

Somerset Partnership NHS Foundation Trust

RH5

Community end of life care

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RH5F8	West Mendip Community Hospital		
RH5G5	Frome Community Hospital		
RH5G2	Wincanton Community Hospital		
RH5X7	Williton Community Hospital		

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service Good I

We rated community end of life care overall as good. We rated the service as 'Good' for being effective, caring, responsive to people's needs and well led at local levels. Safety was rated as requires improvement.

Somerset Partnership NHS Foundation Trust did not solely employ its own team of palliative care nurses or doctors. They had no one member of staff whose sole responsibility was to lead end of life care. Community nurses provided end of life care to patients in their own home with support from palliative care nurses from the local hospices. Staff in community hospitals provided end of life care to inpatients. The trust hosted the palliative care medical team that had existed for just over a year at the time of our inspection. This trust, two acute trusts and local hospices funded this team. Its remit was to provide advice and support across the majority of Somerset and all the providers who funded their posts. The palliative care medical team felt this had improved the continuity of care for end of life patients. However, there was no lead consultant among this group appointed by the trust to lead the team.

Not all staff were reporting medication prescribing errors on the trust incident-reporting system. Patients' care records were not always up to date with their current needs and care plans did not always cover all assessed needs. We found patients' wishes about their end of life care and treatment were not documented in their care records.

We also found references to the Liverpool Care Pathway in some trust forms and the trust end of life policy dated 2015. References to this should have been removed in 2014.

The service had a continuous improvement plan but the dates for completion of the vast majority of the actions were after our inspection so we could not assess its impact.

We observed patients being cared for with dignity, respect and compassion. Patients and their relatives told us how good the care was and that staff were kind, caring and considered the patients' dignity. At the End of Life Care Coordination centre, (This is a nurse-led telephone centre that has an overview of health and social care services available in Somerset. Staff were able to tailor a package of care to meet the patient's needs at the end of life), staff worked effectively with other health and social care professionals to set up care packages and provide equipment quickly for end of life patients who wanted to die at home. The trust was working with other providers and the local clinical commissioning group on devising an end of life strategy for Somerset. This was to make sure patients across Somerset had joined up delivery and continuity of service from all providers involved in their care. Individual teams of staff demonstrated a commitment to deliver good end of life care and to develop end of life provision. The staff we spoke with told us they had a high level of respect for their line managers at local levels and felt able to discuss issues or problems with them.

Summary of findings

Background to the service

Information about the service

End of life care services are provided through community hospital inpatient beds and community nurses supported by external hospice and social care providers. Somerset Partnership NHS Foundation Trust hosts the specialist palliative care medical team with a remit to improve palliative and end of life care for people in the catchment of St Margaret's Hospice. This includes Taunton, Yeovil and Mendip but not East Mendip or part of North Sedgemoor. This amounts to approximately 86% of the total population of Somerset. Bordering palliative care services include those provided by Dorothy House and Weston Hospices. The specialist palliative care medical team also work within the community as part of their job plan. They also offer clinical expertise and care to inpatients at both acute hospitals (Musgrove Park Hospital in Taunton and Yeovil District Hospital) and the St Margaret's hospice units in Taunton and Yeovil as well as the trust's thirteen community hospitals and older people's mental health wards.

The trust had 785 deaths of patients who were on the end of life pathway from September 2014 to August 2015.

Somerset Partnership NHS Foundation trust also runs Somerset End of Life Coordination Centre. This is a nurse-led telephone centre that has an overview of health and social care services available in Somerset and staff are able to tailor a package of care to meet the patient's needs at the end of life. This service is specifically for patients over the age of 18 years, who receive Continuing Health Care fast track funding and their families. Staff are able to set up packages of care and equipment quickly to enable patients to leave hospital or to support patients already at home. This centre has access to the End of Life register. This register enables the recording and sharing of patients' care preferences and key details about their care at the end of life with their consent. The staff can add patients' details on to this on behalf of other health care professionals with the patients' consent.

On this inspection we visited one patient receiving care at home. We visited four community hospitals and spoke with four patients and eight relatives. We also spoke with 20 staff, including nursing and administration staff and three doctors.

Our inspection team

Chair: Kevan Taylor, Chief Executive Sheffield Health and Social Care NHS Foundation Trust

Team Leader: Karen Bennett-Wilson, Head of Inspection for Mental Health, Learning Disabilities and Substance Misuse, Care Quality Commission

The team that inspected this core service included a CQC inspector, specialist nurse and a director of nursing from a hospice provider.

Why we carried out this inspection

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

How we carried out this inspection

We always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?

Summary of findings

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

Before the visit, the inspection team:

- reviewed information that we hold on the trust
- requested information from the trust and reviewed that information
- asked a range of other organisations that the trust works in partnership with for feedback these included NHS England, Somerset clinical commissioning group, Monitor, Healthwatch, overview and scrutiny committees, professional bodies and user and carer groups
- held three listening events before the inspection to hear the views of local people
- reviewed information from patients, carers and other groups received through our website.

During the announced inspection visit from 7 to 11 September 2015, the inspection team:

- visited a total of 88 registered locations
- visited all 32 wards in community hospitals and mental health inpatient units, 52 locations where community services were delivered
- observed how people were being cared for in wards and clinics and accompanied community teams on visits to people's homes, seeing 110 episodes of care.

- reviewed 368 care or treatment records of people who use services
- spoke with 178 people who used the services and 75 carers or family members
- we received 119 comment cards that we had left in a range of patient areas before our inspection. We were also contacted by five people via our public website
- spoke with 423 staff who worked within the trust, such as nurses, doctors, therapists and support staff
- interviewed the chief executive and all the members of the executive team and three of the non executive directors of the board
- attended and observed a council of governors meeting and spoke with four governors
- interviewed other senior managers in the trust, including 83 managers of services, such as ward managers and divisional team leaders
- held 40 staff focus groups
- spoke with 14 external stakeholders, for example, commissioners, other care providers
- attended 37 meetings held by the various teams and services, such as ward rounds, care planning review meetings.

What people who use the provider say

We spoke with four patients and eight relatives. All spoke in the most positively about the kindness of the staff and the service they had received. These comments included,

- "Felt very well looked after" and "always treated with dignity and respect".
- "They look after my relative very well and they are safe here"

- One relative commented that they had received "very little support at the beginning of the diagnosis and everything at the end" which they felt was overwhelming.

All patients and relatives we spoke with told us they had been consulted about decisions and understood what was happening and why.

