

Pennine Care NHS Foundation Trust

RT2

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)
RT2HQ	Ellen House Waddington Street	Oldham Specialist Palliative Care Team and District Nursing Team	OL9 6EE
RT2HQ	Blenheim House	Bury Specialist Palliative Care Team and District Nursing Team	BL9 8RN
RT2C3	Bealey Community Hospital		M26 2QD
RT2C1	Butler Green House	District Nurse Out of Hours Team	OL9 8NG

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

Summary of findings

Ratings

Overall rating for the service	Requires improvement	
Are services safe?	Requires improvement	
Are services effective?	Requires improvement	
Are services caring?	Not sufficient evidence to rate	
Are services responsive?	Requires improvement	
Are services well-led?	Requires improvement	

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service Requires Improvement

We have rated this service overall as requiring improvement. This is because:

- Bury specialist palliative care nursing team did not have sufficient staff to provide a timely service to patients at the end of their life. There was no consultant in specialist palliative care, which meant that highly specialist advice and support regarding complex symptom control was not available throughout the trust.
- Systems or processes were not sufficiently established and operated to effectively ensure the trust was able to assess, monitor and improve the quality and safety of end of life care.
- There was no trust wide method of categorising end of life care incidents and complaints to monitor themes and share learning across the trust.
- The trust had not implemented individual plans of care for end of life patients in each of its geographical location at the time of the inspection.
- There was no structured end of life care training plan or register of training to ascertain the skills of staff in different roles and teams.
- There was no trust wide strategy or vision for end of life.

Summary of findings

Background to the service

End of life care encompasses all care given to patients who are approaching the end of their life and following death. The definition of end of life includes patients who are approaching the last days or hours of life, palliative patients are those patients who have been identified as likely to die within the next twelve months. This can include patients with malignant and non-malignant diseases.

Pennine Care NHS Foundation Trust provides a range of community-based health services for adults and children in Oldham, Bury and Trafford. End of life care was provided by specialist palliative care nurses, district

nurses and allied health professionals such as occupational therapists, physiotherapists and dieticians. All of the end of life care that we inspected was provided in peoples homes.

During this inspection we spoke with representatives of all three specialist palliative care teams, Oldham, Bury and Trafford. We also spoke with district nursing teams in Oldham and Bury each of the locations. We reviewed 21 sets of nursing records. We spoke with managers of Oldham and Bury specialist palliative care teams. We were unable to speak with patients or relatives using end of life services.

Our inspection team

The inspection was led by:

Chair: Aidan Thomas, Chief Executive of Cambridgeshire and Peterborough NHS Foundation Trust

Head of Inspection: Nicholas Smith, Head of Inspection, Care Quality Commission

Team Leader: Sharron Haworth, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialist advisors.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

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

Before the inspection visit, we reviewed information that we held about this service and asked a range of other organisations for information.

Good practice

End of Life Care

- The Oldham SPCT had undertaken a project to seek the views of the Bangladeshi and Pakistani community

Summary of findings

for end of life care. This is an example of outstanding practice because the views of the community were instrumental in the service reshaping the way it delivered care to these communities. Through the changes the service made more people from the Bangladeshi and Pakistani communities had chosen to die in their own home.

- The documentation of medicines management for end of life medication was outstanding. There was a sheet for each medication and the route of admission was clearly stated. The documentation was outstanding because it was so clear. This clarity meant that the opportunity for error was minimised.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The service must implement individual plans of care for patients in receipt of end of life care across the trust.
- The service must develop a trust wide system of incident monitoring for end of life patients to identify themes occurring for end of life patients.
- The service must provide sufficient specialist palliative care staff to ensure that specialist advice and treatment can be provided in a timely manner.

- The service must develop a trust wide end of life strategy which includes a vision of end of life care for all patients and national guidelines for end of life care.
- The service must develop a governance system to monitor the implementation of the end of life strategy.

Action the provider SHOULD take to improve

- The provider should consider whether the services of a specialist palliative care consultant would improve the care to patients with highly complex symptom control requirements.

