

Sandwell and West Birmingham Hospitals NHS Trust

RXK

Community end of life care

Quality Report

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Date of inspection visit: 28-30 March 2017 and 10 April 2017

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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)
RK01	Sandwell Hospital		
RXK10	Rowley Regis Hospital		
RXK27	Leasowes Intermediate Care Centre		

This report describes our judgement of the quality of care provided within this core service by Sandwell and City Hospitals 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 Sandwell and City Hospitals Trust and these are brought together to inform our overall judgement of Sandwell and City Hospitals Trust

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Palliative and end of life services at within Sandwell & City Hospitals NHS Trust provides an integrated service within both within Sandwell & City Hospitals and the community. The community include patients own homes, home from home beds, home from hospice beds and the Heart of Sandwell Day Hospice in Rowley Regis Hospital.

We have rated end of life services overall as outstanding. We rated the safe domain as good and effective, responsive, caring and well led domains as outstanding. This is because:

- Experienced staff provided a compassionate and responsive evidence based service for end of life care patients.
- The service provided comprehensive joined-up care with access to care and treatment in both acute hospitals and in the community, seven days a week, 24 hours a day.
- The service followed evidenced based guidance incorporating NICE Guidance including NICE QS13 End of Life Care for Adults (Nov 2001/updated Mar 2017) and The Five Priorities for Care of the Dying Person (Leadership Alliance 2015).
- Staff were knowledgeable about the trust's incident reporting process and we saw concerns were investigated and learning shared.
- The service had one single point of access for patients and health professionals to coordinate end of life care services for patients known as the Hub. This meant patients received the right care at the right time in the right place.

- The palliative and end of life care service was very well developed across the trust and held in high regard both by staff within the trust and other agencies.
- End of life and palliative care was a priority for the trust. The service was well developed, staffed, and managed as part of the iCARES directorate.
- There was a clear governance structure from community services and department level up to board level. Good governance was a high priority for the service and was monitored at regular governance meetings.
- Staff were proud of their service, and spoke highly about their roles and responsibilities, to provide high levels of care to end of life patients.
- Patients were involved in their care and were enabled to make choices. This included choosing the place where they wished to receive palliative care and where they would prefer to die. The palliative and end of life care team ensured that arrangements were made quickly so they could be within their preferred place of care.
- Advanced Care Plans and Supportive Care Plans (SCP) were used across the trust for end of life patients. They were used as a person centred individual care record to include all the needs and wishes of a patient and their family.

However:

- The trust's 'Anticipatory Medication Guidelines' was due for review in September 2016 but no updated guidance was available. We could not be assured staff were following the most up-to-date guidelines.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Tim Cooper Head of Hospital Inspection Care Quality Commission

The team included a CQC inspector and a community palliative care nurse.

Why we carried out this inspection

We inspected this core service as part of the trusts focused inspection of end of life services.

How we carried out this inspection

We inspected this service 28 to 30 March 2017 as part of the focused inspection of the trust, which included all its end of life services.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we hold about the service provider and asked other organisations to share what they knew. We carried out an announced visit on 30 and 31 March 2017.

We contacted key stakeholders to seek the views that they had recently formed on the trust. Additionally, number of people contacted CQC directly to share their views and opinions of services.

We met with the trust executive team both collectively and on an individual basis. We also met with service managers and leaders, and clinical staff of all grades.

Before the visit, we held focus groups with a range of staff who worked in end of life care seven staff attended this meeting to share their views.

We visited seven patients in their own homes and observed direct patient care and treatment. We talked with eight people who used services and their loved ones, and reviewed care or treatment records of eight people who used services. We spoke with seventeen staff about their work and the service provided.

We carried out an unannounced visit on 10 April 2017 to the Heart of Sandwell Day Hospice, as this was not open at the time of our announced inspection.

What people who use the provider say

- Patients and loved ones of end of life patients spoke very highly of the staff and the service they had received. Comments included, "They are Kings!" and "they are all so lovely". One patient who attended the day hospice told us, "I just wanted to get out and

meet people and I have everyone have been very kind and helpful". The service gave all patients and their loved ones feedback forms to enable them to identify both good experiences and when patient or carer experiences may be improved.

Are services safe?

Good practice

We found the follow to be outstanding:

- The service delivered a partnership model with third sector organisations. The partnership provided a patient focused, individualised, holistic service that was able to provide respite, domestic support and specialist hospice beds in addition to the specialist palliative care.
- The connected palliative care coordination hub provided a single point of access for patients and other health professionals to refer patients requiring palliative care and end of life services seven days a week and with access to professional advice 24 hours a day.
- The urgent response team was available 24 hours a day seven days a week, which enabled the service to respond to patients rapidly when they needed support. This enabled patients the choice to die at home with their symptoms controlled.
- The end of life register with increased awareness in its use from end of life care facilitators, had enabled end of life patients to be quickly identified and receive timely and appropriate care and treatment in their preferred place of care.
- The widespread availability of the supportive care plan (SCP) throughout the trust.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the service SHOULD take to improve

- The trust should review the safeguarding vulnerable adults policy.
- The trust should review the anticipatory medicines policy.