Summary of findings

Good practice

- The end of life care coordination centre enabled patients to be discharged from hospital very quickly with the support of other health and social care professionals to make sure patients were able to die in their preferred place of death, their home.
- The palliative care medical team was hosted by this trust but they worked across a number of other providers to include hospices and the acute trusts. This enabled them to maintain continuity of care for patients being cared for by any of these service providers.

Areas for improvement

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

An action that a provider of a service **MUST** take relates to a breach of a regulation that is the subject of regulatory action by the Care Quality Commission. Actions that we say providers **SHOULD** take relate to improvements that should be made but where there is no breach of a regulation.

Action the trust **MUST** take to improve

- The trust must ensure that all patient records and documentation are up to date with their current needs, with care plans for each assessed need and actions for staff to follow.

Action the provider **SHOULD** take to improve

The trust should:

- ensure that all staff report GP prescribing errors via the incident reporting system
- provide all staff with end of life training
- appoint a member of staff whose role is purely end of life care to make sure the service moves forward
- appoint a lead palliative care consultant to lead the team.

Somerset Partnership NHS Foundation Trust

Community end of life care

Detailed findings from this inspection

Requires improvement 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated community end of life care as requiring improvement for being safe.

We found that patients' records were not up to date with their current needs and care plans did not always cover all assessed needs. Care plans also lacked actions for staff to follow in meeting the needs of patients. In the community, there was duplication of records, as staff had to complete both electronic and paper records for each patient.

We saw no advance planning documentation in use and we did not see patients' wishes about their care and treatment recorded. Advance planning is where patient's wishes about their end of life care and treatment are recorded. The trust was planning to pilot a new care and communication care planning documentation for end of life.

Not all staff was reporting prescribing errors via the trust's incident reporting system. Therefore the trust were not able to investigate these and put actions in place to reduce the chance of them happening again.

Detailed findings

Incident reporting, learning and improvement

- Staff we spoke with across the trust (including community hospital staff and community nursing teams) had access to and knew how to report incidents of harm or risk of harm using the trust's online reporting system. A senior member of staff at West Mendip Community Hospital told us about the procedure once an incident form was completed by a member of staff. It was logged by the risk management team and a senior member of staff from the hospital would review incidents relating to the hospital and lessons to be learned from them. (We did not see any of the investigation reports.) Information was fed back to staff at ward meetings. We saw a copy of the minutes of a staff meeting held at this hospital, which demonstrated that feedback was given about incidents.
- At West Mendip Community Hospital we found a medication prescribing error on a patient's medication administration record, which occurred before our inspection. A member of staff told us they had identified the error and was going to report it. A community nurse told us about a prescribing error with a syringe driver but when asked if they had reported it via the incident reporting system they said they did not like to report GP errors as it might make relationships difficult. This meant that medication errors were going unreported.

Are services safe?

- From October 2014 to December 2014, the trust had reported nine medication errors for end of life care in the community and the community hospitals. We were shown the investigation findings into these. Where the investigations had identified areas of learning, these were recorded. For example, one related to a ward not having enough medication for a syringe driver for the weekend. The investigation report mentioned that this was going to be shared with the nursing staff to make sure they always had enough medication to cover weekends. Staff at community hospitals and in community nursing teams told us they always made sure they had enough medication to cover weekends and bank holidays.
- The trust monitored incidents in end of life care for example, pressure ulcers. From April to June 2015 the Quarterly High Risk Areas Report to the Clinical Governance Group Meeting reported 38 incidents, of which 10 were pressure ulcers/skin damage. The trust told us this was being investigated by the pressure ulceration best practice group. We asked the trust for more details about these pressure ulcers incidents. The trust told us they had all been investigated and gave us an example of this. Three pressure ulcers were found to be unavoidable and good robust practice had been identified. These pressure ulcers were attributed to end of life skin changes and rapid deterioration in the patient's condition.

Duty of Candour

- The Duty of Candour sets out what service providers must do to make sure they are open and honest with patients and their families when something goes wrong with their care and treatment. Staff we spoke with had an understanding of the term duty of candour and were aware of their responsibilities relating to it. A senior member of staff gave us an example of an incident with a syringe driver and that staff had spoken and written to the family of the patient as the patient was end of life and dying. They had told the family about the learning that was to be shared with staff following this incident.

Safeguarding

- All staff spoken with said they would contact the trust's safeguarding team for advice if they felt a patient was at risk of abuse. We spoke with staff involved in the care of patients, who were able to describe different types and signs of suspected abuse – for example, neglect,

financial or physical abuse. The majority of staff in locations we visited told us they had completed safeguarding awareness training. The percentage of community nursing staff who had completed safeguarding adult training level one was 84.2% in July 2015. For the 13 community hospitals, the rate of level one safeguarding training for adults completed ranged from 77.1% at West Mendip Community Hospital to 100% at Williton Community Hospital in August 2015.

- Information including a flow chart about how to make a safeguarding alert was easily visible on walls of wards and the community nurses' offices.

Medicines

- There were safe arrangements for the management of patients' medication at community hospitals and within the community teams.
- Ward stocks contained commonly used end of life medicines so they were readily available for prompt use when patients were admitted. We saw stock control checks were undertaken weekly which were all correct. We found this medication was stored securely.
- Staff told us they had received training in the use of syringe drivers (a pump used to deliver pain relief and other medication to a patient through the skin for a specific period) which ensured that they were competent to administer drugs in this way for patients who were at the end of their life. The trust provided us with copies of training records for both community and hospital nurses.
- In West Mendip Community Hospital, registered nurses said there were always two registered nurses available if required to set up or renew a syringe driver. Community nurses were able to set and renew a syringe driver alone if they felt competent and had completed the training and competency assessment.
- Community nurses told us about a 'just in case' box of medication for use with patients who were at the end of their life. These boxes were stored at the patient's home. This was an easily identifiable box containing prescribed medications from an advisory list in line with the trust's policy. This enabled community nurses or other healthcare professionals (such as GPs) to give patients a single dose of medication to treat symptoms including pain, nausea and vomiting. A member of staff gave us an example of when these boxes had been individualised,

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for a patient at risk of chest infections. Anticipatory prescribing had been used to ensure antibiotics were included in their 'just in case box' to enable the registered nurses to commence more promptly.

- The trust had produced information leaflets for patients, for example, opioids use for palliative care patients and another about the use of fentanyl patches. Community staff and community hospital staff had access to these leaflets to give to patients.

