Northumbria Healthcare NHS Foundation Trust

RTF

Community end of life care

Quality Report

Northumbria Healthcare NHS Foundation Trust
Tel: 0344811811
Website: www.northumbria.nhs.uk

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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)
RTFFS	North Tyneside General Hospital		
RTFFS	North Tyneside General Hospital	Bondgate Surgery, Infirmary Close, Alnwick	
RTFFS	North Tyneside General Hospital	Nursery Park, Ashington	
RTFFS	North Tyneside General Hospital	Sir GB Hunter, The Green, Wallsend	

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

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

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

Summary of findings

Ratings

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

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Overall summary

Overall, we rated community end of life care as outstanding because:

The feedback from people who used the service and those who were close to them was extremely positive about the care received by patients nearing the end of life. We saw that staff were motivated to go the extra mile to meet patient's needs and the care patients received exceeded their expectations. Results from the 2014 cancer patient experience survey showed Northumbria Healthcare NHS Foundation Trust was in the top ten best performance trusts. Families were very positive about staff and the service they received. The service demonstrated a high level of compassionate care to patients and their families. We saw that staff were motivated to go 'the extra mile' to meet patients' needs. We observed a commitment to providing care that was of a consistently high standard and focused on meeting the emotional, spiritual and psychological needs of patients as well as their physical needs.

There was a clear vision and strategy that focused on the early identification of patients at the end of life, patients being cared for in their preferred place of care and the use of partnership working to develop services. The strategy clearly communicated the vision of integrated services across the community and acute sectors to support patients being cared for in their preferred place of care. There was end of life care representation/ leadership at trust board level and we saw evidence of active engagement in end of life care at board level. There were innovative approaches being implemented to achieve the joined up service within acute and community end of life teams. There was comprehensive leadership within the palliative care service with clearly defined leadership roles. They were passionate about the service and encouraged staff to deliver high quality care. Local managers were proactive and came from a clinical background. They demonstrated an understanding of the current issues facing the service. There was a clear sense of pride and belonging amongst staff at all levels within the end of life care teams. Each person's role was seen as being equally as important as the next. Staff appeared to have a genuine respect for each other within the team. Staff we spoke with demonstrated a commitment to the delivery of good quality end of life care. There was evidence that staff felt proud of the care they were able to give and there was positive feedback from nursing and care staff as to the level of support they received from the specialist palliative care team.

The trust was in the top ten and came 6th out of all trusts in England for the quality of care reported by the Cancer Patient Experience Survey 2014.

Staff understood their responsibilities to raise concerns and to record safety incidents. There was an open culture in reporting incidents and there were systems in place to learn from incidents and reduce the chances of them happening again. There was good identification of patients at risk of deterioration and we saw evidence of the use of emergency health care plans in ensuring that all patients had a plan in place should their condition deteriorate. There was appropriate equipment available in patients' homes and use of anticipatory prescribing of medicines at the end of life. Mandatory training levels were good, with all community palliative care staff up to date across all localities.

The trust provided effective end of life care to patients. Patients in need of end of life care were identified at an early stage in their care, and staff were alerted to patients who were known to the community team or on a palliative care register. The trust had implemented the Care of the Dying Patient document which was being used as a guide to delivering high quality end of life care.

Policies and guidelines were all evidence based and we saw excellent examples of multi-disciplinary and multi-agency working and collaboration.

The partnership with Marie Curie provided additional flexibility to enable specialist palliative care staff to provide support to patients at the end of life. This was irrespective of the complexities of their condition. Also there were strong links between the hospital liaison service, Marie Curie and the specialist palliative care staff. There were integrated person-centred pathways that involved these different service providers. Services were flexible, provided choice and ensured continuity of care.

Summary of findings

Background to the service

Northumbria Healthcare NHS Foundation Trust provides community end of life services across Northumberland and North Tyneside. Specialist palliative care is provided as part of an integrated service across the hospital and community teams and the service sits within the trust's Community and Social Care business unit.

There are two community specialist palliative care teams (SPCT), one for Northumberland and one for North Tyneside. These provide support and advice for patients in their locality with complex needs and symptom management issues at the end of life. The community teams work jointly with the acute SPCT team and are based at Wansbeck General Hospital. In the community, there is access to 10 whole time equivalent (wte) Macmillan nurses, two wte Marie Curie nurses, eight wte specialist palliative care nurses and three wte physiotherapists. The MacMillan nursing and palliative care physiotherapy services are based at Hexham, Ashington and Alnwick. The community services are delivered at home and at Hexham, Blyth, Rothbury, Berwick and Alnwick community hospitals. The teams work closely with other health professionals in nearby trusts, charitable organisations and the community to ensure that all patients achieve the best possible quality of palliative care.

During our inspection, we observed care being delivered by SPCT nurses and district nurses. We spoke with 33 members of staff in total including the palliative care matron, a community palliative care consultant, specialist palliative care community nurses, Macmillan nurses and palliative care physiotherapists. In addition we spoke with district nurses and a mortuary technician. We spoke with ten patients and five relatives and visited patients in their own homes and in community settings. We looked at the records of fifteen patients receiving end of life care.

We visited palliative care services at Hexham, Ashington and Alnwick. Additionally, we also visited a community nursing team based in Hexham and at the Sir GB Hunter Memorial Hospital in Wallsend.

Our inspection team

Our inspection team was led by:

Chair: Dr Linda Patterson OBE, Consultant Physician.

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

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

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?

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

Before visiting, we reviewed a range of information we held about the core service and asked other organisations to share what they knew. We analysed both trust-wide and service specific information provided by the organisation and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well led. We carried out an announced visit from 9 – 13 November 2015.

What people who use the provider say

Patients and relatives we spoke with were positive about the care they received. We were told that staff were approachable, responsive, caring and compassionate. Patients told us they couldn't have asked for better care and relatives said they felt supported by both specialist and district nurses.