Good

Are services safe?

By safe, we mean that people are protected from abuse

We rated safe as good because:

- Openness and transparency about safety was encouraged. Staff were fully supported to raise concerns and incidents. They understood and fulfilled their responsibilities to raise concerns, report incidents and near misses. Monitoring and reviewing activity enabled staff to understand risks and gave a clear, accurate and current picture of safety.
- Performance within palliative and end of life care services showed a good safety record. When something did go wrong, there was appropriate thorough investigation. Lessons were learnt and communicated to support improvement in other areas as well as services that were directly affected.
- Staff working within end of life and palliative care services had received up to date mandatory training.
- Safeguarding vulnerable adults and children was given priority within the palliative and end of life service. Staff had taken appropriate steps to prevent abuse from occurring, responded appropriately to any safeguarding concerns and worked with others to implement protection plans.

Are services safe?

- Staff numbers and skill mix were planned, implemented and reviewed to ensure that people received timely care and treatment. Any staff shortages were responded to quickly and adequately. There were effective staff handovers to ensure staff were aware of and managed risks to people who used the service.
- Staff assessed, monitored and managed risks to people who used the service on a day-to-day basis. This included signs of deteriorating health and any increase in distressing symptoms. A consultant and palliative care clinical nurse specialist were either on duty or on call to discuss patients and their treatment needs 24-hours a day, seven days a week.

However;

- The trust's safeguarding vulnerable adults policy had not been reviewed since August 2016, as required.

Detailed findings

Safety performance

- The palliative and end of life care service had a good track record on safety. There were no never events or serious incidents reported by end of life service between 1 February 2016 and January 2017. Never Events are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- The nurse manager for palliative and end of life care services told us that a root cause analysis investigation of a never event and serious incident would be undertaken if required.

Incident reporting, learning and improvement

- Staff reported incidents via an electronic system. Managers reviewed all incidents to highlight themes and patterns. We saw evidence of this. The nurse manager told us that they reviewed all incidents to check for any trends in concerns.
- Between February 2016 and January 2017, staff working within the palliative and end of life service reported 19 incidents. There were 16 no harm and low harm incidents and three moderate harm incidents reported. Incidents included identified power, phone and information technology failures, which could lead

to delays in patients contacting the service for advice. One incident related to a medication error and another to lack of availability of anticipatory pain relief for a patient.

- Staff told us and we observed that incidents and any patient concerns were discussed during staff meetings and staff handovers. We reviewed team meeting minutes from October 2016 to March 2017 and found discussion about ensuring referrals were made to the end of life register, ongoing recruitment to the end of life teams and opening of the new day hospice.
- The community nursing services were not part of the end of life service but did provide end of life care. We visited some end of life patients who also received care from community nurses alongside a named palliative care nurse. The community team leader told us and we saw that learning from one incident highlighted that records of the patients being informed of how pressure ulcers developed had been insufficient. We saw that a patient involvement care plan had been included that identified how pressure ulcers could be prevented and community nurses and the patient or their carer signed to confirm they had received this information.

Duty of Candour

- Duty of candour is a regulatory duty that is related to openness and transparency and requires providers of health and social care services to notify patients (or relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to the person.
- Staff told us about incidents that duty of candour may relate to including some avoidable pressure ulcers and medicine errors resulting in harm. There had been no incidents, which required duty of candour (DoC) investigation within palliative and end of life care service.
- We spoke with 12 staff and asked them about DoC; all were aware of their DoC responsibilities with regards to being open and honest with patients in their care.

Safeguarding

- Staff we spoke with were knowledgeable about their role and responsibilities to safeguard vulnerable adults and children from abuse. They understood

Are services safe?

what processes to follow and reflected safeguarding legislation and local policy. We found that the trust's safeguarding vulnerable adults policy had been due for review in August 2016, but had not been updated.

- The trust target for safeguarding training both vulnerable adults and children (level 1 and level 2) was 85%. The end of life team had exceeded the trust safeguarding training requirements. At the time of the inspection, 100% of staff had completed safeguarding adults level 1 and 85% of staff had completed safeguarding adults level 2 training. In addition, 100% of staff had completed safeguarding children level 1 training and 92% of staff had completed safeguarding children level 2 training.
- Staff we spoke with were able to describe the trust's safeguarding policy and reporting procedure. We saw information displayed for staff to make quick references to when required.
- We observed staff discussing safeguarding concerns in relation to end of life patients who had vulnerable dependents in the multidisciplinary meeting (MDT). We heard that appropriate arrangements had been made despite some frustration by staff with another agency. Staff told us they felt very well supported by senior staff and told us they could contact the safeguarding lead should they require further advice.

