

Hertfordshire Community NHS Trust

RY4

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)
RY448	Howard Court	Gregans House	
RY448	Howard Court	Apsley One	



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

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

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

We found that the overall rating for this service was requires improvement.

We spoke to a number of staff working in different areas and they told us that they received information in newsletters and meetings from the trust. We attended multidisciplinary team meetings and saw evidence of wide communication throughout the services we visited.

However we saw that supervision and staff support was not always effective. This was because clinical supervision was provided by hospice clinicians on an informal basis, and the trust had no formal system in place to support managers in their clinical practice. Staff told us that they did not always receive clinical supervision, so people could not be sure that the service was providing an up to date and well-led service.

The service had procedures in place to safeguard people from harm but the policy was difficult for staff to follow and could have led to a misunderstanding of the correct process.

We saw evidence of comprehensive maintenance records for the environment and equipment, and saw that this was implemented in the areas we visited. We saw clean and organised working environments in the areas we visited.

We looked at care planning documentation and saw that the needs of people were documented clearly with their plan of care to ensure that it was safe and effective for people using the service. However we did not see evidence that a new care planning system had been implemented following the Liverpool Care Pathway being discontinued nationally. Staff told us, that new care plans were being developed following the discontinuation of the Liverpool Care Pathway, but had not yet been implemented. Care plans were in place for individual patients to reflect their choices and wishes but they were not specific end of life care plans.

A specific end of life care policy was not in place for staff to follow at the time of our inspection.

People who used the service and their families were complimentary about the way staff cared for them, and we saw interactions between staff and people which was caring and respectful.

Recent changes had been implemented in the trust where the palliative care services had been integrated into the community and based with district nurses to enable more effective communication between the teams. The trust was currently recruiting into these vacant positions. This has resulted in a higher case load for senior nurses and managers.

We saw that changes had been made in the way the service was run in response to problems and changes in legislation that had been identified by the managers. This showed that the service was learning from challenges and improving the service they provided. Staff told us that they had been under pressure from lack of staff and as a result workloads had increased. We saw that the manager at Apsley House had implemented a staffing level action plan for use when staffing levels dropped to five specialist palliative care nurses or below, however this system had not been implemented by the trust or shared at Gregans House at the time of the inspection. However, the trust informed us this had been subsequently implemented.

Staff told us that some GP services in the area did not use the same computerised records system and this caused communication difficulties for staff working with different electronic systems. The trust was working closely with partners to improve communication.

There were no clear goals set for the service that staff could describe to us. There was not a clear written development strategy or vision statement for the service. However, following the inspection, the trust told us this document was being developed. We saw evidence of this document.

Staff felt recent changes imposed on them integrating into the community locations were not fairly consulted with the teams. This had led to staff leaving and increasing the workload for the palliative care teams. However, the trust told us that staff had been consulted with and showed us evidence of the consultation process that took place commencing December 2013.

Summary of findings

Background to the service

The palliative care services provided by Hertfordshire Community NHS Trust are located at:

Gregans House – Base for the Palliative Care Team.

Apsley One – Base for the Palliative Care Team.

Robertson House – offices used for nurses but not a permanent base.

The Specialist Palliative Care Team was made up of trained professionals including Clinical Nurse Specialists, a Consultant and Associate Specialist in Palliative Medicine, Family therapist and administrative staff. The team provided a service for approximately 90 GP

practices across Hertfordshire. The service aims to improve a person's quality of life through physical, spiritual, social or psychological support of the patient and those close to them. Much of the work involves seeing patients who need specialist intervention in a nurse led Clinic, or visiting patients in their normal place of residence, offering them and their families/carers practical and emotional support.

The service had no inpatient facility, however, works closely with local hospices. We visited four people in their homes with palliative care nurses and observed the care that was given.

Our inspection team

Our inspection team was led by:

Chair: Elaine Jeffers, Director of EJ Consulting Ltd, Bradford Hospitals NHS Foundation Trust.

Team Leader: Helen Richardson, Head of Hospital Inspections, Care Quality Commission.

The team of 29 included CQC inspectors and a variety of specialists: district nurses, a community matron, a GP, a community physiotherapist, a community children's nurse, palliative care nurses, a specialist safeguarding nurse, specialist sexual health nurse, a dental nurse, a governance lead, registered nurses, and an expert by experience who had used community services.

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme. An early inspection was requested by the provider to support the trust's submission as an aspiring foundation trust

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit between 16th February and 20th February 2015. We visited eight locations. During the visit we held focus groups with a range of staff who worked within the service, such as nurses and therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/

Summary of findings

or family members and reviewed care or treatment records of people who use services. We met with people

who use services and carers, who shared their views and experiences of the core service. We carried out an unannounced visit to one of the inpatient units on 2nd March 2015.

What people who use the provider say

We visited four people in their homes during this inspection. Due to the nature of their illnesses we were not able to speak with three of the people who used the service.

One person told us that they thought the service was prompt and thought that the care provided was very good.

Good practice

The trust has implemented information systems around end of life care for people with learning disabilities. This meant that people with learning difficulties were supported in understanding their conditions and the services available to them, and enabled them to go home sooner from hospital.

We saw a Specialist Palliative Care Nurse identify that a person was not receiving benefits that they were eligible for and arranged to this to be put into place.

Areas for improvement

Action the provider **MUST** or **SHOULD** take to improve

Action the provider **SHOULD** take to improve

- The trust should take steps to ensure that all staff receive appropriate support via effective clinical supervision.