Good practice

Outstanding Practice

- The trust had implemented consultant-led community end-of-life care services and secured specialist status of services. These were based around localities, with each GP surgery having a named palliative care clinical nurse specialist and consultant. The trust had appointed in conjunction with Marie Curie, a service manager to work across hospital and community settings. The trust had embedded single multi-disciplinary meetings in Northumberland and North Tyneside, enabling discussion of complex patients across the region via teleconference.
- The chaplaincy had developed a tool for the assessment of patient's spiritual needs that provided staff with prompts that made it easier for them to have this discussion with patients.
- The trust was in the process of developing a 24-hour rapid response service to get supportive and specialist care to end of life patients and reduce hospital admission where appropriate.

Northumbria Healthcare NHS Foundation Trust

Community end of life care

Detailed findings from this inspection

Good ●

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as good because:

Staff understood their responsibilities to raise concerns and to record safety incidents. There was an open culture in reporting incidents and there were systems in place to learn from incidents and reduce the chances of them happening again. There was good identification of patients at risk of deterioration and we saw evidence of the use of emergency health care plans in ensuring that all patients had a plan in place should their condition deteriorate. There was appropriate equipment available in patients' homes and use of anticipatory prescribing of medicines at the end of life.

Mandatory training levels were good, with all community palliative care staff up to date across all localities. An integrated electronic records system was in use across specialist palliative care staff community and the acute hospital sites with also many GP practices having access.

Safety performance

- There had been no never events in the community end of life care service. Never events are serious incidents that are wholly preventable.
- Safety was managed through the effective reporting of incidents. The trust had an incident reporting and investigation policy and this was embedded within the trust. The trust used an electronic reporting system to record all incidents.
- Every member of staff we spoke with within the service, at all levels and grades, could explain the reporting process and felt confident incidents were dealt with robustly and in a timely way.

Incident reporting, learning and improvement

- Staff we spoke with told us that when an incident occurred it would be recorded on the electronic system for reporting incidents.
- We reviewed incidents reported between 01 July 2014 and 31July 2015. Staff from community end of life care at localities across Northumberland and North Tyneside had reported 13 incidents. The severity of each incident was recorded appropriately and indicated the level of harm caused by the incident.
- All staff were aware of, and had access to the trust's online incident reporting system. This allowed staff to report all incidents and near misses where patient safety may have been compromised. Staff were aware of what should be reported and were encouraged to do so.

Some staff said they received feedback from incidents they had raised and gave an example of an incident involving management of a syringe driver. As a result, new guidelines were introduced.

- During our inspection we saw minutes from team meetings where incidents had been discussed.
- Weekly multidisciplinary meetings and monthly management meetings took place during which information from around the trust, including learning from incidents, was shared.
- Staff were aware of their responsibilities in relation to duty of candour and being open with patients when incidents occur and we were given an example of a medication incident where the patient and family were informed.

Cleanliness, infection control and hygiene

- The trust had an infection control policy and all staff received training in infection prevention and control. The level of compliance across the community end of life services was above the 85% target set by the trust.
- We examined an analysis of the hand hygiene audits carried out across Northumberland and North Tyneside and noted the compliance target of 98% was exceeded across all services.
- We spoke with staff in clinic and in home settings. All the staff had a good understanding of infection control practices.
- We observed staff using personal protective equipment appropriately, such as aprons and gloves.

Safeguarding

- All staff on the team received safeguarding training in line with their role. All specialist palliative care staff had completed the mandatory training for safeguarding adults level one. Completion of safeguarding children level 2 training was also 100%.
- Patients and their relatives we spoke with told us they were encouraged to tell staff if they had any safeguarding concerns.
- Staff understood their role with regard to keeping patients safe and reporting any issues. A member of staff told us of concerns they had raised about a patient living with a family member who was unable to provide support around personal care and nutrition and hydration as they worked full time. . A safeguarding concern was raised and in agreement with the family, the patient decided to be supported in a local care home.
- The trust had appropriate safeguarding systems in place with policies and procedures in place in relation to safeguarding adults and children.

Medicines

- Medicines were well managed. Community patients who were identified as requiring end of life care were prescribed anticipatory medicines which are those drugs that are prescribed for use on an 'as required' basis to manage common symptoms that can occur at the end of life. Having anticipatory drugs available in the home allows qualified staff to attend and administer drugs which may stabilise a patient or reduce pain and anxiety and prevent the need for an emergency admission to hospital.
- We visited a patient in the community who had anticipatory medicines prescribed and these were available and stored safely in their home for when they were required.
- Medicines were prescribed using guidance from the Northern England Strategic Clinical Networks. The guidance was available on the intranet and as part of the trusts Care of the Dying Patient (CDP) document. The guidance included different scenarios for a range of symptoms that could be experienced at the end of life.
- We looked at 15 prescriptions and administration records in the community and saw they were completed clearly; including the times of administration of medicines prescribed 'as required'.

Environment and equipment

- Staff told us that they did not experience any issues with obtaining or maintaining equipment for end of life care patients. Syringe drivers were obtained from a trust wide equipment library and these were accessible to community staff out of hours. Specialist mattresses were also available and district nurses could access these as needed.
- The NPSA Rapid Response Report; Safer ambulatory syringe drivers1 (NPSA/2010/RRR019) published in December 2010, advised that all healthcare organisations that use ambulatory syringe drivers should change over to devices with specific safety features.

- We observed the use of McKinley syringe drivers in the community which incorporated these safety features and saw that regular administration safety checks were being recorded.
- A Macmillan physiotherapist worked as part of the community team. They would assess patients' needs in relation to their home environment and identify equipment required. For example, we visited a patient who told us of the great service they were receiving including the quick delivery of their wheelchair.
- Staff told us that equipment was accessible within a few hours for patients at the end of life who were being discharged.
- We found all the equipment in use was clean and had been PAT (portable appliance test) tested and serviced where required.