Medicines

- For community services, patients' medication records were kept with their patient records in their own homes. Medicine records detailed all the medicines the patient was prescribed and identified anticipatory medicine.
- Anticipatory medicines are an important aspect of end of life care. They are prescribed drugs in order to control symptoms such as nausea, pain, chest secretions and agitation. We reviewed eight medication records and found seven had anticipatory medication prescribed in accordance with local policy and national best practice. Prescribing staff had clearly documented frequency, dosage and parameters for use. The eighth patient did not require anticipatory medication prescribing at the time of the visit.
- The palliative and end of life care team had seven advanced nurse prescribers within the team. We

observed that nurses who were qualified to prescribe medicines ensured patients did not have to wait to be seen by a doctor for pain or other symptom management.

- We did not see any medicines administered during our inspection. However, we saw community specialist palliative care nurses assessing patients requiring additional medicines, for example for a dry and coated mouth and for increase in pain relief. The community nurses took time to explain about how the medicines should be taken to relieve these symptoms.

Environment and equipment

- During 2011, the National Patient Safety Agency mandated that all Graseby drivers (a device for delivering medicines by continuous infusion) should be withdrawn by 2015. The McKinley T34 syringe drivers were being used by the trust, which is in line with national recommendations. Staff told us that use of a syringe driver was additional training and an assessed competency for end of life care and palliative care. The palliative and end of life service team had trained 745 of the trusts staff in the use of the McKinley T34 syringe driver.
- Training records showed palliative and end of life care service staff had to conduct syringe driver training and pass an assessed competency.
- Staff told us and we saw that they were able to order and obtain equipment promptly for patients who were receiving end of life care.
- We saw equipment in patients' homes such as specialist mattresses and cushions to prevent pressure ulcers.

Quality of records

- We reviewed seven completed patient records. We found records were appropriately completed and updated.
- Palliative and end of life care services (which included community services) used the supportive care plan (SCP) for patients within the last year of their life. This was a multi-disciplinary care plan, which ensured appropriate assessments of symptoms were carried out. One additional patient was a new referral to the palliative care team from another hospital trust, the nurse specialist spoke about the supportive care plan and put this in place for this patient.

Are services safe?

- Patients also had an advanced care plan (ACP) that enabled them to identify and have support to access their preferred care, which was tailored to their individual needs.
- We found that the SCP and ACP were kept with patients in their own homes, when they were in a home from home bed or when they attended the day hospice. We saw that staff had completed the SCPs and ACPs we saw appropriate, dated and signed entries. The SCP contained the team contact details (the connected palliative care coordination hub), risk assessments, care plans, anticipatory drug information, current condition and details relevant to the patient's choices regarding their death.
- We also visited end of life patients who received their day-to-day care by community nurses but also had a named palliative care nurse. We found that community nurses also used the SCP to check they had the most up-to-date information about the patient.
- Records of all end of life patients (and on the end of life register) who had died each month were reviewed to check they had received the care they had chosen and needed. Further information is included within the effective domain within patient outcomes heading of this report.

Cleanliness, infection control and hygiene

- During visits with community staff to patients' homes, we witnessed good hand hygiene with staff washing their hands pre and post-patient care. Community staff had alcohol gel, to disinfect their hands while away from their base and when required in addition to hand washing.
- We observed the appropriate use of personal protective equipment, such as disposable gloves and aprons when administering care to a patient.
- Staff followed the arms bare below the elbow guidance in all community setting we visited including patient's own homes.
- We observed equipment was appropriately cleaned when staff had used it. For example, we saw that community nurses cleaned equipment they used to take patients' blood pressure and temperature.

Mandatory training

- The trust had one integrated team that provided treatment and support to end of life and palliative care

patients both within the community and within the acute hospitals. Information provided by the trust showed as at the 7 March 2017 93% of community end of life and palliative care staff had received all required mandatory training. The trust target for mandatory training was 85%.

- Mandatory training compliance for staff working within palliative and end of life care included: conflict resolution 100%, equality and diversity 100%, fire safety 96%, food safety 100%, harassment and bullying 100%, health and safety 100%, infection control 85%, information governance 100%, medical devices 76%, medicines management 84%, moving and handling (non patient load) 50%, moving and handling (patient handling) 96%, basic life support 67% and safeguarding vulnerable adults and children level 1 and level 2 100%.

Assessing and responding to patient risk

- Patients' records incorporated regular assessments of their needs to identify, minimise risks and maximise symptom control. Records we observed showed that staff had regularly reviewed patients.
- There was a clinical nurse specialist available seven days a week within the hospital and then on call during evening and weekends alongside a consultant in palliative care. This ensured that there were experienced palliative care staff available to provide advice to other professionals when required.
- The connected palliative care coordination hub was open 8am to 8pm every day. Between 8pm and 8am, calls were taken by the GP out of hours services who then contacted the urgent response team if an end of life patient required treatment such as a syringe driver within the community. A senior nurse triaged and prioritised all calls based on individual risk and patient need. Staff told us urgent cases were seen within 30 minutes and information we saw confirmed this.

Staffing levels and caseload

- We found that palliative and end of life services had sufficient staff to meet patients' needs in a timely manner.
- There were 1.6 whole time equivalent (WTE) palliative care medicine posts. The consultants provided care, treatment and advice for the all end of life patients within Sandwell and City Hospitals and within the

Are services safe?

community. Consultants told us that with the success of the palliative and end of life care team and just two consultants this was a challenge especially when one consultant was on leave.