Environment and equipment

- All hospitals and trust premises we visited appeared visibly clean and tidy.
- At West Mendip Community Hospital, the defibrillator we checked was ready to use and on charge. We saw evidence of daily checks of this machine and the resuscitation equipment.
- For patients in receipt of fast track Continuing Health Care Funding (CHC) staff were able to obtain equipment via the End of Life Care Coordination Centre. The type of equipment available included hospital type profiling beds, pressure relieving mattresses and commodes. For patients who were not in receipt of this funding the community nurses were able to order the same equipment for them.
- The NHS National Patient Safety Agency (an agency established to improve patient safety in hospitals) recommended in 2011 that all Graseby syringe drivers should be withdrawn by the end 2015. Following the recommendation, an alternative appropriate syringe driver had been introduced into the trust. Staff told us they had been using these for a while and they were provided with training.
- Staff in the community told us they could always obtain a syringe driver, as there was a tracking system in place managed by the End of Life Coordination Centre.
- We observed community nurses disposing of ampoules they had used for the syringe driver in a safe manner when using these in a patient's homes. Once the sharps boxes were full, the community nurses took them to one of the trusts locations to be disposed of safely.

Quality of records

- Not all patients' records were accurate and up to date with their assessed needs reflected in plans of care

which could compromising the quality of care provided. We found records on the trust's computer system were stored securely as each member of staff had a secure log in.

- We examined three patients care records at Frome Community Hospital on the trust's computer system. All care plans were on the trust's computer system, however some paper records were still being used, for example, food and fluid charts.
- The first patient had been admitted to the ward the day before our visit and their care plans on the computer system had not been completed. Therefore, staff did not have details about this patient's needs or the action need to meet them.
- For the second patient we found their care plans lacked detail on how to meet their needs. For example, one care plan said 'to assess mobility on admission and develop a rehabilitation plan'. There were no other details in this care plan regarding the rehabilitation plan. Additionally the plan had not been updated to reflect that the patient was currently receiving end of life care and was unable to mobilise due to being bed bound. There was also no care plan in place to meet their personal care needs, as they required help from staff with washing and dressing. Another of this patients care plans contained very little details on how to manage their nephrostomy tube. We asked a senior member of staff about this specific care plan, and they agreed the detail was insufficient and told us they would going to address this.
- We reviewed one set of patient's notes in the community. We found they did not have a care plans in place for catheter care or pain control. This may have led to incomplete care and the patient being in pain.
- We found pain assessment forms were available but were not always being used or completed in full. One patient in Frome Community Hospital had one in place but it was not completed in full, as the staff had not asked the required questions as part of the assessment. Another patient we visited at their home had a syringe driver in place plus they were receiving an extra dose of pain relief prior to having a wound dressing change did not have a pain assessment form in place. However, both patients were having their pain needs met by staff.
- At West Mendip Community Hospital, we observed one patient had a fluid chart to monitor their fluid intake and output. We found there was only one entry for input and one entry for output on the chart when we visited in

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the afternoon. We would have expected to see their breakfast, lunchtime and any other drinks recorded, and their output. The previous day also had very few entries and this had not been added up for the 24 hour period. This patient required close and accurate monitoring of their fluid intake and output due to their condition therefore, it was important these were completed in full.

- The community nursing teams had a dedicated palliative care planning pack for use for patients receiving care at home or in a care home or nursing home. The pack contained a range of documents linked to end of life care for example, an assessment of needs, a section to write care plans, risk assessment documentation for falls and pressure ulcers and information about how to manage certain symptoms like nausea and vomiting. Staff told us they did not always use this if the patient was already had care planning documentation in place but would have updated this reflect their care needs.
- Staff told us the trust computer system did not always contain all care plans that may be required. For example, one patient needed a care plan for mouth care. Staff said they were able to access the library for care plans on the trusts computer system but it did not always have a care plan they needed. The trust told us this system was to assist staff with care planning but it was not a comprehensive list of care plans. Staff were able to add in care plans to meet patients individual needs. Whilst care plans we saw were not always individualised to this patient we did find some of the nursing progress notes very informative about patients' conditions.
- Community staff told us there was a lot of duplication of records as they had to document details on the trusts electronic system and maintain paper records in the patient's own home. They did have hand held devices for completing the trusts electronic system but these were not working at the time of our inspection. This meant that patients paper we saw records were not up to date with their care needs and this could place them at risk of not having their needs met. We did not see the computer records.
- We saw no advance planning documentation where patient's wishes were recorded about their care and treatment they wanted at the end of their life in use. We were shown the trust's new documentation they were planning on piloting which was a new care planning and

communication tool that would prompt staff to record patient's wishes around their treatment and where they wanted to die. This would be available for all trust staff to use.

Cleanliness, infection control and hygiene

- There were infection prevention and control systems in place to keep patients safe. For example, protective clothing for staff to wear and access to hand gel. The ward areas we visited were visibly clean. There were hand gel and hand washing facilities available for staff and visitors to use. We observed staff using the hand gel and washing their hand once they had finished caring for a patient. Single rooms were available to care for patients who had infections to reduce the risk of cross infection to other patients.
- We observed community nurses washing their hands prior to attending patients in their home and they had access to protective clothing for example, gloves and aprons if they were required.
- The Community Hospitals at Williton and Wincanton had their own mortuaries. Procedures were in place for caring for patients once they had deceased and included how to inform the undertakers if the patient had an infection. The 'Last Offices' policy was contained in the trusts End of Life policy 2015 and this had clear guidance for staff including what protective clothing was required.
- For community hospitals without a mortuary, there was a contract in place with a dedicated undertaker. The trust's end of life policy contained details for staff to follow if the deceased patient had an infection; this included completing specific notification form that would be given to the undertakers.

Mandatory training

- End of life training was not included in the trusts mandatory training but end of life e-learning training was available for all staff.
- Staff training was being monitored. Community staff told us they could book onto training via the trusts computer system. A member of the administration staff monitored staff training and notified them when it was due. Some community staff told us they had to cancel some training due to the pressure of work and often completed on-line training in their own time.
- At West Mendip Community Hospital, a senior member of staff told us all staff had completed life support

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training and the use of the defibrillator machine. This was because if a patient had a respiratory or cardiac (heart attack) arrest the staff would have had to contact an emergency ambulance as no doctors were on site 24 hours a day

- We saw the training matrix of mandatory training for the Palliative Care Medical Team. The training topics were marked as 'red' if they required this training and 'green' if they had completed the training. The team were up to date with their mandatory training.