Quality of records

- There was a trust wide electronic record system in place that enabled sharing of patient information within the team and with other health care professionals. All staff had access to this.
- Staff told us they did not have mobile devices to access the electronic system and therefore needed to update electronic records at the base office. On occasion, patients' electronic records were not updated immediately as going back to the base office was not always practicable at the end of a shift. However, staff told us paper records at peoples homes' were updated at the time of the visit and electronic records were updated the following day where required.
- During our inspection, we looked at the care records of 10 patients across the end of life care services. The records were well organised and information was easy to access. Records were complete and up to date and included records of capacity and consent. There was evidence of discussions with patients about their condition, advanced care planning and their resuscitation status was clearly documented.
- We reviewed four DNACPR forms. The forms were kept in the front of patient notes, had clearly documented decisions with reasoning and clinical information and had been signed by a consultant. They also recorded discussions with patients and relatives.
- In the community, DNACPR forms were kept in a yellow envelope so as to be easily accessible to community staff and family members and could be sent with the patient in the event of a hospital admission.
- Information governance training was part of the annual mandatory requirement for all staff and 95% of the SPCT were up to date with this against a target of 100%.
- We reviewed a clinical audit report dated April 2015 which showed 85 end of life documents were audited. Results showed the document was inconsistently completed, care plans not used as per process and some data fields were missing from the document. An action from this was that a new regional document was agreed with a roll-out date of June 2015.

Mandatory training

- The trusts had a target of 85%. We found that community specialist care staff had completed 100% of the trust mandatory training. This training included risk management, health and safety, infection prevention and control, moving and handling and adult safeguarding level one.
- Generalist nursing staff we spoke with confirmed they had received training in the use of syringe drivers.

Assessing and responding to patient risk

- Specialist support was available with Palliative Care Units operating a 24 hour service. There was a Palliative Care Consultant on call service seven days a week together with a 24 hour Palliative Care Helpline which was nurse led and situated at Marie Curie Hospice.
- The trust used the Northern England Strategic Clinical Networks guidance on caring for the dying patient and care planning document. The guidance included identifying patients at the end of life, holistic assessment, advance care planning, coordinated care, involvement of the patient and those close to them and the management of pain and other symptoms.
- We saw that changes in a patient's health or vulnerability was recorded and any additional preventative measures were put in place such as pressure reducing mattresses or therapies to improve mobility or combat eating or other disorders.
- We observed a SPCT multi-disciplinary meeting and saw that risks to patients were discussed as part of a routine review of their care and ongoing evaluation.
- We spoke with relatives who were aware of how to access help and support should a patient's condition deteriorate when they were being cared for at home.
- The trust had implemented a treatment escalation plan (TEP). A TEP discussion gave patients and the clinical team the opportunity to look at the overall plan of care

and incorporated a range of potential treatments that patients may benefit from, coupled with the treatments that patients would like to receive should they need them. The trust process included TEPs in all admission documentation packs. On discharge, key decisions in the TEP were communicated either in the discharge letter or the patient's Emergency Health Care Plan (EHCP).

Staffing levels and caseload

- In Northumberland and North Tyneside, there were 10 whole time equivalent (wte) Macmillan nurses, two wte Marie Curie nurses, eight wte specialist palliative care nurses and three wte physiotherapists. There were five palliative care consultants employed across the trust at the time of our inspection. Staffing levels were in accordance with guidance produced by the Association for Palliative Medicine of Great Britain and Ireland, Consultant Nurse in Palliative Care Reference Group, Marie Curie Cancer Care National Council for Palliative Care and the Palliative Care Section of the Royal Society of Medicine. This guidance recommends at least two whole-time equivalent community-based consultants in palliative medicine and at least five SPC nurses per 250,000 population.
- Staff we spoke with told us their caseloads were manageable and they had sufficient staff to deliver good quality end of life care. Community nurses told us their case loads averaged 20 patients at any one time. Data showed that caseloads for community SPCT nurses were generally between 19 and 23 patients at the time of our inspection.
- Caseloads were discussed each morning by each of the end of life care teams. The needs of each patient, details of new patients, changes both expected and unexpected to the patient's health or circumstances were discussed which then allowed an appropriate response to be planned from the most suitable member of staff.
- Staff in all areas we visited during the inspection told us they were busy, but they felt they had sufficient time to provide a meaningful and quality experience for their patients. Patients told us that with very few exceptions, staff were unhurried and willing to spend time explaining procedures and health issues with them.

Managing anticipated risks

- Major incident and winter management plans were in place. Senior staff had access to action plans and we saw that these included managers working clinically as appropriate, staff covering from different areas and prioritisation of patient need. Staff from all services told us they had completed, or were in the process of completing, an emergency preparedness plan. The plan documented a list of service contingencies, which, in the event of an emergency, would ensure continuity of service delivery. A trust assurance process was in place to ensure compliance with NHS England core standards for emergency preparedness, resilience, and response.
- The trust had a lone worker policy that was known to staff. We visited three different areas of the trust and each team followed the lone working policy. However staff in Alnwick told us of concerns they had as the team all worked on a part time basis and on some days the lone worker could have difficulty contacting another member of the team.

Outstanding ☆

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 end of life care as outstanding for effective because:

End of life care services were well resourced and we observed a truly holistic approach to the assessment, planning and delivery of care and treatment to patients. Patients in need of end of life care were identified at an early stage in their care and staff were alerted to patients admitted who were known to the team or on a palliative care register. The trust had implemented the care of the dying patient document which was being used as a guide to delivering high quality end of life care.

The trust had recently introduced a seven day rapid response service for palliative care. The primary aim was to introduce a community based service that would work between community and hospital services to enable patients at end of life to stay in their place of choice. We saw that treatment escalation, emergency healthcare plans and advance care plans were in place to support patients and those close to them in making decisions at the end of life.

There was a commitment to working collaboratively, innovative ways to deliver joined-up care through effective and regular multi-disciplinary working. This was demonstrated through services that worked across both acute and community settings. The palliative care team had established a holistic approach to provide effective discharges and transfers within community services. There were established links with GPs, district nurses, local nursing homes and at the local Marie Curie Hospice.