Pennine Care 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

End of life service required improvement for safe because:

- The specialist palliative care team in Bury was not adequately staffed to provide a responsive service. The impact of this was that the week before inspection the team had been running a waiting list. Two patients had waited to be dealt with by SPCT, one patient had waited for five days with complex symptoms.
- There was no specialist palliative care consultant in Oldham to provide a community service for end of life patients. This meant that there was no medical advice available for the use of the most highly specialist medication to treat very complex symptoms.
- The trust did not collect and analyse incidents for end of life patients. They were collected and analysed as part of community adults. This means that the trust were not able to identify themes which occurred in end of life care.
- There was a poor standard of documentation in Bury district nursing notes for end of life patients.

However,

We found that community services carried out a comprehensive range of risk assessments for individual patients when they came to the end of their life. This included nutritional and fluid balance assessments, assessments for pressure ulcers and falls.

Incident reporting, learning and improvement

- From the data provided to us there were no never events or serious incidents identified as occurring in end of life services between 1st January 2015 to 30 November 2015.
- The trust had an electronic system for recording incidents and all staff we spoke with knew how to report incidents and could give us examples of what types of incidents they reported.
- We found that the trust did not have a system in place to identify incidents occurring in end of life services. They were being recorded as part of community adults team.
- As incidents were not recorded as attributable to end of life patients there was no opportunity to identify themes or learn lessons relating to end of life issues.

Are services safe?

- Specialist palliative care staff gave us examples of two incidents involving end of life patients which had been escalated to the head of nursing for investigation.

Duty of Candour

- Duty of candour is a legal duty placed upon health care services to inform patients if a mistake has been made relating to their care, which has led to moderate or significant harm.
- The trust had a duty of candour policy in place. All staff that we interviewed were aware of the policy and that their responsibilities in relation to duty of candour required them to be open and honest with patients and families when things go wrong.

Safeguarding

- The trust had a safeguarding policy in place for children and adults. Staff we spoke with were able to demonstrate that they understood the process for reporting safeguarding concerns and some staff gave instances when they dealt with a safeguarding issue.
- Safeguarding training was provided as part of the trust annual mandatory training programme. All staff we spoke with in all locations had completed their safeguarding training.
- Trust wide data demonstrated that 96% of staff had completed adult safeguarding training to level 1 and 99% of staff had completed children's safeguarding to level 1.
- In the reporting period up to January 2016, 96% of SPC staff had completed children's safeguarding level 1 training and 90% had completed adult safeguarding level 1 training. The trust target was 95%.

Medicines

- We observed evidence of a robust system of medicines management operating across end of life services. There were separate sheets for each end of life medication and there was also a separate sheet for controlled drugs.
- The trust used the prescribing guidelines from the local integrated clinical networks, which were based on national guidelines.

- From the medical notes we reviewed, we saw evidence of anticipatory medications being prescribed and given in accordance with prescription in all locations. Medicine reviews were completed and inappropriate medication was discontinued.
- From medical records we noted that syringe driver volumes were regularly checked and we noted them to be accurate.
- We observed that the trust had placed the prescribing guidelines on a small credit card sized card. This was left in all community and primary care locations and staff reported that they had received very positive feedback on the card.
- Out of hours staff told us about one occasion when end of life drugs were not available and there was delay in providing them to the patient.

Environment and equipment

- All staff that we spoke with had access to the specialist equipment that they required to provide care for patients at the end of their life.
- There was a system in place for the timely provision of equipment where patients at the end of their life were discharged home as their preferred place of care.
- There was a system in place for the provision, decontamination and upkeep of battery operated syringe drivers.

