consent in relation to the Mental Capacity Act.
 - Throughout our inspection, we did not meet with or review any patients that lacked the capacity to make informed consent.
 - The 'do not attempt cardiopulmonary resuscitation' (DNACPR) orders were kept at the front of the patients' medical notes, allowing easy access in an emergency and were recorded on a standard form with a red border. All of the DNACPR orders were easy to read and were transferable to hospital from the community for both adults and children.
- During our inspection, we reviewed seven DNACPR orders; all of the orders had been appropriately completed in line with national guidance.
 - The provider undertook monthly audits of DNACPR orders in place for patients in the community wards but did not audit DNACPR orders for those patients cared for in their own home as this was the responsibility of the GP. Where a decision was taken that a 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) order was appropriate then a DNACPR form was completed and placed in the patient records. An audit carried out by the organisation of DNACPR forms for the period April 2016 to September 2016 showed the percentage of forms that were complete was 100%.
 - The provider recognised patients must be involved in DNACPR decisions, and it is best practice to involve families as well. In the same DNACPR audit 67% of forms, included documented evidence of communication with the patient and 95% of forms included documented evidence of communication with patient's relatives. It is not always possible to discuss DNACPR with patients especially those who are acutely unwell or lack the capacity to make decisions. In all of the cases where DNACPR was not discussed with patient, there was documented evidence for not doing so.

Are services caring?

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

We rated caring as good because:

- Throughout our home visits to patients, we observed nursing staff providing holistic person-centred care
- There was a strong, person-centred culture. Staff treated patients with compassion, dignity and respect.
- Patients and their relatives felt involved in the care provided. Patients' social, emotional and religious needs were met and relatives valued the emotional support they received.
- We observed throughout our inspection and in accordance with the National End of Life Care Strategy (Department of Health 2008), staff speaking about the patients they cared for with compassion, dignity and respect.
- On two separate home visits to patients, we saw excellent holistic care undertaken by the nurses. The nurses demonstrated a good awareness of the patient's needs and wishes. The nurses provided good support showing kindness and gave the patient and relatives the time they needed.
- Patients and family members we spoke with told us they felt involved in the care delivered. We saw staff discuss care issues with patients and relatives and these were clearly documented in patient's notes.

Compassionate care

- Throughout our home visits to patients (both adults and children), we observed nursing staff providing holistic person-centred care. Without exception, we found the care and treatment of patients and support for their families and those important to them to be kind, empathetic and compassionate. On our home visits, we saw that staff treated patients with dignity and respect. Nurses were sensitive towards the needs of patients and supported them in a professional manner.
- Patients knew the nurses by name and confirmed that they regularly saw the same team of nurses. Staff took time to listen to patients, give reassurance and took time to ensure patients understood what was happening.

- Nurses took time to consider the needs of family members who were caring for a dying person. This included an assessment of the care givers emotional state and support for arranging additional services or respite care.
- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care, which was kind and promoted people's dignity. Without exception, patients and relatives told us staff were extremely kind and caring.
- We observed throughout our inspection and in accordance with the National End of Life Care Strategy (Department of Health 2008), staff speaking about the patients they cared for with compassion, dignity and respect.
- On two separate home visits to patients, we saw excellent holistic care undertaken by the nurses. The nurses demonstrated a good awareness of the patient's needs and wishes. The nurses provided good support showing kindness and gave the patient and relatives the time they needed to ask questions or disclose their hopes and fears.

Understanding and involvement of patients and those close to them

- We saw that staff discussed planned care and treatment with patients and relatives. We also observed staff explain treatments with patients, family members and care givers.
- Patients and family members we spoke with told us they felt involved in the care delivered. We saw staff discuss care issues with patients and relatives and these were clearly documented in patient's notes.
- All staff delivered end of life care in a respectful and holistic person-centred way. Staff took into account the patients' and care givers individual preferences.
- We saw staff giving guidance and discussing literature available for patients and their relatives. This included a booklet about the end of life and what they might expect to happen.

Emotional support

- During home visits, we saw that nurses discussed patients' personal and social interests and provided

Are services caring?

opportunities to discuss how patients and those close to them could plan for their future and continue to engage in social activities, even when the symptoms of their condition may have restricted them

- All staff considered emotional support as part of their role. Staff completing home visits demonstrated knowledge of patients and their individual situations. Emotional support was tailored to each patient's,

caregivers separate set of circumstances, and we saw that appropriate emotional support was provided. For example, on one home visit, we saw the community nurse provide emotional support for a family member of the patient.

