

North Tees and Hartlepool NHS Foundation Trust

RVW

Community end of life care

Quality Report

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Date of inspection visit: 7-10 July 2015
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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)
RVWAA	University Hospital Hartlepool		







This report describes our judgement of the quality of care provided within this core service by North Tees and Hartlepool NHS Foundation 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 North Tees and Hartlepool NHS Foundation Trust and these are brought together to inform our overall judgement of North Tees and Hartlepool NHS Foundation Trust

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

Overall rating for this core service Good

The Specialist Palliative Care team worked as part of a multidisciplinary team covering the acute and community based services, with specific team members dedicated to providing the community element of specialist care. Their role was to assess, support, deliver, monitor and evaluate end of life and palliative care provided by the trust. Services provided safe, co-ordinated care and we saw that staff were focused on continual learning and service development. Equipment used for patients at the end of life was easily accessible in the community and staff told us they felt they had the resources they needed to deliver quality care.

End of life care within the trust was influenced by national guidance such as the 'Gold Standards Framework' and we saw that good multidisciplinary working was in operation with the needs of the patient at the centre of all care activities. Patients and relatives we spoke with told us the care they received was delivered

with care and compassion and that they were respected and treated with dignity. The trust was working towards a seven day specialist palliative care service and we saw that the needs of the local population were considered when reviewing the service provided. Improvements had been made to fast-track the discharge of people at the end of life and all staff were aware of and involved in, supporting patients to be cared for in their preferred place of care.

The specialist palliative care and end of life care services were well-led with both medical and nursing staff working to ensure the service meets the needs of patients. However, there was limited evidence that the end of life care strategy and service development had pro-active involvement at board level. In addition, in their support of the community inpatient service at University Hospital Hartlepool, the specialist palliative care team operated within a reactive rather than pro-active framework.

Summary of findings

Background to the service

Information about the service

End of life care is delivered by community staff throughout the Stockton and Hartlepool localities of North Tees. End of life care is also delivered on the community in-patient ward at University Hospital Hartlepool (UHH). The specialist palliative care team (SPCT) provides support and advice for patients with complex needs and symptom management issues at the end of life. The community SPCT works as part of a multidisciplinary team with the acute SPCT who are based at University Hospital of North Tees (UHNT).

The community SPCT operates as two nursing teams, one based in Stockton and the other in Hartlepool. In Stockton there were three WTE (whole time equivalent) SPC community nurses, one WTE physiotherapist and one 0.69 WTE allied health profession (AHP) technician. In Hartlepool there were four WTE SPC community nurses, one 0.89 WTE occupational therapist and five Macmillan carers. There was one 0.8 WTE SPC consultant who worked across the community services and one WTE SPC nurse consultant who worked across community and acute services. The integrated acute and community SPCT was managed by a senior clinical matron. SPCT community nurses were aligned with GP surgeries and district nursing teams.

Although the SPCT teams operated a multidisciplinary approach, the two community teams had developed as separate teams and were not structurally integrated across the region. We were told that, to ensure equity of service, the structure was in the process of being reviewed, with plans to fully integrate the community specialist teams across both localities..

During our inspection we visited the inpatient ward and mortuary at UHH. We also visited six patients in their homes where we observed care being delivered by both SPCT nurses and district nurses and spoke with patients and their relatives. In total we spoke with seven patients and six relatives. We spoke with members of the SPCT including: the clinical matron, community consultant, nurse consultant, specialist community nurses and Macmillan carers. In addition, we spoke with district nurses, clinical matrons, ward nurses, ward doctors, healthcare assistants, allied health professionals and a hospital based discharge facilitator. In total we spoke with 28 staff. We looked at the records of four patients receiving end of life care and eight 'DNACPR' (do not attempt cardiopulmonary resuscitation) forms.

Our inspection team

Our inspection team was led by:

Chair: Helen Bellairs, Non-Executive Director, 5 Boroughs Partnership Trust

Team Leader: Amanda Stanford, Head of Hospital Inspection, Care Quality Commission

The community services inspection team included: CQC inspectors and a variety of specialists, Health Visitors, District Nurses, Physiotherapists, Occupational Therapists, Community Matrons, Dentist and an Experts by Experience (people who had used a service or the carer of someone using a service).

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

To get to the heart of patients' experiences 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 held about the core service and asked other organisations to share what they knew. We analysed both trust-wide and service specific information provided by the organisation and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well-led. We carried out an announced visit from 7 to 10 July 2015.

What people who use the provider say

Patients and relatives we spoke with were positive about the care they received. We were told that staff were

approachable, responsive, caring and compassionate. Patients told us they could not have asked for better care and relatives said they felt support by both specialist and district nurses.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- Ensure that the review of the Specialist Palliative Care Team covers the educational, developmental and support needs of staff on the community inpatient unit at University Hospital of Hartlepool

- Ensure that pain control medicines are prescribed and administered at the intended interval of time.
- Evidence how the end of life care strategy and development of services is aligned at board level.

North Tees and Hartlepool NHS Foundation Trust

Community end of life care

Detailed findings from this inspection

Good 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

There were effective procedures in place to support the safe care for patients at the end of their lives and we saw evidence that incidents were reported, reviewed and that learning was identified. Safety incidents relating to end of life care were reviewed by the specialist palliative care team and learning shared. We saw that anticipatory medicines were prescribed for patients at the end of life and that these medicines were available in patients' homes in the community.