Quality of records

- We reviewed 20 sets of district nursing patient notes for recently deceased patients. Five of these notes were from patients in Oldham, five in Bury and 10 in Trafford. Across EOL services there were different systems of records management in place. The trust had partially implemented an electronic records system, but the roll-out of the system had been halted because it was recognised that some services did not have the capacity to fully implement the change. The uneven implementation of the system was observed to have caused practical difficulties for teams working together. These difficulties impacted upon the communication between teams regarding specialist advice and treatment plans.
- In Oldham the SPCT, which used electronic records, completed their treatment plans in the electronic

Are services safe?

patient documentation system. However, the district nursing teams in Oldham were using paper notes. In the five sets of notes that we reviewed in this location there was no note of SPCT treatment plans in the patients' notes used by district nurses. Thus patients were being referred to the SPCT for specialist advice and this specialist advice was not available to district nurses or out of hours district nurses when they were visiting patients. SPCT staff reported that they would verbally discuss and communicate with district nurse colleagues, but agreed that these discussions did not appear in paper notes. We raised this issue on inspection with the trust and were informed that there should be a multi-agency communication sheet in the paper notes, which was for the communication between practitioners of different teams. We did not see evidence of this communication sheet being used in Oldham district nursing notes. When we raised this issue with staff during inspection, it was agreed that it was an omission. There was immediate action to rectify the omission by staff in that they reported that they would be using the multi-disciplinary communication sheet from that point. The difficulties with written communication between SPCT and district nursing team could be seen to have impacted detrimentally on patients' care and this was illustrated by a serious complaint received by the service about co-ordination between SPCT and visiting district nurses and the out of hours service.

- In Bury we reviewed five sets of district nursing notes and observed that the SPCT did contribute to the multidisciplinary communication sheet and thereby communicated their specialist advice. In Trafford we saw evidence of communication between SPCT and district nurse colleagues in the paper notes.
- From the five sets of district nursing notes that we reviewed in Oldham we could not find evidence of consideration of the key issues in the management of patients at the end of their lives. These key issues were the management of anticipatory medications, preferred place of care and preferred place of death.
- In Bury we found a poor standard of documentation in district nursing notes. We found post-it notes were stuck into patients' paper notes in two instances. These notes contained information about a patient, but the patient was not identified and there was no way of knowing if

the note referred to the patient in whose medical records we found it. In a third instance a lined piece of paper, torn out of a small spiral notebook, had been inserted into the notes. This piece of paper contained lists of medications which were being prescribed to a patient, the patient was unidentified, the document unsigned and undated.

Cleanliness, infection control and hygiene

- There was a procedure in place to decontaminate syringe drivers between each use.
- There were infection prevention and control systems in place to keep patients safe. The ward areas we visited were visibly clean. There was sufficient provision of personal protective equipment such as gloves and aprons and hand gel was available.
- Staff undertaking community visits reported that there were adequate supplies of all personal protective equipment for use in patient homes.

Mandatory training

- There was an annual mandatory programme in place for all trust staff. The mandatory training programme included level 1 child and adult safeguarding patients, infection control, moving and handling, health and safety, equality and diversity, conflict resolution, PREVENT, information governance and fire safety. There were no end of life modules on the mandatory training programme.

Assessing and responding to patient risk

- From case notes that we reviewed we found that a range of risk assessments were undertaken for patients at the end of their life. We identified the following risk assessments being used; a waterlow assessment for pressure ulcers, malnutrition universal screening tool (MUST) and falls assessment. We noted that these risk assessments were regularly reviewed where appropriate.
- District nursing staff reported that daily team meetings were held with each district nursing team to discuss patients individually and communicate any deterioration in end of life patients. We observed a district nursing handover of all patients on the caseload of an Oldham district nursing team and noted that end of life patients were discussed in full.

Are services safe?

- We were told that SPCT and district nursing teams liaised on a very regular basis, as frequently as the patient required, about developing risks. When risks were identified referrals were made to other professionals, for example, the dietician or the occupational therapist.
- There was an out of hours district nursing service for end of life patients requiring unplanned emergency support.

Staffing levels and caseload

- The staffing levels of Oldham SPCT and Trafford SPCT were adequate for the needs of the local population.
- It was reported to us that Bury SPCT had poor levels of staffing. The impact on patients can be demonstrated by the fact that the team held a waiting list to see those patients referred to them. An example was given of a patient experiencing pain who was referred to the service on a Friday for pain management and the team were unable to visit until Wednesday of the following week.
- When we visited the Out of Hours (OOH) service, staff reported that after 12am, there was only one qualified member of staff on duty. Consequently, if two end of life patients required a visit to deal with symptom control, the district nurse would have to prioritise which patient would be seen first. This situation was further compounded by the large geographical area covered by each out of hours team, which created further delay.
- There were no specialist palliative care consultants to provide specialist advice to patients in the community.