- The trust should implement auditing systems to monitor the service and ensure that evidence based practice is implemented and regularly reviewed.
- The trust should implement an appropriate person centred end of life care plan process with a defined end of life care policy.

Hertfordshire Community NHS Trust

Community end of life care

Detailed findings from this inspection

Good 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

Staff understood the incident reporting system and there were good examples of local level learning from incidents. However, there was inconsistent trust wide learning or sharing of information from complaints or incidents, although at a local level we saw examples of staff using their initiative to learn from problems.

The service had procedures in place to safeguard people from harm but the policy was difficult for staff to follow and could have led to a misunderstanding of the correct process.

Systems were in place to ensure medicines were managed safely.

We saw that records were generally stored securely.

Effective procedures were in place for staff to manage infection prevention and control precautions.

Staff had had the mandatory training provided by the trust; however, apart from safeguarding and Mental Capacity Act training, the service was not reaching the trust's targets for training.

Staff turnover had been high but the service had plans in place to manage the risks to the delivery of care and treatment. Induction processes were in place for new staff.

We saw that the offices and meeting rooms were well maintained and secure.

Detailed findings

Incidents, reporting and learning

We spoke with staff about the system they used for reporting incidents and they told us about the electronic system which is used by the trust. Staff in each area we visited told us about this process and told us that their line manager would follow up any incidents. Staff told us that they did not always get feedback from incident reports, but that if they asked their line manager they would be updated about the outcome.

There were no recent events that staff could describe to us, although during our inspection we saw how staff managed incidents and how they escalated the issue to the appropriate people.

We saw in practice that not all staff fully understood this process because they described different levels of severity

Are services safe?

of incidents to report on the system. For example, one person said that they would report all accidents, incidents and near misses, when another said that they would report actual incidents.

There were no reported incidents relating to end of life care where there was harm caused to staff or patients in the current reporting period from April 2014 to date. In the previous year, April 2013 to March 2014 the palliative care team reported one avoidable pressure ulcer (in February 2014).

We were told about examples where systems had been put into place following learning from an event by nurses working in the palliative care teams. We heard examples where checking systems had been put in place to keep people safe in relation to medicines.

We were told by a specialist doctor about an incident that was discovered with medicines where a patient had moved between different services. We were told about the process around how this was reported following the trust's policy, and that it was discussed with this person's GP. The learning from this was shared at the multidisciplinary meetings held with the palliative care team to prevent a similar incident re-occurring.

There were good examples of local level learning, but we were not given examples of trust wide learning or the sharing of trust level learning across the trust.

Safeguarding

We observed a situation where a person was at risk of receiving incorrect treatment in an environment that a Specialist Palliative Care Nurse attended with respect to the suitability of their placement. We saw that the member of staff noticed the risk immediately, and took steps to ensure that the person was safe, by arranging a suitable placement in another facility. Although the member of staff immediately informed their line manager, the team were unsure of the trust's procedure for reporting a safeguarding incident, and telephoned the trust's safeguarding team for advice. The team were unable to make immediate contact with someone from the trust safeguarding team. This meant that a delay occurred before the trust contacted the Local Authority safeguarding team to ensure that actions were taken so that this person and other people in the

same environment were not also at risk of harm. We saw that immediate actions were taken to resolve the issues for this individual. However, staff were unaware of their wider reporting responsibilities.

We reviewed the safeguarding policy and saw that this appeared to be misleading staff. For example, the actions staff were instructed to take in the body of the policy when a person was thought to be at immediate risk were less clear than those instructions in place to manage a situation where a person was not at immediate risk.

The flow chart on page 21 of the trust's safeguarding policy designed to be a quick reference document for staff was contradictory to the policy itself. Appendix 1 contained the contact numbers for staff to call, but the flow chart did not make it clear to staff to contact the Local Authority when a person was "in immediate danger". This meant that there may have been a delay in the Local Authority being contacted in the case of a safeguarding incident. Furthermore, other people involved in a similar situation could also have been at risk.

Staff did not fully understand the safeguarding policy. The policy was difficult for staff to follow and could have led to a misunderstanding of the correct process. This meant that people may have been at risk of harm from abuse.

Medicines management

The Specialist Palliative Care Nurse we spoke with did not hold stocks of medicines, but told us that they would review and check on the "just in case" medications that were put into peoples' homes. These are medicines that people may require near the end of their life to relieve symptoms. If they are ready in a person's home, they can be administered immediately, rather than having to wait for a doctor or nurse to visit, prescribe and obtain the medicines.

We were told that risks were monitored when Controlled Drugs (CDs) were provided in the home of a patient, and a lockable unit may be installed to ensure the security of these medicines.

We went on a visit where a Specialist Palliative Care Nurse reviewed a person's medicines and provided useful advice to the family member with regards to medicines. We saw that the nurse made time in the visit to review the effectiveness of the medicines that the person was taking.

Are services safe?

Furthermore, they checked the understanding of both the person who used the service, and their family member who was caring for the person at home. This meant that systems were in place to ensure medicines were managed safely.

Maintenance of environment and equipment

The trust had recently completed a move to integrate the palliative care teams further into the community with other teams such as the district nurses. This meant that the buildings and facilities were shared with other services that were based there. The staff told us this led to better communication between the teams.

At Gregans House we saw that the environment was clean and signs were in place to warn people of the low ceiling above the stairs. In one meeting room we saw that there were side opening windows at waist height which were not restricted. This could have been a hazard to staff. We were told that service users did not access this building.

The environment at Apsley One was clean and well maintained. We saw that the building was shared with other Local Authority services and staff told us that they were able to access estates services for maintenance purposes if they were required.