Staff skills were integral to ensure the delivery of high quality care. Staff had attended a wide ranging level of training courses together with SPCT staff supporting staff across the trust in providing effective palliative care treatment for patients. Consent practices were embedded across the community end of life team. Staff were supported with to follow in relation to best interest decisions for patients who did not have capacity to make decisions about care and treatment

Evidence based care and treatment

- The trust used the Northern England Strategic Clinical Networks guidance on caring for the dying patient and care planning document. The guidance included identifying patients at the end of life, holistic assessment, advance care planning, coordinated care, involvement of the patient and those close to them and the management of pain and other symptoms.
- The CDP document had been implemented to replace the Liverpool Care Pathway that had been discontinued in 2014.
- We saw that the CDP documentation had included national guidance from sources such as the Leadership Alliance for the Care of Dying People, the Department of Health End of Life care Strategy, and the National Institute of Clinical Excellence (NICE).
- The trust has implemented the 'Deciding Right' initiative. This is a north-east initiative for making care decisions in advance. The initiative includes recognising the individual with capacity as key to making care decisions in advance and the needs of the individual who lacks capacity to have decisions made in their best interests in conjunction with Mental Capacity Act (MCA).

Pain relief

- We saw guidance available for staff on symptom management including the need for pre-emptive prescribing of medication at the end of life. Patients who were considered to be in the last days/weeks of life were appropriately prescribed anticipatory medicines for these symptoms including pain.
- Patients we spoke with told us their pain was well managed and that staff were quick to respond to requests for additional medicines when pain occurred.
- The end of life care teams supported patients by liaising with GPs and district nurses regarding best practice in relation to care and treatment including pain management.
- We observed district nurses and specialist nurses assessing patients' pain levels in the community and saw that they assessed the type and duration of pain as well as factors that made the pain better or worse.

Are services effective?

- Where appropriate patients received pain relief medication through syringe drivers which delivered measured doses of drugs at pre-set times; all qualified nursing staff were trained in the use of syringe drivers.
- Staff told us there were adequate stocks of appropriate medicines for end of life care and that these were available as needed both during the day and out of hours.

Nutrition and hydration

- During home care assessments we saw malnutrition universal screening tool (MUST) risk assessments were undertaken to identify patients at risk of malnutrition. Where required, food and liquid intake was recorded and patient weight was monitored.
- The CDP document included an assessment of patient's nutrition and hydration status and guidance about the patient's choice to eat and drink, even if they had swallowing difficulties.
- During the home visits we attended, we saw staff spend a significant amount of time during the visit reviewing and discussing the patient's needs including nutritional needs. All the patients and relatives we spoke with felt the patient's nutrition had been managed appropriately.
- There was a strong culture of meeting comfort requirements at the end of life and staff we spoke with were clear that nutrition and hydration needs were led by the patient's view of their nutritional needs.

Technology and telemedicine

- The trust had implemented a new electronic record system for use by the SPCT across all hospital sites that was aligned with the system used by community teams and GPs. This enabled staff to access patient records and communicate details of patient care in real time with other disciplines.

Patient outcomes

- Trust data showed an increase in patient deaths in their usual place of residence. In Northumberland this had increased in line with the national average and in North Tyneside this had exceeded the national average. For example, this figure had increased from 41.6% in 2010 to 50.3% in 2014 compared to the national average of 44.7%. There was good integrated working across the acute and community services within the trust to achieve deaths at home.
- Through the Trust's End of life Steering Group, a new hospital service jointly provided with Marie Curie was implemented to facilitate discharge to the patient's preferred place of death. A new role named a palliative care nurse was established to run alongside the existing structure of a specialist nurse or consultant to work five days a week. The role had three functions: to support all patients and carers of dying patients, whether complex needs were involved or not, to support the rapid discharge pathway by ensuring key components are carried out for complex discharges, and to follow patients home and remain involved during first 24 hours until community services have taken over care
- The trust supported patients to achieve their preferred place of death either through rapid discharge to home, hospice or nursing home or by ensuring appropriate care for patients who wished to die at the hospital.
- Systems were in place where a patient who was known to the palliative care team would generate an alert to the team on admission and when started on the CDP document. The alert system facilitated out of hours care as the CDP document alert provided details of patients who were on the end of life pathway within the community to the out of hours team.

Competent staff

- Members of the specialist palliative care team had specialist training in palliative care including degree modules. In addition, the palliative care nursing team had completed advanced communication skills training or were scheduled to attend.
- The SPCT provided a three day course on the effective management of palliative patients through a multidisciplinary approach. Specific subjects covered included spiritual care, communication skills, breaking bad news and symptom management. Staff working within the community attended an annual palliative care training day where they received specific training updates to support the care of patients at the end of life. This enabled staff to gain up to date knowledge from the specialist nurses and allied professionals who participated in the delivery of the training. Specific training courses were designed around the needs of different staff groups, for example newly qualified nurses and health care assistants. Feedback from healthcare assistants included comments around the value of specific practical aspects of care such as mouth care, symptom control and supporting the spiritual and

Are services effective?

emotional needs of patients and their families. We viewed evaluation reports where 90% of attendees fed back that the course content was of an excellent standard.

- All staff told us they were up to date with their mandatory training. Staff gave examples of the content which included; customer care, conflict resolution, equality and diversity, safeguarding vulnerable people, information governance, and, infection control.
- We saw that all nurses within the community SPCT had received an annual appraisal and we were told that training and development plans were aligned to this process. SPCT staff across the trust attended clinical supervision sessions. Without exception, all staff told us this was excellent and they were very positive about the trust supporting them to attend.