Staff had access to guidance on anticipatory prescribing by the trust intranet. Controlled drugs were available and stored securely in line with national guidance on the Holdforth Unit. However, we found because medicines' records did not always direct the right time to administer them, there was a risk some medicines for pain relief (that were time sensitive), might not be given correctly.

Appropriate equipment was available on the community inpatient unit and in patients' homes and we saw that syringe drivers were monitored using appropriate safety checks.

Safety performance

Incident reporting, learning and improvement

- Staff delivering end of life and specialist palliative care understood their responsibilities with regard to reporting incidents. Staff we spoke with told us that when an incident occurred it would be recorded on an electronic system for reporting incidents.
- The SPCT told us they would be involved in a review of incidents where they had been identified as relating to end of life care or if the team were directly involved. This was a standing agenda item for the SPCT monthly team meeting.
- Themes identified by the community SPCT included: non-completion of DNACPR forms; issues around discharge from hospital relating to medication; and documentation and end of life care support for patients in care homes in the community. We saw that these areas were being addressed as part of the specialist palliative care work plans.
- We viewed 26 incidents that had been recorded that related to end of life care in the community. We saw that action had been taken relating to changes to practice as a result of learning from the incidents.
- Incidents were investigated with the involvement of relevant staff and we saw that they were given time to

Are services safe?

reflect and learn. Staff working on the community inpatient unit told us they had weekly meetings where incidents, and risks and complaints were discussed and where staff were encouraged to reflect and learn.

- Staff were aware of their responsibilities in relation to duty of candour and being open with patients when incidents occur and we were given an example of a medication incident where the patient and family were informed.

Safeguarding

- Systems were in place to protect people in vulnerable circumstances from abuse. Staff were knowledgeable about their roles and responsibilities in relation to ensuring vulnerable adults and children were safeguarded. Staff understood what constituted a safeguarding concern and could demonstrate the processes to raise a safeguarding alert.
- Completion of mandatory training for safeguarding adults level one by specialist palliative care staff was at 95% against a target of 100%. Completion of safeguarding children level 2 training was 100%.

Medicines

- Medicines were well managed. Inpatients and community patients who were identified as requiring end of life care were prescribed anticipatory medicines: anticipatory medicines are 'as required' medicines that are prescribed in advance to ensure prompt management of increases in pain and other symptoms.
- We visited a patient in the community who had anticipatory medicines prescribed and these were available and stored safely in their home for when they were required.
- There were guidelines on the trust intranet (NHS North of England Cancer Network) for medical staff to follow when prescribing anticipatory medicines. Medical staff we spoke with were aware of the guidance and how to access the SPCT for advice should they need it.
- Prescriptions and administration records we looked at in the community were completed clearly, including the times of administration of medicines prescribed 'as required'.
- Prescriptions for regular (12 hourly) opiate based medicines on Holdforth community inpatient unit were not recorded for administration at specific times. For example, prescriptions were recorded for administration at 'morning' or 'bedtime' rather than a specific time 12

hours apart from the previous dose. As a result, medicines that are designed to be given at 12 hourly intervals would sometimes be given at 11 or 13 hourly intervals. This meant there was a risk of a patient experiencing breakthrough pain; however patients we spoke with told us they were comfortable.

- We saw in practice that during each visit, the SPCT would review patients' medications.

Environment and equipment

- Inpatient and community services had access to appropriate equipment to keep people safe and comfortable.
- Two different syringe drivers were in use in the community and the community in-patient unit. Staff told us this had not presented delays in patients being discharged home as the community syringe driver would be set up on the ward prior to discharge.
- District nurses we spoke with told us they had no problems accessing equipment for patients at the end of life in the community. Syringe drivers were obtained from a trust wide equipment library and these were accessible to community staff 'out of hours'. Specialist mattresses were also available as required and district nurses could access these as needed with no problem.
- A community based occupational therapist worked as part of the SPCT. They would assess patients' needs in relation to their home environment and identify any equipment required. An AHP (allied healthcare professional) technician was also part of the SPCT and would support the patient by sourcing the equipment required.
- Staff told us that for patients at the end of life who were being discharged via the fast track route, equipment was accessible within a few hours.
- The mortuary at University Hospital Hartlepool was well equipped. We were told that the capacity was adequate and saw specialist equipment that included bariatric trolleys. The temperature of the mortuary fridges was recorded on a daily basis and should the temperature fall outside of the normal range, the estates department were notified by an alarm on the fridge.

Quality of records

- The SPCT used an electronic record system that enabled sharing of patient information within the team and with other health care professionals. District nurses told us they used the same electronic record system.

Are services safe?