Both palliative care teams told us that they did not stock equipment for patient use; for example mobility aids, electric beds or mattresses, but that they could arrange for equipment to be loaned to people in their homes if a person had an identified need. This was managed by a separate department.

Records systems and management

We saw that most records were held on an electronic system. This system was shared across the majority of the trust, but in both areas we inspected Specialist Palliative Care Nurses told us that some GPs did not have the same system. This caused issues with data sharing. For example, the trust used paper forms for “do not attempt to resuscitate” (DNACPR) as some GPs could not access this information from the electronic system. The trust told us that they were aware of this issue with the computer system and were working on resolving it.

Both palliative care teams spoke to us about the “message in a bottle” system that the community teams put in place for people being cared for in the community. We saw the “bottle” that was a brightly marked container kept in the patient’s home. It was used to hold documents containing

important medical wishes and information. Staff from other services, for example, paramedics, nurses, doctors and social workers could access this information in an emergency and act on the information contained within it. This meant that people who used the service were protected from receiving inappropriate treatment.

On one occasion during our inspection we saw that a computer screen display was left on with personal information about a person who used the service. This office was in use by multiple staff. This meant that records could be seen by people who were not required to have access to this information for their work. However, we noted that the office was not accessed by members of the public or people who used the service.

A Specialist Palliative Care Nurse showed us how they accessed the computer system remotely via a secure laptop. They were able to access information about people in order to carry out their roles effectively. The nurse told us that they did not use the system in public, but that their mobile access allowed them to update their documentation in a variety of private locations so that personal information about people who used the service was protected.

Cleanliness, infection control and hygiene

In all the areas we visited we saw cleaning schedules to ensure the environment and equipment had been cleaned. We saw dated “I am clean” labels on equipment and appliances to indicate to staff and visitors that the item had been cleaned and was ready for use.

The offices we visited had bathroom facilities for staff to wash their hands, which were clean and stocked with hand soap and hand drying facilities. We witnessed most staff washing their hands between tasks; however on one occasion we observed that a member of staff did not sanitise their hands on entry to a care home. Work surfaces were clear and unchipped, and bins were not overfull.

Mandatory training

There were systems in place to ensure that staff had training to enable them to carry out their roles effectively. However, records we received from the trust confirmed that by December 2014, staff working in the end of life service, had missed the trust’s target of 90% of staff completing their mandatory training, with the exception of safeguarding and Mental Capacity Act training. The

Are services safe?

managers of each team told us that they did not have access to these records and had to rely on a colleague to provide them with this information. Staff told us it was often difficult to travel some way to attend training, particularly the shorter courses. However the trust did provide on line training for that which did not have to be delivered face to face.

We saw that staff working in end of life services, were not required to attend training in subjects specific to their working area, but that additional courses were available for staff to attend if they wished to.

Assessing and responding to patient risk

We saw that the Specialist Palliative Care Nurses, District Nurses, and other members of the multidisciplinary team (MDT) had regular meetings to discuss their patients, their level of need and any risks. We observed a multidisciplinary meeting at Gregans House where staff discussed the needs of people who used the service. This included a discussion regarding a person using the service and the fact that they had identified that the full time carer of this person required extra support. The team were able to discuss the options available to them. As the person using the service had expressed that they did not wish to have support of the palliative care team, but the family member did, staff told us that it was not usual procedure, and that “they were not allowed” to assist the carer if the person using the service had declined assistance. They told us this was a common problem that had not been addressed by the trust. However, despite this, staff did what they could to support carers.

We were told that joint visits, where two members of staff attended the patient’s home, would be arranged if the patient’s condition warranted it. We saw that during the MDT that joint visits were discussed to introduce further services to people receiving care.

Staffing levels and caseload

Staff told us that there had been a high turnover of staff recently, and at Apsley One, the Palliative Care Team had recently recruited five registered nurses. Some nurses had a high case load, but the team manager had adapted their role to take on more patients and less management tasks

while the trust recruited more nurses. Staff told us that they worked above their usual hours at times or worked flexibly to cover the workload of their colleagues to ensure that services were not delayed.

We spoke to a new member of the nursing team and they told us that their caseload had been developed slowly to allow them time to adjust whilst they were working through their induction. Senior nurses were supporting recent recruits by managing a larger caseload themselves.

At Apsley One, the manager told us that there was a procedure in place for staff to follow if the numbers of Specialist Palliative Care Nurses dropped to lower than five in a day. The procedure was designed so that the service would still be able to provide a safe service to people, and prioritised staff tasks to make effective use of the resources available. We spoke with the manager who implemented this system and we were told they had put it in place as there was no system to identify staffing shortfalls. This meant that there was a system in place to ensure that the service was able to provide a safe service, although this was implemented by local managers and not at trust level. We saw that this system had not been implemented at Gregans House, which meant that there was no consistent system in place across the service to ensure it continued to provide a consistent and safe level of care where there may be staffing issues.

Managing anticipated risks

We spoke to the Palliative Specialist Nurses based at Gregans House about their lone working policy. They told us that they had a system to ensure each member of staff “checks in” at the end of their shift so that all staff were accounted for. The nurses told us that they would occasionally plan visits in pairs or with other professionals if there was seen to be a risk where a person may have high levels of anxiety. This meant that systems were in place to protect staff when working alone.

Major incident awareness and training

We saw that the offices and meeting rooms were well maintained, fire risk assessments and records were in place, staff signed in and out of the building, and there was a secure system at main entrances to maintain security. This meant that systems were in place to ensure the risk of fire was monitored.

