

Bradford District Care Trust

TAD

End of life care

Quality Report

New Mill
Victoria Road
Saltaire
Shipley
West Yorkshire
BD18 3LD
Tel: 01274 228300
Website: www.bdct.nhs.uk

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This report describes our judgement of the quality of care provided within this core service by Bradford District NHS Care 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 Bradford District NHS Care Trust and these are brought together to inform our overall judgement of Bradford District NHS Care Trust

Summary of findings

Ratings

Overall rating for End of life care services

Good



Are End of life care services safe?

Good



Are End of life care services caring?

Good



Are End of life care services effective?

Good



Are End of life care services responsive?

Outstanding



Are End of life care services well-led?

Good



Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	4
Background to the service	5
Our inspection team	5
Why we carried out this inspection	5
How we carried out this inspection	5
What people who use the provider say	6
Good practice	6
Areas for improvement	6

Detailed findings from this inspection

Findings by our five questions	7
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Summary of findings

Overall summary

End of life services were safe. There were arrangements in place to minimise risks to patients, including health risks and risks of harm to the patient. In general, staffing levels were safe and there was on-going monitoring to make sure that the number of staff on duty was flexible and met patients' needs.

Arrangements were in place to manage and monitor infection control, medicines, and the safeguarding of people from abuse. There were also dedicated teams to support staff and make sure that policies and procedures were implemented.

Staff knew the process for reporting incidents, near misses and accidents and were encouraged to do so. In addition, learning from incidents was shared between teams and across the organisation.

Services were effective, evidence-based and focused on the needs of patients. We saw some examples of very good collaborative work and innovative practice.

We also found evidence that patients approaching the end of life were identified in the right way. Care, including effective pain relief, was delivered according to their personal care plans, which were regularly reviewed. Patients in the last days of life were identified quickly and appropriate action was taken.

The majority of staff were up-to-date with mandatory training and there were systems in place to make sure that staff received regular appraisals. However, the clinical supervision of staff varied across the service and some staff did not have regular protected time to reflect on clinical practice.

End of life services were caring. Patients and relatives told us that staff supported them well and we observed that staff were compassionate and caring. Staff were also aware of the emotional aspects of caring for people with end of life illnesses, and made sure that specialist support was provided for people where needed.

The service understood the needs of the people it cared for, and developed services to meet those needs. There were systems in place to make sure that patients were able to access the right care at the right time, and that services were flexible enough to fit in with patients', and their families', lifestyles. This included, for example, their individual preferences, spiritual, ethnic and cultural needs. We saw excellent examples of staff making sure that the needs of patients with a learning disability accessing end of life care were understood and taken into account.

Systems were in place to encourage patients and their carers and/or families to provide feedback. There were also complaints procedures available and we saw that complaints were handled effectively.

End of life services had a clear vision and strategy to improve and develop high-quality end of life care. Managers and staff understood the roles and responsibilities of governance and quality performance. While most staff were aware of the trust's vision and strategy, not all staff knew about these.

Local managers provided good leadership and support, and most staff felt engaged with senior management. There was a positive culture in the service and staff felt that the leadership models encouraged them to be supportive of each other and compassionate towards people who used the service. In addition, staff were encouraged to raise problems and concerns about patient care without fear of being discriminated against.

People were encouraged to give their views on the service. We saw that these were heard and acted on, and that information on patients' experience was reported and reviewed, alongside other performance data. Where issues were identified, action plans were put in place to make improvements to patient care.

Summary of findings

Background to the service

The hospice at home team provided care for patients and carers where the patient had a life-limiting condition and where they were in the last six to eight weeks of life. The service was delivered in patients' homes, district-wide, by two teams.

The palliative care team provided care for patients with life limiting conditions. They provided specialist advice and symptom management. The service was delivered in patients' homes in the Bradford area.

