

North Somerset Community Partnership Community Interest Company

1-293935970

Community end of life care

Quality Report

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Date of inspection visit: 29, 30 November, 1,2 13 and
14 December 2016

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
1-310911016	Castlewood	Community end of life care	BS21 6FW

This report describes our judgement of the quality of care provided within this core service by North Somerset Community Partnership Community Interest Company . Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by North Somerset Community Partnership Community Interest Company and these are brought together to inform our overall judgement of North Somerset Community Partnership Community Interest Company

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	5
Background to the service	6
Our inspection team	6
Why we carried out this inspection	7
How we carried out this inspection	7
What people who use the provider say	7
Outstanding practice	7

Detailed findings from this inspection

The five questions we ask about core services and what we found	8
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Summary of findings

Overall summary

Overall rating for this core service GOOD

We rated end of life care provided by North Somerset Community partnership as good because.

- Comprehensive patient safety information was discussed in nurse meetings which included patients who might be at risk of pressure ulcers and other health risks.
- Patients had care from staff who had specialist training in end of life patient care.
- Risk was assessed and managed positively enabling patients to stay in own homes. Staff ensured they responded to patients with increased needs.
- Equipment and care packages to support patients at home and discharge from hospital were put in place promptly through a 'fast track' (Continuing Health Care) system for end of life patients. Records showed assessments and action plans were completed quickly and promptly passed to the care coordination centre.
- Staff we spoke with understood consent and decision-making requirements of the Mental Capacity Act (2005) code of practice. Patients who did lack mental capacity for decision-making were supported by staff in making best interest decisions in accordance with legislation.
- Pain and symptom relief was prioritised for patients receiving end of life treatment and care. Anticipatory or 'just in case' medicines to manage symptoms such as pain and nausea were prescribed and stored in patients' homes so they were readily available when required.
- Patients and relatives we met with spoke positively about the care they received. We observed respectful, dignified and compassionate communication between staff, patients and relatives.
- Staff providing end of life care were highly regarded by relatives of deceased patients for their kindness, caring and compassionate attitude.
- The care coordination centre and community services planned and delivered services to meet needs. There was coordination with other local end of life care services including hospices, acute trusts and a national provider of cancer nurse services. The organisation worked with the clinical commissioning group to ensure the services met the needs of the local population as far as possible.
- Priority was always given to patient's receiving treatment and care at end of life. We observed during shift handovers how staff worked flexibly to prioritise patients whose needs became urgent. Care was provided 24 hours a day, seven days per week and there was access to end of life and palliative care advice at any time of the day or night.
- Staff listened to complaints and concerns and improved the service.
- The end of life and palliative care planned and action plans were based on the six national ambitions published by the National Palliative and End of Life Care Partnership, (2015). The outcomes were also based on achieving the five priorities of good end of life care (Leadership Alliance for the Care of Dying People, 2014)
- Staff we spoke with were clear about their roles and they understood what they were accountable for.

However:

- There was variable compliance in assessing and recording risks for patients in their last year of life.
- The programme of clinical and internal audit for end of life and palliative care was not yet embedded.

Summary of findings

Background to the service

End of life care in North Somerset was provided by five community based teams. There were four integrated care teams and one urgent and specialist care team which included the end of life care coordination centre team. End of life care was provided by district nurses, support workers and administrative staff who were based in the teams. Care was coordinated by the lead nurse for the end of life care coordination centre, managers of community teams, team coordinators and clinical leads. End of life care was provided for patients who were anticipated to be in the last year of life.

Staff providing end of life care were employed by, North Somerset Partnership Community Interest Company which was formed in 2011. Care was also provided from Clevedon community hospital. We did not inspect the hospital as it was closed for maintenance work.

North Somerset Partnership was commissioned to deliver an end of life and palliative care service for patients over age 18.

The four community teams were based at Weston Town, Worle, Gordano Valley (based in Clevedon) covering towns and high population areas. One team referred to as 'the rurals' was based in the medical centres in Langford and Nailsea and provided services to less populated areas of North Somerset. The care coordination centre service, rapid response teams and teams that operated late night and weekends were located within the urgent and specialist care team. Staff in these teams supported the community teams by providing 'fast track' continuing health care (CHC) assessments, accessing funding and providing additional specialist advice. The team provided specialist advice and urgent care and support for patients

needing care in last few weeks and days. The centre also worked with other community staff involved with end of life care and local authority workers. The end of life care coordination service comprised a lead nurse for the end of life care coordination centre, one full time and two part time band six nurses, seven full time palliative care support workers, one full and two part time administrative workers.

End of life care services were provided Monday to Friday 08.30 to 9pm by the End of life care coordination centre. In addition to care provided by community and district nurses, end of life care was also available provided by a rapid response team and an 'out of hours' team within urgent and specialist care. Rapid response, and out of hours services were provided 24 hours a day, seven days per week. Advice, care and treatment were also provided through GP practices, two local hospices and a specialist cancer nursing service who provided support and advice to patients of North Somerset Partnership.

During the visit we observed care and spoke with one patient and two relatives of people who were or had been receiving end of life care. We also spoke with 19 staff in services providing end of life care. The staff we spoke with were nurses, therapists, managers, support workers and administrative staff in the end of life care coordination centre and in community teams. We also spoke with staff in the services that provided care and treatment after 9pm.

We reviewed 17 records, nine paper and eight electronic care and treatment records of people who used or had used end of life care.

Our inspection team

Our inspection team was led by:

Chair: Graham Nice, Managing Director, independent healthcare management consultancy

Team Leader: Tracey Halladay and Catherine Campbell, Care Quality Commission

For end of life the team included two CQC inspectors and one specialist advisor with a background in care for end of life.

Summary of findings

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of people who used the providers services' experience of care, we asked the following five questions:

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

We did this before visiting by, reviewing a range of information we held about the provider and asked other organisations to share what they knew. We then carried

out an announced visit on 29 and 30 November and 1 and 2 December 2016. We also carried out an unannounced visit with two inspectors 14 December 2016.

During the visit we observed care and spoke with patients and relatives of people receiving care. We also spoke with 19 staff in services providing end of life care, such, nurses, therapists, managers, support workers and administrative staff. We reviewed nine paper and nine electronic care and treatment records of people who used the service.

What people who use the provider say

Patients and relatives we spoke with were very positive when talking about the quality of the care they were or had received.

- People said staff visited and gave nursing care to their partner until they died, "came in as strangers, left as friends".
- Others said staff offered to come back to wash and dress their partner who had died, as the staff washed and dressed the patient, they heard them chatting to the patient as if they were still alive, which moved them.
- One person told us the staff 'were magnificent, so kind, respectful of [my partners] dignity, funny, friendly, amazing at their job....massively supportive' They said the staff made it possible to keep their partner at home to die, which was what the patient wanted.

Outstanding practice

- Some patients relatives were enabled to give care to relatives after assessment and training by end of life care coordination centre team.
- The end of life care coordination centre had established a library of books in each of the eight teams (for example learning disability, community nurses). This had been enabled by money raised by friends of a patient. They covered all children's age ranges who might be affected by a death in their life.
- The end of life care coordination centre were providing staff with 'shadowing' opportunities so that they could work alongside experienced workers in end of life care. This approach was intended to ensure that workers recruited knew what the role entailed and had the right qualities to work in end of life care.

North Somerset Community Partnership Community Interest Company

Community end of life care

Detailed findings from this inspection

Good 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated the safety of end of life care to be good because:

- Incidents were reported and lessons shared with staff and improvements made when things went wrong. Where staff had been involved with medicine errors investigations were thorough including root cause analysis and we saw records of learning shared.
- Patients identified as requiring end of life care had medicines prescribed in advance of requiring them in order to be able to promptly manage changes in pain or other symptoms.
- Patients had care from staff who had specialist training in end of life patient care.
- Risk in the community was managed positively enabling patients to stay in own homes.
- Staff ensured they responded to patients with increased needs. For example the need for a change to medication to manage symptoms at the end of life.

- Staff confirmed the needs of end of life patients and their families were given priority over other routine clinical work. Patients had care from district nurses and care coordination centre staff who had specialist training in end of life and palliative care.

However:

- While we observed inconsistencies between paper and electronic records the impact was less in this service

Safety performance

- Patient safety briefing information was discussed daily for patients at end of life by community and district nurses. We observed a range of staff handovers between community and district nurses, end of life care coordination centre and continuing health care staff. Information covered included skin integrity, potential self neglect and mobility issues.
- The provider had instigated a pressure ulcer prevention plan for 2016/17 and had been using 'Skin Changes at End of Life' guidance since June 2016. Pressure ulcers were monitored. Overall the provider demonstrated a decreasing rate of occurrence and lessening of severity

Are services safe?

of pressure ulcers including at those at end of life. This demonstrated improved and safer care for all patients at risk particularly those at end of life or receiving palliative care.