Multi-disciplinary working and coordinated care pathways

- The palliative care team had worked closely with community services, including GPs, district nurses and the community palliative care team at the local Marie Curie Hospice.
- Multi-disciplinary team (MDT) working was an integral part of the aims and objectives of the SPCT and members of the SPCT participated in MDT meetings and worked with other specialists and district nurses to support good quality end of life care across the community.
- The SPCT held a consultant led clinical review meeting at NSECH every week and the team attended an SPCT MDT meeting on a weekly basis with both community and acute teams The MDT was attended by staff from a variety of disciplines including medicine, nursing, physiotherapy, social work, occupational therapy, psychology services and the chaplaincy.
- We observed a trust wide MDT meeting and saw that there was in-depth discussion about patient care within a framework of collaborative working to meet patient need. The meeting was attended by acute and community from across the Northumbria region. The meeting was held at Wansbeck Hospital. We saw staff which were based in Hexham, Berwick, North Tyneside and Alnwick were able to access the meeting by a video web link. Northumbria Health NHS Foundation Trust covered a large geographical area this was an effective way of staff accessing the weekly MDT. Staff we spoke with commented on how the video web link service eliminated the long trip to attend meetings. We observed a clinical nurse specialist as they completed a home visit with a new patient. Having discussed the patient's circumstances with them, the nurse explained to the patient that they would contact their GP to update them. This demonstrated the positive links between the services. The electronic record system was also an effective link between community colleagues and local GP practices who used the same system.

Referral, transfer, discharge and transition

- The trust was working on an implementation plan to introduce a seven-day rapid response service for palliative care. The primary aim was to introduce a community-based service that would work between hospital and community provision to enable patients at the end of life to stay in their place of choice and access specialist input. Other aims included preventing avoidable admissions to acute care and assisting rapid discharges from acute care.
- Patients were referred and transferred appropriately. The planning of discharge to an alternative place of care was an MDT process, which included the input of hospital and community staff, as well as support agencies who were involved in providing end of life care to patients at home.
- Staff told us patients could be discharged home in hours with appropriate support from the community nursing team by using a fast track pack that contained all the documentation needed, including medication request forms. We viewed a 'rapid discharge' checklist which was used as part of this process.

Access to information

- The trust had implemented a single electronic patient record system across both community and acute palliative care services to enable co-ordination and integration of care, eliminating six different record systems across the service and improving data collection. Staff found this to be a positive improvement in working practice.
- The CDP document provided a clear guide to clinical staff in the assessment and identification of patients' needs. Information was recorded in a clear and timely way so that all staff had access to up to date clinical records when caring for and making decisions about patient care.

Outstanding ☆

Are services effective?

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Where DNACPR forms were in place, we saw that the patient was involved in discussion about the decision where they had capacity to make decisions, or that an assessment of their capacity had been recorded in their medical notes and decisions were made in their best interests.
- We viewed assessment documents for patients identified as being at end of life. We saw prompts for guidance for staff to follow in relation to best interest decisions for patients who did not have capacity to make decisions about care and treatment, including in relation to nutrition and hydration.
- The specialist palliative care team had completed consent and mental capacity act training and this was repeated annually in mandatory training.

Outstanding ☆

Are services caring?

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

Summary

We rated caring as outstanding because:

Feedback from people who used the service and those who were close to them was extremely positive about the care received by patients nearing the end of life. We saw that staff were motivated to go the extra mile to meet patient's needs and the care patients received exceeded their expectations. Results from the 2014 cancer patient experience survey showed Northumbria Healthcare NHS Foundation Trust was in the top ten best performance trusts.

Staff were very caring and demonstrated a high level of compassionate care to patients and their families. We observed a commitment to providing care that was of a consistently high standard and focused on meeting the emotional, spiritual and psychological needs of patients as well as their physical needs. This was apparent through the development of a tool to help staff better assess the spiritual needs of patients, with elements of spiritual care being incorporated into end of life care training.

Partnership working with patients and those close to them was evident. There were systems and processes embedded to record the patient's wishes relating to their treatment and care, advance care planning and appropriate escalation of treatment. Staff offered patients a variety of holistic treatments with emotional support being recognised for its importance within the trust. Staff on numerous occasions stayed with patients at their preferred place of care at the end of life. This was provided in conjunction with community nurses. This service provided additional support to families and a consistency to patients who were at a very stressful and emotional period.

There was a strong, visible person-centered culture. Staff were highly motivated and inspired to offer care that was kind and promotes people's dignity. Relationships between people who use the service, those close to them and staff were strong, caring and supportive. These relationships were highly valued by people and their families.

Compassionate care

- We attended six home visits during our inspection; the compassion we witnessed during these visits was outstanding. On one occasion the palliative care nurse discussed DNACPR with the patient. This patient had previously refused any discussion around DNACPR, however on this occasion we witnessed the nurse sensitively and empathetically talk with the patient through this process. On another occasion we saw a discussion around the patient's concerns about being a burden on their partner and thinking about care homes being a future possibility. The patient was concerned about the costs. We saw the nurse discuss the many options regarding future care and how there were possible pathways where costs could be covered by the state.
- Patients were treated with dignity, kindness and compassion. Patients and relatives we spoke with told us that staff were professional, supportive and kind. We observed care being provided and saw that patients were treated with compassion, dignity and respect. A patient told us of the tremendous support she and her husband had received from the team. They told us the team was always available and would respond to any request or get in touch with the right person who could resolve the problem. We viewed feedback from palliative care patients in the community that included comments about how caring staff were and how safe patients felt in their care.
- We observed staff caring for patients in a way that respected their individual choices and beliefs and we saw that records included sections to record patient choices and beliefs so that these were widely communicated between the teams. Chaplaincy staff told us that a lot of time and resource had been invested in meeting the spiritual needs of patients and their relatives. They had spent time working on what spirituality meant to people and had developed a tool to assess people's spirituality and emotional needs on admission. Staff training had included aspects of spiritual distress and the provision of support. The lead chaplain told us they had felt overwhelmed by the investment the trust had made in meeting people's spiritual needs.

- In the Macmillan nurses' survey, community nurses' survey and the day hospice survey, 1,774 patients responded with 98% overall satisfaction with the quality of care. Subjects covered whether patients would be extremely likely or likely to recommend the service to friends, whether patients were being treated with dignity and respect, and whether patients were being involved in their decisions of care and receiving clear information.