Our inspection team

Our inspection team was led by:

Chair: Angela Greatley, Chair, The Tavistock and Portman NHS Foundation Trust

Team Leader: Jenny Wilkes, Head of Inspection – Hospitals Directorate (Mental Health), Care Quality Commission (CQC)

The team included inspectors, inspection managers, Mental Health Act commissioners, a pharmacist inspector and an analyst.

We also had a variety of specialist advisors, which included a palliative care specialist nurse and Experts by Experience.

Why we carried out this inspection

Bradford District Care NHS Trust was inspected as part of the second pilot phase of the new inspection process we

are introducing for community health services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

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?

The inspection team always looks at the following core service areas at each inspection:

1. Community services for children and families – this includes universal services such as health visiting and school nursing, and more specialist community children's services.

2. Community services for adults with long-term conditions – this includes district nursing services, specialist community long-term conditions services and community rehabilitation services.
3. Services for adults requiring community inpatient services.
4. Community services for people receiving end-of-life care.

We carried out an announced visit of end of life care services between 16 and 20 June 2014. Before visiting, we reviewed a range of information we hold about Bradford District Care NHS Trust and asked other organisations to share what they knew about the provider. During our visit, we held focus groups with a range of staff, including district nurses, health visitors and allied health

Summary of findings

professionals. We observed how people were being cared for and talked with carers and/or family members. We also reviewed the personal care or treatment records of patients.

We accompanied nurses from the hospice at home team to a number of people's homes to talk to patients and their relatives about their experiences. We also used information provided by the organisation and information that we requested.

In addition, we interviewed over 30 staff across all designations and roles. This included qualified nursing staff, specialist nurses, health care support workers, team leaders and managers. Some interviews were conducted on a one-to-one basis, while other group discussions were arranged as focus groups.

What people who use the provider say

We received a range of comments from patients and their relatives, both through comment cards as well as those we spoke with during the inspection. The comments were

overwhelmingly positive, with patients commenting on the quality of staff, high standards of care they had received and being able to access the right care at the right time.

Good practice

- The Bradford and Airedale Network for People with Learning Disabilities had a team of nurses, doctors, psychologists and social workers who supported people, their families and carers. The service had involved people in the production of easy-read guides and DVDs, which explained what happened at the end of life and how to plan for it.
- Patients on the Gold Standards Framework had access to The Gold Line. This was a dedicated service for patients and carers which could be accessed as an alternative to phoning 111, when the GP surgery was

closed or if patients were finding it difficult to get help during the day and required advice. The Gold Line was manned by a senior nurse and the service was available 24-hours a day, seven days a week.

- End of life services had employed two palliative care liaison workers who accompanied patients from ethnic backgrounds and their carers through their end of life journey providing emotional support and identifying a holistic and culturally appropriate care package. A female, bilingual health support worker was also available for female patients to discuss personal health issues.

Areas for improvement

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

- The trust should improve systems to make sure that all staff have access to regular protected time for facilitated, in-depth clinical supervision.

- The trust should develop formal documented competency assessments for health care support workers when double-checking syringe drivers.

Bradford District Care Trust

End of life careEnd of life care

Detailed findings from this inspection

The five questions we ask about core services and what we found

Good 

Are End of life care services safe?

By safe, we mean that people are protected from abuse

Incidents, reporting and learning

Staff were aware of the process for investigating when things had gone wrong. We found staff were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic system and were encouraged to do so.

Staff reported the culture for raising concerns was open and transparent which supported them to report concerns and incidents.

Staff confirmed they had received feedback from incidents during team meetings and handovers, and practices were in place to share information and learn across the organisation. For example, learning had taken place following a delayed discharge from hospital and the service had introduced a reactive nurse to ensure rapid facilitated discharges for patients wishing to be cared for at home.