This meant that there were no medically led community clinics. The impact this had on patients was that patients with the most complex and challenging symptoms were not able to benefit from the services of a consultant. Such specialist advice was required for new medications and the use of highly specialist medications such as ketamine.

- The trust had previously part funded a specialist palliative care consultant post for 0.3 of a whole time post, but the post holder had retired. The trust had tried to recruit to this post but had been unsuccessful. It was reported to us by a service manager that the trust was considering changing post to a Nurse Consultant post. It was unclear whether the trust had considered whether a nurse consultant would be able to fully advise on the highly specialist medication needs of some end of life patients. Staff reported that they were concerned about losing the specialist function of a consultant in palliative care.

Managing anticipated risks

- The trust had a major incident plan and each area had adapted business continuity plans.
- The trust had a winter management plan incorporated in their business continuity plan to ensure end of life care patients received a safe and appropriate level of service in adverse weather conditions.

Major incident awareness and training

- Staff had access to the major incident plan (dated November 2015) via the trust intranet and received training on this during their induction.

Are services effective?

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

Summary

- End of life services required improvement for the effective domain because:
- There was no consistent implementation of an individual plan of care (IPOC) for patients at the end of their life across the trust. We saw evidence that Trafford had fully implemented an individual plan of care, that there was limited implementation in Oldham and an absence of implementation in Bury.
- There was no consistency to the level of skill and training for community staff in relation to end of life care. Some areas identified a training plan for end of life care and had established a training programme that was well attended by community nursing staff and other areas had not done so.
- However;
- We found evidence that patients received evidence based care for particular aspects of their care such as wound management and urinary catheters.
- Staff had a good understanding of consent in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards.

Evidence based care and treatment

- Trafford, Bury and Oldham had developed a IPOC to replace the LCP. This care record had been developed around the CCG locality basis.
- In Oldham in the five sets of notes of deceased people we reviewed, the IPOC was used in one instance. Oldham DN staff reported that they didn't use it because they hadn't been trained. However, we were informed that Oldham SPCT had undertaken a programme of training in the use of the care record for district nursing staff, which was attended by staff.
- In the six sets of notes that we reviewed in Bury, we did not find any evidence of the IPOC being used. Bury district nurse staff reported that it hadn't been introduced yet and that they hadn't been trained to use it. The EOLC facilitator in Bury had set up training sessions to train district nurses in how to use the IPOC,

but they were very poorly attended. An example of this was one training session, with capacity for 20 places, had two staff booked onto it. These two staff later cancelled their attendance.

- In the 10 sets of records that we reviewed in Trafford we observed the IPOC in place in every set of notes. It was fully completed in an appropriate manner.
- Advance care planning (ACP) is a nationally recognised means of improving care for people nearing the end of life and of enabling better planning and provision of care, to help them live and die in the place in the manner of their choosing. We found evidence that there was a disparity in advanced care planning between the different boroughs. In Trafford there was evidence of advanced care planning in all the notes that we reviewed. In Oldham from the five sets of notes we reviewed there was evidence of advanced care planning in two records. In Bury we found no evidence of advanced care planning in the six sets of notes that we reviewed. We raised this matter with specialist palliative care staff who commented that most district nurse staff in this area had not received training in ACP. We were told that there were plans to deliver training in ACP, but it was difficult for staff to be released for training.
- We found evidence in notes that evidence based care pathways were used for patients with wound management requirements and indwelling urinary catheters.