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

New care planning processes were being developed by the service following the discontinuation of the Liverpool Care pathway but had not yet been implemented. There was not an appropriate person centred end of life care planning process fully in place. Care plans were in place for individual patients to reflect their choices and wishes but they were not specific end of life care plans.

A specific end of life care policy was not in place for staff to follow at the time of our inspection.

The service did not have robust auditing systems to monitor the service, for example objective monitoring of pain, to ensure that evidence based practice was implemented and regularly reviewed.

The trust monitored the choice of patients preferred place of care so that they could aim to meet their wishes. This information was used so that the trust could monitor how often patients achieved their wishes.

Staff were trained appropriately with an induction on recruitment. Further training in communication and specialist courses were available if staff wished to attend.

However we saw that supervision and staff support was not always effective. This was because clinical supervision was provided by hospice clinicians on an informal basis, and the trust had no formal system in place to support managers in their clinical practice.

We observed multidisciplinary team meetings and saw planned schedules of meetings which enabled effective communication within the trust.

Staff attended networks with an End of Life Network, and Gold Standard Framework Meetings, in order to learn and share the latest developments in end of life care. This information was disseminated at multidisciplinary meetings so that other clinicians benefitted from this knowledge.

Information packs had been developed for people who used the service so that they were able to read about services at their own pace, and keep contact details for future reference.

We saw documentation that people signed following advanced decisions for their care were made, and staff told us about the process for making best interest decisions where patients were deemed to have fluctuating or reduced capacity. This meant that staff understood the requirements of the Mental Capacity Act (2005).

Detailed findings

Evidence based care and treatment

Staff told us that they were implementing the "Preferred Priorities of Care" plan following the discontinuation of the Liverpool Care Pathway (LCP) nationally and locally in August 2013. Care plans were in place for individual patients to reflect their choices and wishes but they were not specific end of life care plans. This new plan had not been implemented fully and work was continuing to progress this project, but there was no plan in place to bridge the gap while the system was implemented.

We looked at care planning documentation and saw that the needs of people were documented clearly with their plan of care to ensure that it was safe and effective for people using the service.

A Holistic Needs Assessment template was being developed to include core holistic assessments plus specialist assessments such as choices regarding DNACPR, carer support and organ donation. The service had not met its target of implementation in December 2014 of this holistic assessment tool.

A specific end of life care policy was not in place for staff to follow. We did see a document, dated June 2014, reviewing the action required by the trust to replace the LCP. This document recommended that an end of life policy be implemented. However, at the time of the inspection, this policy, even in draft format was not in place.

Are services effective?

Trust staff met regularly with the local hospice to network within end of life care. Staff attending these meetings learned the latest evidenced based practice and news relating to end of life care and shared it with the multidisciplinary team to improve practice.

We saw that doctors from the hospice provided support to the trust, however there was no evidence that the trust had its own system in place to ensure that they were acting on the latest research and practices.

For example, the doctor we spoke to mentored staff and implemented their own audits and meetings relating to specific clinical need in the area. However there was no evidence that the trust were involved or monitoring this research and resultant practice.

Pain relief

The specialist palliative care doctor told us that spinal cord compression research took place, but pain management audits were not part of the audits carried out by staff.

We saw that during the first visit by a member of the end of life team, pain scores were included in the initial assessment in the patient's homes. Pain levels and response to analgesia (pain relieving medicine) was reviewed at each visit and recorded. However there was no formal pain scoring tool used to objectively assess a patient's pain and their response to prescribed analgesia. Furthermore, this meant a patient's pain was not measured quantitatively and therefore could not be audited, to ensure patients received the most effective pain relief.

Nutrition and hydration

We saw that patients' nutrition and hydration needs were assessed by the palliative care team once a patient had been referred to them. We attended a visit and observed a palliative care nurse discussed diet and fluids with a patient to ensure that nutrition and hydration needs were being met in their home. We saw a palliative care nurse reviewing prescribed high calorie drinks for a patient. However, there was no formal structure or risk assessment in place to assess, review or audit the nutrition and hydration needs of patients.

Approach to monitoring quality and people's outcomes

The service did not have robust auditing systems to monitor the service and ensure that evidence based practice was implemented and regularly reviewed.

A specialist palliative care doctor told us that the trust participated in audits around pain and spinal cord compression. They told us that psychological needs were assessed. Support and counselling was provided where it was felt patients would benefit from this. The doctor was not able to show us these audits, and told us that this information was carried out in conjunction with their work at the local hospice. It was not clear that this work had been directed by the trust.

We saw the trust's board meeting minutes dated November 2014, as part of the trust's Clinical Effectiveness Programme 2014 to 2015 that an End of Life Care audit was planned, however the status in the minutes stated: "Not yet initiated but within target. Meeting to be arranged." Two further audits, Brief Pain Inventory and Famcare2, service evaluation of bereaved relative's satisfaction with end of life care, were, "in progress" as led by the Specialist Palliative Care at that time.

Staff could not describe what quality audits were carried out when we asked them.

Staff told us that there had been an audit group in place but this had been suspended due to staffing constraints, but it was due to be restarted in the near future.

In a document entitled, Palliative and End of Life Care Network High Level Work Plan 2014-2016, we saw that training and development was prioritised but there was no reference to audit or quality monitoring.

A Specialist Palliative Care Nurse showed us the electronic patient care assessment form. This included a section to enter where people preferred to receive their care, for example; if they had chosen to stay at home during their last days of life. We were told that these questions were asked sensitively, and at an appropriate time. This meant that the trust could monitor the number of people that received their preferred place of care, and it allowed staff to know at an early stage what people's wishes were.