- We saw that both specialist and generalist staff were able to access the records of patients at the end of life. Staff told us whilst there had been some issues accessing the system when out on community visits the trust was working with them on developing a solution. Staff did not feel that this had impacted on patient care.
- We reviewed six Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms in the community inpatient unit (Holdforth). Five forms were kept in the front of patients' notes. Decisions, with reasoning and clinical information were clearly documented and signed by a consultant. Discussions with patients or relatives were clearly recorded. However, one form was a photocopy, did not detail evidence of a discussion with the patient or their family and cited 'frailty' as a reason for the DNACPR.
- In the community, DNACPR forms were kept in a yellow envelope. This was to ensure the form was easily accessible to community staff and family members and could be sent with the patient in the event of a hospital admission. However, we saw on one visit that the DNACPR form was not in the yellow envelope and could not be found. The SPCT Clinical Nurse Specialist took action to follow this up at the end of the visit.
- The two DNACPR forms in the community that we reviewed had been completed well with discussions with the patient and relatives recorded as appropriate.
- We viewed a trend analysis report of DNACPR forms across the trust and saw that action had been taken to improve the recording of DNACPR decisions, particularly in relation to appropriate authorisation. Quarterly audits of DNACPR forms were being carried out and the results were presented to the resuscitation committee.
- 89% of SPCT staff had completed mandatory Information governance training against a target of 100%.
- We visited the mortuary at University Hospital Hartlepool and saw that it was clean and well maintained and that hand washing facilities were available.
- We spoke with the mortuary technician and viewed mortuary protocols and saw that relevant infection control risks were managed and there were clear reporting procedures in place.
- Staff had access to personal protective equipment (PPE), such as gloves and aprons. Staff were seen to be using PPE, washing hands and using hand sanitising gel.

Mandatory training

- Mandatory training was provided for all staff and was undertaken by all staff providing end of life care. Data produced by the provider stated that 95% of specialist palliative care staff were compliant with training requirements in relation to consent, infection control and managing violence and aggression. 80% of staff had attended training in fire safety, resuscitation and patient handling.
- Only 50% of specialist palliative care staff had attended training in dementia, against a target of 75%.
- The SPCT manager was aware of areas where attendance at non-mandatory training needed improvement and was working towards ensuring training targets were reached.
- The SPCT provided education on a formal and informal basis which included staff from external organisations, including those working in local nursing homes.
- Generalist nursing staff we spoke with confirmed they had received training in the use of syringe drivers.

Assessing and responding to patient risk

- Staff assessed and managed patient risk as part of an ongoing holistic assessment process. We observed good use of general risk assessments for patients receiving end of life care. This included the assessment of risk in relation to nutrition and hydration, pressure ulcers and falls.
- Nursing, medical and therapy staff recorded daily changes to patients' conditions in their notes. In the community, advice and support regarding deteriorating patients was available from the SPCT.
- We observed a SPCT multi-disciplinary meeting and saw that risks to patients were discussed as part of a routine review of their care and ongoing evaluation.

Cleanliness, infection control and hygiene

- There were infection control and prevention systems in place to keep patients safe. The in-patient areas we visited appeared to be clean.
- There were sufficient hand wash basins, liquid soap, paper towels, hand gels and protective equipment available.
- Staff undertaking community visits had adequate stocks of hand gel and PPE (personal protective equipment) to take out with them.

Are services safe?

- Where a patient was being cared for at home, relatives we spoke with were aware of how to access help and support should the patient's condition deteriorate.
- We observed the Gold Standards Framework (GSF) in use throughout the community: the Gold Standards Framework is a model that enables good practice in the care of patients at the end of life. We saw that this was used as a tool to assess patients in their last year or the last days of life.
- The SPCT were using a virtual ward approach to identify patients in the last year of life. The aim of the virtual ward is to prevent un-planned admissions by using the systems of a hospital ward to provide multidisciplinary case management in the community. This meant that the SPCT were able to identify and monitor patients at risk of deterioration. Allocation to a virtual ward was based on: the identification of patients who were likely to be in the last year of life; frequency of hospital admissions; and where patients were being cared for using the 'care for the dying patient' document.
- The community SPCT was divided into two teams. One team covered Stockton, the other Hartlepool. There were three whole time equivalent (WTE) specialist palliative care nurses in Stockton and four WTE specialist palliative care nurses in Hartlepool. A 0.8 WTE palliative care consultant was in post for the community and there was a WTE palliative care nurse consultant across both acute and community services.
- In Stockton community there was a WTE specialist palliative care physiotherapist, a WTE occupational therapist and a 0.69 WTE technician. In Hartlepool there was a 0.89 WTE occupational therapist.
- In Hartlepool there was a team of Macmillan carers who supported patients in the community who were nearing the end of life.
- Staff we spoke with told us their caseloads were manageable and ward staff told us they had sufficient staff to deliver good quality end of life care. Community SPCT nurses told us their caseloads averaged 20 patients at any one time.

Staffing levels and caseload

- Staffing levels were sufficient to ensure that patients received safe care and treatment. End of life care was provided in the community (and on the inpatient unit at University Hospital Hartlepool) seven days a week by ward staff and community teams. Specialist palliative care was provided from 8am to 5pm five days a week. Out of hours and at weekends, end of life care was provided by general community and inpatient staff who could access specialist support from a consultant on-call rota.

Managing anticipated risks

- Major incident and winter management plans were in place. Senior staff had access to action plans and we saw that these included: managers working clinically as appropriate; staff covering from different areas; and prioritisation of patient need.
- Emergency equipment was available on the community inpatient unit at University Hospital Hartlepool. Staff had been trained in resuscitation.

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

The management, assessment and planning of care by the community SPCT was effective. We saw a strong evidence base in terms of end of life care guidance. This had influenced the development of the caring for the dying patient document that had been rolled out across the trust. We saw good use of clinical audit. For example, action had been taken against the results of the National Care of the Dying Audit (NCDAH) and learning had been shared across community services as well as acute. We observed good multidisciplinary working across the SPCT and between the specialist and generalist staff. Generalist staff could develop their end of life care skills by attending workshops or by shadowing the SPCT.