- There were eight community palliative care clinical nurse specialists (CNS) staff working fulltime hours and two CNS working 0.6 WTE.
- The community CNS were split into two teams: north and south. Patients told us and we observed that they had a named CNS. Staff told us that with the north and south teams, this aided continuity with patients getting to know other CNSs in the team if their own CNS was off duty.
- We asked CNS about their caseloads they told us that the target was no more than 30 patients at any time and this was achieved. They told us if they had a caseload with several patients requiring considerable support, they would receive assistance from other CNS within the team.
- Within the connected palliative care hub there was a lead band 7 (band 7 relates to a senior sister or ward manager) end of life care facilitator, five band 6 (band 6 relates to junior sister) WTE end of life care facilitators with one WTE vacant post, 1.3 WTE band 5 care coordinators and five band 2 administrators. There were staff on duty at all times. Staff took calls from the hub between 8am and 8pm, seven days a week. Between 8pm and 8am, the doctors' out-of-hours service, took calls with messages forwarded to end of life care facilitators and the urgent response team operated 24 hours a day, seven days a week.
- The urgent response team had one WTE band 7 team leader, nine WTE band 6 palliative care nurses and one health care assistant (supplied for each shift by another private organisation. There was usually at least two staff on duty. The service operated 24 hours a day, seven days a week.
- Staff and managers told us that the Macmillan therapy team included occupational therapists and

occupational support workers, who worked with patients within the acute hospitals. One occupational therapist (OT) we spoke with told us they had also given advice and support when needed for community end of life patients. This OT said they welcomed the extension of the service into the community. A new occupational therapist commenced employment with the trust two weeks following our inspection to work primarily undertaking visits to end of life patients in the community.

- The day hospice had one full time occupational therapist and two health care assistants working 1.6 whole time equivalent (WTE), a 0.6 WTE vacant post and a WTE driver employed. A band 7 palliative care nurse specialist also supported the day hospice.
- Staff told us that any staff shortages were responded to quickly and adequately. Clinical nurse specialists told us they would ensure that required patient visits were made to cover an increased demand for visits or staff sickness. Staff working for the out-of-hours community nursing service and urgent response team told that if there was any staff sickness both teams would work together to enable patient visits to continue and keep staff safe.

Managing anticipated risks

- In order to lessen gaps in the service and respond to capacity requirements, the team have commenced a rotation between acute and community specialist palliative care nurses. Staff explained that working alongside community nurse specialists enabled them to have greater awareness of the needs of patients in the community. We saw that this has enabled staff to work in both acute or community settings and when required respond to patient need.
- There were effective staff handovers to ensure staff were aware of and managed risks to people who used the service.



Are services effective?

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

Summary

We rated effective as outstanding because:

- There was an excellent holistic approach to assessing, planning and delivering end of life and palliative care and treatment.
- There was effective and excellent multidisciplinary working to ensure that patients received innovative, efficient and joined up care that reflected their needs and choices.
- Evidence based care and treatment were used to support the delivery of high quality end of life and palliative care.
- There were robust systems in place to monitor and improve quality and patient outcomes. The end of life service performed considerably better than the England average for all of the five clinical indicators.
- The continued development of staff competence and skills was recognised as being integral to ensuring high quality end of life and palliative care.
- Staff could access the information they needed to assess, plan and deliver individualised care to patients in a timely way.
- Consent to care and treatment was obtained in line with legislation and guidance including the Mental Capacity Act 2005. Staff fully supported patients to make decisions and, where appropriate, their mental capacity was assessed and recorded.
- The trust used do not attempt cardio pulmonary resuscitation (DNACPR) records which were appropriately completed and were used in accordance with the Mental Capacity Act 2005.

However;

- There was a need for the anticipatory medicines policy to be reviewed as the last available policy required review by September 2016.

Evidence based care and treatment

- We found that the team provided end of life care in line with current evidence based guidance, standards, best practice and legislation. For example, the Department of

Health's end of life care strategy (2008) and NICE quality standards for end of life care, which included care of adults in the last days of life, NICE guidelines (NG31 December 2016).

- The palliative care and end of life service provided care and support for patients within the last 12 months of life. We found that since the removal of the "Liverpool Care Pathway" (LCP) nationally, the trust had developed a personalised end of life care plan called the advanced care plan (ACP). The trust had redeveloped and relaunched the ACP to ensure it met patient's needs.
- 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 and manner of their choosing. We saw that the trust had audited the use of the ACP between 1 January 2017 and 31 March 2017. Results showed that 78% of patients had an ACP. Information provided by the trust identified that the number of patients with an ACP had improved each month with just 7% of patients having an ACP in place in April 2016.
- The trust had anticipatory medicines guidance' however, the guidance was due for review in September 2016 but no updated guidance was available. This meant we could not be assured staff were following the most up-to-date guidelines for anticipatory medicines.
- The end of life care facilitators visited in-patient wards daily, spoke with all grades of doctors, GP practices, nursing homes and other community services to raise awareness about the palliative and end of life care service. The promotion of the palliative and end of life care service, increased awareness of the service and end of life register, to ensure patients received high quality, timely and responsive care that met their needs.
- All patients who were identified in the last 12 months of life (with their consent) were referred onto the end of life register. Patients on the end of life register could be tracked and admission or discharges from hospital were flagged to ensure that the palliative and end of life service were aware of their admission, to ensure they received timely evidence based care.