- From July 2015 to June 2016 there were 46 serious incidents reported of which 85% (39 incidents) were reported by the community adult services. The majority of these incidents (74%) related to the development of grade 3 or 4 pressure ulcers that patients developed while receiving care. The aim of the organisation was to reduce the incidents of grade three pressure ulcers by 30% and grade four pressure ulcers by 50% by March 2017. The overall incidents of pressure ulcers were reduced by 52% for grade three and by 63% for grade four pressure ulcers for the year by March 30 2016 when compared to the number of pressure ulcers from the previous year.
- In the community, the most common serious incident related to end of life care was pressure ulcers. Pressure ulcers were graded based on severity, between one and four, grade four being the most serious. In April 2016 there were seventeen category two pressure ulcers with no grade three or four reported. Actions had been put in place to reduce the risk of end of life patients acquiring an avoidable pressure ulcer. This included the supply of appropriate equipment, improved medicines management, increased staff training and improved risk assessment tools. In September 2016 there were eight category two pressure ulcers reported with no grade three or four reported. This trend demonstrated the organisation was improving the prevention of avoidable pressure ulcers and care.

Incident reporting, learning and improvement

- Incidents were reported, learning was shared with staff and improvements made when things went wrong. We spoke with 19 staff across services providing end of life care. These staff demonstrated a good understanding of their responsibilities and use of systems to report incidents and near misses. Staff were aware of what type of issues to report such as pressure ulcers, falls and medicine errors. We saw examples of reporting from incidents in a patient's home setting including pressure ulcer care and medicine management.
- The provider had six quality priorities for 2016/17, which were developed from a review of incident investigations and complaints. The six quality priorities included a

reduction in pressure ulcers and better end of life care through improved individualised care planning. The priorities were supported with a programme of improved end of life training for registered nurses.

- All relevant staff were involved in incident reviews or investigations. Staff received feedback regarding all incidents they had reported. Incident information which was required to be shared more widely was highlighted during shift handovers and during team and learning event meetings.
- Between April and September 2016 the organisation had shown 100% compliance for reporting Serious Incidents (SI) within 48 working hours. This complied with national guidance (Serious Incident Framework Supporting learning to prevent recurrence NHS England April 2015)
- We reviewed investigations into the two incidents relating to medicines management and saw evidence of comprehensive investigation with shared learning and actions such as better security for medicines being implemented.

Safeguarding

- Staff we spoke with in the end of life care coordination centre understood their responsibilities for safeguarding of adults vulnerable to abuse and demonstrated an understanding of what kind of issues might alert them to consider potential safeguarding issues. Staff told us what they could do to respond to the patient in a safe and supportive manner, were knowledgeable about assessing safeguarding needs for the patient and those around them in the household. They told us they would consider the wellbeing of partners or children when visiting patients in their home. We were given several examples of previous safeguarding practice and one that was ongoing during the inspection.
- Adult safeguard training included modern slavery, female genital mutilation, domestic abuse and self-neglect. Compliance with adult safeguarding training (level two) for the end of life care coordination centre team was 88% against the organisation's target of 90%. Compliance with children's safeguarding training level two was 78% against a target of 90%.
- There was up to date guidance and support available to staff through the intranet. The processes and practices which were essential to keep patients and those close to them safe had been identified and put in place and communicated to all staff.

Are services safe?

- Staff in the end of life care coordination centre team told us that they reported safeguarding concerns to the safeguarding lead and direct to the local authority. The organisation had a safeguarding team that supported staff across the organisation. Leads provided feedback from meetings to staff via email. There was also a weekly newsletter sent from the organisation that the safeguarding leads used to advise staff of important safeguarding information.

Medicines

- Systems, and practices which were essential to manage medicines appropriately across the organisation were in place however they were not always followed. These were communicated to staff through training to support patients at the end of their life and when receiving palliative care. The medicines policy was due for review in September 2017.
- However, we saw an example of where community nurses had cared for patients in their home and the process for accounting for medicines had not been properly followed. Not all community staff were aware of the policy to guide how often the controlled drugs should be counted and signed for. Staff told us that when a patient, who was prescribed controlled drugs, had died the controlled drugs should be counted and signed for by a member of staff and a relative wherever possible. During a review of patient records we found one controlled drug record for a patient who had died where this had not happened, this meant that on that occasion not all controlled drugs in patients home could be accounted for.
- Where staff had been involved with medicine errors, investigations were thorough including root cause analysis and we saw records of learning shared. Two medicines related errors had been recorded including drugs reported as missing from the most recent event September 2016 both were investigated and actions taken.
- We saw medicines stored appropriately in patients' homes and managed by staff according to policy.
- Clear guidance on medicines was available to assess, manage and review a range of end of life symptoms such as anxiety or shortness of breath. Medicine management information was printed on the back of the 'community palliative care drug chart'. This was kept in each patient's care record and enabled staff to have easy access to additional information.
- Medicine audits were being carried out to improve patient care. The end of life care coordination team had been collecting information every month on the number of patients provided with anticipatory medicines. This was to inform better practice and identify and issues regarding the prescription and provision of anticipatory medicines. The audit had not been completed at the time of our inspection.

Environment and equipment

- Most patients were receiving end of life care in their own home. Community nurses told us they had access to equipment such as syringes, sterile packs and wound dressings. Stock was held at the staff bases and collected as required. Staff described that equipment was easy to order and that in most instances there was a same day delivery for standard stock items.
- Nurses confirmed there were enough syringe drivers (a device used to deliver medicines just beneath the skin) in teams to meet patient's needs. Although there were times when equipment had been transferred from other teams to meet local increase in demand. Syringe driver usage was audited and tracked so that staff knew where equipment was and when it needed servicing.
- There were safe processes in place for managing waste and clinical specimens. Sharps bins were taken to patients' homes and we observed district nurses safely disposing of used sharps equipment. Staff carried clinical waste bags in their car boot to enable safe segregation of waste but did not transport waste in their cars. When staff obtained samples such as blood tests from patients, these were transported in plastic boxes with a lid to the GP surgery where they would be sent for testing.
- Staff were able to order specialist equipment such as hoists and beds which was delivered quickly and often on the same day. Allied healthcare professionals visited patients and their carers to provide training in the safe use of the equipment on the day of delivery. On one visit we observed additional equipment needed put in place immediately to aid skin care

Quality of records

- Patients' individual care records for care in the last year of life were not always written and managed in a way that protected people from harm. Improvements were required to patient's records. We reviewed nine paper and eight electronic care and treatment records of

Are services safe?

people who used the service. Whilst we observed inconsistencies between paper and electronic records the impact was less in this service than in community adults as a whole.

- The issues were noted on the organisations risk register (30 November 2016). The issues included inconsistencies in the way patients notes in general were recorded on the paper and electronic system as well as the ability of staff to complete records of interventions in a timely way on the same day as seeing a patient.
- The organisation was in the process of introducing electronic care records but staff had experienced difficulties in being able to connect remotely to the electronic systems used by the organisation. This meant that the majority of patient records were paper-based and stored in the patient's home and staff were using a mix of paper and electronic recording. Community based staff completed contemporaneous paper-based records in the patient's homes, they were legible and staff signed and dated entries. Staff then completed electronic patient records when they returned to the office or the next day if completing visits meant that they did not have time to return to the office to complete records.
- Specialist services such as the end of life care coordination centre completed patient records using the electronic system. However clinical leads documented care interventions in the paper-based care records at the time of visiting a patient and a more comprehensive documentation was logged on the electronic patient record later. The variations in recording and timeliness of information being available on both paper and electronic records meant we were not assured that all electronic patient records were contemporaneous and up-to-date for patients supported by community teams. This could be a risk to the management of end of life patient care for those in their last year of life. If nurses were called out in the evening or overnight, they may not have access to up-to-date electronic records of patient visits until they arrived at the patient's home.
- We reviewed one record of a patient being supported by district nurses and the end of life care coordination centre, eight paper records (nine paper records) of recently deceased patients and eight electronic records of patients receiving care through the care coordination centre. Information was either in paper or electronic records but not always on both.
- During the announced inspection we saw electronic records that were compliant with policy for screening patients in last few hours or days supported by the end of life care coordination centre.
- Patient records in the care coordination centre were compliant with policy.
- We saw evidence in most paper records and all electronic records we reviewed that end of life care documentation met national guidance in specific areas. For example they included records of; discussion of the dying person's wishes with other members of the care in the record of care of the patient at the end of life. (National Institute for Health and Care excellence NG 31 December 2015). Where this had not taken place it was not clear if the conversation was not appropriate at the stage we reviewed which would account for the gap or patients deterioration had been too rapid for all conversations to take place. This sometimes occurred when patients transferred from acute trusts to community settings.
- We saw evidence in most paper records and all electronic records we reviewed that met national guidance concerning discussion about cardio pulmonary resuscitation.(Treatment and care towards the end of life: good practice in decision-making', General Medical Council, 2010)
- Six of the eight patient records we reviewed had a treatment escalation plan (TEP) form in place. Two of the eight did not have all of the information completed in the form although the information was recorded elsewhere in patient notes.
- The end of life care coordination centre collected information relating to whether do not attempt cardio pulmonary resuscitation or DNACPR were in place when patients were referred to them. The information collected April to November 2016 identified 337 patients being supported by the care coordination centre, of these, 113 (34%), did not have a DNACPR in place or recorded in other care records when they were referred. TEP and DNACPR completion was part of clinical audit. The forms were stored at the front of the patient held paper-records so as to be easily accessible to inform

Are services safe?

staff of decisions about treatment in an emergency. The missing information on the form could lead to inappropriate action by staff causing emotional stress for patients and those close to them.