Cleanliness, infection control and hygiene

There were policies and procedures for infection prevention and control. Staff reported they had received infection control training. Policies were adhered to such as 'bare below the elbows' dress code and we saw staff

regularly washed their hands and wore personal protective equipment such as gloves and aprons when providing personal care. We saw audits were carried out for hand hygiene which reported compliance at 90% and above.

Maintenance of environment and equipment

Premises run by the trust were noted to be clean and well maintained. There were procedures for the management, storage and disposal of clinical waste, environmental cleanliness and prevention of healthcare acquired infection guidance. Procedures were in place to make sure that equipment was regularly maintained and fit for purpose. Patients were provided with information detailing the procedure for equipment repairs and reporting of faults. There were arrangements in place in patients' homes for the handling, storage and disposal of clinical waste, including sharps.

Medicines

There were appropriate systems in place to protect patients against the risks associated with the unsafe use and management of medicines. The majority of palliative nurse specialists had undergone training for non-medical

Are End of life care services safe?

prescribing. Staff followed clear guidelines for prescribing medicines for patients receiving end of life care and these were reviewed during clinical network group meetings to make sure that national guidelines were followed.

Safeguarding

There were effective safeguarding policies and procedures, which were understood and implemented by staff. Staff were aware of the trusts' whistleblowing procedures and the action to take. Trust data showed the majority of staff providing end of life care services had received mandatory training in the safeguarding of children and vulnerable adults. Staff we spoke with demonstrated a good understanding of the different types of abuse and how to detect these.

Records

The service had direct access to electronic information held by other community services, including GPs. This meant that staff could assess up-to-date information about patients, for example details of their medical history and medicines.

Records were completed to a good standard and contained a clear pathway of care which described what the patient should expect at each stage of their treatment.

The service had clear expectations of the documentation that should be used in end of life care, including the process for the verification of death and care after death.

Lone and remote working

There were systems in place to promote the safety of staff when lone working. Staff told us they operated a joint working system for high risk activities. We saw reporting systems were in place to ensure the whereabouts of staff were known and staff were provided with mobile phones and could contact their office base during emergencies. Where patients received care in their home, staff carried out environmental and health and safety assessments.

Adaptation of safety systems for care in different settings

Staff took account of and adapted services to meet patient's needs. We saw examples of staff working proactively with other clinicians across the trust to assess patients regularly so that an end of life care plan could be made or adjusted, taking into account the patient's wishes and families' views.

Assessing and responding to patient risk

Staff were aware of key risks such as falls and pressure care. We saw risk assessments were completed and staff responded to findings by referring people for additional assessments or for relevant equipment.

We observed safe patient handovers, which took place between staff shifts. The senior nurse provided a clear clinical overview and identified relevant information to ensure patient safety. An out-of-hours handover form remained in the patient's home giving guidance to staff who may be called. There were systems in place for taped handovers, which enabled staff who were out on visits to receive a comprehensive handover from colleagues which ensured continuity and safety of care.

Staffing levels and caseload

The trust had recently invested in palliative care staffing levels to develop the provision of a seven day service. Staffing levels were benchmarked with other similar community trusts and were determined against the dependency of patient needs. Patient dependency levels were reviewed daily and staffing and skill mix was adapted to ensure patients received safe and appropriate care.

Staff we spoke with told us they were able to meet people's needs but found it a challenge at weekends due to the geographical areas they covered and the unpredictable number of emergency calls. They told us it was not always clear who had responsibility across services to provide elements of care. The trust was undertaking a review of nursing services and one recommendation was to see how hospice at home could be embedded within community nursing services to remove fragmentation of service.

Deprivation of Liberty safeguards

Staff received training in Deprivation of Liberties Safeguards (DoLS) There were no patients with DoLS restrictions within the end of life care services at the time of our inspection. However, the staff we spoke with demonstrated a good understanding of the trust DoLS policy, which outlined the process for DoLS and staff were aware of the legal requirements of the Mental Capacity Act 2005.