- Emotional support was also provided to patients and their families through a variety of services, such as the local hospice.

Are services responsive to people's needs?

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

Summary

We rated responsive as good because:

- The provider had a good understanding and planned services that met the needs of the local population.
- Staff worked as part of multidisciplinary teams and routinely engaged with local hospices, the local NHS trust, adult social care providers and other professionals involved in the care of patients.
- At Halstead, St Peters and Braintree Community Hospitals there were dedicated adult end of life care beds situated in side rooms within the community hospitals inpatient wards. The side rooms were specially adapted for end of life patients as they had facilities including a couch/sofa bed for relatives to stay on and had built in overhead hoists.
- There was open access for relatives to visit patients who were at the end of life on the community.
- The provider delivered respite care for children and young people up to the age of 19 years. This was delivered from the Essex Palliative Integrated Care Children's Respite Service (EPIC).
- As a result of an EPIC family survey more provision of activities were introduced, for example, the EPIC team arranged for children to go out for the day on a specially adapted canal boat and were looked after by the EPIC team.
- Patients and caregivers knew how to contact the community nursing teams when queries or problems arose.
- Patients and caregivers we met reported that staff responded quickly to questions with phone calls and visits as required.

However, we also found;

- We found there was no auditing of the fast track discharge process for end of life care patients.

Planning and delivering services which meet people's needs

- The provider worked with other organisations and the local community to plan services that met patient's

needs. For example, the provider worked with a local day hospice to ensure a provision of day therapy services, bereavement services and a hospice at home service.

- During our inspection, we saw the provider's nursing teams throughout the community and in partnership with the local hospice at home, and night-time nurses delivered general palliative care.
- We observed care delivered in the community. We saw staff made every effort to ensure that people's needs were met, which included medicines being delivered, equipment being provided and support for relatives being put in place.
- Patients under the care of Provide adult services were seen daily as a minimum but sometimes two to three times per day dependent on their nursing and care needs. We saw that each patient had an individual care plan.
- Within the children and young people services, the children's community nursing service daily and sometimes twice daily to assess their symptoms visited children. Liaison took place between the specialist nurse if there was a change in symptoms and the management plan was amended accordingly.
- Patients identified as being in the last days or hours of life were mostly nursed on wards at Halstead, St Peters and Braintree Community Hospitals. There were dedicated adult end of life care beds situated in side rooms within the community hospitals inpatient wards. The side rooms were specially adapted for end of life patients as they had facilities including a couch/sofa bed for relatives to stay on and had built in overhead hoists. Nursing staff we spoke with told us those patients recognised as being in the last hours or days of life were, where possible, nursed in a side room to protect their privacy and dignity. This was not always possible and was dependent upon the patient capacity on the wards.
- As part of the care provision for children with palliative care needs the provider delivered respite care services for Essex Palliative Integrated Care Children's Respite Service (EPIC). EPIC was part of Provides children's specialist services business unit and sat within the children's specialists services.

Are services responsive to people's needs?

- EPIC cared for children and young people (up to 19 years) with palliative needs live in the Essex area with a life-threatening condition, who lived in the Essex area and who is registered with an Essex GP. Needs are assessed under a nationally recognised criteria for paediatric palliative care.
- EPIC provided personalised respite care in the home for children and young people with palliative-care needs. Respite in the home could be provided on a 24/7 basis 52 weeks per year.
- Respite hours were originally commissioned to deliver 440-480 hours of direct care per month; however this has been revised to 195-235 from September 2016 due to maternity leave within the team
- As a result of an EPIC family survey more provision of activities were introduced, for example, the EPIC team arranged for children to go out for the day on a specially adapted canal boat and were looked after by the EPIC team.
- There was open access for relatives to visit patients who were at the end of life on the community wards.
- A chaplain visited the community inpatient wards twice a week. The wards also had an end of life bereavement box, which contained keepsakes for the family and loved one of the person who had died.