- Although the referral figures showed 34% did not have a DNACPR in place, we were told that all of the patients without this in place were offered a conversation to discuss with the relevant professional GP, hospice or acute trust. Patient choice was noted and implications were discussed.
- Staff told us that when patients had died, they collected the paper-based records and stored these securely in the locality offices in locked filing cabinets. Electronic and paper records we reviewed were stored securely by the organisation in the bases and on the electronic systems with password protection.

Cleanliness, infection control and hygiene

- Staff followed processes and policies that protected patients at end of life and receiving palliative care from healthcare associated infections. We saw that standards of cleanliness and hygiene were maintained through compliance with policies. Staff used aprons, antiseptic hand gels and disposable gloves. They also used sterile packs and appropriate techniques and personal protective clothing before providing any patient treatment or care.
- We observed community nurses who provided end of life care wash their hands and use antiseptic hand gels before and after providing any patient care. Antiseptic hand gels were also used in between patient visits.
- Procedures were in place and followed by community nursing teams to minimise infection control risks if there were any relevant issues related to a patient death in their own home. This included notifying the coroner if the patient had a notifiable disease.
- However, there was not a robust system in place for auditing compliance with hand hygiene across the adult services as some teams did not submit data for the annual audit and some submitted incomplete returns. For example only returning hand hygiene and not results for when carrying out wound dressing or practice to reduce or prevent infection (asepsis).
- Gordano Valley returned data for asepsis (100%), and hand hygiene (100%).
- Weston returned data for hand hygiene (98%) only.
- Due to recent staff and operational change, the end of life care coordination team had been unable to provide

audit data for infection prevention and control for a recent report to the provider board meeting 1 October 2016. However, there was a plan to include the information in the action plan for end of life and palliative care for 2016/17.

Mandatory training

- The end of life care coordination centre staff were trained in the safety systems, processes and practices and attended a range of mandatory training every year. Some mandatory training was face-to-face training while other training could be accessed electronically.
- Not all mandatory training was within targets. Although in a small team two people not achieving would give a below target result.
- The organisation introduced pain awareness as mandatory training for all staff in April 2016, which required a once only attendance and completion. At the time of our inspection, compliance for end of life care coordination centre team was 22% against a target of 85% (two staff completing the training of nine eligible). However, it was recognised there were still three months left for staff to complete this training.
- 12 care coordination centre staff had achieved the targets with some of their mandatory training, for example; 91% for manual handling, safeguarding children level 2, safeguarding adults level 2 and Mental capacity act 2005 and deprivation of liberty safeguards and 100% for pressure ulcer awareness.
- However, some other mandatory training rates had not been achieved; for example 71% for infection control, equality and diversity and health and safety and 65% for fire safety.

Assessing and responding to patient risk

- Risk was often recorded in the risk assessment plans in the paper records and always on an electronic system for patients in the last few days and hours by the end of life care coordination team. The electronic information was able to be quickly accessed by all staff. The electronic information was also available to GPs and was shared verbally with other organisations such as the ambulance service when appropriate.
- For patients at end of life in last few hours or days risks were assessed and regularly reviewed. This included

Are services safe?

deterioration in health and well-being and any medical emergencies. Out of hours patient's risk assessments were reviewed by the community rapid response and out of hours teams.

- We reviewed eight electronic records from the end of life care coordination centre team and saw that patients had risk assessments completed and appropriate actions put in place. Risks on the electronic system were available to GPs and the providers out of hours team. Risks assessed included: pressure care, nutrition and hydration, infection risks and adverse effects from medicines. Patient risks were reassessed during each contact, but the paper care plans were not always updated accordingly.
- We observed during shift handovers how staff worked flexibly to prioritise patients whose needs had become urgent. This included how care was planned between 08.30 to 9pm and during out of hours. Staff ensured patients identified as having increased needs were promptly responded to. End of life care coordination staff and community nurses confirmed the needs of end of life patients and their families were given priority over other routine clinical work. We saw and heard examples of this when we visited and spoke with staff including face to face meetings, telephone messaging and via electronic records. For example: patients with the need for a change to medicines or for more effective management of symptoms or the provision of a syringe driver
- Risks in the community were managed positively. We were told of patients with the mental capacity to make decisions who had decided to accept risk that could have been reduced in order to maintain their choice and independence. This included not complying with advice on treatment to continue lifestyles that may not have been supporting optimum health and well being.
- Each day the community nurse teams discussed patient treatment, risk and care needs. This ensured end of life patient care was as consistent and safe as possible. Specialist end of life and palliative care and medical advice for symptom control was available 24 hours, seven days a week. This was from nurses in the end of life care coordination centre, link nurses and clinical leads in community care teams, out of hours teams, hospices and GPs.
- We observed information boards in locality bases which displayed essential information that supported the

management of risk for patients who needed end of life care. This included information related to safeguarding, pressure area care, medication and visits that might require two staff at a time to attend. We saw the safety information was referred to during staff shift handovers. The four community teams worked with and shared information appropriately with GP practices and medical centres.

- Patients screened to be at high risk of malnutrition could be referred to the providers community dietitians to improve their nutritional status and quality of life, and reduce their risk of infection, falls, pressure ulcers, and hospital admissions.

Staffing levels and caseload

- There were sufficient staff numbers within the end of life care coordination centre team to ensure that patients were protected from harm. The care coordination centre team comprised one full time band seven lead nurse for the end of life care coordination centre providing clinical, strategic and operational leadership for end of life and palliative care. The team consisted of, three band six nurse (one full time, one 30 hours and one 16 hours) managing continuing health care, seven band two palliative care support workers or PCSW (full time) and three administration staff (one full time, one 36 hours, one 15 hours). The vacancy rate for the PCSW in the end of life care coordination centre team was 1.8 whole time equivalent.
- The lead for end of life was in the process of seeking a rebanding for the 1.8 PCSW vacancy. The palliative care support workers were considered to be working above their current band within the end of life care team. There were also plans to assess the match between team size and skill level and demand.
- The arrangements for using bank, and agency staff within the end of life care coordination centre protected patients from harm.
- There were 69 requests for staff from the internal bank to provide end of life care 1 July 2016 to 20 January 2017. Over half the requests were met (overall 62%).
 - Seven of the eight requests were met for band six staff (87%)
 - Three of the five requests were met for band three staff (60%)
 - Thirty-three of 56 were met (59%) for band two staff.
- Within the team the lead had developed a shadowing system where workers from the internal bank could try

Are services safe?

working shifts caring for patients at end of life. This built in experience for bank workers and if they were suitable they could be offered an opportunity to apply for any upcoming vacancies. The experience had improved the filling of shifts from the bank for band two and three staff.

- There was one end of life link registered professional in each locality team who worked with a clinical or associate clinical lead to support the work of district nurse and other professionals involved with end of life care. This ensured that patients had care from staff who had specialist training in end of life patient care.
- The community teams calculated local caseloads for patients at end of life by using an end of life 'Gold Standard Framework Board' system. This was a board kept within each office, which staff referred to at shift start and handover and enabled the teams to be aware of how many and what type of condition needed support that day.
- The organisation reported a sickness rate of 4.47%, which meant they were within their target of less than 4.5% of their workforce being off sick.

Managing anticipated risks

- Staff we spoke with demonstrated a clear understanding of the organisation's lone working policy which was accessible on the intranet. They ensured colleagues knew where they were intending to go and regularly contacted each other to provide updates.
- Patients' individual care plans included risk assessments and action plans associated with pets and other worker safety issues. Electronic recording systems recorded alerts, for example the need for two staff to visit, if there were safeguarding issues, or there was a key safe for access.
- Risks to the service were anticipated and planned for in advance. Winter and other system pressures were continually monitored by senior staff home visits were reallocated as necessary to other teams to ensure end of life patients were visited.

Major incident awareness and training

- There were arrangements in place to respond to emergencies and major incidents. The organisation had a business continuity plan to maintain business as usual where possible. The plan was available to all staff on the intranet. Locality team managers, were knowledgeable about the escalation plan.

Are services effective?