Patient outcomes performance

We saw an example of a document called "Planning for your future care - A Guide". This document was designed to give information to people who used the service, and their carers. It included sensitive subjects including case studies,

Are services effective?

guidance on legal matters, and advice on communicating wishes. This was produced by the National End of Life Care Programme 2012. This meant that people were provided with information about end of life care. However this did not include advice around services available to people specifically in Hertfordshire.

We asked in all the locations we visited what care planning tool the trust were using in replacement of the Liverpool Care Pathway which has now been withdrawn from use. Both palliative care teams told us that they had developed a person centred care plan; however this had not been implemented. The service had a target date for this Individualised Care Plan for the Dying person to be implemented in March 2016.

We were shown an assessment document called “Preferred Priorities for Care” which was designed to prompt people to think about and document their wishes and plan for care, at an early stage. This meant that people who used the service had information and an opportunity to consider their wishes and to enable staff to plan the care pathway from an early stage in their illness.

Competent staff

Both palliative care teams we inspected told us that they had recently recruited staff nurses to fill vacancies. We spoke to three newly employed nurses who told us how positive their induction programme and the support they had received from their line manager had been.

All of the staff we spoke to told us that they had attended advanced communication training which taught them to effectively manage demanding situations, giving them confidence in knowing when it was appropriate to discuss sensitive subjects.

The two palliative care service managers told us that prior to the employment of the nurses they had to take on more of the clinical tasks and less management work. This meant that they were unable to complete management and training.

We spoke to two nurses that had recently been recruited by the trust into the palliative care team at Apsley One. They told us that they had been commenced onto an induction programme, and spoke about the advanced communication course they had attended, and the degree

course in palliative care that was available to staff. They told us that they received monthly supervision from their line manager to support them in developing into their new role.

However we saw that supervision and staff support was not always effective. This was because clinical supervision was provided by hospice clinicians on an informal basis, and the trust had no system in place to support clinical quality leads in their clinical practice. Staff told us that they did not always receive clinical supervision so people could not be sure that the service was providing an up to date and well-led service.

Most staff had had an annual appraisal and from information we received from the trust during the inspection, we found that 100% of staff in the East and North Hertfordshire team had had an appraisals. However, only 50% of the staff in the Hertfordshire valleys team had had an appraisal in the past year: this was below the trust overall average of 83%. The trust target for staff having had an annual appraisal was 90%.

Multi-disciplinary working and coordination of care pathways

We spoke to a specialist palliative care doctor at Apsley One. They told us that they visited patients with the Specialist Palliative Care Nurses if a patient had complex symptoms and required extra support. They told us that they liaised with the patient’s GP to ensure that information was shared. This meant that information was communicated effectively within the multidisciplinary team, to ensure that people who used the service received effective care.

A newly recruited nurse told us, “We work very closely with the district nursing teams which allows good communication and provides a seamless service for people”. This meant that staff facilitated a smooth pathway for people to move between the services they used.

The trust had a system where there was a duty nurse available during working hours to take calls from people who used the service, prioritise or triage their care requirements, then allocate tasks for the nursing team. This meant that people who used the service had access to a clinical professional for advice or for further support, thereby minimising delays. This meant that there were systems in place to provide a prompt and effective service.

Are services effective?

Referral, transfer, discharge and transition

We saw that referrals were made to care services by a wide range of health professionals, and a system was in place to ensure that the referrals were appropriate. A nurse reviewed the referrals before allocating them to the team.

A palliative care nurse told us that the teams had increased referrals to clinics to improve the pathway for people who used the service. This was particularly helpful in the past when vacancies had not been recruited into immediately. This meant that patients that were able to travel could book a clinic to see a specialist, so that visit caseload for Palliative Care Nurses could be reduced.

We attended a visit with the palliative care team where a patient who used the service was managing their symptoms at home and did not require further immediate visits from the team. The nurse explained that they could call the service to arrange a visit if they felt they required support and made it clear that they could be contacted from numbers on the supplied leaflets.

People who used the service told us that support was provided for them in the community once they were discharged from a hospice. Furthermore, they told us that staff understood their individual situations.

Availability of information

Information packs had been developed for people who used the service so that they were able to read about services at their own pace, and keep contact details for future reference.

Consent

All of the staff we spoke to explained to us how they obtained consent from patients to carry out care and manage confidential information. The service followed the trust policy for obtain consent, which was implemented in April 2014.

Staff told us that the multidisciplinary team worked together to support important decision-making concerning patient care. Staff could explain the procedure to seek authorisation for a deprivation of liberty, and told us that they have access to advocacy services, although they were not able to give examples of when this had been used.

We saw documentation that people signed in advanced decisions for their care, and staff told us about the process for making best interest decisions where patients were deemed to have fluctuating or reduced capacity. This meant that staff understood the requirements of the Mental Capacity Act (2005).

We looked at five Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms that were in use in the trust. We saw that the trust was proactive in arranging these forms to be completed early in a patients' care. All five forms that we saw had been fully completed, and in one case we checked that this had been translated onto the trust's electronic record system. This meant that there was a system in place to communicate these decisions to professionals who did not have access to the trust's computer system. Staff told us that DNACPR forms were not monitored through auditing.

Are services caring?

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

Summary

On four visits with the Specialist Palliative Care Nurses we saw that the staff communicated and acted in a caring and gentle way with the people who used the service.

We saw compliments and cards from people who used the service thanking the staff for the service they had provided.

Staff told us how important the experience of the patients was to them, and how they worked hard to ensure that patients and their carers had as much support and advice as they could provide.