Assessing and responding to patient risk

- Staff assessed risks to patients' and responded to them well. At the community hospitals we visited we saw in three patients' records that staff had used the Adult Acute Escalation Proforma called 'SBAR' (situation, background, assessment and recommendation) and Early Warning Score (EWS) to indicate if the patient was becoming unwell and if they needed to obtain medical support. Out of hours medical support was provided by the out of hours NHS 111 service.
- The local hospice provided out of hours advice to nursing and medical staff. The Palliative Care Medical Team participated in an on-call rota for off-site telephone advice and support 24 hours per day seven days per week. This was able to be face-to-face if needed within the hospice sites. During the out of hours period the On Call Palliative Care doctor was also able to provide specialist palliative care advice to the out of hours GP service by telephone.
- Community nurses told us that if an end of life patient and their family required support for the whole night they would contact the End of Life Coordination centre who held the lists of staff from other providers that could stay with the patient and family.
- Staff at the Community Hospitals told us that prior to the weekend the GP would ensure end of life patients were prescribed medication for pain relief and symptom control.

Staffing levels and caseload

- The trust hosted four medical Consultants in Palliative Medicine (3.2 Whole Time Equivalent WTE) and an Associate Specialist in Palliative Medicine (0.8 WTE). They covered this trust, two acute trusts and two hospices. The team had been in post for about a year

and had a remit to provide palliative and end of life care to patients using these services. Each of these consultants and associate specialist had designated hospitals, hospices and community areas they covered.

- The trust did not employ any specialist palliative care nurses. End of life care was provided by community nurses with support from other providers, for example, hospice nurses and domiciliary care agencies. Community nurses provided seven day working from 8am to 10pm. Outside of these hours the out of hours nursing service would visit patients if required. This was to ensure continuity of care for patients 24 hours a day. Care for end of life patients was included in the daily caseload of visits for community nurses.
- Community nurses told us visits to patients who were receiving end of life care always took priority over other visits for example, wound care. If they had a member of staff go off sick, they would review their workload for that day and move visits if necessary. They also said that as they were part of wider community 'hub' or team they were all based in one location and other community nursing teams would help them out. For example, we visited the Taunton 'hub' where community nurses for this whole area were based in one location. No one we spoke with said that there were any difficulties in obtaining support.
- General medical cover for the Community Hospitals we visited was provided by allocated GPs. For example, in Frome Community Hospital medical cover was provided Monday to Friday 8am to 6pm by an allocated GP who was experienced in palliative and end of life care. Out of hours, medical cover for community hospitals and the community nursing staff was provided through the NHS 111 service.
- The End of Life Care Coordination Centre covered all of Somerset. This was a nurse led telephone service that had an overview of health and social care packages in this area for end of life patients. They had six staff in total and they provided a seven day a week service during office hours. Staff, patients and their families could access the centre seven days a week for advice, help in obtaining equipment and night sitting service.

Managing anticipated risks

- Staff in the community hospitals told us during bad weather they would get to their nearest hospital to work if at all possible. Staff said they had access to four wheel

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drive vehicles that would help get them into work and they would ensure there were extra supplies of food, drinks and medications if bad weather was anticipated so they could continue to meet patient's needs.

- Community nursing staff told us that should the weather impact on their ability to access rural areas,

prioritisation of the most vulnerable patients took place and this included end of life. A list of 'at risk' patients was held on the electronic record keeping system. Access to a 4x4 off road transport was available and community nurse hubs and offices had a plan of action.

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.

We rated community end of life care as good for being effective.

There was evidence the trust was meeting some National Institute for Health and Care Excellence (NICE) guidance in meeting the needs of end of life patients. However, we found some trust documentation that referred to the Liverpool Care Pathway that should have been phased out during 2014 to make sure patients were not being put at risk of unsafe care.

At the End of Life Care Coordination centre, staff worked effectively with other health and social care professionals to set up care packages and provide equipment quickly for end of life patients who wanted to die at home.

The Palliative Care Medical Team had just started a 'train the trainer' programme to train senior staff in end of life care so they could pass on this training to other staff.

Detailed findings

Evidence-based care and treatment

- NICE guidance QS13 (End of Life Care for Adults) recommends that all references to the Liverpool Care Pathway should have been phased out by the end of 2014. However, we found references to it in a number of forms still being used in the trust. For example, 'Instruction for Nurses in the Event of Expected death'. At Frome Community Hospital we found copies of the Liverpool Care Pathway booklet, which a senior member of staff removed when we pointed it out to them. The trust End of Life policy dated June 2015 used the Marie Curie Delivering Choices Programme palliative care pathway, which also made reference to the Liverpool Care Pathway. We had been told that the trust was working in line with the latest guidance and was looking to update its end of life policy and bring in a new individualised care and communication plan that was waiting to be trialled just after our inspection.
- National Institute for Health and Care Excellence (NICE) guidance Improving Supportive and Palliative care for adults with cancer 2004 states that there should be seven day face-to-face specialist service 9am to 5pm. At the time of our inspection, this was not being provided

by the trust. The Palliative Care Medical team we spoke with told us they had no plans to provide this service. Specialist advice was available by telephone 24 hours a day seven days a week.

- The trust provided us with evidence of compliance with NICE Clinical Guidance CG140 - Opioids in Palliative Care. As part of this, they devised a number of leaflets for patients about the use of opioids. We were shown copies of the leaflets.
- The trust told us they were planning to review their end of life policy, which would involve a multidisciplinary working group of key trust staff.

Pain relief

- Patients receiving end of life care were seen to have their pain managed and controlled but records of pain assessment tools were not always in place.
- The trust had pain assessments tools in place for staff to use to assess patients. However, these were not always being used or completed in full.
- We examined three patients' records who were receiving pain relief medication from staff both in the community and hospital settings. We found one patient in the community who was having their pain managed effectively had no pain assessment tool or care plan in place. The two patients in hospital had pain assessment tools in place but they had not been completed in full, for example, one patient had not been asked the list of questions, which formed part of the assessment. Both patients told us staff managed their pain effectively and both were pain free. One patient did not have a care plan in place for pain either.

Nutrition and hydration

- Nutrition and hydration was well managed. The patients we saw in the community hospitals and in the community were supported to be able to eat and drink.
- Nutrition screening tools were used to determine how best to support patients and ensure they received adequate food and fluid. We saw the Malnutrition Universal Screening Tool (MUST) being used. However,

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this tool was not included the community palliative care records pack used for end of life and palliative care patients. Staff told us they had access to the MUST tool in other care records and they used this.