Pain relief

- Patients identified as needing end of life care were prescribed anticipatory medicines. These 'as required medicines' were prescribed in advance to properly manage any changes in patients' pain or symptoms. We saw that these medicines had been administered appropriately.
- We did not see a consistent use of formal pain assessment tools within the patient records that we reviewed. When we raised this issue with members of a district nursing team, it was evident that there was confusion about how pain was assessed. We were told

Are services effective?

by a nursing educator that the trust did use a formal pain assessment tool and they were surprised that it wasn't being consistently used by district nurses. This evidence meant that we could not be assured that patient's pain was assessed and controlled in a consistent way.

Nutrition and hydration

- We saw evidence across the trust, in all the notes that we reviewed, that risk assessments for nutrition and hydration were regularly undertaken for patients at the end of their life. The malnutrition universal screening tool (MUST) was undertaken for every patient that we reviewed. Where a patient was identified as at a particular risk referral was made to a dietician. In Oldham a dietician was part of the specialist palliative care team. MUST scores were not regularly reviewed in all records that we looked at.
- We saw evidence in the notes that hydration requirements were assessed and fluid balance was reviewed regularly.

Patient outcomes

- We saw evidence from a clinical audit carried out in Oldham that indicated positive patient outcomes for people receiving end of life care. There was evidence that in 50 cases preferred place of care discussions took place 84% of the time. This evidence was not supported in the 10 case notes that we reviewed but was obviously a larger sample. There was evidence of a medication review, a pain assessment completed and assessment for presenting symptoms undertaken in 100% of the 50 cases reviewed. In 96% cases there was evidence of multidisciplinary discussions having taken place.
- We did not see evidence of clinical audit for end of life care for Trafford or for Bury.

Competent staff

- All specialist palliative care staff were highly trained with the appropriate post graduate training and some staff had masters level qualifications in relevant subjects.
- Data provided to us by the trust confirmed that 21 out of 23 SPC staff had received an annual appraisal in the past 12 months.
- There was no trust wide training programme or identified competencies for district nurses in relation to

end of life care. We were informed by those representing the trust that there was essential to role training for community adult nurses which included, the following sessions: Priorities of Care and individual care documentation training, Advance Care Planning and UDNACPR, Conversation for Life, Sage & Thyme, End of Life Care update and syringe pump training, Individual Care Planning Training, Essential and Core Skill Training – which included end of life care for new starters within the service and Palliative Care. We saw evidence of presentations for syringe pump training and central venous catheter training. We were given attendance list for these presentations which appeared to indicate two staff had attended. We were also given care co-ordinator training sessions attendances which indicated that a number of trust staff attended these sessions, but we could only identify four district nurses from this list.

- In Trafford and Oldham SPCT reported that they had developed a training programme for district nurses around end of life issues. We were provided with evidence of training for aspects of End of Life Care such as syringe pump in palliative care. When we spoke with district nurses in Oldham they commented that they had not received any training on end of life issues and that they would value training on relevant topics. The end of life facilitator in Bury had developed we do not strong plan for district nurses but they were poorly attended. The district nurses that we spoke with in Bury commented that they were unable to attend training because they could not be released from their duties as a result of staffing shortages.
- We were told by staff and managers that all district nursing staff had been trained in the use of syringe drivers.
- We did not see limited documentary evidence regarding attendance of district nurses on training programmes for end of life care.

Multi-disciplinary working and coordinated care pathways

- There was good multidisciplinary working across all areas. We were told about frequent liaison between different disciplines when providing care for patients

Are services effective?

who had reached the end of their life. However, we did observe that although frequent liaison meetings were reported by all staff, they were not always documented in patient notes.

- District nurses attended meetings at GP surgeries to discuss the ongoing needs of patients. MacMillan nurses and community matrons also attended these meetings.
- We were told that some SPCTs included rehabilitation therapists such as occupational therapists and physiotherapists, but all teams did have access to multidisciplinary support and could make referrals to other professionals.

Referral, transfer, discharge and transition

- The trust had in place different rapid discharge arrangements, organised around the different borough localities, for those end of life patients wishing to return to their own home to receive care. We did not see evidence that the trust monitored how quickly rapid discharges were completed.
- Responding to patient's choice for their preferred place of care is part of national best practice guidance. We saw evidence displayed on the wall of the Bury SPCT, that preferred place of care/death was achieved in 86% of cases.