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

Summary

We rated the effectiveness of end of life care to be good because:

- Pain and symptom relief was prioritised for patients receiving end of life treatment and care. Anticipatory or 'just in case' medicines to manage symptoms such as pain and nausea were prescribed and stored in patients' homes so they were readily available when required
- Specialist end of life and palliative care advice for symptom control was available 24 hours, seven days a week. This was available from nurses at the end of life care coordination centre, link nurses, clinical leads and through local hospices and GPs.
- The end of life and palliative care planned for patients was based on the six national ambitions published by the National Palliative and End of Life Care Partnership, (2015). The outcomes were also based on achieving the five priorities of good end of life care Leadership Alliance for the Care of Dying People, (2014)
- Staff in the community teams had appropriate qualifications, skills, knowledge and experience to deliver care and support to end of life patients. This included district nurses, end of life and palliative care link professionals, and clinical and associate clinical leads.
- Staff demonstrated that end of life care was 'everybody's' business. This supported an understanding that good end of life and palliative care in the community could not be provided without meaningful partnership working with others.
- Assessments and action plans were completed quickly and passed to the care coordination centre. Equipment and care packages to support patients at home and discharge from hospital were put in place promptly through a 'fast track' (Continuing Health Care) system for end of life patients.

- Staff we spoke with understood consent and decision-making requirements of the Mental Capacity Act (2005) code of practice. Patients who did lack mental capacity for decision-making were supported by staff in making best interest decisions in accordance with legislation.

However

- Not all patients supported by the community teams receiving end of life and palliative care in last year of life had nutrition screens completed. This was determined on staff professional discretion. There did not appear to be a uniform statement recorded in the notes or records to this effect.

Evidence based care and treatment

- The organisation used relevant and up-to-date guidelines to ensure evidence-based care was followed for end of life care. There was a process of ensuring all standard operating procedures were more clearly supported by National Institute for Health and Care Excellence guidelines (NICE). At the point of our inspection, practices were being benchmarked against current NICE guidelines. This was part of a planned audit programme and there was a clear plan in place for these changes to happen.
- Staff demonstrated in practice how they supported end of life care for patients and those people close to them with evidence based treatment and care. For example following the guidance, six national ambitions for end of life care (2015). The guidance supported patients to receive individual care, access should be fair, coordinated and equal, it should maximise comfort and wellbeing, with educated and supported staff and communities. We saw examples of this in patient records and practice we observed.
- The service also delivered care based on achieving the five priorities of good end of life care (Leadership Alliance for the Care of Dying People 2014). This included: recognising dying, communicating about dying, the person and those close to them being involved, and exploration of what is important those around the dying person and an individual plan of care agreed and coordinated delivered with compassion.



Are services effective?

- The end of life care provided was informed by some of the quality statements in the National Institute for Health and Care Excellence (NICE) QS13 End of Life Care for Adults, for example QS3 assessment, care planning and review, QS15 workforce training, QS13 verification and certification.
- We requested data to support compliance with NICE CG140 Opioids in palliative care but we did not receive data with relevant dates so we could not assess compliance.
- Standards were monitored to ensure compliance through supervision, team meetings, learning events and appraisal. This was done by the end of life lead, clinical leads, end of life link professionals and community team managers. We saw action plans in place to address issues where the organisation was not able to fully implement guidance. For example where patients could not die in their preferred place of care. However this aspect was not entirely within the organisations control.
- Some GP practices held Gold Standard Framework (GSF, Royal College of General Practitioner, 2011) meetings and registers. The Gold Standard Framework supports the delivery of end of life care through processes such as advance care planning. The aim is to improve the quality of care, coordination and patient outcomes through improving knowledge skills and attitudes. Community and district nurses and end of life care coordination centre staff and other professionals attended these meetings. However some organisations said that community nurses were not always able to attend due to pressure of other work. We saw GSF notice boards in some of the district nurses' base rooms. These showed at a glance where patients were during their treatment and what support was in place or was required to be set up.
- At surgeries where Gold Standard Framework meetings were not held, district nurses attended other multidisciplinary meetings to help identify patients approaching end of life care needs.
- The service avoided discrimination on the grounds of age or disability when making care and treatment decisions. We spoke with 19 staff. They demonstrated they understood end of life care was focused on the approximate last 12 months of a person's life and was not just about cancer but was also related to any illness or condition that limited a person's life.

Pain relief

- Pain and symptom relief was prioritised for patients receiving treatment and care at end of life. Anticipatory or 'just in case' medicines to manage symptoms and pain was prescribed for end of life patients and stored in their homes. This ensured medicines were readily available when required.
- Staff were trained to use syringe drivers for administering medicines to alleviate symptoms at end of life and for palliative care. This included medication to manage pain, nausea and vomiting.
- The end of life care coordination service had started using a pain score tool that had been developed for use for assessment of pain in people living with dementia, learning disabilities and patients who did not communicate verbally at end of life. This provided more uniform pain assessment and enabled staff to communicate patients needs better.
- Pain and other symptoms were managed and reviewed during each contact and documented in care records. We saw patients were encouraged to describe and rate their pain and symptoms and where appropriate those people close to the patient were also asked their opinions. The patient's GP or specialist was referred to for pain and symptom control when required, and this was documented in electronic and paper records. When required, the district nurses completed joint visits with other specialist nurses to review complex pain and symptom control.
- Specialist end of life and palliative care advice for symptom control was available 24 hours, seven days a week. This was from nurses in the end of life care coordination centre, link nurses and clinical leads in community care teams, hospices and GPs.
- During the unannounced part of the inspection we spoke with one patient about their experience of receiving end of life care and they said that pain and nausea were well managed.

Nutrition and hydration

- Not all patients supported by the community teams receiving end of life and palliative care in last year of life had nutrition screens completed. Not all paper records showed appropriate nutrition and hydration assessments were completed in line with the policy. The providers Nutrition and Hydration Policy required all

Are services effective?

adult patients to be screened for malnutrition using the Malnutrition Universal Screening Tool (MUST) on admission to a caseload for each new episode of care within the service.

- Discussions at the nutrition link nurse meeting (19 October 2016) where the minutes recorded there was low compliance with MUST score entered on the electronic patient records. Also there was no evidence that compliance with MUST screening for patients new to the caseload or a repeat care episode was monitored. Staff had identified the recording of MUST assessments on the electronic patient records was variable with only 68% compliance.
- Minutes of Palliative Care Link Nurse Group Meeting held 15 November 2016 recorded that for patients referred in the last days of life, there was no need to carry out full assessment but, recommended complete skin assessment and other risk assessment and combine with the tool used to record patient information at end of life.
- When we requested confirmation about the process we were told there were exceptions made, but they were not currently formalised within the Nutrition and Hydration Policy. This was being addressed by the dietician and specialist services staff. This situation had led to the inconsistent recording.
- Record-keeping had changed as a result of community record keeping audit but still required improvements. During the unannounced visit we reviewed nine patient records for patients at end of life. One of the nine did not have the required assessments such as malnutrition universal screening tool (MUST) a tool used to assess patient's risks of malnutrition. This could pose a risk to those patient's care as potential risks had been missed, or not recorded.
- Staff we spoke with explained that they used professional discretion and that it was sometimes inappropriate to assess using the MUST tool as it caused relatives caring for those at end of life additional stress about the patient eating and drinking when they did not want to. There did not appear to be a uniform statement recorded in the notes or records to this effect.
- There were plans for January 2017 when the providers statutory and mandatory training programme would include a 90 minute training session for all existing staff and new starters on Malnutrition screening, awareness,

and management. This was planned to increase awareness of the need to carry out screening, and confidence to screen patients accurately and provide some basic nutrition advice where appropriate.

Patient outcomes

- Outcomes for patients receiving end of life care and treatment were monitored.
- Supporting end of life patients to be in their preferred place of care is part of national strategy (DH, 2008, Leadership Alliance for the Care of Dying People, 2014). Difficulties in sourcing care to support patients at home or in their place of choice was the main reason that some patients died in places not of their choosing. This was monitored by the service and reported back to the clinical commissioning group to inform planning for care for the future. Figures were available for patients referred to the end of life care coordination centre who were in their last few days or hours. The information already collected showed that some of the intended outcomes were being achieved for patients at end of life in last few hours or days of care. For example for all but one month from April 2016 to October 2016 between 25% and 69% of patients referred for end of life care had received care in their home. In October 88% of patients died in their preferred place. However other months figures were lower (39% in June 2016). Figures were often influenced by availability of care, speed of referral or quality of discharge planning by other organisations.
- Staff were able to tell us how some outcomes had improved for patients over the last 12 months e.g. Continuing Healthcare Care application and agreement for patients at end of life had increased significantly which meant that patients had access to better support and funding. The continuing health care referral acceptance rate had improved from period October – December 2015 to period July -September 2016. Patient numbers were 54, 84, 111, 93.
- The majority of audits for end of life and palliative care were planned for completion during 2017. The strategic and operational lead for end of life had begun collating performance and outcome information for the first annual report for end of life care due to be published April 2017. The end of life care coordination centre had been collecting 49 individual lines of outcomes data. For example 'number of patients who have had contact with the care coordination centre achieving their preferred place of care' and 'number of packages of care that were



Are services effective?

unable to be supported by the coordination centre'. Some of this information was being collected and monitored to report to the local clinical commissioning group. Due to this starting only recently they were unable to provide comprehensive figures with how outcomes compared with other services or information relating to patients in their last year of life.

- Staff in the community teams were aware of the type of conditions that were categorised as 'end of life'. However it was not possible during the inspection to accurately measure the total number patients who were in their last year of life which would assist in managing community and district nurse case load as there was no central record.