We saw that one Specialist Palliative Care Nurse was able to give advice to a person who used the service with regards to the benefits that they were eligible to receive, and arranged for this to be put in place for the person. This was an example of outstanding practice that we saw during the inspection.

Staff had received training in communication and we saw on each of our four visits that staff used appropriate communication skills with patients. On one particular visit a person was distressed and the Specialist Palliative Care Nurse visiting them gave a high level of emotional support to the person and was able to assist in resolving some of their issues for them.

At a multidisciplinary meeting we observed staff discussing the emotional needs of patients and their carers as well as their physical and social needs. Staff did their best to support families and told us that sometimes they visited in pairs so that one person can provide care to the patient while the other staff member could provide advice and support to their carer.

Staff encouraged people to care for themselves in their own homes and facilitated contact with other professionals to enable them, for example by providing equipment.

Detailed findings

Compassionate care

We spoke to all levels of staff in the palliative care teams we visited, and all of them told us that the patients experience was important. One staff member told us, “We are here to help them live, even though they are dying”.

We attended four visits with the palliative care nurses and attended the homes of people who used the service. We saw nurses delivering care in a kind way with respect to patient’s carers or relatives and their environment.

We watched staff interacting with people who used the service in a polite and tactful manner. Staff told us that they would look for cues from the person so that they did not ask unnecessary questions which may have upset them.

All of the staff we spoke to told us that they had taken part in communication training. This helped them in their role when asking people sensitive questions about their choices for end of life care, or in discussing bad news with patients, their families and carers.

We attended a visit with a Specialist Palliative Care Nurse and saw them identify the level of care the patient needed. They were able to give advice on the benefits that they were eligible to receive, and arranged for this to be put in place. This was an example of outstanding practice that we saw during the inspection.

The palliative care service received a quarter four (January to March 2014) Net Promoter Score of 70% and a quarter one (April to June 2014) Friends and Family Test score 2014/15 of 76% which was above the trust target for this feedback of 75%.

Dignity and respect

We accompanied Specialist Palliative Care Nurses on four visits to people in the community, and observed the way that staff spoke to people who used the services and their carers. Staff were careful to ask for consent before entering people’s homes, and we saw that they spoke to them in a kind and respectful manner.

Patient understanding and involvement

Staff told us about a situation where an Independent Mental Capacity Advocate (IMCA) had been used and best interests meeting had been held where a person who used the service lacked capacity with regards to making a decision around a feeding tube. This meant that the person was involved in the decision as far as possible and ensured that the processes to comply with the Mental Capacity Act 2005 was followed.

Are services caring?

We saw consent forms that patients were given to sign in agreement that their care details could be shared amongst other health professionals in order for the trust to provide holistic care.

Emotional support

We observed a multidisciplinary team meeting at Gregans House where we listened to staff discussing the emotional needs of patients using the service and how families and carers were coping with the situation they were in. The staff raised a number of ways they could assist the families.

On all four of the visits we attended with the Specialist Palliative Care nurses we saw that staff were supportive to people and allowed them time to communicate. On one visit we saw that a patient was upset and the staff member comforted this person kindly and explored avenues to help them.

Staff told us that a psychiatrist was available to the team to provide support to people who used the service. We spoke to the psychiatrist and they told us that they would visit people in their own home to provide support if it was identified that emotional support was required.

Carers of people referred to the service for palliative care did not receive support if the patient decided that they did not want the input of the palliative care team.

Promotion of self-care

Staff working within the two palliative care teams told us how they felt it was important to them to be able to help people to be as independent as possible in their own homes, if they chose to receive their care there. A team manager told us that they worked together with district nurses and occupational therapists to provide equipment and support. Equipment provided included electric adjustable beds, pressure relieving mattresses, and mobility aids. This enabled patients who used the service to manage at home and care for themselves as far as possible.

Are services responsive to people's needs?

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

Summary

We found that the trust provided information to people in a variety of different ways. Leaflets were available in different languages, interpreters were available in person or over the telephone, and easy read information was developed for people with learning disabilities. Information packs were provided to patients with information about other services provided to them and how to contact them. This meant that people could contact other professionals in their own time.

The trust held specific meetings to discuss end of life care for people with learning disabilities. We were told that no other trust carried out such meetings.

Nurses were on call throughout the working day to answer calls from patients and carers and give clinical advice immediately over the telephone. This meant that patients did not have to wait to access advice. For example; they did not have to wait to be called back or for their call to be passed on to a clinician.

People had timely access to the service and did not have to wait for advice. Visits were arranged promptly when required, but clinics were also available so that patients could plan their care according to their social wishes.

The service had a robust complaints procedure in place that was understood by staff.

Detailed findings

Planning and delivering services which meet people's needs

We saw the document, HCT Palliative and End of Life Care Network - high level work plan 2014 to 2016, which described development plans for the service in order to improve, but lacked detail about what tasks were. One of the actions described was to support the development and implementation of, "One Chance to Get it Right." This followed the recommendations of a review of the Liverpool Care Pathway by the Department of Health. This initiative included the ongoing strategic engagement with local commissioners on plans including the development of individualised care plans; commissioning routine holistic needs assessments, access to seven day rapid response,

potential prime provider models, and the implementation of an Electronic Palliative Care Coordination System (EPaCCs). Plans were in place to support the Integration of Specialist Palliative Care in the locality teams with a review of the roles of Specialist Palliative Care Nurses (SPC) designed to ensure specialism was protected and developed further and to ensure SPC staff received adequate support to perform their role. The service had not met all the target dates for these plans due to the complex nature of negotiations with the local commissioners. However, discussions were ongoing.