SPCT nursing staff were aligned to district nursing teams and GP practices and we saw that specialist nurses supported the use of the Gold Standards Framework within the community. We observed good practice in terms of pain assessment and management and all patients we spoke with told us their pain was well managed.

Evidence based care and treatment

- The SPCT delivered care in line with evidence based guidance such as the 'North East Cancer Network Palliative and End of Life Care Guidelines'. The guidance was available on the hospital intranet with hard copies available in clinical areas.
- The trust had developed, and was using, a 'Caring for the Palliative Care Patient and their family in the last year of life' policy and framework for end of life care. This was developed using national guidance including: the 'National End of Life Strategy (2008)'; the 'National End of Life Programme: Routes to Success Guide (2012)'; the 'NICE QS13 Quality Standards for End of Life Care for Adults (2011)'; 'Derbyshire End of Life Guidance (2010)'; 'More Care, Less Pathway A Review of the Liverpool Care Pathway (2013)', as well as the document produced by the 'Leadership Alliance for the Care of Dying People (2013)'. Care was being planned and delivered in accordance with the guidance. In response to the national withdrawal of the Liverpool Care Pathway' (LCP) in July 2014, the trust had developed,

and was using a Caring for the Dying Patient (CDP) document. The CDP document was based on national guidance and supported the delivery of the trust's framework for end of life care.

- The Gold Standards Framework (GSF) was in use to support the development of good quality end of life care in the community across both Stockton and Hartlepool. The framework was used to help staff identify the needs of patients at each stage of their care through to detailed assessment.

Pain relief

- There were tools in place to assess and monitor pain, and pain control was a priority for staff involved in end of life care. Staff we spoke with told us they took into account patients' verbal and non-verbal expression of pain.
- Patients we spoke with told us their pain was well managed and that staff, when pain occurred, were quick to respond to requests for additional medicines.
- We viewed the records of one patient on the Holdforth unit at UHH and saw that their regular slow release pain medicine was prescribed 12 hours apart. We saw that the medicine had been given regularly, however when we viewed the controlled drug register we saw that the times the medicine was given was variable. This meant that the patient would sometimes get the medicine every 12 hours but this varied and could be 11 or 13 hours apart. When we saw that there were issues with the timing of pain relief we asked the patient if their pain was under control and they said it was.
- We observed district nurses and specialist nurses assessing patients' pain levels in the community and saw that they assessed the type and duration of pain as well as factors that made the pain better or worse.
- Where appropriate patients had syringe drivers which delivered measured doses of drugs at pre-set times. All qualified nursing staff were trained in the use of syringe drivers.
- Staff told us there were adequate stocks of appropriate medicines for end of life care and that these were available as needed both during the day and out of hours.

Are services effective?

Nutrition and hydration

- Nutrition and hydration were assessed and monitored. Patients were routinely assessed using the 'Malnutrition Universal Screening Tool' (MUST) which is used to identify nutritional risks.
- Using the CDP document, nutrition and hydration needs at the end of life were assessed from both the medical and nursing perspectives. Assessments included patient choice and comfort and for patients without the mental capacity to make their own decisions, we saw prompts to assist staff to make decisions in the patient's best interests.
- There was a strong culture to promote comfort at the end of life. Staff we spoke with were clear that nutrition and hydration needs were led by the patients' needs and their comfort.
- Specialist palliative care staff told us, to promote comfort at the end of life, they would regularly provide advice to generalist staff about nutrition, hydration and regular mouth care.

Patient outcomes

- The trust had taken part in the 2013/14 National Care of the Dying Audit (NCDHA) where they had not achieved five out of seven organisational key performance indicators. The trust had performed well in the use of clinical protocols for the prescription of medications for the five key symptoms at the end of life. The trust had performed below the England average in eight out of ten clinical key performance indicators. This included discussions with patients and relatives regarding their recognition that the patient is dying and a review of patients' nutritional and hydrational requirement.
- We saw that all of the areas identified for improvement as part of the NCDHA had been addressed through the development of the CDP document and the end of life care framework.
- We viewed an audit of the CDP document that had been undertaken by the nurse consultant and saw that ongoing improvement work was being carried out in the areas identified through the NCDHA audit. Although the NCDHA audit focuses specifically on hospital care at the end of life, it was evident that the trust had used the learning to develop the services across both acute and community end of life care. For example, we saw that in-depth assessments of nutrition and hydration needs

were being carried out as part of the CDP document that had been developed following the audit. The CDP document also provided a framework for the Priorities of Care of the Dying Person.

- The trust collects feedback from the family of patients cared for at the end of life using the 'Family's voice carer's diary'. We saw that individual teams in the community were given feedback from this and that there were opportunities to learn from the experiences of patients and their relatives.
- The trust had audited hospital based preferred place of care and advance care planning documentation. We saw there were plans to audit the quality of the discussions held as part of the next NCDHA audit. We did not see specific audits relating to advance care planning in the community.