Are services effective?

- The end of life care facilitators visited all wards daily to review both known palliative and end of life care patients and also other patients who may be in the last short hours or days of their life. This ensured that all end of life care patients were identified and received evidenced based care.
- The team manager told us that all ward deaths were reviewed monthly to see which patients had a supportive care plan (SCP) in place. Information provided by the trust for February 2017 showed that 43% of all patients who died within the trust were on the SCP.
- Patients remained under the care of their main specialist (such as a respiratory consultant) and would receive specialist end of life care from the palliative and end of life team. This ensured they received timely evidence based care to keep them comfortable and reduced the need for unplanned hospital admissions.
- The palliative and end of life care team did not participate in the Gold Standards Framework Accreditation Scheme. Information provided by the trust indicated that this was a joint decision between the service and commissioners as the service had been commissioned by stakeholder engagement.

Pain relief

- Pain relief was identified as part of the supportive care plan, which was used by health professionals to assess, plan and deliver appropriate and timely patient care.
- We saw that patients received excellent holistic multidisciplinary care to manage their pain and may receive both traditional medicines or alternative therapies such as reiki, massage, reflexology and Indian head massage
- Doctors prescribed anticipatory medicines, which included pain relief when requested by the palliative care nurse specialists. These 'as required medicines' were prescribed in advance to manage any changes in patients' pain or symptoms. We saw that these medicines were appropriately prescribed and met best practice guidelines (NG31). Staff told us and we observed that strong pain relief was administered alongside other pain relief which keep patients comfortable.
- We observed that staff discussed pain management plans with patients and their relatives. We observed that

staff asked patients if they had any pain and how often they were taking their 'as required' pain relief. We observed that staff identified a need to increase pain relief for two patients and discussed various options.

- Community palliative care nurses told us they either visited or telephoned patients at least weekly to ensure that they had advice available and were kept comfortable.
- We observed that community staff sought advice from the palliative care team in the relation to pain control for one patient. A clinical nurse specialist went out the same day to visit the patient, review their pain relief and provided assurance to the patient and their loved ones.
- We visited one patient who had expressed a wish not to have strong pain relief so they would remain alert for as long as possible, we found that staff had respected their wishes.
- We saw that a pain assessment tool was part of the supportive care plan (SCP). This meant there was assurance that patient's pain was reviewed, assessed and controlled in a consistent way.

Nutrition and hydration

- We saw that a nutritional risk assessment was in place as part of the SCP to assess, plan and deliver patient care. The nutritional assessment identified risks to the patient's dietary intake and actions, required to ensure they had sufficient nutritional intake. We saw that the nutritional assessment was reviewed during each patient consultation and supported the delivery of effective and timely patient when required
- We observed staff discussing diet and fluid intake with patients and their families to promote their wellbeing and comfort.
- We observed that staff checked for signs of mouth infection that would make eating and drinking more difficult. We observed that staff prescribed medicines for two patients for oral thrush that would both make them more comfortable and help them feel more like eating and drinking.
- We observed staff discussed the use of high nutritional drinks that may help patients if their nutritional intake was compromised.
- We saw that patients who attended the hospice were given a hot meal, which they enjoyed. Staff told us and



Are services effective?

we observed that those patients who were unable to eat their dessert were able to 'take it away'. We spoke with one patient who told us that despite their poor appetite they had thoroughly enjoyed their lunch in the café.

- The multidisciplinary meeting discussed difficulties patients may have such as nausea, vomiting, eating and drinking and treatment options that were available.

Patient outcomes

- The trust used an advanced care plan that identified patient's choices and preferences for palliative and end of life care.
- The trust respectively audited records of patients who had died to review the care and treatment they had received. The audit between 1 January 2017 and 31 March 2017 showed: 78% of patients had an advanced care plan in place, 76% of patients achieved their preferred place of care (trust target 70%) and 72% of patients achieved preferred place of death (trust target 70%).
- Information provided by the trust showed that 77% of patients (this was higher than the trust target) did not experience a hospital admission in the last month of life in February 2017.
- The hospital contributed to the End of Life Care Audit, 2016. The trust carried out the national audit programme to support critical evaluation and reflection on the current clinical practice regarding the care of dying. The Ambitions Framework sets out six ambitions to bring about an overarching vision of care for end of life patients.
- We saw all the ambitions reflected in the care and support patients received and staff told us and we saw that these were the standards and ambitions they worked to and formed the basis of specialist palliative and advanced care planning.
- The End of life Care Audit: Dying in Hospital 2016 showed that the trust performed better than the England average for all of the five clinical indicators, scoring over 85% (average score 93.2% compared to the England average score of 73.6%) for all measures.
- The trust had taken part in the End of Life Care Audit – Dying in Hospital for England (2016). The audit identified the performance of the integrated end of life palliative care team. Results identified the control of key symptoms that could be present around the time of death and showed there was documented evidence that: pain was controlled in 79% of cases; agitation/

delirium in 72%; breathing difficulties in 68%; noisy breathing / death rattle in 62% and nausea/vomiting in 55%. If results are restricted to those with known length of stay (LOS) less than 24 hours, there was documented evidence that anticipatory medication (prn) was prescribed for the key symptoms: for pain in 75% of cases; agitation/delirium.