- Dietician or speech and language therapist's referrals were available for those patients that needed input if required.
- We saw evidence of daily fluid charts in use but these were not always appropriately completed, therefore staff did not have an accurate records of patients input and output.
- The trust told us they will also be reviewing the use of sub cutaneous fluids (where fluids are given via a needle under the skin) for end of life care patients, and they have recently reviewed, and updated their policy. Staff have been made aware of this updated guidance and end of life patients will be offered food and fluids dependent on their assessed needs and condition.

Patient outcomes

- The trust had not audited the Palliative Care Medical team since their appointed about a year ago as they said they wanted to establish the service first. The team were involved in the trust audit of injectable medications in 2014 to make sure patients received medication in a safe way. Staff both in the community and hospital settings were invited to take part and included staff who gave end of life care. The audit highlighted areas of strength and areas that needed improvement in relation to injectable medications. An action plan was put in place and the trust told us this has been met.
- The trust had not contributed to the Royal College of Physicians National Care of the Dying Audit 2014 as this was designed for acute hospitals rather than community trusts.
- The trust had participated in 'Voices': a National Survey of Bereaved people which took place in 2012 and 2013. The trust was part of wider group, across Bristol, North Somerset, Somerset and South Gloucestershire NHS area team; therefore, the results were not specific to this trust. The aims of the survey were to assess the quality of care delivered in the last three months of life for adults who died in England and, to assess variations in the quality of care delivered in different parts of the country and to different groups of patients. Each area was rated in the top 20%, middle 60% or bottom 20% of area teams. This area (Bristol, North Somerset, Somerset

and South Gloucestershire) was rated in the top 20% for respect and dignity always shown from local community nursing team, GP's and hospital doctors and nurses. They were also in the top 20% for pain being relieved completely all of the time at the last hospital admission. This area was rated in the 60% middle of local teams for pain relieved all of the time whilst at home.

- In March 2013, the trust undertook an audit of their end of life services through review of a number of patient records from both community hospitals and the community. The purpose was to assess compliance with, and full implementation of the End of Life Strategy and NICE Quality Standard for End of Life Care. One of the key strengths from this report was that patient's families/carers were well supported during a very difficult time. An action plan was developed and the seven actions had been met. For example, one of the actions was to heighten awareness of the Electronic Palliative Coordination System (EPACCS) and its usage within Community Hospitals. The EPACCS is a register where with patients consent their wishes about end of life care were recorded. The sort of information stored on this system included preferred place of death, diagnosis/complications, consent to share information and just in case box status. The trust said they have plans to re-audit in 2016/17.
- Trust staff were participating in a trial to assess the impact of regular early specialist symptom control treatment on quality of life in malignant mesothelioma. This is a national trial, which started in March this year; therefore, no results were available at the time of our inspection.
- The trust had raised a concern in relation to symptom control management, which was being addressed in a number of ways and particularly incidents relating to out of hours medical services. For example, the trust had sent up regular meetings with the out of hour's service to discuss concerns.

Competent staff

- Staff told us they could access end of life training provided by the local hospice but this was not part of the trust's mandatory training. Some staff were aware that the trust provided e-learning end of life training. The trust provided us with training figures that 42 staff

Are services effective?

both community and hospital based attended end of life training from March 2015 to August 2015. It was not clear if the trust or one of the local hospices provided this.

- The trust told us end of life training from one of the local hospices was being provided for staff that cared for homeless people. We were not given details of the number of staff who were attending this training.
- Face to face, training was offered to staff from the Palliative Care Medical team. Staff were also able to attend training events held by one of the local Hospices.
- The trust was training some staff from community hospitals and community nursing teams to become a Palliative Care Train the Trainer and had so far held two sessions. This purpose of this was to make end of life training more accessible for staff by the link trainers providing local training and updates.
- A palliative care supervision meeting for all staff, which included both hospital and community staff had taken place at one of the community hospitals led by a consultant from the Palliative Care Medical team. This was for staff to come and discuss any issues or concerns with them and the group. They had plans to increase these sessions across the trust.
- Some registered nurses were trained in verification of death both in the community setting and in community hospitals. This was to reduce the impact on the medical teams and ensure a timely response
- We saw staff in the community teams and the community hospitals we visited had access to 'The Palliative Care Handbook 2014'. This book provided staff with information on symptom management and pain control. Staff told us they used this book for reference for end life patients.

Multi-disciplinary working and coordinated care pathways

- Our observation of practice and discussion with staff demonstrated effective multidisciplinary team (MDT) working practices were in place.
- The End of Life Care Coordination Centre was set up to take the burden off community staff in arranging equipment and domiciliary care packages for patients who were wanting to die at home and who were in receipt of Continuing Health Care (CHC) fast track funding. They were able to arrange this very quickly for example in a couple of hours if required. The centre took referrals from a number of professionals for example,

community nurses, community hospitals and acute hospitals. Their role involved liaising with a number of other health and social care professionals for example, providers of domiciliary care packages for both the package of care and equipment. Staff at this centre told us that a qualified nurse, occupational therapist, or physiotherapist undertook the assessment for equipment and they would then send them the details of what was required. During our visit to this centre, we observed a member of staff manage a referral. This had come from a discharge nurse at one of the local acute hospitals. The patient had a terminal diagnosis and had been granted CHC fast track funding and they wanted to be cared for and die at home. The member of staff read through the referral which contained details of their care needs and what domiciliary care package they required and equipment. The member of staff sent an e-mail to request the equipment and domiciliary care package. Within 30 minutes, they had a response from a social care provider who was able to take on the domiciliary care package. The equipment was also ordered quickly and the company who supplied the equipment would contact the patient's family. The staff told us they also spoke with the referrer to confirm the arrangements and start date. They would also liaise with the community nurses who would be caring for this patient once they were discharged home and the domiciliary care provider.

- Another role of this centre was to set up night sitting service for end of life patients as they had details of staff who were from other providers who were available. They maintained records of where staff were.
- Some community nursing teams told us about the four weekly 'Gold Standards Framework' meetings they attended with the GP's. The Gold Standards Framework helps teams to deliver more effective care at end of life and is informed by patient and carer preferences. They also told us they found these useful for identifying patients who may come on to their caseloads for end of life care. Patients had diagnoses of cancer and other life limiting conditions for example, motor neurone disease.
- The community nurses told us they were responsibility for patients care in their own home and they liaised with other health and social care professionals involved in their care.

Are services effective?