Competent staff

- The lead nurse for the end of life care coordination centre had joined the organisation in May 2015. They had the appropriate qualifications, skills and knowledge to lead the end of life and palliative care service with the additional support available from the lead nurse for managed care when required.
- Levels of qualification to provide end of life care in the end of life care coordination centre included;
 - Six 'generic support workers' called palliative support workers who had completed assistance level certificates in end of life care.
 - Four registered nurses had attained the practice level in end of life care.
- Staff in the community providing end of life care also had appropriate qualifications, skills, knowledge and experience to deliver end of life care and support. For example In the last 12 months
 - Six nurses had completed a level 3 Diploma end of life care course at a local university. Four nurses were planned to commence the January 2017 intake of this course.
 - One nurse had an advanced degree in palliative care (Masters of Science Palliative qualification)
- There were 28 end of life link nurses in various team including the learning disability team and one occupational therapist who provided and end of life link role. End of life link staff supported practice of others in the teams.
- At the end of September 2016 89 Clevedon Hospital and Community team staff had been trained to use syringe drivers out of total 121 eligible staff needing to train (73% attainment).
- Community and district nurse and other staff's learning needs for end of life care had been identified and positively responded to. For example
 - 45 band two to four staff, 38 allied health professionals, 99 registered nurses (band five and above) had completed a course on pain management. Evaluations showed that staff found the course enabled them to understand pain management better.
 - Thirty-one registered nurses had completed verification of death training. Evaluations showed that it enabled them to know when to notify coroners and how to complete records better.
 - A senior manager had completed a course on compassionate care with a better understanding of empathy in end of life care.
 - The health care support workers based with the district nursing teams were encouraged and supported to attend an end of life training course.
- The organisation had a quality priority to become a dementia friendly organisation, which included dementia training for all staff. At the time of our inspection dementia training compliance exceeded the organisation's target of 85% with more than 97% of staff in community adult nursing teams and urgent and specialist care teams having completed the training. The end of life care coordination centre had achieved 93%.
- There were records of appropriate induction for the staff in the end of life care coordination team.
- The organisation operated a system whereby appraisals occurred during the first three months of the financial year (April -June). Compliance with this was generally high; records showed staff in end of life care coordination centre had achieved 86% against an organisational target 95%. The goals set in appraisals had an emphasis on personal and service development. We reviewed appraisal records and saw discussions around these occurred at regular supervisions throughout the year.
- Staff records demonstrated regular supervision had taken place in line with policy. Staff said they benefitted from regular formal supervisions and had the opportunity to discuss particular concerns at any point without having to wait for pre-arranged supervision. We observed staff being able to engage with the end of life lead in impromptu supervision when staff had been involved with particularly stressful or upsetting work. We

Are services effective?

also saw records where staff performance that did not support the organisation's values and aims was identified and managed and staff were supported to improve.

- However, training was an item on the risk register as the service felt there were not enough staff with all the skills needed to provide the optimum end of life care. For example; more staff able to carry out verification of death and use syringe drivers were needed. New staff were supervised until they were assessed as competent and confident to use syringe drivers independently with patients.

Multi-disciplinary working and coordinated care pathways

- Multidisciplinary working in order to coordinate patients' treatment and care was integral to end of life care practice. Staff, including those in different teams and services were involved in assessing and planning care for patients who used the service. This included work with other professionals or services external to the organisation for example hospice and acute trust staff. This was evident in patients' electronic records, and through discussions with staff and direct observations.
- Patients receiving end of life care assessed as requiring fast track treatment and care were supported through the end of life care coordination centre and the continuing health care nurse team. The role of the coordination centre team was to arrange rapid access to care and support directly with internal and external services. We observed how individual care packages of support were organised for patients based on individual needs. The coordination service acted as a link between the patient and their family, professionals and agencies. We saw staff liaise with senior managers, the clinical commissioning group, continuing health care staff and other providers to arrange and review care. This was to ensure the services provided were timely, appropriate and dealt directly with any issues or concerns. Staff told us that when a patient's care package had been sourced they kept this under review to be reassessed if needs changed. We saw electronic records of this.
- Community staff demonstrated that end of life care was 'everybody's' business. This supported a thorough understanding that good end of life and palliative care

in the community could not be provided without meaningful partnership working with others. Hospice staff spoke highly of the joint work with the end of life care coordination centre and of the community teams.

- We saw an example of multi-disciplinary working with other providers in a meeting at a hospice, staff worked with hospice staff to assess and plan ongoing care and treatment in a timely way when patients moved between teams or services. However nurses were not always able to attend all hospice meetings.
- We spoke with other professionals involved in end of life care. This included GPs and consultants, allied health professionals, hospital and hospice staff, care agencies and pharmacists. They told us that North Somerset Community Partnership staff had positive relationships with other professionals and services. Although access to care packages seemed to be an issue for delaying care at home.

Referral, transfer, discharge and transition

- The end of life care coordination team had received a relatively consistent rate of continuing health care referrals of between 41 to 58 a month between November 2015 October 2016 (total 596). They had also received
 - 4898 face to face contacts
 - 6700 contacts by telephone
 - The centre had enabled 150 patients avoid admission to hospital or helped in their discharge through provision of equipment.
- We observed staff in the end of life care coordination team accepting referrals that involved continuing health care assessment and application for funding. Care packages were organised to enable patients to be safely transferred between services or to home. Communication between the teams in the end of life care coordination centre, the 'CHC nurse' and the clinical commissioning group was good.
- Community and district nurses also supported patients in the last few hours of days of their life who chose to receive care at home. Staff confirmed that sometimes a lack of care agency staff (external provider) could delay the start of a patient's care package, and this was particularly problematic during holiday season and within rural areas. The care coordination centre team in conjunction with North Somerset Clinical Commissioning Group had restructured some finances so that they had flexibility built in to care provision (up

Are services effective?

to 107 hours of palliative care support worker time over a week). This and the community nursing teams, working in partnership with local hospices and other providers were able to fill some gaps in care until care packages could be sourced.

- Data showed that some patients were not always able to access care at the time needed. For the period April 2016 to October 2016 the care coordination centre received 62 referrals with 28 having care provided but 34 were unable to be supported. Other agencies such as hospice had noted this as a potential issue but were aware this was not always within the providers control as care was often sourced from external agencies or funders. For the period April 2016 to October 2016 out of 210 referrals to external agency seven patients died before care was available from external providers.

Access to information

- Information needed to plan care was available to relevant staff in the care coordination centre in a timely and accessible way.
- There were difficulties in connecting to electronic records from mobile electronic devices for mobile working which meant that electronic patient records were not always up-to-date. This meant that in the event of an unexpected referral to the rapid response team out of hours, staff could not access up-to-date information about patients needs before attending.
- There were clear processes for staff to communicate between teams and when referring patients to other teams or services including GPs. The electronic patient records allowed staff to share information about

patients with GPs. It also allowed staff to access information about medication and blood test results, which meant that they were able to explain these to patients if required.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff we spoke with understood the relevant consent and decision-making requirements of the Mental Capacity Act 2005 and code of practice. Patient's consent to care and treatment was sought in line with Mental Capacity Act 2005 legislation and guidance. Patients who lacked capacity for decision-making were supported by staff and best interest decisions were made when required in accordance with legislation.
- Staff told us consent was requested before treatment and care was provided, and documented in patients' care records. Patients and relatives told us staff always explained what they wanted to do and asked for permission before proceeding. We observed this in practice and staff checked if patients understood or had any questions.
- Records documenting consent in the care coordination centre were compliant with guidance, one record of the nine we reviewed in the locality teams did not have a record of a capacity assessment.
- There was a policy to support staff with issues relating to deprivation of liberties safeguards (DOLS). Staff understood what DOLS meant and that they needed to be aware of this when visiting patients in care homes. Staff stated they would seek advice from managers if they had any concerns about a patients circumstances that might amount to them being deprived of their liberty unlawfully.

Are services caring?

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

Summary

We rated caring in end of life care to be good because:

- Patients and relatives spoke positively about the care they received.
- We observed respectful, dignified and compassionate communication between staff, patients and relatives.
- Staff providing end of life care were highly regarded by relatives of deceased patients for their kindness, caring and compassionate attitude.
- Staff offered emotional support to patients and relatives to enable them to cope with their care, treatment and death.

Compassionate care

- We attended several meetings and listened to staff handovers where patients care was discussed in a compassionate, dignified and respectful manner. Discussion in meetings was patient-centred, with staff often referring to 'what does the patient want'.
- We visited a patients' home to observe staff working with patients who were receiving end of life care and staff were compassionate and respectful when they spoke and when they delivered care.
- Staff respected people's privacy and dignity during physical or intimate care which was usually delivered in their own home or a care home. We spoke to a recently bereaved relative who had provided care for their partner at home. They told us the staff providing care had talked with their relative at every stage of care. The relative said, "There were lots of tears and laughter" with staff. The relative told us of a conversation they had with care co-ordination staff who organised equipment for their partner and for them, they had been given "anything I wanted". The staff were very compassionate and provided numbers to contact occupational and physiotherapy services to enable their partner to die at home which was their preferred place of death. The relative said staff visited and gave nursing care to their partner until they died, "came in as strangers, left as friends".
- We heard how staff cared for the body of a person who had died, in a sensitive and dignified manner. A relative told us staff offered to come back when their partner died to wash and dress them, as they had cared for the

patient for a long time. As the staff washed and dressed the patient, the partner heard them chatting to the patient as if they were still alive, which moved them. Often staff attended funerals of patients they cared for.