Managing anticipated risks

There were systems and processes in place to maintain patient safety. The end of life care teams were well placed within the localities they served. There was routine engagement by the teams providing end of life care

Are End of life care services safe?

services within the trust as well as external organisations such as the hospitals, GP's and local hospices so staff were kept informed and could make arrangements for patients that were awaiting referral for end of life care services. Patients were triaged and assessed accurately so that safe treatment and care was provided to guard against risks associated with their condition. Risk assessments in areas such as falls, pressure care and nutrition were complete and updated as patient's needs changed.

Contingency plans were in place in the event major events, such as outbreaks of flu or winter weather affecting staffs ability to travel.

Major incident awareness and training

There was a documented business continuity plan for teams providing end of life care services and this provided instructions for staff on how to manage key risks that could affect the provision of care and treatment. Staff received mandatory training in fire safety and health and safety. There were clear instructions in place for staff to follow in the event of a fire or other major incident.

Are End of life care services effective?

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

Evidence based care and treatment

Individual roles and responsibilities were understood by staff in the delivery of evidence-based care. This included involvement in the development of policies and procedures, and in the assessment and monitoring of the quality of care provided to people requiring end of life care. Care pathways demonstrated they had referred to NICE (National Institute for Health and Care Excellence) guidelines and the Gold Standards Framework (GSF) to make sure that patients were appropriately assessed and supported with their end of life needs.

Evidence showed that staff followed nationally recognised guidance which focused on assessing factors indicating possible deterioration of patients nearing the end of their lives, so that care could be anticipated and given earlier, before crisis point was reached.

We looked at how the service had responded to changes in the use of the Liverpool Care Pathway (LCP). The clinical lead for palliative care told us the service had undertaken an audit of patients who were on the pathway; two patients expressed a wish to remain on the LPC and were reassessed on a regular basis by the specialist palliative care team to make sure that the LCP remained appropriate for them. The LPC was withdrawn for use for any new patients and interim guidelines had been developed to support patients in the last days of life. This showed the service had responded to concerns regarding implementation of the LCP and ensured a safe approach.

There was a joint policy with all healthcare providers in the Bradford and Airedale district for Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) which followed professional standards and national guidelines. We saw that in each case appropriate consultation had been undertaken with the patient or their relatives and DNACPR decisions and review dates had been clearly documented.

Pain relief

Records showed patients were provided with options and information relating to pain relief. Those requiring pain relief had pain assessment charts in place which included end of life tools such as symptom control management.

Records showed anticipatory planning was undertaken to reduce the risk of escalating symptoms. For example, during the last few days of life the palliative care team provided a 'just-in-case' box of medicines. This enabled appropriate anticipatory prescribing for patients without delay. Appropriate systems for the safe custody and checking of controlled drugs and syringe drivers were in place which reduced the risk of inappropriate use. Although regular competency assessments were carried out to enable health care support workers to act as a second check for syringe drivers, we found the assessments were not being formally documented.

Nutrition and hydration

Nutrition and hydration assessments were completed on all appropriate patients. These assessments were detailed and used nationally recognised nutritional screening tools. Patients were supported with food and fluid intake.

Patient outcomes

We saw evidence that end of life services monitored the performance of their treatment and care. Data for 2012/13 showed that the percentage of patients who died in their preferred place of death was 82% against a target of 75%. The service also participated in national audits and surveys such as the Association for Palliative Medicine pilot survey of pain management however the results of this were not available at the time of inspection as they had not been published. Records showed the service contributed data about end of life care to the National Minimum Data set to inform national palliative care networks. The data for 2013/14 was still being compiled.

Performance information

The trust used the NHS Safety Thermometer which is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free care'. The data for palliative care services showed 100% harm free care was being achieved.