The plan highlighted training requirements and the need to research the needs of the population, but did not describe in detail how this was to be achieved. It described one action point to, "explore opportunities for research in End of Life Care in Hertfordshire with support from HCT Research Advisory Group". This point was marked as ongoing with no target date or progress documented.

The plan further identified a need for support to carers of patients and detailed the implementation of an assessment tool, evaluation of carer support, and a process that intended to audit the success of this process.

Equality and diversity

A palliative care manager told us that the community area covered by the trust was large and covered groups of people from different cultural backgrounds and languages, under approximately 90 GP services.

To enable effective communication with patients and carers whose first language was not English, we were told that leaflets were available in different languages. These could be accessed via the trust's intranet that all staff had access to. We were also told that the staff had access to translators either in person or over the telephone to assist a person who used the service where English may not be their first language.

We saw that one person we visited did not speak English as their first language, and the staff member did not have this information prior to the visit. The member of staff chose their words carefully and spoke with family members to ensure what was said was understood. We were told that

Are services responsive to people's needs?

translators were available to the nurses on their visits. The nurse told us that if subsequent visits were required, they would ensure the translator was available so that the individual could communicate effectively more easily.

Meeting the needs of people in vulnerable circumstances

We were told by a specialist palliative care doctor about information packs had been developed for people with learning disabilities. They described the potential difficulties with communication and that regular multidisciplinary meetings were held in order to improve the service provided to this group of people.

At Apsley One we spoke with a palliative care specialist doctor who told us about multidisciplinary team meetings that were held in order to evaluate the care services in end of life for people with a learning disability. This allowed the team to expedite discharge from hospital, where the environment may have been unsettling for them. We were told about a resource pack that had been developed to inform these patients of specialist services available to them and numbers to call for assistance and support.

There was no evidence that the trust had developed a plan to meet the needs of people living with dementia.

Access to the right care at the right time

We saw that the trust had a system in place where calls during the day were handled by a registered nurse with a palliative care background. This meant that assessments could be completed over the telephone and some advice given immediately to people who used the service without the need for people to be referred to another service. This staff member would also triage the calls, allocate visits to the palliative care team where necessary and provide visit information to the caller.

We were told that patients had said that generally they preferred being able to plan their visit to the clinic, rather than wait for a nurse to attend their house, where under recent pressures this may have been delayed. This meant that systems were in place so that people had timely access to services.

We attended a visit with a Specialist Palliative Care Nurse where they assessed a patient that had been newly referred to the service. They explained the service and gave an information pack to them and their carer so that they had contact details of any services they may wish to contact.

During this visit the nurse asked the patient questions relating to their care requirements that may have been required from other services, to ensure that they have access to the services best suited to their needs.

The person we visited who used the service told us that they felt the service was timely. They told us their visit was planned within "a couple of days" which suited them. Both staff and patients told us that there was no wait to access services or get ongoing support.

We were told by administration staff that the palliative care teams were currently meeting the trust's target of people receiving their end of life care in their preferred place. We were shown data that demonstrated the trust was achieving above 90% success in people receiving care in their chosen place.

From information provided by the trust for the period November 2014 to January 2015 we found that this was not recorded for all patients.

- 1012 out of 1793 patients requiring palliative care had had their preferred place of care recorded on their patient record. This represented 56% of patients having this choice for receiving care recorded.
- 362 out of 1793 patients requiring palliative care had not had their preferred place of death recorded on their patient record. This represented 29% of patients not having their preferred place of death recorded.

There were no trust targets in place for these outcome measures.

Complaints handling and learning from feedback

The service had a robust complaints procedure in place that was understood by staff. We were shown completed feedback forms, all of which showed positive comments. We saw no negative comments.

We asked staff about complaints that had been received about the service and no-one was able to describe any to us. A member of staff told us that, "People very rarely complain, we provide a sensitive service to patients and help them when they are struggling". We did not see a record of complaints in any of the areas we visited.

The trust told us that there had been three complaints for the year 2014 regarding the palliative care team, two of which had been upheld. The complaints had been investigated and responded to within 28 days, in

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accordance with the trust's policy. We were given an example of an action that had been carried out in relation to a complaint, to ensure that the same problem from which the complaint arose was not repeated.

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 found that there was some disengagement in the local leadership of the trust and the staff working in palliative care services.

There was not a clear written development strategy or vision statement for the service and no clear goals set for the service that staff could describe to us.

We saw the “HCT Palliative and End of Life Care Network - high level work plan” for the trust from 2014-2016 which was a development action plan but lacked detail about what tasks were and how they were going to be achieved.

The Liverpool Care Pathway (LCP) was withdrawn nationally and locally in July 2013. The trust had not implemented a replacement care plan. There was no specific end of life care plan.

Staff felt recent changes imposed on them integrating into the community locations were not fairly consulted with the teams. This had led to staff leaving and increasing the workload for the palliative care teams.

We saw that staff gave people who used the service opportunities to feed back their experiences so that this could be collated externally and lessons learnt from the comments.

Detailed findings

Service vision and strategy

We spoke to the manager of the Palliative Care Teams about the development of the service. There was not an effective written strategy outlining the development of the service but there was a development action plan in place (HCT Palliative and End of Life Care Network high level work plan 2014-2016) which set out the key areas for development. It had been recorded within this plan that the implementation of the Care Plan for the Dying Person, replacing The Liverpool Care Pathway, which had been withdrawn from use, should be in place by March 2016. However, most staff were not able to tell us about this plan.