Understanding and involvement of patients and those close to them

- We saw that clinical staff spoke with patients about their care so that they could understand and be involved in decisions being made and patients and relatives all told us they had been fully involved in the care provided and had a clear understanding of what was happening at all times. Patients told us that their medication and treatment had been explained to them including any possible side effects and the benefits they might see from taking medication.
- Patients preferred place of care and their individual choices and preferences featured as a primary focus when planning care. We saw that the care of the dying patient document used by the trust included prompts to assist them with talking through key issues with patients and their relatives.
- There was evidence of patients and/or their relatives being involved in the development of their care plans. For example, we saw advance wishes were discussed with patients and their relatives and recorded within the care planning document.

Emotional support

- Staff told us they felt they had the time to spend with patients and provide the emotional support to meet their needs.
- Staff told us occasions when patients were supported in their preferred place of death. For example, a patient expressed to be at home at their last days of life. Staff supported the patient who required ventilation equipment to be transferred from hospital to home. This was supported by consultants, SPCT staff and community nursing teams and staff continued to provide care and support for the patient and their family throughout the duration of their stay at home.
- Another member of staff also provided care and support to a patient in their own home. The member of staff lived in a remote part of the trust and made themselves available to support a patient who lived nearby to stay in their own home. This was liaised with the SPCT and the community nursing team.
- Throughout our inspection, we visited patients at the end of life care in their homes and in inpatient areas. We saw that staff were polite and courteous; patients appeared genuinely pleased to see staff and in respect of home visits, staff were treated almost as family by patients and their relatives or carers.
- We asked staff if they assessed relative's emotional needs prior to the patient's end of life. Staff told us that when the nurse met the patient for the first time, they undertook an assessment of the emotional status of family members using a pre-bereavement checklist. This allowed the nurse to determine what level of support might be needed in the post bereavement stage.
- Staff developed trusting relationships with patients and their relatives by working in an open, honest and supportive way. Throughout our inspection we saw that staff were responsive to the emotional needs of patients and their relatives. The palliative care team, the chaplaincy, local registered charities, clinical psychologists and psychiatrists from a nearby acute trust were all available to provide appropriate psychological support to patients, relatives and staff. Bereavement support was provided by the bereavement support officer for relatives of patients in the community in-patient ward. A nurse told us about many examples of complimentary therapies such as massage and reiki were available at the nearby hospice.
- During the home visits we saw nurses take an active interest in the patient's social needs and made suggestions to assist patients could continue to engage in social activities even when the symptoms of their illness may have restricted them. A patient told us about how the physiotherapist had encouraged him to accept trying a wheelchair to increase his independence. The patient was against it at first but told us it was the best thing they had ever done.

Outstanding ☆

Are services responsive to people’s needs?

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

Summary

We rated responsive as outstanding because:

Community end of life care services were extremely responsive to the needs of individual patients and to the needs of the local community as a whole. The trust had established the integration of the palliative care service across the trust and partnership working with third sector organisations to enhance services. This enabled a more ‘joined up’ way of working across acute and community services.

We saw evidence that more patients were dying at home and that the trust was supporting increasing numbers of non-cancer patients. Specialist support was available seven days a week from palliative care consultants and specialist nursing services. The trust had introduced a rapid discharge service within the palliative care service to provide a comprehensive, joined up service to patients and their families in all settings.

The trust had adopted an innovative approach to providing an integrated person-centred pathway of care in partnership to provide services that were flexible, focused on individual patient choice and ensured continuity of care. There was an open and transparent approach to handling complaints.

Planning and delivering services which meet people’s needs

- Services were planned and delivered to meet patient’s and relative’s needs. Staff were very clear that the key priority was ensuring patients were cared for in their preferred place of death wherever possible.
- The palliative care strategic plan included the imminent achievement of full seven day working (January 2016); initially focusing on the development of a community based rapid response service. The aim of the service was to “provide a comprehensive, joined up palliative care service to patients and their families in all settings.” A particular focus for this was to assist rapid discharge from acute care and to prevent avoidable admission to acute care.
- Work had been undertaken to increase specialist palliative care support to patients with non-malignant disease. This had increased across the trust by more than 200% from 280 referrals in 2013/14 to 643 referrals in 2014/15. This increase included the hospital liaison team. The percentage share of patients with non-malignant disease being supported by the team had increased from 27% to 30%.
- A palliative care steering group was in operation to guide the trust in delivering effective palliative and end of life care. Membership of the group included key staff and representatives from a variety of specialities including elderly medicine, general practice and general medicine. This helped to ensure that responsibility for good quality end of life care did not solely sit with the palliative care team.
- The trust had integrated the palliative care service across the trust and developed partnership working with third sector organisations to enhance services in a more ‘joined up’ way of working across acute and community services. Specific examples included the integration of the palliative care management structure with a head of service, operations manager and clinical matron covering the trust-wide palliative care service.
- The hospital liaison team model was one that had been developed jointly with the Marie Curie charity organisation. Resources invested by both the charity and the trust were used to create joint posts and strengthen collaborative working to meet the holistic needs of patients in both hospital and community environments. One example was the introduction of the band five palliative care nurse role with a focus on facilitating rapid discharge that included escorting patients into the community and providing support through the transition into community services. Staff we spoke with gave us examples of where this approach had worked successfully in supporting patients through their discharge to their preferred place of death.
- North Tyneside provided a day hospice offering patients the opportunity to attend on a weekly basis to have their palliative care needs addressed while living in their home environment. In addition, patients could be seen by a palliative care clinical nurse specialist / Macmillan nurse or palliative medicine consultant at home.
- We were provided with data from the trust which showed people’s place of death. Trust data showed a

Are services responsive to people's needs?

yearly increase in patient deaths in their usual place of residence and the rate to be consistently slightly better than the England average. In Northumberland in 2011/12 the rate was 43.6% (England average 42.4%), 2012/13 was 44% (England average 43.9%) and 2013/14 was 44.8%, (England average 44.7%). In North Tyneside, in 2011/12 the rate was 43.3%, 2012/13 was 48.7% and 2013/14 was 50.3% which exceeded the national average. The figures reflected an established integrated service working across the acute and community services within the trust to achieve home deaths.