Competent staff

Staff that had recently gone through the induction programme were positive about it, and staff were able to

Are End of life care services effective?

access professional training in line with their specialism. Records showed over 80% of staff had completed mandatory training and had received performance reviews. All staff we spoke with told us they had had an appraisal within the last 12 months and staff thought it was a supportive and valuable process. Staff experience of clinical supervision was variable across teams and some staff were not accessing regular protected time for facilitated, in-depth clinical supervision. Further work was needed to ensure supervision was effectively implemented.

Use of equipment and facilities

There was continuous liaison between end of life services and equipment loans with access to timely provision of equipment particularly beds, mattresses and syringe drivers. Staff told us equipment could be provided at short notice. Records showed that staff were trained in the use of relevant equipment, for example there was a programme in place for syringe driver training.

Multi-disciplinary working and working with others

Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary

team (MDT) working practices were in place. Staff told us there was effective communication and collaboration between teams who met regularly to identify patients requiring visits or to discuss any changes to the care of patients. As a minimum, the service held a full MDT reassessment of patients led by a named senior medic every three days as well as on-going daily reviews.

The service used an Electronic Palliative Care Coordination System to support the co-ordination of care so that people's choices about where they die, and the nature of the care and support they received, was respected and achieved wherever possible. This enabled key medical information and conversation about end of life care wishes to be communicated across areas and with external providers and services.

Co-ordinated integrated care pathways

Care records showed the involvement of other agencies in providing integrated care pathways, for example staff worked closely with national and regional palliative care networks. We saw examples of excellent holistic integrated care pathways. This clearly detailed anticipated care that had been drawn up by the multidisciplinary team and were patient and family focused.

Are End of life care services caring?

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

Compassionate care

We observed positive interactions between staff and patients in their homes. Patients were treated with compassion and empathy. We observed staff speaking with patients and providing care and support in a kind, calm, friendly and patient manner. The patients we spoke with were very complimentary about staff attitude and engagement. One person told us they couldn't praise the staff more, they said that "the hospice at home team nurses were marvellous and they couldn't have been more helpful."

Dignity and respect

We observed staff treated patients and their relatives with dignity and respect. Patient confidentiality was respected when delivering care, in staff discussions with patients and their relatives and in any written records or communication.

Patient understanding and involvement

Patients and relatives we spoke with all indicated they were involved in care decisions. Staff appropriately identified patients approaching the end of life and patients were offered and given the opportunity to create an advanced care plan, including preferred priorities of care. Records contained evidence of consent from patients for treatment. Clinical records showed patients who had an Advance Decision to Refuse Treatment (ADRT) were clearly documented and staff were aware and complied with national and specialist guidance for the management of patients with an existing ADRT.

Where patients were unable to make decisions about their treatment, records showed assessments of the person's mental capacity and best interests had been taken which followed the principles of the Mental Capacity Act 2005.

Emotional support

Patients and relatives told us they were well supported when they had been told difficult diagnosis. We observed that staff used a holistic approach encompassing physical, social and spiritual well-being and this was incorporated into care planning. Staff had undertaken training in 'Sage and Thyme' communication skills which is a tool used to guide healthcare professionals into and out of conversations with someone who is distressed or concerned. Access was available to a psychologist and social worker who provided pre- and post-bereavement support. We observed emotional support was available for family carers to enable them to pursue a life of their own alongside their caring responsibilities. The hospice at home service completed carers needs support plans and signposted carers to carer bereavement support and information services.

Promotion of self-care

Due to the complex needs of patients receiving end of life care services, it was not always possible to promote self-care. However, the patient records we looked at included person-centred care plans based on the individual needs and preferences of patients.



Are End of life care services responsive to people's needs?

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

Service planning and delivery to meet the needs of different people

We found the service had a good understanding of the different needs of people it served and planned, designed and delivered services to meet those needs. There was evidence that staff actively engaged with local commissioners of services, the local authority, other providers, GP's and patients to co-ordinate and integrate pathways of care that met the health needs of patients. Service specifications were in place which detailed the aims, objectives and expected outcomes for patients nearing the end of their life and were monitored against national and local performance indicators. Outcomes showed patients were receiving a high quality service.