Competent staff

- End of life and palliative care was provided by well trained and competent staff. There were seven whole time equivalent (WTE) specialist palliative care nurses covering Stockton and Hartlepool community and one 0.8 WTE palliative care consultant.
- SPC nurses told us they had the opportunity to develop their roles by attending relevant training and conferences and by taking part in projects.
- We saw that all nurses within the community SPCT had received an annual appraisal and we were told that training and development plans were aligned to this process.
- Members of the SPCT across the trust attended monthly group supervision sessions where there were opportunities to reflect on their practice.
- District nurses had access to opportunities to develop their end of life care skills and knowledge. Staff told us they were actively encouraged to work alongside the community SPCT and that all new district nurses would spend a week shadowing the SPCT. We were told this had been so successful that existing district nurses, as part of their development, were now able to shadow the team for a week.
- All members of the SPCT were trained in level two psychology support.

Multi-disciplinary working and coordinated care pathways

Are services effective?

- Members of the SPCT participated in multidisciplinary team (MDT) meetings, working with other specialists and district nurses to support good quality end of life care across the community.
- The SPCT in each locality met daily to discuss patient care and workloads and had a weekly multidisciplinary clinical meeting attended by all the SPCT and other professionals including: an occupational therapist; physiotherapist; therapy technician; palliative care consultants; the nurse consultant; and the chaplain.
- At the MDT meeting we observed there was in-depth discussion about patient care within a framework of joint working to meet patient need.
- Community SPC nurses (District nurses told us), would spend time at their base during the week, liaising and communicating with community teams and reviewing end of life care as needed for patients.
- The SPCT worked closely with local hospice services and we saw evidence of agreed local pathways, with patients moving between services effectively.

Referral, transfer, discharge and transition

- Data we reviewed showed that staff used preferred place of care discussions with patients and their families to inform staff where they would like to be cared for at the end of life.
- Patients were referred and transferred appropriately. The planning of discharge (or transition to an alternative place of care) was a MDT process which included the input of hospital and community staff, as well as support agencies who were involved in providing end of life care to patients at home.
- At University Hospital Hartlepool, Holdforth Unit, there was a discharge facilitator who would coordinate the discharge to preferred place of care for patients at the end of life who wanted to be transferred to a service of choice or discharged home.
- We viewed a rapid discharge checklist and were told this was used for patients who had chosen to go home for the last days of life. Patients were identified through guidance and prompts within the CDP document. Patients known to the SPCT were case managed using the virtual ward system. Staff we spoke with told us there was a fast track pack that contained all the documentation needed, (including medication request forms) and they said that as long as there was care available in the community patients could be discharged home in hours.

- In Hartlepool, there was a team of Macmillan carers who, in the event of a fast-tracked discharge, would provide care for patients until a care package was in place. In Stockton, care was provided by care agencies or carers from a local hospice.
- We visited one patient in the community who told us they had been discharged from hospital within 24 hours of deciding home was their preferred place of care at the end of life.

Access to information

- We saw that information needed to plan and deliver care and treatment, including risk assessments and care plans, were shared appropriately and made available to relevant staff. Patients were cared for using relevant plans of care to meet their individual needs.
- Once a patient had been identified as being in the last days of life staff would use the CDP document. This guidance included prompts for staff to assess patient symptoms, identify advance decisions, discuss spiritual needs and agree options regarding hydration and feeding.
- We viewed records that included detailed information about the management of symptoms, discussions and interventions. We also saw that when patients were seen by the SPCT, information and advice was clearly recorded so that staff could easily access the guidance given.
- District nurses told us there had been some issues with patients being discharged from the acute hospital in terms of access to information. However, we were told there had been some recent improvements in this area.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Specialist palliative care staff training around consent was at 95%. All specialist staff we spoke with understood the Mental Capacity Act and issues around deprivation of liberty safeguards.
- We viewed eight DNACPR forms, six on Holdforth and two in the community. We saw two examples of DNACPR decisions being recorded for patients who did not have the capacity to be involved in discussions about the situation. In both cases we saw that the decision had been discussed with the patient's relatives and that the decision had been recorded so as to be clear that due consideration had been taken for the patient's ability to be involved.

Are services effective?

- For patients at the end of life who did not have capacity to make decisions about care and treatment, we viewed prompts on the Caring for the Dying Patient (CDP) document relating to best interest decisions, for example, about nutrition and hydration.
- The trust was using guidance from the 'Deciding Right' Northeast NHS document 'an integrated approach to making care decisions in advance'. We saw that this was

included in the DNACPR decision making form in terms of recognising when a patient has made an advanced decision. Emergency Healthcare Plans (a care plan covering the management of an anticipated emergency) were in use for some patients although we did not see Emergency Healthcare Plans for any of the patients we spoke with during our visit.

Are services caring?

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

Summary

Patients and their relatives spoke positively about the care they received in the community. We observed interactions between staff and patients and saw that these were kind, caring and compassionate. Relatives we spoke with told us staff would spend time supporting them alongside the patient and that they showed a good deal of care and compassion. Relatives and friends of patients were encouraged to participate in the 'Family's Voice' research where they could feedback on their experience of care as it happened.

In all interactions staff were seen to treat patients and relatives with dignity and respect. We saw that staff would find ways of making the experience of care as easy as possible for people. One particular example was the development of a pleasant environment at the entrance to the mortuary at University Hospital of Hartlepool where relatives could sit and spend time.