Equality and diversity

- Equality and diversity training was delivered to all staff as part of their induction to the trust.
- The SPCT provided staff group reflective practice sessions and group debriefs for wards, teams and staff groups (nursing and medical). The team also provided ad hoc one-to-one support for staff. Staff told us access to interpreting services was good. In many cases, they used the telephone service; however, they had not experienced any problems when they needed to book an interpreter to attend an appointment.
- Individual end of life care teams provided information for patients and their families as and when patients came into their care. Guidance leaflets and information about health issues relative to people's diagnosis were available. Written information was available for patients and their families and although these were written in English, staff were able to obtain the information in other formats such as large print and audio as well as in different languages.

Meeting the needs of people in vulnerable circumstances

- Community services provided access to support and advice for caring for patients living with dementia and learning disabilities with the availability of the learning disability nurse and the community dementia services. Staff told us that that dementia and learning disability health passports were used on a regular basis when caring for patients with a learning disability.
- Personalised, individual care plans ensured that care was tailored to meet the needs of the individual at the end of life. Patients and family members we spoke with told us that their care was individualised and we observed discussions around care and treatment decisions that demonstrated this.
- Emergency health care plans, treatment escalations plans and advance care planning were all seen to be in use and embedded in practice. The wishes, choices and beliefs of individuals were seen to be incorporated into all plans and we saw good evidence of recorded discussions with patients and their families about their care at the end of life.

Access to the right care at the right time

- The community SPCT responded to referrals from consultants, GPs, community staff and acute hospital staff on the same day or the following day if the referral had been submitted in the latter part of the day.
- The trust had introduced a rapid discharge service within the palliative care service with the aim of providing a comprehensive, joined up palliative care service to patients and their families in all settings and assist rapid discharges from acute care as well as prevent avoidable admission to acute care.
- The end of life care team engaged with patients as early in their treatment as they could to make the initial assessment and liaise closely with GPs, district nursing teams and other health providers in an advisory and support capacity. They provided a range of interventions both in people's homes and in community settings enabling patients to receive treatments.
- Specialist support was available with Palliative Care Units operating a 24 hour service. There was a Palliative Care Consultant on call service seven days a week together with a 24 hour Palliative Care Helpline, which was nurse, led and situated at the Marie Curie Hospice.
- End of life care teams worked closely with local ambulance teams in order to help identify appropriate options if ambulance staff were called to end of life care patients to provide support in their home or care home setting. This was to prevent unnecessary hospital admission.
- Nurses in the community told us they felt a seven day service from the community would benefit patients. However, there were concerns expressed that the trust might struggle to fill the required number of posts in some of the more rural areas.
- Most hospital locations were easily accessible to each local community. However, if patients required to attend the main site, this could result in travel journeys of over an hour with some parts of the trust not having good transport links.

- We saw that advice given by the specialist care team was recorded in the patient notes with a sticker accompanying entries so that staff could quickly access the advice given.

Learning from complaints and concerns

- Very few complaints were received by the Community SPCT.
- Complaints and concerns were listened to and learning was used to improve services. For example we saw that members of the SPCT and district nursing team had supported a patient and their family around concerns regarding the patient's discharge from hospital. The family told us their concerns had been addressed.
- A proforma was in use in the community nursing teams where there was space for compliments and complaints to be recorded during the nursing handover. Staff told us this enabled them to capture feedback from patients and relatives as it was given. The feedback was reviewed by the community matron.
- Staff gave us examples of complaints they were aware of, including one where they had supported a patient who had complained of financial abuse from a family member. This led to a safeguarding alert being raised.

Outstanding ☆

Are services well-led?

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

Summary

We rated well-led as outstanding because:

There was a clear vision and strategy that focused on the early identification of patients at the end of life, patients being cared for in their preferred place of care and the use of partnership working to develop services. The strategy clearly communicated the vision of integrated services across the community and acute sectors to support patients being cared for in their preferred place of care. There was end of life care representation/leadership at trust board level and we saw evidence of active engagement in end of life care at board level. There were innovative approaches being implemented to achieve the joined up service within acute and community end of life teams.

The trust had implemented consultant-led community end-of-life care services and secured specialist status of services. These were based around localities, with each GP surgery having a named palliative care clinical nurse specialist and consultant. The trust had appointed in conjunction with Marie Curie, a service manager to work across hospital and community settings. The trust had embedded single multi-disciplinary meetings in Northumberland and North Tyneside, enabling discussion of complex patients across the region via teleconference. The roll out of a seven-day service across the community end of life service was due to begin in January 2016. Additionally, a seven-day palliative care consultant service was already in place.

There was comprehensive leadership within the palliative care service with clearly defined leadership roles. They were passionate about the service and encouraged staff to deliver high quality care. Local managers were proactive and came from a clinical background. They demonstrated an understanding of the current issues facing the service.

There was a clear sense of pride and belonging amongst staff at all levels within the end of life care teams. Each person's role was seen as being equally as important as the next. Staff appeared to have a genuine respect for each other within the team. Staff we spoke with demonstrated a commitment to the delivery of good quality end of life care. There was evidence that staff felt proud of the care they were able to give and there was positive feedback from nursing and care staff as to the level of support they received from the specialist palliative care team.

The trust was in the top ten and came 6th out of all trusts in England for the quality of care reported by the Cancer Patient Experience Survey 2014.

Service vision and strategy

- A palliative care steering group was in operation to guide the trust in delivering effective palliative and end of life care. Membership of the group included key staff and representatives from a variety of specialities including elderly medicine, general practice and general medicine. This helped to ensure that responsibility for good quality end of life care did not solely sit with the palliative care team.