- The End of Life Audit identified that in the last 24 hours of life, a holistic assessment of the patient's needs regarding an individual plan of care had been completed for 94% of patients (England average of 66%).

Competent staff

- We observed clinical practice, attended staff multidisciplinary team (MDT) meetings and saw that staff working across end of life and palliative care services within the community were competent and knowledgeable.
- Information provided by the trust showed that 71% of palliative and end of life care staff had a palliative care qualification.
- There was a palliative and end of life care staff training plan. Staff told us they were able to access courses on end of life care, which were identified as part of their appraisal, and the trust supported them to attend required courses.
- Staff told us that all new staff completed both a corporate and local induction as soon as possible after commencement with the trust. Information we received from the trust identified that ideally, this should be undertaken within their first six weeks (non-medical staff) or two months (medical staff) and thereafter new staff undertook their mandatory training and any key competencies for their role.
- One new staff member told us that their induction was "excellent" and they were "fully supported" by managers and other staff. They told us that their induction had included a review of their competencies to undertake their role.
- We observed that staff recorded the end of life multidisciplinary meeting and the staff handover of community nurses at Neptune Health Centre electronically. We saw that during these meetings staff



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shared and discussed best practice for patient care. The use of the electronic record also ensured that the information was available for other staff who were not on duty.

- The nurse manager (band 8b) and lead nurse palliative care (band 8a) both had a specialist qualification in palliative care
- Compliance with appraisals for community end of life and palliative care staff was 95% (February 2017), which met the trust target of 95%. The end of life care facilitators had an ongoing remit to provide training in end of life treatment and care.
- The specialist palliative care team had developed an end of life care training plan for staff within the trust (which included community settings). The training programme was an eight week (deliverable in two hour sessions) rolling programme, which included using the supportive care plan and prognostic indicators, advance care planning - 'My Life', initiating difficult conversations regarding end of life including do not attempt cardio pulmonary resuscitation (DNACPR) and symptom control at end of life. The subjects covered in the eight session programme and competencies were: Identifying the dying patient; Comfort care; Symptom control; Modifying care, including advance care planning; Communication; Care planning; Spiritual care; Care after death.
- We saw a list of all courses the palliative and end of life service staff had attended. For example, five staff had attended the three-day palliative care conference, four staff had conducted the sage and thyme communications course, and one nurse had completed a reflexology course. The 'SAGE & THYME' model and foundation level workshop had been developed by another trust to teach the core skills of dealing with people in distress. Staff attendance at conferences and relevant training courses ensured the service and its staff were kept updated with any advances related to palliative and end of life care in order to provide individualised care for its patients.
- In the End of Life Care Audit 2016, the trust answered yes to six of the eight organisational indicators. The two questions the trust answered no had been addressed at the time of our inspection. We found that a staff-training programme which included communication skills with patients in their last hours or days had been undertaken by the end of life facilitators.

- Staff were encouraged to complete other training applicable to their role. For example Princess Alice palliative care course (through hospices/GPs), medicines prescribers course and the advanced palliative care course.

Multi-disciplinary working and coordinated care pathways

- We observed excellent, effective multidisciplinary working across end of life community services. Staff told us that one integrated team and one connected palliative care coordination hub for both acute and community settings, ensured timely access to end of life professionals.
- The trust provided a truly holistic approach to planning and people's discharge or transfer to other services. We saw safe use of innovative approaches to care, which included comprehensive assessments of patients' clinical needs, as well as their mental and physical health and wellbeing, and nutrition and hydration. Staff worked collaboratively to understand the range and complexity of people's individual needs.
- The palliative and end of life care team had weekly multidisciplinary team (MDT) meetings. We observed an MDT and found it was structured with all decisions and treatment discussed and recorded. Consultants, specialist nurses and therapists, as well as community partners who managed the home from home beds within the community attended the MDT. We observed that all complex patients, new patients and any patients who had died in the previous week, were discussed to ensure patients received the best ongoing evidenced care and treatment. We observed that the MDT included a section, which reviewed practice of what went well, and areas that could be improved.
- We observed that the MDT provided support, teaching and supervised practice for all staff who attended, with discussions on medicines for difficult symptom control and when review by the consultant was required.
- We observed that the team worked closely to ensure continuity of care when patients were discharged from acute to community care, or into a home from home bed.
- Information provided by the trust identified that extended members of the MDT included other clinical nurse specialists (from outside end of life and palliative care), pharmacist, physiotherapist, dietitian, complex discharge nurses and chaplaincy.