Compassionate care

- Patients were treated with dignity, kindness and compassion. Patients and relatives we spoke with told us that staff were professional, supportive and kind. We saw that patients were treated with respect.
- We observed staff caring for patients in a way that respected their individual choices and beliefs and we saw that records included sections to record patient choices and beliefs so that these were widely communicated between the teams.
- Patients and relatives we spoke with told us they were happy with the quality of care they received and that staff treated them with respect and maintained their dignity.
- We viewed feedback from patients in the community that included comments about how caring staff were and how safe patients felt in their care.

Understanding and involvement of patients and those close to them

- Patients and family members we spoke with told us they felt involved in the care delivered.
- Staff discussions with patients and relatives about care issues were clearly recorded in patients' notes.

- The caring for the dying patient document used by the trust included prompts for discussing issues of care with patients and relatives.
- The Gold Standard Framework was widely used in the community for patients in the last year of life and was designed to help involve people in the planning of their care.
- Guidance literature was available for patients and their relatives. This included a booklet about the end of life and what they might expect to happen.
- The palliative care nurse consultant had a lead role in Family's Voice, a nationally developed survey tool for improving communication during end of life care. The survey works to collect information from relatives and friends about the quality of care provided at the end of life by the use of a daily diary. Relatives could record aspects of care around the degree of symptoms the patient is experiencing including pain, nausea and distress. They could also record if the care and support the patient and relatives was receiving was sensitive. The use of the diary enabled staff to review relatives' experience of care and learn from it.
- Feedback from the Family's Voice project was visible in the community services we visited. Staff we spoke to told us the feedback had enabled them to look at their practice and make changes if needed. We were also told that it had helped them to communicate more openly with relatives.
- We saw documentation about advance care planning and saw that patients were asked about their advance wishes and these were recorded and accessible to all staff involved in their care.
- The bereavement support officer/mortuary technician told us how they involved patients and relatives in care after death, including visiting patients on the community in-patient ward to see what their wishes were and to discuss what would happen after death.

Emotional support

- Staff told us they felt they had the time to spend with patients and provide the emotional support to meet their needs.

Are services caring?

- We observed community and specialist nurses assessing people's emotional needs as a matter of routine when visiting them at home.
- Specialist palliative care nurses were trained in advanced communication skills and the nurse consultant in palliative care offered cognitive behavioural therapy (CBT) to patients with anxiety and depression. We were told that CBT was available in patients' homes if they were unable to attend a clinic appointment.
- Support was available from chaplaincy and psychology teams and staff we spoke with told us this was readily available to patients and their relatives at the end of life.
- Bereavement support was provided by the bereavement support officer for relatives of patients in the community in-patient ward.
- The mortuary technician provided bereavement support and information at University Hospital of Hartlepool. We observed an interaction with a bereaved family and saw that they were treated with care and compassion.
- A bereavement support leaflet was available for relatives offering guidance on: viewing arrangements; how to register a death; organ and tissue donation; and funeral arrangements, together with a list of advice and support organisations and how to contact them.

Are services responsive to people's needs?

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

Summary

Services were planned and delivered to meet people's needs, including those people in vulnerable circumstances. We saw that preferred place of care was seen as a priority for patients and figures in 2014/15 showed a 27% increase in fast track discharge across the trust from the previous year. Staff and patients alike reported that the SPCT were quick to respond to patient need and that referrals were prioritised based on need.

We saw that the SPCT were working on developing seven day working once a review of the community teams had been completed. We saw that patients on the community inpatient unit at UHH were referred to the SPCT but we did not see the same level of proactive engagement as we did on the acute wards or with the district nursing teams.

Planning and delivering services which meet people's needs

- Services were planned and delivered to meet the needs of patients and relatives. Staff were very clear that a particular priority was ensuring patients, wherever possible, were cared for in their preferred place of death.
- The trust had developed a 'framework for supporting adults with progressive, life limiting illnesses'. The framework embedded the priorities of care of the Leadership Alliance for the care of the dying patient (LACDP), being: recognition of dying; sensitive communication; patient and those close to them involvement in decisions; the needs of those important to the patient are actively explored; and, an individualised plan of care is agreed.
- The framework prioritised patients being cared for in their preferred place of care at the end of life and there was a clear aim to increase the percentage of patients in the local community dying in their preferred place of care.
- We viewed figures for fast track discharges to a patient's preferred place of care across a two year period and saw that in 2014/15 there had been a 27% increase in fast track discharges across the trust compared with the

previous year. Staff we spoke with told us a good proportion of this was patients wishing to die at home, as well as those being discharged to hospices and care homes.

- As part of the development and redesign of the trust's palliative integrated care pathway consideration had been given to the needs analysis of the local population, including the needs of diverse groups. We saw that care after death honoured people's spiritual and cultural wishes and we saw that information about spiritual and cultural wishes was recorded in patients' records. There was a multifaith chapel within the hospital.
- Priorities in terms of planning future services included a move to a seven day specialist palliative/end of life care service.

Equality and diversity

- Patients receiving end of life and palliative care were treated as individuals.
- All staff, as part of their induction to the trust, received equality and diversity training.
- The chaplaincy service provided support and pastoral care for people of all faiths. We were told that chaplaincy staff were able to access leaders of different faiths in order to meet the spiritual and faith needs of patients and their relatives.
- A multi-faith prayer room was available at University Hospital of Hartlepool for patients on the community inpatient ward. The multi-faith room included ablution facilities and spiritual books for different faiths.