- There was a clear vision and strategy for end of life care. This centred on the identification of all patients at the end of life, the provision of an integrated service between hospital and community services, the provision of a seven day service, enabling patients to stay in their place of choice and to improve patient outcomes and experience.
- This vision was consistently articulated by staff we spoke with. Staff told us the strategy was in the process of being reviewed alongside a revised service delivery model. The end of life strategy aimed to identify all patients with palliative care needs and ensure those needs were met through direct care, advice, information and education, provide a comprehensive, joined up palliative care service to patients and their families in all settings, enable patients to die in their place of choice, offer emotional and practical support to patients, carers and family members and to provide specialist input where needed.
- The trust was clear that they were committed to providing end-of-life care in the patient's place of choice and to enable people with life-threatening illnesses to lead the fullest life that people can have. Teams worked very closely with other departments to deliver care:

community nursing, chaplaincy, psychology and pharmacy. Additionally links had been established with other palliative care providers: Marie Curie Hospice Newcastle, North Northumberland Hospice, Tynedale Hospice and St. Oswald's Hospice to ensure patient care is seamless and offers choice.

- Specialist palliative care was moving to a seven-day model and full integration with other SPCTs across the region. The North Tyneside locality was due to move to a seven days service in January 2016.

Governance, risk management and quality measurement

- The Specialist Palliative Care Team reported within the Community and Social Care directorate. The service was held to account by the palliative care steering group. The group consisted of trust directors, senior trust staff from related services and lay representation to ensure independence and accountability.
- The service was led by a Head of Service, Matron in Palliative Care, General Manager and Operations Manager. The Head of Service was responsible for the strategic leadership and governance of the service and worked closely with CCGs to ensure the service met patient needs and national standards.
- Weekly and monthly team meetings took place in all the teams we met with. Standing agenda items included incidents, complaints, plaudits and policy updates. Staff at all levels told us the meetings were a useful source of information, encouraged staff to engage with issues and enabled learning to be passed across the teams and the trust. We checked minutes of meetings and saw that what staff had told us was reflected in the notes.
- Internal measurements of quality included place of death data and use of other metrics including patient feedback and analysis of patient activity.
- We saw a specific risk register for the specialist palliative care service. One example of a risk identified was poor service quality due to weak clinical audit arrangements or governance programmes. Control measures in place included the creation of a central evidence repository. The risk register was actively reviewed.
- Audits were completed and information shared with teams to show performance and highlight targets. One such area was mandatory training. The trust had set itself a target of 90% of staff across the trust to attend mandatory training. The SPCT had exceeded the trust targets.

Leadership of this service

- The General Manager and Operations Manager managed operations and resources to deliver the service aims. The service leadership was responsible to the Palliative Care Steering Group and a trust End of Life group consisting of senior trust staff from related services with lay representation.
- The post of Matron in Palliative Care role was created jointly with Marie Curie Care and had two aims: to ensure that the trust had the highest standard of end of life nursing in acute and community services and to provide nursing leadership to the service.
- The trust's palliative care steering group was chaired by one of the trust's executive medical directors and there was end of life care representation/leadership at trust board level. We saw evidence of active engagement in end of life care at board level.
- There was comprehensive leadership within the palliative care service with clearly defined leadership roles. They were passionate about the service and encouraged staff to deliver high quality care.
- Local managers were proactive and came from a clinical background. They demonstrated an understanding of the current issues facing the service.
- Staff told us they generally felt that the trust was committed to the ongoing development of end of life care services. Staff felt well connected to teams across the trust and all commented positively about the effectiveness of the MDT meeting which was held weekly.

Culture within this service

- There was evidence that the culture of end of life care was centred on the needs and experience of patients and their relatives. Staff told us they felt able to prioritise the needs of people at the end of life in terms of the delivery of care.
- There was a clear sense of pride and belonging amongst staff at all levels within the end of life care teams. Each person's role was seen as being equally as important as the next. Staff appeared to have a genuine respect for each other within the team.
- Staff we spoke with demonstrated a commitment to the delivery of good quality end of life care. There was

evidence that staff felt proud of the care they were able to give and there was positive feedback from nursing and care staff as to the level of support they received from the specialist palliative care team.

- The trust provided emotional support for staff as they recognised this was an important aspect in caring and provided staff with an outlet facilitating them to maintain their ability to continue caring for patients with complex needs and their families.
- Staff at Ashington and Hexham told us that senior staff were supportive, including the matron who often visited the unit.
- Staff told us that monthly ward meetings were held in which staff were able to contribute their views or concerns. Staff reported being proud of the service, the team and their job.

Public engagement

- The trust was in the top ten and came 6th out of all trusts in England for the quality of care reported by the Cancer Patient Experience Survey 2014.

Staff engagement

- The community inpatients staff survey showed 83% of staff felt satisfied with the quality of work and patient care they delivered. 91% felt their role made a difference to patients. Overall, 123 respondents contributed to the staff survey.

Innovation, improvement and sustainability

- The trust had implemented the Six Steps programme. This programme was originally developed as a programme of learning to develop awareness and knowledge of end of life care in nursing and care homes. As part of this initiative, end of life care training was provided by members of the specialist palliative care team to nursing and care home staff. The aim was to ensure end of life patients received high quality care in all settings.
- The chaplaincy had developed a tool for the assessment of patient's spiritual needs that provided staff with prompts that made it easier for them to have this discussion with patients.
- The trust was in the process of developing a 24-hour rapid response service to get supportive and specialist care to end of life patients, reduce hospital admission where appropriate and enable the patient to stay in their place of choice.
- The trust had implemented consultant-led community end-of-life care services and secured specialist status of services. These were based around localities, with each GP surgery having a named palliative care clinical nurse specialist and consultant. The trust had appointed in conjunction with Marie Curie, a service manager to work across hospital and community settings. The trust had embedded single multi-disciplinary meetings in Northumberland and North Tyneside, enabling discussion of complex patients across the region via teleconference.
- An electronic alert was implemented which was triggered when a palliative care patient was admitted to hospital, enabling timely interventions.