Are services effective?

- Staff told us the team worked with other specialisms such as oncology, respiratory, cardiovascular, surgery and old age and when possible attending ward round to provide effective end of life care.
- The end of life care facilitators had provided teaching to general practice, community staff and other professionals in advantages of the end of life register and supportive care plan.
- Community palliative care nurses and end of life facilitators attended GP surgeries to discuss the supportive care plan, the end of life register and effective and evidenced based end of life care. This ensured that other health professionals were aware of the end of life register and its value, promoting excellence in end of life care.

Referral, transfer, discharge and transition

- The service had one main referral point and enabled excellent and timely access to services.
- Referral to end of life services could be made direct to the connected palliative care coordination hub ('hub') by patients, carers and health professionals. Contact could be made between 8am and 8pm by telephone call, email or fax. Between 8pm and 8am, calls were directed to the out-of-hours doctors, service with palliative care calls forwarded to end of life care facilitators and the urgent response team.
- The 'hub' received the information, which was passed to an end of life care facilitator (who is a nurse) who assessed urgency and action required.
- Patients identified to have less than one year of life could be referred onto the end of life register to enable tracking of their care and treatment to ensure they received appropriate and timely care.
- Patient referrals to the hub may include a need for specialist palliative care advice, referral to the urgent response team, the home from home or hospice bed, Macmillan therapy team or referral to the Heart of Sandwell Hospice. The hub was the centre point for all these services.
- The palliative and end of life care service was one integrated team. We saw although teams were spilt into acute and community, the service was seamless across both the hospitals and community. Community patients admitted into hospital were highlighted by the end of life facilitators so they could be reviewed and their

progress and discharge to the community monitored. When patients were discharged, the hub would alert the palliative care nurse specialists so they could continue to review their care when they returned home.

- The transition of care from hospital to the community was discussed for all patients as part of the team's multidisciplinary team meetings.
- Care records, which detailed patients' deaths, place of death, care before and after death were reviewed to assess those patients received safe and appropriate care, which had met their choice and needs.

Access to information

- We reviewed information on the trust intranet that staff used to support their work and saw information was clear and accessible. This enabled staff to access information about evidence based patient care and treatment through external internet sites.
- The trust had an end of life register for patients who were identified to be in the last 12 months of their life. The register provided information about end of life patients, their treatment and preferred choices, to ensure they received timely and appropriate care.
- Staff received corporate emails that included information from the Chief Executive about their work within the trust and other updates about particular themes, such as training, on a regular basis.
- We observed that staff shared information during handovers, team meetings and within the multidisciplinary meetings.
- The trust had a quality improvement half day where information was shared with end of life and palliative care staff.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We saw that staff obtained consent before they provided treatment. They sought permission from patients to put them on the supportive care plan and end of life register and we saw their consent was recorded.
- Nursing staff 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 effective?

- Consultants told us that they undertook mental capacity assessments when required. We observed community staff gaining informed consent appropriately prior to carrying out any procedures during a home visit.
- We reviewed eight patient records and found do not attempt cardio pulmonary resuscitation (DNACPR) forms in seven of the eight records we looked at. We found that staff completed all DNACPR records appropriately with decisions explained to the patient and their loved ones and a record made of those discussions. We observed that DNACPR included information about the patient's mental capacity to make a decision about resuscitation in an emergency. We found that staff acted appropriately and in accordance with the mental capacity act.
- Patients records included information about discussion with both the patient and their loved ones about the DNACPR form.
- We observed that one patient did not have a DNACPR form. The nurse later explained this was because when they had originally discussed it, the patient had become very distressed, as they had recently lost some very dear friends. The nurse said they would discuss it again in the future when they were less stressed.
- The End of Life Care Audit 2016 showed that a DNAR CPR order was in place for 94% of patients' notes at the time of death.
- We observed that the DNACPR did not have an option to review the decision. Whilst this was not an issue for those patients whose records we looked at this may be an issue for patients elsewhere in the trust who recover after a major illness.
- Staff told us that training on the Mental Capacity Act 2005 was included as part of safeguarding training.



Are services caring?

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

We have rated caring outstanding because:

- Feedback from people who used the service and those close to them was consistently positive about the way that staff treated people.
- There was strong, visible person centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted patients dignity.
- Relationships between patients, people they were close to and staff were strong, caring and supportive. These relationships were highly valued by staff, patients and people who were close to them. People said that they were well cared for and staff go the extra mile
- Staff empowered all people to have a voice and demonstrate they understand the importance of involving people and those who matter to them in decisions about their care. People's choices and preferences were always valued and when possible acted upon
- Relatives said staff kept them fully informed and they were involved in decisions about care.
- We saw that patient's emotional and social needs were highly valued by staff and were embedded within their care and treatment.
- Staff were highly motivated and inspired to offer care that is kind and compassionate and displayed determination and creativity to overcome obstacles to achieving this.