Meeting the needs of people in vulnerable circumstances

- The Gold Standard Framework (GSF) was in use within the community to develop good quality end of life care based on the wishes and preferences of the individual and was used to help staff identify the needs of patients at each stage of their care through detailed assessment. This included support to people in vulnerable circumstances. For example, the SPCT had worked with local care homes to improve end of life care for patients with dementia.

Are services responsive to people's needs?

- Staff we spoke with had a good understanding of safeguarding issues and of the Mental Capacity Act 2005 and how this impacted on caring for patients who did not have capacity. In this situation, we saw evidence of best interest meetings being carried out.
- Staff told us they could access support and advice from the trust's learning disability nurse or the community dementia services.
- We saw that a specialist palliative care community nurse specialist (CNS) had taken part in a regional dementia group working with the CCG. The aim of the group was to improve delivery, joint working and communication around end of life care for patients with dementia living in care homes in the region. Specific areas of improvement included: the development of palliative care registers within the care homes; improving record keeping; advance care planning; DNACPR decision making; and developing regular multidisciplinary team meetings for patients on the palliative care register.
- Emergency Health Care Plans (EHP) were in use across the community in the event of a health care emergency to ensure patient need and good standards of communication were met. The plans were designed to be used for patients who did not have the mental capacity to make decisions so that their care could be planned within a best interest process. We didn't see an emergency health care plan in use at the time of our inspection but staff were familiar with the process.
- At the entrance to the mortuary at UHH, staff had created and maintained a peaceful garden space so that relatives viewing their loved ones had a pleasant environment in which to sit.

Access to the right care at the right time

- The community SPCT responded to referrals from consultants, GPs, community staff and acute hospital staff. The team aimed to respond to all referrals within 24 – 48 hours.
- The trust only had partial data available for response times for the Stockton SPCT and none for Hartlepool. The data available showed that 82% of patients were seen within 48 hours.
- Referrals were prioritised based on assessed patient need and staff on the community in-patient ward and general nurses in the community told us that if a patient required urgent review the community SPCT would

respond immediately. Clear referral criteria was used and specialist palliative care staff worked closely with general staff to ensure understanding of the criteria and assessment processes.

- Patients told us staff were responsive to their needs. One relative told us that when a patient had been in pain in the community, nursing staff responded to their call within minutes.
- A review was underway across the region with an aim of ensuring that access to services was equitable and based on the needs of the local community. We saw an action plan relating to this work and there was a clear timeline for this to be developed. Specialist staff were aware a review of the service was being carried out.
- We also viewed plans to develop a seven day specialist palliative care service as part of the redesign and development of the palliative care integrated pathway. The completion date for this was March 2016 following the review of community SPCT services. District nurses in the community told us they felt a seven day service from the community SPCT would benefit patient care out of hours.

Learning from complaints and concerns

- Complaints and concerns were listened to and learning was used to improve services. For example, we saw that members of the SPCT and district nursing team had supported a patient and their family around concerns about the patient's discharge from hospital. The family told us their concerns had been addressed.
- Compliments and complaints were recorded during the nursing handover. Staff told us this enabled them to capture feedback from patients and relatives as it was given. The feedback was reviewed by the community matron.
- The trust did not code complaints specific to end of life care so we did not see any specific complaints at the time of our inspection. However, the palliative care nurse consultant told us they frequently conducted manual searches of the electronic system in order to pick up on any complaints that involved patients at the end of life. The number of complaints collected in this way were not available. The SPCT would provide specialist input in relation to reviewing complaints to ensure learning is occurring and shared.
- Staff we spoke with gave us examples of complaints they were aware of, including one where they had supported a patient and family in the community

Are services responsive to people's needs?

following a problematic discharge from hospital. The patient's family told us staff in the community had been supportive and they had been able to resolve the issues and concerns they had.

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 observed strong leadership from the SPCT and senior staff in the community. There was trust board representation for end of life care although we did not see evidence of proactive executive involvement in terms of the development of the end of life care strategy. There was a commitment and culture for providing high quality end of life care that was patient focused. Work was underway on a review of SPCT community services to ensure they were equitable and meeting patient need across Stockton and Hartlepool. The SPCT had been involved in developing a framework for end of life care that had influenced the development of a regional document.

Innovation was apparent across the SPCT as a whole, in particular we saw evidence that the team had worked with care homes in the community to develop end of life care for patients with dementia. Another example of innovation was the use of the virtual ward model that helped identify patients in the last year of life so that they could have the care appropriate to them in the community.

Service vision and strategy

- There was a vision for end of life care that staff we spoke with consistently described. Staff told us the strategy was in the process of being reviewed alongside a revised service delivery model.
- A number of work streams were in place to develop the strategy, including education, communication and the development of the service model.
- The trust was clear that they were committed to ensuring those approaching the end of their lives were cared for in their preferred place of care and that care provided would be high quality, timely and appropriate to patient needs.
- There was a clear aim that specialist palliative care was a service that would move to a seven day model and that there would be full integration of the SPCTs across the region. We viewed action plans with a timeline for completion and implementation of the new service model by March 2016.

- We saw that the development of the trust's end of life care strategy involved ongoing communication and liaison with the CCG and other service providers, for example local GPs and hospices.
- Staff we spoke with told us they felt end of life care within the trust was sufficiently prioritised and that there was progress in moving the service forward in continuing to meet the needs of patients.
- Staff said they felt that the senior specialist palliative care staff drove forward quality improvements and change and that there was continued commitment to developing the service to meet the ongoing needs of patients and their families.