- Information in the friends and family test results patient experience surveys said in 2015/16 98.5% (5992 of 6086) patients returned the survey and said that they were treated with dignity and respect.

Understanding and involvement of patients and those close to them

- The service organised relevant equipment and the district nurse visited and organised care to meet the patient's needs and wishes. The relative told us the staff 'were magnificent, so kind, respectful of [my partners] dignity, funny, friendly, amazing at their job....massively supportive' The relative said the staff made it possible to keep their partner at home to die, which was what the patient wanted.
- Staff ensured sensitive communication took place between staff and the dying person. A relative we spoke to told us their partner was offered day care at a local hospice but declined, as they wanted to stay in their own home. The relative felt this was handled sensitively and knew they could ask for more should they have needed it.
- We also spoke with a patient who did not require immediate help but said they knew care would be arranged as soon as needed and this was reassuring.
- Staff understood the impact of care, treatment or the condition had on patients' wellbeing and on those people close to them, both emotionally and socially. The end of life lead had established a 'lending library' of books available for patients and relatives. Patients and relatives could keep the books if they wished. Staff gave an example of how this library service had helped a patient with a young family, who was struggling to talk with their children about the illness. The library provided them with a copy of a book that enabled them to talk with their children and prepare them for their death.
- Information in the friends and family test results patient experience surveys said 98.1% of 5736 patients would recommend the provider (2016 to date), up from 97%.

Are services caring?

- The fast-track nurse provided further information about their care and treatment and practical help to enable understanding and involvement of patients and relatives.

Emotional support

- Care provided to people at the end of life met the psychological needs of people receiving care and those close to them. A relative gave us an example of where the staff rang and said they had some time free and asked would the patient like some company. This provided the relative with a much-needed break. The relative told us they were very touched by this 'little act of thoughtfulness'.
- Relatives and carers received appropriate and timely support and information to cope emotionally with their care, treatment or condition. We spoke to two recently bereaved relatives about their experience of emotional support they received from staff providing care at end of life. One relative told us they felt they could ask staff anything and if they did not know, they would find out.
- District nurses completed a post bereavement visit to relatives about a week after death. A district nurse we spoke to said the removal of equipment and nursing notes from the patients had to be done with sensitivity and compassion in the post bereavement visit. They also left a contact number with the bereaved relatives for them to discuss any concerns or just to provide a way to speak to someone.

Are services responsive to people's needs?

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

Summary

We rated responsiveness of end of life care to be good because:

- The care coordination centre and community services planned and delivered services to meet needs. There was coordination with other local end of life care services including hospices, acute trusts and a national provider of cancer nurse services. The organisation worked with the clinical commissioning group to ensure the services met the needs of the local population as far as possible.
 - There were arrangements so that patients had the equipment they needed in place to support care and treatment should they wish to die at home.
 - Where people's needs were not being met this was identified and used to inform further service planning and development.
 - Services took account of the needs of individual patients and staff spoke about the importance of not being judgemental in the way they cared for patients. Staff spoke of respecting people's choices as to their way of living.
 - Care was provided 24 hours a day, seven days per week and there was access to end of life and palliative care advice at any time of the day or night.
 - Staff were trained to be able to verify an expected death of a patient in a community setting.
 - Staff listened to and improved the service because of concerns and complaints. The provider had identified the gaps in the service the complaint had brought to light and actions were taken to improve the service. Patients and those close to them who used the service knew how to make a complaint or raise a concern, their concerns and complaints were listened and responded to.
- with other local end of life care services including local hospices, acute trusts and a national provider of cancer nurse services. Commissioners and other stakeholders were involved in planning services.
- The services provided reflected the needs of patients and those close to them who were referred to the care coordination centre and the community nurse teams. They ensured flexibility of choice and continuity of care wherever possible.
 - There were arrangements so that patients had the equipment they needed in place to support care and treatment should they wish to die at home. Although carers were not always available to ensure patients could be cared for at home. Where people's needs were not being met this was identified and used to inform further service planning and development. Information was being collected and used about patients needs to inform the planning and delivery and development of services so that more patients could die in their preferred place of care. Planning included
 - Increased take up of end of life care training
 - Improved use of end of life specific care plans
 - Community staff rotation to experience more end of life care
 - Improved engagement with GP practice that did not have gold standards framework meetings
 - Improver links with acute trusts for discharge planning work
 - End of life care coordination centre team capacity review
 - We saw reports that were sent to commissioners about activity such as referrals for continuing health care and numbers of patients who had died before care was made available or put in place.
 - The strategic and locality leads had identified local challenges, such as increased availability of palliative care support workers and better education for the provider as a whole for end of life care. We were shown action plans and team reports, which took account of the challenges both within and outside of the service. These documents had been reported to the executive
- Planning and delivering services which meet people's needs**
- The end of life care coordination centre and community services planned and delivered services to meet the needs of the local population. There was coordination

Are services responsive to people's needs?

team and shared within clinical teams. The action plans enabled the service, to understand the challenges and the changes needed and supported monitoring of progress.

- The end of life care lead attended regional strategic meetings to inform the development of services in the region.
- We spoke to a palliative care link nurse, who told us that patients usually arranged for their own religious or spiritual needs to be met, such as chaplaincy or imam visits. District nurses were aware of patients' different beliefs as they may have affected treatment options.
- Staff recognised when people who used services and those close to them needed additional support to help them understand and be involved in their care and treatment and enabled them to access this. For example; one patient who had few care needs during the day, needed more support at night, due to anxiety. The fast-track nurse assessor in partnership with care funded by the local clinical commissioning group worked to provide 'sleep in care' five nights a week for the patient and their carers which lessened the patients and the carers anxiety.

Equality and diversity

- Services took account of the needs of individual patients and staff spoke about the importance of not being judgemental in the way they cared for patients. Staff spoke of respecting people's choices as to their way of living. We saw this when staff were discussing patients needs in meetings. In the night service, we saw visits prioritised to take account of the whole person including their social situation including the needs of their relatives and carers rather than just 'did the person need a syringe driver' or what medication might be needed.
- Staff we spoke with knew how to report concerns about disrespectful, discriminatory or abusive behaviour or attitudes through the providers electronic incident reporting system. Staff we spoke with about end of life care had not encountered any incidents of this type to report. Advocacy services were available through the Patient advice and liaison service, for people 18 or above, those with disabilities or physical or sensory impairment. This information was provided by end of life care coordination team in their written information.

Meeting the needs of people in vulnerable circumstances

- Services were delivered in people's homes wherever possible and staff gave advice about aids to mobility to enable patients to stay at home.
- Services took account of the needs of different people including those in vulnerable circumstances. Some patients receiving end of life care choose not to comply with their treatment and this increased the risk of avoidable pressure ulcers. The tissue viability service had developed a protocol, which described the processes staff should follow if patients chose not to comply with their recommended treatment plans. This gave community nurses a structure on which to base their own decisions and advise patients. The protocol also enabled staff to record and respect the decisions of their patients.
- Referrals for end of life care in the community were accepted by either the end of life care coordination centre or the community nursing teams regardless of the person's age, life limiting condition, beliefs or any personal circumstances.
- The community teams worked in a responsive manner. Nurses told us if they needed to spend additional time with patients or their families who were at end of life, their planned work was often shared between, and completed by others within their team. Although sharing between teams was not as common.
- Staff showed an understanding of patients' support networks and packages of care were arranged to assist patients based on individual needs. We saw this documented in care records. There were examples where carers had asked that they support their partners both of whom were considered potentially vulnerable adults and teams had worked to keep both people supported and to enable the choices of the patient at end of life.
- The organisation had a quality priority to become a dementia friendly organisation, which included dementia training for all staff. At the time of our inspection dementia training compliance exceeded the organisation's target of 85% with more than 97% of staff in community adult nursing teams and urgent and specialist care teams having completed the training. The end of life care coordination centre had achieved 93%.
- End of life link nurses were based in all teams to enable better end of life care for all patients. For example there



Are services responsive to people's needs?

were six nurses in the rapid response North and South and Night service, one in the heart Failure Service and two in the Learning Disabilities Team. They provided advice and guidance to staff on end of life care as well as working with other staff involved to deliver end of life care. Contact numbers for end of life care services was available in a leaflet given to patients and relatives.