Equality and diversity

- All staff received awareness training in equality and diversity as part of their induction to the organisation and on an ongoing basis as part of their mandatory training. Data showed 100% of the community nursing team had undergone equality and diversity training and 99% of the community children and young persons' team. This was better than the provider target of 95%.
 - We saw the provider had an equality and diversity inclusion policy, which included information on the provider's commitment to building a workforce, which reflects the wider community. It also covered aspects the Equality Act 2010 as well as organisational and individual responsibilities.
 - Throughout our inspection, we observed staff were non-judgemental in their approach to the care of patients and families. For example, we observed staff explaining medication to a person who had a learning disability using language the person understood and taking extra time to explain the medication in detail and answer questions.
- Most buildings we inspected were easily accessible and adhered to the requirements of the Disability Discrimination Act 1995 and the Equality Act 2010. For example, at Moulsham grange children's centre, we saw there was a lift in-situ, which was large enough to accommodate a person in a wheelchair or a parent with a pushchair.
 - Staff were able to access interpreters for people whose first language was not English, or who had a sensory disability.
 - Patients and relatives who used the services told us that they were treated as individuals.
 - There was equipment available to support people with disabilities. For example, during one of our home visits, we saw a hoist was readily available to assist the patient with transferring in and out of bed

Meeting the needs of people in vulnerable circumstances

- Where appropriate, equipment such as profiling beds and pressure relieving mattresses were provided to support patients who wished to die at home; an external provider delivered this. The supplier was responsive and staff confirmed equipment was delivered quickly to patients' homes to facilitate hospital discharge or prevent admission to hospital.
- Hospice nurses would visit the community wards to deliver specialist advice to Provide nursing staff if needed.
- End of life care services were accessible to all members of the community including patients who were living with dementia and who had learning disabilities.
- Care plans we looked at for inpatients and patients being cared for in the community included an assessment of emotional and spiritual needs.
- At the community hospitals, menus were available in pictorial format to assist end of life care patients with either a learning disability or living with dementia to understand and make meal choices.
- We looked at the menu on each ward we visited. The menu had a main section, which included special diets, and a vegetarian section.
- District nurses would complete bereavement visits to the families of patients who had died. Counselling services were available at the local hospice.

Are services responsive to people's needs?

- There was no specific end of life care pathway for patients with learning disabilities or living with dementia. However, staff told us all end of life care was delivered on an individual and holistic manner so that individual needs were both recognised and assessed.
- Patients and caregivers knew how to contact the community nursing teams when queries or problems arose.
- Patients and caregivers we met reported that staff responded quickly to questions with phone calls and visits as required.

Access to the right care at the right time

- The provider had a community hospital discharge policy for all patients, not specifically end of life care patients.
- There was no rapid discharge policy for end of life care patients, as they were normally transferred to the care of the provider either from a community setting or from the local NHS trust.
- All patients or relatives, including those at the end of life, could access community health services through the central point of access service (CPA). This was a call centre and was available from 8am to 11pm every day including weekends and bank holidays. Providing a single point of contact enabled a consistent approach to triage calls and respond to patients' needs. Call centre staff assessed the level of urgency against documented criteria. There were four levels of response, urgent (within four hours), non-urgent/same day (within 24 hours), next day (within 48 hours) and after 48 hours. Call centre staff signposted patients to other agencies if more appropriate, for example GPs, NHS Accident and Emergency services or ambulance services. Staff within the integrated care teams worked an on-call rota in order to respond to urgent calls. The central point of access was not specifically for end of life care patients, but for all patients cared for by the provider.
- Staff told us, the service would undertake a fast track assessment process for an inpatient at the end of life who wished to return home. This is a discharge within three days. The provider did not audit the fast track assessment process, this meant, information was not available to state if the fast track discharge process regularly met its three day target.

- Staff could obtain support from a local palliative care specialist unit provided by a local NHS trust, GP service and the out of hours palliative care dedicated phone line provided by the local hospice
- Provide community-nursing teams worked very closely with the hospice at home team who were able to deliver the same standard of hospice care in patient's own homes if that is where the patient preferred to be. The hospice at home team worked closely with GPs and district nurses to ensure patients could be cared for and die in their own home if that is where they wished to be.
- The community nursing team worked collaboratively with other staff to facilitate rapid discharge home from the local NHS trust. The families of children and young people were given advice on whom to call for support out of hours. Provide children's community nurses team contacted an out of hours dedicated phone line service if required.
- Within Provide adult services after 11pm, patients were advised to contact the out of hours GP service and were provided with the information to do this.

Learning from complaints and concerns

- The provider had an up-to-date complaints policy. The policy was available for staff to access on the provider's intranet. The policy and procedure provided guidance and standards for the handling of complaints.
- Information on how to raise a concern or make a complaint was available in the community hospital wards we visited. Patients and relatives told us they would feel comfortable raising a complaint with ward or community nursing staff if necessary.
- Data showed the end of life care service received one complaint between June 2015 and November 2016 specific to the service. The complaint necessitated duty of candour requirements, which the provider had fully complied with.
- Staff could not remember when a complaint was last made about the service were not able to give us any examples where they had experienced learning and change from complaints and concerns.