- As the Palliative Care Medical Team worked across this trust, two sites of the local hospices and two acute hospitals, they were able to maintain continuity of care for patients who were admitted to any of these.
- We spoke with an occupational therapist (OT) who told us they were involved in the care of end of life patients. If patients were admitted into a community hospital and wanted to go home to die, they were able to train carers quickly with equipment for example, hoists. They also said they could get equipment out to these patients the same day. They had very strong links with the local hospice team and there was an OT in the hospice team they worked closely with they were able to do joint visits if needed. Their aim was to ensure they meet the wishes of patients at the end of their lives.

Referral, transfer, discharge and transition

- Somerset Primary Link managed access to the community inpatient beds for all patients across Somerset and prioritised palliative care admissions where possible. This contributed to patients at the end of their life being in their preferred place of care when being discharged from an acute hospital or admitted from home via their GP. All of the trust community hospitals provided end of life care but there were no designated end of life beds. Staff in Community Hospitals told us there had not been any issues with end of life patients obtaining a bed.
- For patients in receipt of CHC fast track funding, packages of care and equipment could be set up in two hours if required improving the pathway for the patient. We observed the staff at the End of Life Care Coordination centre deal with a referral they had received from one of the acute trusts. The patient wanted to die at home and staff ordered the equipment immediately. They received a response to the request for a package of care from a domiciliary care provider within 30 minutes.
- This centre was also able to set up night care for patients as they had access to the duty rotas from all providers who provided a night service. This meant patients had access to care whenever they needed it.

Access to information

- For patients in the community staff completed both paper records, which were held in the patients' home and input information to the trust's computer system.

To enable full access to information and continuity of care if patients were visited by the out of hour's community nursing service, they would have had access to the computer system prior to visiting.

- For patients who were referred to the End of Life Coordination Centre we saw how quickly information was sent to the centre from other health care professionals making a referral. For example, discharge nurses from the acute trust and how this was passed on to the relevant other professionals like the community nurses who would be caring for the patient. This was to make sure patients were discharged home quickly and efficiently so they were able to die in their preferred place.
- The Palliative Care Medical team told us about Electronic Palliative Coordination System (EPaCCS). The trust had access to this at the End of Life Care Coordination Centre and could enter details on behalf of other health care professionals with the patients consent, for example, GP's. This register enabled the recording and sharing of patients care preferences and key details about their care at the end of life with their consent. The system had been taken over by another provider which had caused difficulties as health professionals were required to record this information in a number of places, and they all had different computer systems that were not linked to the EPaCCS.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff told us they asked for patients' consent prior to delivering any care. We saw in the community nursing records patients were also asked to give consent for their information to be shared with other healthcare professionals such as GPs and specialist palliative care nurses, etc. This form also asked for details of any Lasting Power of Attorney or Court Appointed Deputy. If the patient was not able to sign or had no one with legal power to do it on his or her behalf, it included a section for a best interest decision.
- The community nursing teams we spoke said told us all the end of life patients they were currently caring for at home had capacity to make their own decisions. They were able to explain how to make best interest decision and this would be done with the patients GP.

Are services effective?

- Community nursing teams were aware of 'Do Not Attempt Resuscitation' (DNAR) decisions made by their patients. The documented decisions were held in the patient's home and also recorded in the community team offices.
- At the Community Hospitals we visited, we saw DNAR recorded in six patients' notes. These had been completed by the GP's who were overseeing the hospitals. Five patients had capacity to be involved in their DNAR decision. One person had been assessed as not being able to make or be involved in the decision about their DNAR status. Due to their medical condition, a best interest decision had been made by the GP and the form stated this had been discussed with their relatives who were in agreement with the decision. On the back of the form was information on how it should be completed. Staff confirmed that if a patient was not for resuscitation this would also be documented on their medication administration chart. We also saw on shift handover records that a patient's resuscitation status was recorded so all staff were aware.
- The staff at the Community Hospitals we visited said they did not have any end of life patients subject to a Deprivations of Liberty safeguard.
- The trust had been completing monthly audits of community inpatients where resuscitation status was recorded within 24 hours of admission or where appropriate the next working day. It had been noted since the introduction of the trust's computer system in the autumn of 2014, there was a marked improvement for timely recording of DNAR at community hospitals.

Are services caring?

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

Summary

We rated community end of life care as good for being caring.

We observed patients being cared for with dignity, respect and compassion. Patients and relatives we spoke with told us staff were caring and looked after them well.

Patients and those close to them were involved with their care. They told us they had been consulted about decisions and understood what was happening and why.

Spiritual support was available to patients and their families in the community hospitals.

Detailed findings

Compassionate care

- Patients were treated with compassion. During a visit to a patient in the community, we found staff delivering high standards of care. They were kind and showed empathy, respect and compassion to the patient and their carers/relatives.
- We spoke with a patient who was being cared for at home and they told us they “felt very well looked after” and “always treated with dignity and respect”.
- We saw feedback from relatives of patients who had received end of life care at Frome Community Hospital. Examples of the feedback included “it is impossible to speak too highly of the staff dedication, compassion and understanding during the period our relative was with you”, “thank you for caring and showing kindness to ... while they were with you” and thank you for the support given to various family members”.
- One relative told us in Frome community Hospital “they look after my relative very well and they are safe here.”

Understanding and involvement of patients and those close to them

- Patients and those close to them were involved with their care. We spoke with six relatives in community hospitals and two relatives in a patient’s home. They told us they had been consulted about decisions and understood what was happening and why.

- The patients we spoke with all acknowledged that they had been involved in their care, their wishes had been taken into consideration and they had an understanding of what was happening to them.
- One patient told us they saw a doctor nearly every day and they could ask any questions they had and they felt they had honest answers from them.
- We spoke with relatives of patient who was being cared for in their own home and they commented that they had received “very little support at the beginning of the diagnosis and everything at the end” which they felt was overwhelming.

Emotional support

- The trust employed 10 chaplains and they had support from nine volunteers. They covered all community hospitals to include mental health and represented various denominations, for example, Christian, Roman Catholic and Methodist. They also had a countrywide list of contacts for other religions. Seven of the community hospitals had a quiet room where the patient and their families could attend.
- The Palliative Care Medical team told us they were able to provide bereavement support to families following the death of their relative in both the hospital and community setting.
- Community nurses told us they visited the families of a deceased patient following their death to provide support to them. If they felt the family required more support, they would refer them on to other organisations for example, charitable organisations.
- We were told about a clinical supervision session that took place for some community staff following an incident involving an end of life patient. The Palliative Care Medical Team told us they wanted to increase these sessions to provide support for staff providing end of life care.

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 community end of life care as good for being responsive to people's needs.