Access to care as close to home as possible

Patients on the Gold Standards Framework (GSF) had access to The Gold Line. This was a dedicated service using tele-health for patients and carers which could be accessed as an alternative to phoning 111, when the GP surgery was closed or if patients were finding it difficult to get help during the day and required advice. The Gold Line was manned by a senior nurse and the service was available 24 hours a day, seven days a week to take calls. The nurses provided support and advice and referred patients to other services including GP's, community nurses or the hospice. Data for four months up to March 2014, showed that 35 patients using the Gold Line had avoided unnecessary admission into hospital. District nurses' working alongside the hospice at home teams reported a favourable impact in enabling patients to be cared for at home.

During a home visit we observed the gold line service in use. As part of the home visit we contacted the gold line service using the patient's iPad system. On the system we were able to see and speak to the triage nurse who answered the call. We also spoke with the patient and their relative and they told us how reassuring they found it to have this system in their own home.

Access to the right care at the right time

Staff told us that patients were referred to the end of life care services through a number of routes including via GP or consultant referral, or they could visit local hospices or self-refer. The service actively used the GSF to plan the right care for people as they neared the end of their life. With the

patient's permission they were registered on the GSF and were given a gold standard patient care card. The gold standards care plan showed staff had followed patients' needs and wishes to get the care that they wanted in the right place. Patients were highly complementary of the service and confirmed they had received a co-ordinated and seamless service.

There were effective systems in place to identify patients who had a rapidly deteriorating condition and required access to the fast track pathway for NHS continuing healthcare. Records showed patient needs were met without delay following discharge from hospital with all the appropriate equipment and support being available within four to six hours.

Flexible community services

Patients and relatives told us that services were accessible and tailored by staff to meet their individual needs, at the times and in the places to best suit their lifestyle. The hospice at home team provided a seven-day service, operating from 8am to 10pm, patients could access the specialist palliative care service during the week flexibly from 8am to 5pm. Out-of-hours care was provided by the district nursing teams and there was good access to the on call palliative care consultants, hospice staff, GP's, social care and hospitals.

Newly referred patients were seen within four hours of a referral being received by the hospice at home team. Patients accessing specialist palliative care services were triaged and urgent referrals were seen within two working days.

Meeting the needs of individuals

There was evidence of proactive outreach programmes and service adaptations to meet the needs of people in vulnerable circumstances. For example, there was evidence of collaborative working with national networks to ensure palliative care needs for people with learning disabilities were met. The Bradford and Airedale Network for People with Learning Disabilities had a team of nurses, doctors, psychologists and social workers who supported people,



Are End of life care services responsive to people's needs?

their families and carers. The service had involved people who used the service in producing easy-read guides and DVDs which explained what happened at the end of life and how to plan for it.

There was constructive engagement with hard to reach groups and ethnic minorities. The service had employed two palliative care liaison workers who accompanied patients and their carers through their end of life journey providing emotional support and identifying a holistic and culturally appropriate care package. A female bilingual health support worker was available for female patients to discuss personal health issues. The liaison workers attended weekly multidisciplinary (MDT) meetings and worked with staff to make sure that care and treatment was planned and delivered to reflect patients' ethnic, spiritual and cultural needs. Evaluation of the service showed very positive patient experiences and improved access rates. The role had been shared across health and social care services in Bradford and across palliative care services in the UK.

Access was available to nurses who specialised in specific diseases. The clinical nurse specialists were involved in setting up a 'one-stop' motor neurone clinic, which incorporated an MDT approach to care. Patients accessed a range of services such as speech and language therapy, social workers and physiotherapy during their outpatient clinic attendance.

Moving between services

Records showed patients and their families had been involved throughout their care pathway and their wishes had been considered. We saw that discussions had taken place to ensure the best outcome for patients. Patients and their relatives had been asked about their wishes for their preferred place of care and this had been accommodated where possible.