- Patients and relatives were provided with support to meet individual needs. One relative told us how the care coordination centre staff had contacted them on a Friday as they were aware that the situation was stressful. they recognised the relative was very tired. They arranged for a night sitter to be booked for the Sunday night for which the relative was grateful. Once the relative told the end of life clinical coordinator that they could no longer cope providing care throughout a 24 hour period, the response was rapid. Relatives told us, 'everything happened so quickly'

Access to the right care at the right time

- Staff used their knowledge and skills to anticipate needs in advance so that patients could access care and treatment in a timely way to minimize the time patients had to wait for treatment or care. Patients with the most urgent needs were prioritised for care and treatment during staff handover or in gold standard framework meetings. The end of life care coordination centre had 107 hours per week that could be deployed to support end of life and palliative care and nine support workers to maximise the flexibility and reduce delay. There were some delays waiting for care packages that were not within the control of the provider.
- Access to treatment and care for end of life was available 24 hours a day, seven days per week. End of life care in the community within patients' homes was provided by community and district nurses, other community teams and end of life care coordination centre staff. Specialist end of life advice and support was accessible at all times either through the day team Monday to Friday 08.30 to 9pm or via the rapid response team and then through the out of hours team. There was also access to care and advice through two local hospices who worked with North Somerset Community Partnership.
- Partnership working with other services and professions was embedded within end of life practice. This enabled increased ability to access the right care for patients and

families when required. We saw that needs for patients in last few hours or days were reviewed and evaluated at every contact. For patients in their last year of life paper records in the community did not always show this.

- Staff were trained to be able to verify an expected death of a patient in a community setting. This meant essential processes could be completed in a timely way, often by staff already known to the deceased patient and family. When training had been completed, a GP was required to assess and sign off practice.
- The end of life care coordination centre collected some data in order to report patient numbers to the organisation and their clinical commissioning group for example from April 2016 to October 2016;
 - The number of face to face contacts the team had recorded was 4898
 - The number of contacts by other means – for example telephone was 6700
 - The care coordination centre had supported 406 patients during April 2016 to October 2016 (ranging from 44 in July to 91 in April)
- The end of life care coordination centre were collecting information which showed the percentage of patients dying in their preferred place of care. During the period April and October 2016 between 25% and 69% of patients referred for end of life care had received care in their home. In October 88% of patients died in their preferred place. However other months figures were lower 39% in June 2016. Figures were often influenced by availability of care, speed of referral or quality of discharge planning by other organisations.
- Staff were able to tell us how some outcomes had improved for patients over the last 12 months e.g. Continuing Healthcare Care application and agreement for patients at end of life had increased significantly which meant that patients had access to better support and funding. The continuing health care referral acceptance rate had improved from period October – December 2015 to period July -September 2016 was 54, 84, 111, 93.
- Senior staff from the community teams took part in a teleconference each morning with senior managers. Staffing levels, caseloads and bed availability were discussed in order to understand operational demands. The senior management team would then dial into a

Are services responsive to people's needs?

regional teleconference to share their information and to gain a picture of operational pressures across different services (including local NHS trusts and ambulance services) across North Somerset.

Learning from complaints and concerns

- Patients and those close to them who used the service knew how to make a complaint or raise a concern. Contact details were available and located on the front page of the patient care record which was kept within patient's homes and on information given out by the end of life care coordination centre team.
- Patients were encouraged to complain or raise a concern and we saw examples where this had happened. The system for making a complaint was easy to use. The provider reported 31 complaints between 7 August 2015 and 1 August 2016. One was for end of life care which was not upheld and no complaints were referred to the Ombudsman.
- Staff spoke about local resolution being a factor in reduction of numbers of complaints and efficient management of concerns raised before they became formal complaints.
- For patients and those close to them concerns and complaints were listened and responded to. The issues

raised were used to improve the quality of care by looking for ways to make service improvements. Complaints were discussed in different meetings at different levels from board meeting to team meetings; this meant that staff across the organisation were aware of patients complaints and any changes made or suggested as a result.

- For example the provider had received a complaint about end of life care to a patient. We saw evidence of discussion about the identified service gaps the complaint had brought to light and outlined the actions taken to improve the service. Changes included: the appointment of a lead nurse for the end of life care coordination centre, improved pain management policy and assessment tools approved by the clinical cabinet, a programme of staff training, and the provision of the syringe drivers directly within teams rather than contracted from another provider.
- Complaints were handled effectively and confidentially with regular updates and a formal record kept. Complaints were explained appropriately to the patient and those close to them, we saw there was openness and transparency about how complaints and concerns were dealt with.

Are services well-led?

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

Summary

We rated well led in end of life care to be good because:

- The organisations vision for end of life and palliative care was clear and there was a credible strategy to deliver it for care in the last year and to last few hours of life.
- The vision and strategy was embraced by the community teams through the managers, clinical leads and end of life link workers in provision of end of life and palliative care.
- Staff we spoke with were clear about their roles and they understood what they were accountable for. The governance framework ensured that responsibilities were known, quality, performance and risks were understood and managed.
- There was a process for providing assurance to the chief executive and the board for risk, quality and performance of end of life and palliative care through feedback in meetings.
- There were arrangements for identifying recording and managing risks, issues and mitigating actions.
- The leadership and culture of the end of life and palliative care service reflected the vision and values of the organisation. All leaders we spoke with encouraged openness and transparency and promoted good quality care.
- The director of nursing was the identified board lead for end of life and palliative care. There was also a non-executive director who represented the end of life and palliative care.
- The culture within end of life and palliative care was centred on the needs and experience of patients and those close to them who used the service.
- Community team managers we spoke with understood the particular pressure that end of life and palliative

care brought. For example the demand on numbers of staff to deliver care as well as the emotional aspect of end of life care. Managers we spoke with were supportive, professional and accessible to staff.

- Staff were actively engaged and their views were reflected in the planning and delivery of services
- Staff who raised concerns were supported and valued and action was taken as a result of concern.

However

- The systematic programme of clinical and internal audit for end of life and palliative care was not yet embedded.

Leadership of this service

- Significant changes in the executive team included a new chief executive and director of nursing, an interim director of human resources and an interim chief operating officer. However the strategic and operational lead for end of life care had been with the organisation since May 2015 and this provided continuity. Further continuity was added by the lead for managed care who provided additional support for the end of life lead. The role was supported in the community by team managers, link professionals and clinical leaders. The end of life and palliative care team lead demonstrated they had appropriate skills, knowledge and experience of end of life services, commissioning and management to oversee the strategic planning and operational delivery of the service provide by the end of life care coordination centre. Where there were identified gaps in familiarity with adult provision support for the end of life lead support was available from other senior nursing staff in the organisation.
- Despite the changes in senior management, the leadership and culture of end of life and palliative care reflected the vision and values of the organisation. All leaders involved with end of life care we spoke with encouraged openness and transparency and promoted good quality care.
- The director of nursing was the identified board lead for end of life and palliative care. There was also a non-executive director who represented the end of life and



Are services well-led?

palliative care for the provider. The non executive was engaged by the board. The leaders of the end of life and palliative care service were able to describe the challenges to good quality care and they were able to identify the actions needed to address them and we saw this in minutes of meetings and action plans

- All leaders we spoke with were described by staff as visible and approachable and encouraged appreciative supportive relationships within teams. Community staff we spoke with felt part of the overall end of life and palliative care service.

Service vision and strategy

- The overall vision of the organisation was 'healthy communities where people are cared for close to home and supported to maintain their independence'. The vision was enabled in end of life care by the care coordination centre and community teams end of life care practice of trying to ensure the right care, in the right place, at the right time.
- Some senior and specialist nurses felt there had been a period when it had been difficult to develop services in line with the vision, as there had been senior managers in temporary posts. This had resulted in decisions about new services not being made. The new executive team was in the process of introducing a model of care which was focussed on a whole system approach to deliver care closer to home. Staff in leadership roles were aware of the new model of care as were the majority of staff delivering end of life care we spoke with.
- The end of life care coordination centre team lead and staff had a vision and strategy of how to develop services to include more patients while at the same time help to manage capacity effectively while delivering care in a more holistic way. The end of life and palliative care vision and strategy was based on the six national ambitions in National Palliative and End of Life Care Partnership, (2015). We reviewed the end of life care strategy which included assessment and action plans against the six ambitions. These included: individual care, fair, coordinated and equal access, maximising comfort and wellbeing, with educated and supported staff and communities. We saw an action plan and data collection and plans for audit used to support progress against these ambitions.
- The vision and strategy was also based on achieving the five priorities of good end of life care (Leadership Alliance for the Care of Dying People 2014), the priorities

of, recognising dying, communicating about dying, the patient and those close to them being involved in their care, exploration of what is important to those around the dying person and an individual plan of care agreed and coordinated delivered with compassion. We saw an action plan and data collection and plans for audit used to support progress against the five priorities.