Are services well-led?

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

Summary

We rated well-led as good because:

- The lead for end of life care was visible, and there was good local support and leadership for end of life care
- Staff demonstrated commitment to delivering high quality end of life care for their patients.
- There was strong local leadership on the community inpatient wards, within EPIC and in the community. Staff told us they felt supported by their line managers, ward managers and matrons.
- The service had two end of life facilitators to promote the work of the service and cascade learning to staff across the trust.
- The locality leads, clinical nurse specialists and community staff nursing staff were able to tell us the purpose of their service, to provide care and support for patients in their last year of life, and their role within the integrated locality team. All staff, including senior managers understood the importance of end of life care.
- There were good governance structures in place for end of life care through the integrated governance structure..
- Staff had confidence in their managers to ensure training and expertise knowledge was available to improve end of life care experiences for patients and those who were close to them.
- There was good public and staff engagement throughout end of life care services.

Service vision and strategy

- The service had an end of life care strategy. The strategy document included a vision “Everyone can live well in the last year of life and die well, having a dignified death with support available for anyone who needs it”. This was a joint strategy between the local hospice, local acute hospital and Provide. Staff were knowledgeable of the strategy.
- The strategy was available to all staff through the intranet webpage and was sent out through the met compliance system for staff to confirm receipt and

understanding. Met compliance is an electronic system used to distribute policies and key messages to staff and to record the acceptance of policies. Messages ‘pop up’ on the computer screen of staff who are on the network

- In November 2016, the provider had developed a new end of life care plan as part of the strategy. The care plan was based on national guidance and written in line with ‘Ambitions for palliative and end of life care’, a national framework for local action 2015-2020.
- The locality leads, clinical nurse specialists and general district and community staff were able to express the purpose of their service, to provide care and support for patients in their last year of life, and their role within the integrated locality team. All staff, including senior managers understood the importance of end of life care.
- The children and young people’s service within Provide worked to the East of England’s ‘Better Care, Better Lives’ strategic vision for children and young people’s palliative care. This is a Department of Health initiative, which commenced in 2011 and aims to provide every child and young person with a life-limiting or life-threatening condition the right access to high quality, family-centred, sustainable care and support, with services provided in a setting of choice, according to the child and family’s wishes.

Governance, risk management and quality measurement

- Provide had one overall governance structure. All end of life care information was fed into the quality and safety committee through sub-committees prior to reporting to the board.
- End of life care was represented at board level in a number of different ways. For example through high level reports, which had been scrutinised at key committees and had received the final sign off at the quality and safety committee. End of life care facilitators also reported quarterly to the quality and safety committee on preferred place of death outcomes, which were included in the quality board reports.
- Any incidents involving end of life care were highlighted to the board.

Are services well-led?

- Assistant directors presented quarterly assurance reports to the quality and safety committee concerning all aspects of service delivery which included end of life care
- The board consisted of both non-clinicians as well as clinicians who have broad experience in all aspects of end of life care patient care.
- There was a clear management structure within end of life care services. The assistant director managed the service supported by locality managers who were based geographically. Each team had its own team leader who both supported and managed front line staff. All staff knew the structure and knew their roles and responsibilities within the structure.
- There was clear accountability through the structure and staff knew whom they were accountable too.
- Governance for end of life care was part of the integrated governance structure.
- Governance arrangements were in place for risk management and staff told us that they received feedback after incidents had been investigated. Staff also felt confident that incidents led to learning and changes being made.
- The provider had an organisation wide team briefing. This was cascaded to staff through electronic staff communications. Staff told us how to and we saw staff accessing this during our inspection.
- There was an extensive number of policies and procedures available each stating the roles and responsibilities of staff within the organisation. Staff were able to access these documents through the intranet. All the documents we reviewed were up to date and relevant to service delivery.
- All staff we spoke with were clear about their roles and the roles of others within end of life care services.
- There were monthly team meetings across individual teams. Previous meeting minutes indicated where staff shared good practice and highlighted areas of concern.
- Information governance training was mandatory and community nurses told us they were up to date with this training. Following our inspection, we reviewed training information, which demonstrated 100% of the end of life care team had completed information governance training against the provider's target of 95%.
- There were clear lines of accountability including a structure for cascading information to the senior management team and back down to staff delivering care.
- The provider published a monthly newsletter called 'Clinical Matters' which updated front line staff on the latest news.
- Team meetings were scheduled monthly and well attended. Minutes contained relevant information for staff and demonstrated clear cascade of information up and down the management structure including information from the board.
- New policies and procedures were communicated to staff through staff meetings, emails and the weekly updates. All the staff we spoke with were able to demonstrate they received regular communication from the board, head of service and team leaders. This meant that staff were able to keep up to date with current practice and national guidance. An example of this was the recent NICE guidance on diamorphine that staff had received information on prior to our inspection.
- Staff were positive about the structure of the organisation. Staff and managers said the structure of the organisation meant it was easy to escalate issues or risks.
- Patient and staff feedback was reported to the board through the quality and safety committee. For example, we saw feedback concerning 'Kate's story'
- The organisation had a programme for clinical audit, which was used to monitor quality of care given.