Access to information

- District nursing staff had access to patient risk assessments and care plans as these records were left in individual patient's homes. In most areas there was evidence of clear communication between professionals. In Oldham we found evidence that written information from the SPCT was not shared in patient notes. This was raised on inspection and addressed immediately by the Oldham SPCT.
- We saw evidence of a system for the handover of palliative care patients in Oldham with a comprehensive handover sheet being developed by the SPCT. This included information about advanced care planning, anticipatory drugs and emergency contact numbers for specialist advice. We did not see evidence of these handover sheets in the patient notes that we reviewed in Oldham.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- All staff we spoke with were knowledgeable about processes to follow if a patient's ability to give informed consent to care and treatment was in doubt. Staff demonstrated a good understanding of consent in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards.

Are services caring?

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

Summary

We found EOL insufficient evidence to rate caring domain because all were not able to meet with any patients or relatives. However we did note the following:

- We saw evidence of thank you letters and cards which commented on how kind and compassionate staff had been to their loved ones and families.
- We found evidence in patient notes that SPCT involved patients and their families in discussions about their care.

Compassionate care

- We were not able to speak with any patients or relatives on this inspection, but we saw evidence of very detailed thank you letters sent to palliative care teams, which stated how kind and compassionate staff were.

Understanding and involvement of patients and those close to them

- We saw evidence in patient case notes that SPCT involved patients and their families in discussions about their care.

- The Oldham SPCT told us that they contacted bereaved relatives six and 12 weeks after the death of a loved one. After three months relatives are sent a survey asking them about their views on the service. We were told that the service audit the bereavement survey results. We were provided with evidence of this survey. The survey stated that out of the 30 patients who responded to the questionnaire, 22 rated the care they were given as very good, 2 good, 3 fair, 1 poor and 2 very poor.

Emotional support

- The SPCTs provided emotional support to EOL patients referred to them. The SPCTs accepted referrals for patients who require psychological support and taught coping strategies such as mindfulness and relaxation techniques to help patients deal with emotional challenges.

Are services responsive to people's needs?

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

Summary

We found end of life services to be required improvement in the responsive domain because:

- Although we found strong clinical networks based around GP localities and within clinical commissioning groups (CCGs) in Trafford and Oldham, which had developed local plans, we did not find evidence of trust wide planning for end of life services. This meant that in Bury where the CCG had not developed a local strategy, there was no strategy for end of life services.
- We did not see evidence that the trust led discussions to identify gaps in service provision or share good practice for all its patients who required end of life care.
- Out of hours EOL patients were cared for by an out of hours district nursing service. From the evidence we received during inspection we could not be assured that patients in Oldham were being seen in a timely manner for symptom control.

However;

- We found evidence that SPCTs considered the complex needs of different patients who were at the end of their life. We saw evidence that the SPCTs considered the needs of end of life patients who were particularly vulnerable such as patients with dementia and patients who also had a learning difficulty.

Planning and delivering services which meet people's needs

- We found strong clinical networks based around GP localities in Trafford and Oldham. The strength of the collaboration between trust staff and local CCGs ensured that services were planned and delivered to meet the needs of end of life patients in that particular. We did not identify strong planning networks in Bury.
- In addition to healthcare services, we saw evidence of collaborative working with local councils and charitable agencies to provide services to patients at the end of their life.

- Although we found examples of excellent planning systems at a local level, that were responsive to the needs of patients at the end of their life, we did not find evidence of trust wide planning for end of life patients.
- Across the trust there was a disparity between the types of services that this patient group received because services were decided at a CCG level. We did not see evidence that the trust led discussions to identify gaps in service provision or share good practice for all its patients who required end of life care.

Equality and diversity

- The trust provided language, interpreting and translation services to patients whose first language was not English. This included face to face interpreting services, which could be booked in advance. The phone based translation service was available 24 hours a day, throughout the year.
- Staff received equality and diversity training on an annual basis through the mandatory training programme.