Complaints handling (for this service) and learning from feedback

We saw numerous letters and cards expressing positive feedback from patients and relatives about end of life care. Staff were aware of the trust's policy for handling complaints and had received training in this area. Information was given to patients about how to make a comment, compliment or complaint. There were processes in place for dealing with complaints at service level or through the trust's patient advice and liaison service. We found the clinical lead for palliative care was proactive in dealing with complaints before they escalated by visiting patients and their family at home to discuss concerns. Staff told us there was active reflective practice and learning following complaints and improvements had been made in facilitating timely patient discharge from hospital. Records showed complaints about end of life care were minimal.

Are End of life care 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.

Vision and strategy for this service

The end of life service had a clear local vision to improve and develop high-quality end of life care across the Bradford and Airedale district and followed the Department of Health's guidance on the End of Life strategy (2008) and End of Life Care Strategy: quality markers and measures for end of life care (2009). The increase in investment and staff to support a seven-day service supported this vision. Most staff were aware of the trust's vision and strategy, but this was not fully embedded among all staff.

Guidance, risk management and quality measurement

Risk management and quality assurance processes were in place at a local level. End of life service held governance and patient safety meetings and records showed risks were escalated and included on risk registers and monitored each month. Local quality dashboards were also completed which showed how the service was performing against key quality indicators. We found managers were aware of the quality issues affecting their services and shared this with staff.

Leadership of this service

There was a clinical lead and nursing lead for end of life care and the chief nurse had responsibility for oversight of end of life care at Board level. Most staff we spoke with said they were aware of the leadership structures and received good leadership and support from their immediate line managers. Some staff told us members of the trust board were visible and had accompanied them on patient visits. Staff confirmed there were regular formal cascade processes including messages from the chief executive and board of directors.

Culture within this service

Staff reported a positive culture in the service. They reported good engagement and felt they were being listened to. Staff spoke positively about the service they provided for patients. High quality and compassionate patient care was seen as a priority. The trust had introduced 'culture conversation' workshops which

focused on what it felt like for staff to work for the trust and what improvements were necessary to ensure that the culture was truly patient focussed however we found not all staff were aware of or had attended the workshops.

Staff told us they were encouraged to raise concerns about patient care and this was acted on. We found all the staff were dedicated and worked well as a team. Figures showed staff sickness levels were in line or lower than expected targets. The majority of staff told us morale was good.

Public and staff engagement

Staff had participated in the trust's 15 Step Quality Challenge, which is a tool used to improve patient experience. The end of life care challenge team telephoned patients and asked them about their experiences and also made one home visit to a patient and carer receiving services from the team. Everyone contacted was overwhelmingly positive about the care they had received from the team.

Patient feedback was also collected by staff when visiting patients at home using hand held tablet devices. The results for March 2014 showed patients or relatives would be extremely likely or likely to recommend the service to their family and friends.

Patients were invited to present their story to the trust Board to share their experience and facilitate learning, which included a relative accessing palliative care. Their feedback about the palliative care team and how they had introduced them to Marie Curie Hospice had provided a very positive experience.

Staff told us staff engagement was good. They spoke positively about being able to raise concerns with their immediate managers and to make suggestions for improvements.

Innovation, improvement and sustainability

Evidence showed that staff were encouraged to focus on improvement and learning. We saw examples of innovation such as the Gold Line tele-health hub, provision of care and treatment for people with learning disabilities and ethnic

Are End of life care services well-led?

minorities. The palliative liaison service work with ethnic minorities had won a Department of Health and Social Care award under the category 'Improving Lives for People with Cancer' and was awarded with a commendation.

There was good collaboration with local and national palliative care networks including other providers to

improve quality of care and people's experiences. Records showed managers of the service managed financial pressures in a way that did not impact on the quality of care.