Leadership of this service

- There was strong local leadership on the community inpatient wards and in the community. Staff told us they felt supported by their line managers and ward managers. Staff had confidence in their managers to ensure training and expert knowledge was available to improve end of life care experiences for patients and those who were close to them.
- Managers spoke confidently about staff they managed, both their professionalism and commitment to the job.
- Staff told us how they liaised and communicated with other teams within Provide and how they supported each other. The teams held locality meeting to enable all grades of staff to meet and discuss local and organisational information. Staff felt connected to the organisation despite working at different bases because of pro-active communication by managers.
- The chief executive was well known, approachable and respected by staff.
- There was a non-executive director (NED) for end of life care at board level. Non-executive directors work

Are services well-led?

alongside other non-executives and executive directors as an equal member of the board. They share responsibility with the other directors for the decisions made by the board and for the success of the organisation in leading the local improvement of healthcare services. This meant the provider had a designated person at board level to champion the strategic direction of end of life care within the organisation.

- We saw the provider's weekly team briefing which was organisation wide. This was cascaded to staff through electronic staff communications.
- The chief executive delivered a face-to-face team briefing's to senior managers who then shared the information down to teams through team meetings, within one week of the initial briefing. We saw that all staff briefings could be viewed on the staff intranet page.
- Staff told us that the leads for end of life care were visible, and there was good local support and leadership for end of life care.
- Managers we spoke with gave examples of actions taken to improve services provided. For example the provision of extra respite hours through EPIC
- We asked the provider for any board/executive meetings minutes in relation to end of life/palliative care for the past six months. However, we were told there are no papers specific to end of life care.

Culture within the service

- Staff were committed to providing and ensuring patients received a good end of life care experience. Without exception, all staff were committed to ensuring patients received end of life care where they wished.
- We found an open, honest and supportive culture in end of life care services with staff being very engaged, open to new ideas and interested in sharing best practice in end of life care.
- Staff reported positive working relationships, and we observed that staff were respectful towards each other, not only in their specialities, but across all disciplines.
- All staff said they felt confident to raise concerns with their managers.
- The community nurses told us that end of life care was always considered a high priority for them. They also stated that end of life care was "deep-rooted" in their work for patients. They spoke with pride about the importance of helping individuals achieve a comfortable and pain free death.

- There were systems in place to ensure that staff affected by the experience of caring for patient at end of life was supported. There were opportunities for formal debriefings as well as informal support.
- Lone working guidance was available to those staff working in the community. Staff we spoke with were aware of the guidance and we saw systems were in place to keep staff safe. Staff had regular telephone contact with other members of the team throughout their shift.

Public engagement

- The provider had a website that patients could use to find out information regarding services offered. There was information about end of life care on the provider's website.
- Patients and those close to them were actively engaged and involved in decision making about their end of life care. Throughout the delivery of care, staff held open and honest discussions with patients about their end of life care wishes. Patients confirmed this and we observed staff interacting with patients.
- Staff recognised the importance of receiving the views of people who used the service and encouraged them to complete feedback forms.
- EPIC had provided the day out on a specially adapted barge for palliative children and their families as a result of their friends and family feedback.

Staff engagement

- The organisation used an annual staff survey to obtain feedback. However, there was not a staff survey specifically for end of life care.
- Results from the 2015 survey showed that 71% of staff would recommend Provide as a place to work.
- All the staff were able to demonstrate to us that they received regular communication from the board, head of service and team leaders. This meant that staff were able to keep up to date with current practice and national guidance.
- Staff told us they felt engaged and were encouraged to contribute to ideas to shape and improve the service.

Innovation, improvement and sustainability

- Arrangements with external stakeholders meant that patients could access facilities such as day therapy services, hospice at home services and bereavement support.

Are services well-led?

- The organisation held an annual award ceremony for staff in recognition of outstanding performance and accomplishments.