Meeting the needs of people in vulnerable circumstances

- All the specialist palliative care teams were highly responsive to the needs of people in vulnerable circumstances. In Oldham, which had a high number of patients from the Bangladeshi and Pakistani communities, the SPCT had undertaken a survey of patient needs from these communities. From this survey the team had identified reasons why patients from these communities were not choosing to die at home.
- We found evidence that EOL patients with a variety of complex needs were provided with individualised care. In Oldham there was a dementia champion in the SPCT. This enabled the service to deliver individualised care to patients who were dying with dementia. An example of this was that Oldham SPCT used a non-verbal pain assessment tool for these patients.
- In Bury a member of the SPCT liaised closely with patients who were at the end of their life and also had a learning difficulty and adapted communication tools.

Are services responsive to people's needs?

Access to the right care at the right time

- All the specialist palliative care teams provided services Monday to Friday between 8am to 5pm. Oldham SPCT provided a service on Saturday morning from 8.30am to 12.15pm. After 5pm and at weekends the needs of end of life patients were provided by local out of hours district nursing teams.
- If specialist advice regarding symptom control was required to support practitioners or family members, local hospices provided a 24 hour help line with funding from the trust.
- We were told that in Oldham the out of hours service sometimes struggled to see patients as quickly as they would like, because the demand for visits could not always be met with the staffing level. We were given the example of the previous weekend when the service had 10 visits to make to EOL patients, there were four call outs and there were two distressed patients at the same time. We were told that there was a 30 minute phone response time for EOL patients and that team normally see patients within two hours. Staff confirmed that no EOL patients wait longer than three hours for a visit.

- When we discussed this waiting time with the head of nursing we were informed that the trust had a performance target with the local CCGs of four hours. We did not see any documentary evidence regarding the length of time EOL patients waited for an out of hours visit from the district nurse team.

Learning from complaints and concerns

- The trust monitored complaints for each service for each geographical area. Community health services (adults) received 28% of the total number of complaints (319) made to the trust in the reporting period between March 2015 to February 2016. From reviewing the complaints we saw that there were very few complaints relating to end of life care. There were six complaints relating to district nursing input out of hours and one relating to the specialist palliative care team in Trafford.
- We saw from quality governance and assurance committee meeting minutes that complaints were discussed and themes identified to highlight areas for improvement.

Are services well-led?

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

Summary

We found end of life services required improvement in well-led because:

- There was no trust wide strategy or vision for end of life services. The vision for end of life services was present in some CCG areas, but there was no strategy for end of life services that operated above this level.
- There were no governance processes in place to review key end of life service issues such as strategy, values and plans. There were no governance systems to monitor the performance of end of life services against national targets.
- The governance systems in place did not adequately identify and monitor risks within end of life services.
- We found that executive leadership for end of life services was not clear to those providing the service to patients.
- Results from the NHS Staff Satisfaction Survey 2015, showed that the percentage of staff who would recommend the trust as a place to receive care is below the England average 70% compared to 79%. We found that staff satisfaction was mixed.

However;

- The local leadership for end of life services at team level was excellent. All managers we spoke with understood the work of the SPCTs and could identify the gaps in services.
- All specialist palliative care staff that we spoke with were knowledgeable, dedicated and passionate about providing end of life care.

Service vision and strategy

- There was no trust wide strategy or vision for end of life services. In Oldham and Trafford we found evidence of a strong local vision regarding end of life services, led by clinicians and other agencies in each of these localities.

- In Bury we were told that although substantial work had been undertaken by the local CCG to develop a local model of care, this work had been abandoned because of lack of funding.
- The trust took no leadership role, across the health and social care system, in the developing of a strategy or vision for those patients at the end of life patients using trust services. The disparity between both the vision of end of life care and the level of service provision in different areas was accepted as a commissioning decision by local [CCGs].
- Although all staff we spoke with, who were delivering care to end of life patients, were passionate about providing services to people at the end of their lives and asserted that services only had one chance to get it right, some staff believed that EOL services were not a trust priority. However, other staff stated that EOL care was a high priority for the trust.