The trust was working with other providers and the local clinical commissioning group on devising an end of life strategy for Somerset. This was to make sure patients across Somerset had joined up delivery and continuity of service from all providers involved in their care.

The service provided a fast track discharge from hospital to enable patients to return home if that was their preferred place of death. This was coordinated quickly and effectively by the End of Life Care Coordination Centre that had access to health and social care professionals.

We saw evidence that if the trust received a complaint about end of life care, learning from it was shared with staff.

Detailed findings

Planning and delivering services which meet people's needs

- The trust was involved in the Clinical Commissioning Group (CCG) End of Life and Palliative Care Clinical Programme Group. The programme covered the whole of Somerset and included providers from all services such as the acute trusts and hospices. The programme was ongoing at the time of our inspection but we were told the purpose of this was to provide joined up services and continuity of care for end of life patients across Somerset.
- In response to feedback, the trust had set up the End of Life Care Coordination Centre in Wells. The purpose of the centre was to set up health and social care packages for patients in receipt of fast track continuing health funding and to obtain equipment needed to care for these patients in their preferred place of death for example, their home or a nursing home placement quickly. Feedback from the community nurses about this service was that it was a very valuable and worthwhile service as it has speeded up the time care packages, and equipment can be organised for patients who wish to die at home.

- In response to care being delivered in the community and to enable a seem less service the End of Life Care Coordination Centre arranged night support from other providers. We saw staff made every effort to ensure those patients' needs were met, including medicines being delivered, equipment being provided quickly, and support for relatives.
- Two Community Hospitals, West Mendip and Frome, both had side rooms which were often used for patients receiving end of life care to ensure privacy. Both hospitals also had facilities for relatives/representatives of patients so they could stay overnight which included a separate room for them to use. Staff told us if the relative/representative wanted to stay in the patient's room with them, they would facilitate this. Opening visiting for end of life patients was also in place at both of these community hospitals.
- Staff from the Community Hospitals and the community told us that end of life care was not just about patients with a cancer diagnosis and they cared for patients who had died from other conditions. The trust had 785 patients who died who were receiving end of life care from September 2014 to August 2015. Between 1 August 2014 and 1 August 2015, 137 patients died in the trust's community hospitals. Of these 54 (39%) patients had a diagnosis of cancer, which meant 83 (61%) had no cancer diagnosis.
- At the time of our inspection, there were five end of life patients whose needs were being met in hospital but not at their preferred place of death their home. This was because the trust was not able to find care packages (provided by other social care providers) so these patients could be safely transferred home. The trust told us they were meeting about 96% of patients' wishes to die at home. They had examined ways of facilitating the lack of care packages by using their own bank staff and in some cases community nursing staff had taken on the care packages arrangements. However, this had increased their workload. The local Clinical Commissioning Group (CCG) was aware of this.

Equality and diversity

- Translation and interpretation services were available through a contracted service for both patients in

Are services responsive to people's needs?

community hospitals and those receiving community services. Staff in the community told us how they had used the translation service for one patient when transferring from an acute setting to a care home. Staff at the care home contacted the community nurses as they felt the patient did not understand their prognosis. Community nurses accessed the interpreter service and they were able to talk through all this patients concerns as well as establish their wishes about where they wanted to die and be buried. Through the interpreter, they were also able to contact the patient's family.

- At the two community hospitals that had mortuaries staff told us the room where relatives could view the body of their deceased relative could be multi-faith so they were able to meet the religious needs of all patients.
- At the Community Hospitals, we visited they had facilities in place for patients and visitors with a physical disability for example, lifts, wide corridors and disabled toilets.

Meeting the needs of people in vulnerable circumstances

- Community hospitals and community staff had access to support and advice from link nurses for a number of areas, for example, end of life care and dementia. For example, the end of life link nurse at West Mendip community hospital attended meetings at one of the acute trusts and fed back to the staff on the ward. Staff told us the link nurse fed back to them at ward meetings.
- In the Taunton hub for community nurses, they did not have a link nurse for end of life care. A senior member of staff told us they were going to ask a community nurse to take on this role as part of their duties. This role would be a resource for other community staff and they would be invited to attend the end of life best practice group.
- The Palliative Care Medical team told us they were starting to work with their colleagues in the mental health side of the trust to help improve end of life care for patients with dementia or other mental health needs. As this had only just started they were not able to share any examples of where this had improved the end of life care for patients with mental health needs.
- For patients who were receiving CHC fast track funding their families/representatives had access to the End of

Life Coordination Centre, seven days a week via the telephone. The Centre provided information about the care they were receiving and other relevant services available in their community such as carer support.

- The trust had developed some leaflets for patients for example, 'Planning Ahead' which contained details for the patient and their families in how to decide on advance wishes in relation to their care, how to make a will and how to appoint someone to make decisions for them.. Some community staff had received support for a Palliative Care Medical team in how to introduce these leaflets to patients others told us these were new leaflets and they were just starting to give them to their patients. Other leaflets devised by the trust included 'advice about bereavement and useful contacts' and practical information following a death'.

Access to the right care at the right time

- Trust data showed between July 2014 and June 2015 they had received 234 rapid referrals to their End of Life service from acute trusts.
- Community nurses told us they felt they received patient referrals for end of life care in a timely manner.
- During July 2014 to June 2015, the trust received 865 referrals for end of life care, of these 76.9% (665) of the patients had expressed a preference to die in their own home. Data for patients that had died in their preferred place for the same time period showed an average of 96.1% of patients died at their preferred place of death
- Senior staff at Frome Community Hospital told us patients who were in receipt of fast track continuing health care funding (CHC) were able to make the decision to die at this hospital. They told us they did their very best to facilitate this depending on length of stay.
- We spoke with one patient and their relative who told us they were planning to spend their final days of life at this hospital due to their medical and nursing needs as their family were not able to care for them at home.
- For patients in receipt of CHC fast track funding the End of Life Care Coordinator centre were able to set up care packages and equipment very quickly for example, within a couple of hours.

Learning from complaints and concerns

Are services responsive to people's needs?

- The trust had received seven complaints for end of life care between August 2014 and August 2015. We saw where these had been upheld actions had been put in place with evidence in minutes of a team meeting where the learning from a complaint was shared with staff.
- We spoke with the relatives of one patient in the community and three relatives of patients' in the community hospitals and all knew how to make a complaint. We saw information about how to make a complaint on the notice boards in the community hospitals.
- A desktop review was undertaken by the trust in January 2014 following three concerns and five complaints about end of life care between June and December 2013. This highlighted some areas of improvement that the trust needed to make, for example, communication between the community nurses and the out of hour's service. We were told this had improved following meetings to discuss the issues they were having.
- Community nurses told us about other improvements that had been made to the twilight service following a complaint about end of life care. The geographical area had been reduced, as they were not able to get to a palliative care patient in time.