Neither nurses, administration staff, nor managers we spoke to were able to give us a clear picture of the future

plans for end of life care in the trust. Staff told us that there had been so many changes that they did not focus on future plans as, based on their previous recent experience they would be likely to change.

Governance, risk management and quality measurement

We saw steps had been taken to manage risk and measure quality in some areas of the end of life care service. There was an up to date risk register in place, and we saw that staffing levels were recognised as a risk.

A doctor working with the palliative care team told us about some clinical audits such as effective pain management and spinal compression. These audits were devised and developed from incidents or trends that professionals had noticed, but had not been initiated by the trust. Staff could not describe other audits that were carried out when we asked them.

We were told that the nearby hospice provided network meetings which the team attended. However we did not see evidence that the trust was involved with end of life forum groups or outside agencies to improve and share practice with other external organisations.

We saw the “HCT Palliative and End of Life Care Network high level work plan 2014-2016” for the trust which was a strategic development action plan that highlighted areas for improvement and documented the progress against each point. However, the work plan lacked detail about what tasks were and how they were going to be achieved. There was a lack of detail to show whether there were still actions outstanding or whether they had been completed. At least 11 points on the high level work plan described tasks to be achieved which did not reflect any ongoing progress. For example, one point related to staff training on a subject had been signed as completed but there was no part that described the implementation of ongoing assessment or renewal of this particular training. Each item was red, amber or green (RAG) rated, but it was not clear whether this related to the risk attached to the item, or progress against the action.

Are services well-led?

Staff told us that they were implementing the “Preferred Priorities of Care” plan following the discontinuation of the Liverpool Care Pathway nationally and locally in August 2013. We saw a review document, dated June 2014, outlining the trust’s position following discontinuation of the LCP. However, the document contained no action plans apart from implementing an end of life care policy, which had the time of inspection was not available. Care plans were in place for individual patients to reflect their choices and wishes but they were not specific end of life care plans. This new plan had not been implemented fully and work was continuing to progress this project, but there was no plan in place to bridge the gap while the system was implemented.

In the trust board meeting minutes for January 2015, one of the higher level risks on the risk register was regarding Specialist Palliative Care, “Due to low staffing levels due to vacancies, sickness and special leave, leading to the inability to deliver high quality care to patients, resulting in the failure to meet the requirements to deliver the full commissioned service, poor patient experience and low staff morale and increased stress.” This risk was initially rated as a high risk and was now shown as a medium risk due to mitigating actions having been taken. These included flexible staff support and ongoing recruitment.

Leadership of this service

Staff told us that an Integrated Care Meeting had been planned. We attended this meeting and saw that staff used the time effectively to discuss the patients within their care. They told us that they had not been consulted in the planning or reasons behind this meeting, and that they felt that they already met regularly with their colleagues.

We spoke to the managers of each of the Palliative Care Teams and they told us about the structure of their areas of the trust. They told us that they did not hold budgets for their teams. However the level of impact of this was not clear. Furthermore, as they were now becoming integrated with district nursing teams they did not always have oversight of their own staff’s training. This meant that the managers could not be fully autonomous in monitoring the mandatory training of their team, and could mean that training requirements were missed.

We saw that new staff were supported in their roles by the trust and staff told us that they felt they could approach their managers without hesitation.

The trust told us that they have worked hard to improve staff engagement in what had previously been a fragmented set of services, where staff had experienced eight changes of organisational form in 11 years.

Culture within this service

The culture we saw within the service was open and caring. The interactions we saw between staff, families, and people using the service were kind, professional, and not rushed.

A newly recruited nurse told us that she had attended a quality meeting with the trust and had met the director of quality and governance. They told us that the director asked how they were settling into their new role and took time to listen about the staff members’ experience. We were told they were “Very supportive”.

Staff told us that during informal clinical supervisions staff were able to speak to the psychiatrist about complex cases for individual or group debriefing. This meant that staff were supported, and they told us that this was helpful to them.

The managers of the palliative care teams told us that they felt they were listened to, but recent changes in the structure of the teams coupled with lack of full consultation had caused some staff to leave. It was felt that generally workload had increased.

We spoke to administration staff at Apsley One and they told us that they enjoyed working in their team as they knew each person had their individual role, but they would support each other, cross working, where they could. We were told there had been many variations in their working recently with recent changes in the trust, where the palliative care teams had been integrated into the community and based with district nursing teams. They were settled into the way of working and felt supported by their line managers.

Public and staff engagement

In all areas of end of life care services that we inspected we saw that staff sought feedback from visitors and service users from questionnaires so that feedback was provided about the service. The questionnaires were presented in a pack with a stamped addressed envelope so that patients could be confident that their feedback would be handled independently.

Are services well-led?

The trust had engaged both staff and public in questionnaires to seek feedback on the services provided.

The information from public was positive; however the trust did not seek feedback from the public in other formats, for example with public forums, meetings, or other means.

Staff in the palliative care teams told us that they attended regular meetings where information from the trust was shared. However staff told us that in the past they felt that the trust did not listen to their views in changing the service and that tasks were sometimes allocated without consultation or explanation. They told us this experience had led them to believe that they would not be listened to in the future about high level issues. However, low level

suggestions like a request for equipment would be listened to and actioned. We saw an example of this where staff were asked to hold an integration meeting during our inspection.

Innovation, improvement and sustainability

A member of staff told us about the procedures they had put in place in response to working with a smaller number of staff. They recognised that a system should be implemented to ensure the service was able to continue to function during these times.

Staff told us that they currently did not network with wider agencies outside of the trust, which meant that there was no clear system in place to improve the service in line with current evidence based research. We were not given an explanation as to why this did not happen.