Governance, risk management and quality measurement

- Specialist palliative care was managed within the structure of the Out of Hospital Care Directorate (community services).
- We viewed minutes from the monthly SPCT meetings and the care of the dying patient (CDP) review group. Monthly SPCT meetings included standard agenda items such as the risk register, complaints and incidents. In addition updates on work streams, audits and external reports were discussed.
- Out of hospital care directorate meetings were held monthly with a focus on patient safety and quality. There were also regular team meetings for all band 7 and 8 staff within the directorate.
- We saw a specific risk register for the specialist palliative care service. One example of a risk concerned the security of staff working in the community. Control measures in place included the use of mobile phones and training in conflict resolution.
- We viewed minutes of board meetings and saw that end of life care had been discussed in relation to mortality reviews and included in a general agenda item about integrated care pathways across the trust.
- Staff told us that if a risk is identified it should be raised with the senior clinical matron who will liaise with the patient safety team for advice before adding it to the register. New risks would then be discussed at the SPCT monthly meetings.

Are services well-led?

Leadership of this service

- The SPCT was managed by a senior clinical matron, with clinical responsibility for the palliative care consultants, including one community focused consultant.
- We observed clear leadership for end of life care within both specialist and generalist community services. All staff we spoke with in leadership roles had a good understanding of the importance of high quality end of life care and we consistently heard from staff that end of life care was prioritised based on patient need.
- We saw evidence of the SPCT providing end of life care leadership across all services within the trust, extending to external services including GPs and care homes.
- There was an executive lead in post for end of life care. Staff we spoke with told us that the development of the end of life care strategy was largely the responsibility of the SPCT and that a number of resources for development had been sought from external funds. However, we were told that the trust board had committed to longer term funding of posts than had been initially funded by this method.
- While staff on the community in-patient ward told us the SPCT were quick to respond to referrals they did not proactively attend the ward to support ward based generalist staff in the delivery of end of life care. This was a disparity of service compared with the proactive input into the acute wards. Senior SPCT staff told us this was a gap that had developed when acute services moved from UHH and because there were no longer hospital based SPCT nurses at Hartlepool. There were plans to address this as part of the structural review of the service that was due to be completed by April 2016.
- Staff told us they generally felt that the trust was committed to the ongoing development of end of life care services.

Culture within this service

- Staff we spoke with demonstrated a commitment to the delivery of good quality end of life care. There was evidence that staff felt proud of the care they were able to give and there was positive feedback from nursing and care staff as to the level of support they received from the SPCT.

- There was evidence that the culture of end of life care was centred on the needs and experience of patients and their relatives. Staff told us they felt able to prioritise the needs of people at the end of life in terms of the delivery of care.
- We observed good joint team working across the community SPCT and district nursing 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 a priority.

Public engagement

- We were told by staff that a representative from the health care user group had attended the care of the dying patient review group meetings where the care of the dying patient document had been developed.
- The SPCT had also engaged with the local Health Watch group as part of the consultation surrounding the care of the dying patient document.
- The use of the Family's Voice diary enabled staff to engage with relatives of those patients at the end of life, both in terms of the immediacy of care issues and also in terms of learning from their experiences.

Staff engagement

- We were told that members of the SPCT regularly attend directorate and trust events including out of hospital care staff forums and consultation sessions led by the chief executive. District nurses we spoke with told us they were able to attend consultation sessions but none of those we spoke with had attended.
- District nursing staff we spoke with told us they worked closely with the SPCT and were actively encouraged to feedback about the services, their roles and the challenges they faced. We saw that this feedback informed aspects of the SPCT working, including the development of training for district nursing staff. In particular we saw that district nurses were able to shadow SPCT nurses in order to build their confidence about end of life care issues.

Innovation, improvement and sustainability

- The SPCT were focused on continually improving the quality of care and we also observed a commitment to this within the district nursing teams we spoke with.

Are services well-led?

- The trust had established and developed a nurse consultant role which had been key in the delivery of the Family's Voices research, as well as the practice of providing CBT for patients at the end of life.
- The trust's care for the dying patient review group had led on the development of the Care of the Dying document that in turn influenced the development of network wide regional documentation.
- There was community SPCT involvement in the development of high quality end of life care for patients with dementia living in care homes in Hartlepool. This led to the development of care home palliative care registers, advance care planning and the development of a framework for best interest decisions using the principles of the Mental Capacity Act 2005.
- All community SPCT nurses were aligned with GPs and district nursing teams. The trust had developed a virtual ward approach to end of life care and we saw the impact of this in terms of the recognition of patients in the last year of life. Specific innovations relating to this was the recommendation within discharge summaries for GPs to add patients to their palliative care registers so that ongoing specialist support could be provided in the community.
- Recent end of life care training had been developed and the first session delivered using a case study approach to end of life care. The training had been attended by staff from hospital, community and care home settings. As part of this training the SPCT were planning on refreshing the end of life care link role within both acute and community settings across the trust.
- To ensure equity of service between Stockton and Hartlepool community services, a review of services was incorporated in the work on an integrated care pathway for end of life care across the region. This was due for completion in March 2016 with an expected new model of working and integration to ensure the needs of patients in the community are met.