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 community end of life care as good for being well led.

There were lead staff for end of life care at operational and board level, with regular meetings to report issues through the trust governance structure. Risks were identified. However, there was a lack of clarity of leadership of the service as there was no member of staff whose role was purely end of life care.

Staff complimented the leadership at local levels as they felt well supported and they understood some of the pressure they were working under.

The trust had no organisational strategy for end of life care but was part of a Somerset-wide group that was developing a strategy for 2015/16 for the county. The service had a continuous improvement plan but the dates for completion of the vast majority of the actions were after our inspection so we could not assess its impact.

Individual teams demonstrated a commitment to deliver good end of life care and to develop end of life provision. The staff we spoke with told us they had a high level of respect for their line managers and felt able to discuss issues or problems with them.

Detailed findings

W1

Service vision and strategy

- The Clinical Commissioning Group for Somerset chaired a county-wide End of Life and Palliative Care Clinical Programme Group, which had overall responsibility for setting the strategy and coordination of services across Somerset. This group was considering a revitalised End of Life strategy for 2015/2016. Therefore, the trust has not developed its own strategy.
- We spoke with some of the Palliative Care Medical team, who told us they shared the trust's vision to provide patient-centred care and to provide the skills and knowledge for staff in the trust to do this. They also

wanted to ensure palliative and end of life patients received continuity of care across all providers in the Somerset area, which included this trust, some of the acute trusts and hospices.

- The trust had an improvement plan for end of life care but few actions had been completed as the dates for completion were after our inspection. One of the actions that had been met was the use of homeopathic medication for end of life patients and the trust medication policy had been updated to reflect this.

Governance, risk management and quality measurement

- The End of life care service had its own risk register and we saw this contained details about unmet needs of patients due to shortages of care packages available for end of life patients. We were told this affected around four percent of cases and was classed as a high risk. Actions to address this included some community nursing teams picking up the referrals to enable patients to die in their home. The trust had raised the concern with the local Clinical Commissioning Group and were looking at ways of addressing it.
- Another area the trust felt they had concerns but was not included on the risk register was the incidence of pressure ulcers to end of life patients. This was being considered through the pressure ulceration best practice group.
- The End of Life Best Practice group met regularly and fed into the quarterly sub group report for the Clinical Governance Group meetings. We saw minutes of these meetings where they discussed any high-risk areas, for example, the high demand for domiciliary care packages for end of life patients that has resulted in unmet needs. The trust also fed any of their high-risk concerns into the Palliative Care and End of Life Clinical Programme Group, which was led by the local Clinical Commissioning Group and attended by other providers within Somerset, for example, the acute trusts. We also saw minutes of these meetings.

Leadership of this service

Are services well-led?

- There was no member of staff that's job role was purely to lead the end of life service. There was an operations lead for end of life care that had experience and knowledge of end of life and palliative care. However, they also had other responsibilities and duties, as they were a divisional lead for one area. They also lead the end of life best practice group. The Director of Nursing was the end of life link with the board and they fed back to the board any areas where they were they had concerns about end of life services. There was no lead consultant amongst the Palliative Care Medical team, however this had been identified and they were considering whether they needed to appoint one. The service was, therefore, without one lead person who was solely responsible for ensuring the changes needed to take the service forward. As we found trust literature and their end of life policy that still referred to the Liverpool Care Pathway that should have been removed from use. The trust told us they were planning to appoint a member of staff with the sole responsibility for end of life care.
- Locally, individual teams were well led, Staff felt they were able to discuss any concerns with their line managers and felt well supported with good leadership.
- Staff told us they all received copies of the trust newsletter to help them keep up to date with changes in the trust. We were shown two copies of this. We also saw this told staff about changes to any policies and procedures.

Culture within this service

- Staff told us there was a culture of being open and honest. When incidents took place, the trust thoroughly investigated them quickly.
- Staff we spoke with told us they felt valued and listened to by their leadership despite the pressure they were working under. They all felt they worked well in their individual teams.
- All staff we spoke with told us that end of life care was very important to them and this was what staff told us they were most proud of as they felt they all did it very well.
- Community staff told us about the training in 'see something, say something'. This training was to encourage staff to report unsafe or poor practice. They felt this was also about reporting the good work they do as they had received positive feedback from their peers.

Public engagement

- The trust sent us some feedback they had received from families and carers of patients who had received end of life care. They told us they use this information when reviewing the services they provide. They also used feedback from the patient/carer participation group.
- The End of life Care Coordination Centre liaises with families and carers of patients and they obtain feedback about the services they provide.
- If a relative or carer of a patient were not happy with the care of their relative, they would be advised to make a complaint and if they were willing to attend a meeting with the senior district nurses at the District Nursing Best Practice Group.

Staff engagement

- The trust told us they obtained the views of staff about the service provision through their End of Life Best Practice group. This included comments from staff about incidents that had taken place, for example with the out of hours service that has now been addressed in relation to symptom management. They were also planning use the feedback they receive from the group clinical supervision session's that all staff can attend. We were shown the minutes of the only one supervision session that had taken place at the time of our inspection and the feedback from staff was positive.
- Staff will be involved in the piloting of the new care and communication document and their views on this will be used to shape the final version of this.
- Staff from the End of Life Care Coordination Centre held some road shows across the trust during the 'dying matters awareness week' in May 2015 to raise aware of this, the coordination centres role and the trusts new 'Planning Ahead document'. We were told verbally by the staff from the End of Life Coordination Centre that this was successful in raising awareness in trust staff.

Innovation, improvement and sustainability

- The trust told us they had a plan to roll out an extensive education and training plan across the health and social care community to improve end of life care. The End of Life Best Practice Group will be monitoring this. This is still in the planning stage at time of our inspection.
- The trust will also be working with the local Clinical Commissioning Group with the countywide strategy for end of life care.

Are services well-led?

- The Palliative Care Medical Team told us they had a number of plans to move the service forward. For example, they plan to provide training for GP's and other

health care professionals. We were not given a timescale on this. They also told us they would be involved in the feedback about the new care and communication-planning document that will be trialled.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

17(2)(c) must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

Not all patients had care plans for their assessed needs. Some patients' care plans did not contain actions for staff to follow in meeting their assessed needs.