Governance, risk management and quality measurement

- There were no clear and robust governance systems for end of life services in that performance in relation to end of life care was not routinely monitored and reported upon. We were told that there was a trust wide EOL focus group chaired by the Head of Nursing. The EOL focus group was the vehicle by which the board was kept informed on progress for EOL services, via the quality group and subsequently the quality and performance group.
- The work of the EOL focus group was not monitored and outcomes were not accurately reported to the board. An example of this is that the Chair of the EOL focus group was not aware that the IPOC was not being used by district nursing staff and was surprised to be informed this was the case by inspectors. As the Chair of the EOL focus group was not aware of the trust's failure to implement the IPOC, the Board could not have been informed of it, as it was the Chair who reported to the Board on the progress of the EOL agenda.

Are services well-led?

- Risks were not properly identified and reported to the board. An example of the board not being informed about risk was the fact that the SPCT in Bury had a waiting list to be seen. The Chair of the EOL group was not aware that the SPCT was holding a waiting list and patients could be waiting for five days for a visit from a SPCT member.

Leadership of this service

- The executive lead for EOL services was the Medical Director. There was substantial confusion across all SPCTs and district nurses regarding who was the trust lead for end of life care. The majority of staff considered that the lead was the executive director of nursing. The remaining staff said that they did not know who the trust lead was. This is illustrative of why staff consider end of life care not to be a priority for the trust.
- The local leadership for end of life services at team level was excellent. All managers we spoke with understood the work of the SPCTs and could identify the gaps in services.

Culture within this service

- All SPCT we spoke with were committed and dedicated to providing the highest standard of care to patients at the end of their life.
- There was a wide variation in the culture of different SPCTs across the trust. The culture and morale of the SPCT in Oldham was extremely different to the culture and morale of the SPCT in Bury.
- In Oldham the team were extremely positive about the service they provided to patients, were constantly focusing on service improvements and appeared open to responding to complaints about their service. They perceived themselves to be supported by senior managers.
- The morale of the Bury SPCT was very low. Staff we spoke with told us they were disappointed to have put a substantial amount of work into looking at a new integrated model of care for end of life services in Bury, which had been disbanded owing to funding issues.

Public engagement

- The trust actively sought the views of the patients that used their services. The Friends and Family Test was

launched in April 2013. It asks people who use services whether they would recommend the services they have used; giving the opportunity to feedback on their experiences of care and treatment. From September 2015 - February 2016 the percentage of respondents who recommend the trust as a place to receive community care has been similar to the England average. The highest score in the period was in February 2016 where 98% of respondents would recommend CHS services against an England average of 95%.

- In Oldham the SPCT had actively sought the views of the Bangladeshi and Pakistani community and had implemented service developments in response to the views expressed.

Staff engagement

- The percentage of staff who would recommend the trust as a place to receive care is slightly below than the England average - 70% compared to 79%.
- The trust had a lower staff response rate than the England average (13.4% compared to 11.4%) from 1 July to 31 September 2015.
- The trust engaged with staff across all CHS locations to gather views and to share ideas. We saw evidence that local staff survey meetings took place across the Borough with trust leads. These meetings included understanding the strength of teams, service developments and new proposed ideas for services. However, while we saw evidence that the meetings took place in the different boroughs i.e Bury, Rochdale, Trafford. We did not see any evidence of any cross over within the divisions. This did not provide assurance that each area shared its views and ideas across the trust.

Innovation, improvement and sustainability

- The Oldham SPCT had undertaken a project to seek the views of the Bangladeshi and Pakistani community. The team made changes to the way it delivered services to these communities based on the responses it received. Through the changes the service made there had been an increase in the number of people from these communities dying in their own home.

This section is primarily information for the provider

Enforcement actions

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

How the regulation was not met

There was no overarching governance structure for end of life services within the trust. End of life services were not subject to assessment, monitoring and quality improvement at trust level. There was no assessment, monitoring and mitigation of risks relating to the health and welfare of service users, relating to the low staff numbers in Bury Specialist Palliative Care Team or the failure to recruit a Specialist Palliative Care Consultant in Oldham.

This was a breach of regulation 17