- The vision and strategy for end of life care was embraced by the community teams through the managers, clinical leads and end of life link workers who provided end of life and palliative care.
- The progress against delivering the end of life care strategy was monitored and reviewed by the lead nurse for the end of life care coordination centre, the lead nurse for managed care and multidisciplinary managers in community teams.
- The organisation had clear values, which included the delivery of quality care, respect, working in partnership, effectiveness and integrity and some staff we spoke with had been involved in developing them. We saw the values in action when we observed staff caring for patients at end of life. The values had also been embedded in the organisational recruitment process, the aim being to recruit staff who identified with the same values. One local example of this was how the end of life lead was developing staff from within the organisation bank to work in end of life care. This was being achieved by offering 'shadowing' to workers already in end of life care to ensure that staff understood what was needed and that they had the qualities needed.
- Not all the staff involved in end of life care we spoke with were familiar with all the details of the organisational strategy for end of life care or able to describe the values - quality, respect, partnership, effectiveness and, integrity developed by the organisation. However staff understood the principles and overarching ambitions of good end of life and palliative care which had similar themes. We spoke with community and district nurses, managers and other professionals who were able to articulate these principles often as the right care, in the right place at the right time.

Governance, risk management and quality measurement

- There was a corporate risk register, which identified the severity of risks, and the controls in place to mitigate

Are services well-led?

against possible harm. One of the highest risks on the corporate risk register was low staffing levels, including difficulties with recruitment of staff, and the effect this may have on existing staff. Staff numbers and prioritising end of life care had previously had an effect on other care in the community which had generated a complaint. There are risks within end of life that could be highlighted more clearly which do not receive the profile they should on a corporate register e.g. issue with completion of patient records and impact of staffing on other services at peak demand for end of life care had been noted as issues.

- There was a clear process for reporting, feeding back and learning from adverse incidents. We spoke to staff with varying levels of responsibility within this process and staff were confident using it. We saw evidence that learning was discussed and shared at board level; we reviewed minutes of meetings and found that patients' experiences of end of life care – both good and bad experiences – were discussed, and evidence that the outcomes were shared with members of teams. We reviewed minutes of staff meetings in relevant services and were assured that learning from patient experience was shared at all levels and across the organisation.
- Leaders in end of life care we spoke with were clear about their roles and they understood what they were accountable for. The governance framework ensured that responsibilities in end of life care were known, and quality, performance and risks were understood.
- There was a non executive director who had end of life as part of their portfolio. There was a process for providing assurance to the chief executive and the board for risk, quality and performance of end of life and palliative care from the end of life lead to the director of nursing. Assurance was through the director of nursing as an executive of the board. The director of nursing worked with the lead nurse for the end of life care coordination centre for specific issues relating to end of life. The director of nursing also worked with an interim director of operations with the lead nurse for managed care and locality team managers for community focussed end of life issues. For example end of life record keeping for patients not involved with end of life care team.
- Locality team managers were supported by clinical leads, end of life link professionals through to district nurses and others providing end of life and palliative care to patients. The governance framework supported

the delivery of end of life and palliative care in practice. The strategic and operational lead for end of life had begun collating performance and outcome information for the first annual report for end of life care due to be published April 2017.

- The governance and quality committee was chaired by a non executive director and oversaw the quality and safety agenda for the provider. There were sub committees that fed into the overarching committee. The quality and governance team monitored and reported through the relevant groups to the governance and quality committee. Information such as current performance, learning from complaints and patient stories where case studies were discussed to highlight good practice and areas for improvement. The information was provided by the end of life lead and other senior managers.
- The organisations quality committee was responsible for ratification of guidance and policies regarding end of life and reported this information to the board.
- There was no participation in national audits and the systematic programme of clinical and internal audit for end of life and palliative care was not yet embedded. However information was collected by the provider for commissioners and to establish a baseline to inform future audit work. It included 49 areas of practice including numbers of face to face contacts, numbers of patients with 'just in case medications' in community. The provider had only recently been able to collect all the information that was useful for an understanding of performance in end of life and palliative care. The provider had yet to fully integrate the views of patients and those close to them with safety, quality and financial information.

Culture within this service

- The culture within the end of life care coordination centre and of community staff delivering end of life and palliative care was centred on the needs and experience of patients and those close to them who used the service. Staff worked collaboratively to deliver end of life and palliative care often we were told, working outside of their contracted hours. It was evident that community and district nurses and other staff cared passionately that patients received good end of life care, wherever possible, on their own terms. We saw that this culture and these attitudes were embedded throughout the organisation.

Are services well-led?

- There was a culture that encouraged candour, openness and honesty. We saw this in response to complaints and incidents for example.
- Staff we spoke with in the care coordination centre felt respected and valued. They told us they felt supported in their roles, particularly with opportunities to access training to provide better care and to develop and advance practice skills.
- Staff had been supported via policy to address behaviour and performance that was inconsistent with the vision and values of the organisation and the service.
- Community team managers we spoke with understood the particular pressure that end of life and palliative care brought. For example the physical demand on numbers of staff to deliver care as well as the emotional demands. Managers we spoke with were supportive, professional and accessible to staff. The organisation promoted well-being amongst its staff. Staff had access to counselling, free of charge, through the employee assistance scheme. We also saw staff engage in informal or unplanned supervision following stressful events in end of life and palliative care.
- Measures were taken to protect the safety of staff who worked alone or as part of dispersed teams working in the community who worked in challenging circumstances.
- We were told that the recommissioning of the provider's community contract was an unsettling time for the organisation. Some staff felt uncertain about their futures. Following the award of the contract staff were reported to feel more settled.

Public engagement

- Patients and those close to them who used the service, were encouraged to be engaged through friends and family test although many staff felt the test was not entirely suitable for understanding the response for patients receiving end of life and palliative care. Managers we spoke with talked about a more in depth understanding needed than that gained through the friends and family test so that people could respond at a more appropriate time and in a more in depth way. Although formal work had not begun on understanding whether this was possible. Staff we spoke with relied on

there being very few complaints from patients or relatives and those close to patients who had been receiving end of life or palliative care as a positive indicator.

- Patients and those close to them were actively engaged and involved in decision- making about their care. We saw examples of this with patients relatives being trained to provide care when appropriate.
- The views and experiences of patients and those close to them who used the service were gathered and acted upon to shape and improve services and culture. Patient's stories were used in board meetings to highlight particular issues and to encourage staff to be more aware of end of life and palliative care at all levels of the organisation.

Staff engagement

- The organisation staff survey was published in May 2016. It was not clear how many members of staff from each service had responded but the response rate had declined in comparison to the previous year with just 37% which meant that just over one third (226 employees) of the total staff had completed the survey.
- However, the results from the survey had improved in comparison with the previous year's survey by more than five percent. Staff felt they had the tools, equipment and facilities to carry out their job effectively, delivering value for money services and being treated fairly if staff were involved in an error, near miss or incident. The report demonstrated there was a good culture for reporting of incidents with 94% agreeing or strongly agreeing that they were encouraged by the organisation to report a safety concern.
- Some of the survey results also showed a decline of five percent or more. For example where staff felt the organisation did not do so well; these included being involved in and making suggestions and decisions where changes affected their work. The organisation had undergone a substantive change in executive leadership roles and this was reflected in the staff survey; staff did not always know who leaders were, communication was not always good between teams, and leaders in the organisation did not always give a high priority to patient care and providing quality services.
- We did not see this reflected in connection with end of life and palliative care in the care coordination centre or within community team

Are services well-led?

- The survey highlighted that staff felt they worked well in teams. 63% of staff were 'extremely likely' to recommend the organisation as a place to work to friends and family.
- The survey showed that 20 employees (nine per cent) had experienced harassment, bullying or abuse from managers or team leaders and that in 52% of the cases staff did not report it. We did not see this reflected in connection with end of life and palliative care in the care coordination centre or within community team.
- The organisation nominated and awarded individuals and teams for exceptional commitment, care, compassion, competence, courage and communications a member of the end of life care coordination team had been nominated.
- The organisation had a staff council who's aim was to represent the views of staff in a forum that could be heard by the executive team. We were told that this system was in the process of being redeveloped due to it not being considered an effective means of communication.
- The Joint Union Management Partnership (JUMP) meetings provided a forum for communication and negotiation with staff representatives concerning issues about workforce developments and transformation. The staff forum to encourage innovation focussed on business development and service improvement was currently reviewing the terms of reference.
- There was a monthly managers newsletter which enabled the communication of key workforce

information to all provider line managers, including updates from the workforce development forum, JUMP and sharing of information linking to key initiatives for example. health & wellbeing and Commissioning for Quality and Innovation

- Staff and others had been invited as assessors for the interview of the new chief executive. Other staff members were recruited to be part of focus group discussions.

Innovation, improvement and sustainability

- The end of life care coordination centre were providing staff with 'shadowing' opportunities so that they could work alongside experienced workers in end of life care. This approach aimed to ensure that workers recruited to the service knew what the role entailed and had the right qualities to work in end of life care.
- The lead nurse for the end of life care coordination centre had also begun negotiations attempting to increase the band of the PCSWs. This was to enable a better retention and recruitment strategy in end of life care to reflect the nature of the complex and demanding work carried out by the PCSWs.
- The end of life care coordination centre had established a library of books in each of the eight teams (for example learning disability, community nurses). This had been enabled by money raised by friends of a patient. They covered all children's age ranges who might be affected by a death in their life.