Compassionate care

- All patients and relatives we spoke with spoke highly of the staff and the service that their loved ones had received. One person told us, "They have all been very kind; I don't know what I would have done without them". One relative told us, "Everyone has been so very kind". We saw that staff spoke to patients and their relatives in a caring and compassionate way.
- We visited one home where the patient was in the last days of their life. The nurse was extremely compassionate when they spoke to the patient and their relative and gave them as much time as they needed. They sat with the patient and held their hand. We observed the nurse spoke gently and kindly about their wishes and ensuring they were kept pain free and comfortable.

- We observed one nurse specialist kindly encouraging a patient in a home from home bed to take small sips of fluid to keep them comfortable whilst respecting their wishes about strong sedation.
- We observed that staff were respectful to patients and spoke to them in a courteous manner and asked their permission to examine them. We saw that staff ensured that patient's dignity was maintained and ensured they were treated with respect.
- One relative told us that their clinical nurse specialist had arranged for the palliative care consultant to come to see them as they had been given inconsistent information about the patient's life expectancy from hospitals outside the trust. The relative told us the staff have been so good as they know just how upset I have been.
- Another relative said, "They have shown kindness and care to all of the family."
- We observed staff in the day hospice were kind and caring to patients. The manager introduced us to one patient with painful legs and told us they had found them the most comfortable chair to help their legs and the patient told us the staff had been lovely.
- Relatives confirmed that they and their loved ones were shown respect, dignity and compassion throughout their care.
- The trust surveyed end of life patients and their loved ones, to identify their experiences of the care they received. We saw that staff discussed the completion of this survey and asked the patient to complete and explained it enabled them to see what they were doing well and any improvements needed. Between 1 October 2016 and 28 February 2017 there were 37 patient surveys returned of which 35 surveys identified that they were extremely likely to recommend the service and two patients identified they were likely to recommend the service. All people (patient, carer, relative or friend) who answered said they had been treated with respect (37 people).

Understanding and involvement of patients and those close to them

- We observed that nurses explained about treatment choices to patients and their loved ones. This ensured



Are services caring?

they had understood treatment options that were available to them. We visited one patient whose condition had recently deteriorated the nurse specialist discussed the use of a syringe driver at this time with the patient and their loved ones to ensure they were kept comfortable.

- Relatives told us they had been consulted about decisions and understood what was happening and why.
- Staff gave us examples of where the relatives had been informed of choices the patient had made which their loved ones did not agree. They told us how they had supported the patient and explained the choices the patient had made to their relatives.
- The patient survey between 1 November 2016 and 28 February identified that 30 people said they had been involved in choices about their care and one person said they had not.
- The End of Life Audit identified that there was evidence that: the needs of the person(s) important to the patient were recorded in 85% of patient records (compared to 56% England average); in the last 24 hours of life a holistic assessment of the patient's needs regarding an individual plan of care had been completed for 94% of patients (England average of 66%).

Emotional support

- Staff built up trusting relationships with patients and people they were close to by working in an open and supportive way. We observed that patients and their

loved ones were given good emotional support. Staff asked them how they were and how they were managing and provided them with information to access advice and support.

- We heard examples when staff had provided support beyond what would be expected. For example, one parent (requiring palliative and end of life care) with dependent children and with no family support would go out when visits had been arranged because they were worried that their children may be taken away. The nurse would call back later and on their way home to check them.
- We heard that the consultant had arranged to go and visit an end of life patient in their own home to give them the results of their tests, as the patient had become very unwell and they knew the family were worried about their rapid deterioration.
- We heard about people who wanted to ensure that their animals were rehomed so they could “die in peace”. Staff from the team provided them and their families with help to do so.
- We observed that emotional care was provided to both the patient and their loved ones in several of the patient homes we visited. We observed people given the time to talk and given opportunity to voice their fears for the future and in other cases to cry.
- Information provided by the trust and within staff meeting minutes identified that the end of life facilitators were able to make referral to bereavement services when required.
- Information provided by the trust showed that families were sent bereavement cards following the death of their loved one.



Are services responsive to people's needs?

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

Summary

We have rated this service as outstanding for responsiveness. This is because:

- The service was tailored to meet the needs of individuals who required palliative and end of life care. The service was delivered in a way to ensure flexibility, choice and continuity of care.
- The trust worked creatively with commissioners and other providers of end of life and palliative care to plan new ways of meeting the needs of end of life and palliative care patients. The service had a strong focus on innovative approaches of providing integrated care pathways, particularly for patients with complex or multiple needs
- The trust had designed services in conjunction with its community and other partner agencies that provider palliative and end of life care to enable people to access services. Access to care, support and advice was managed and timely to take into account patient's needs, including those with urgent needs.
- There was speedy access to care, support and advice for palliative and end of life care patients 24 hours a day, seven days a week.
- Arrangements for palliative patients and patients at the end of their life to receive care and treatment in their preferred place of care were models of best practice in integrated, person centred care.
- There were innovative approaches to providing palliative and end of life care that involved other providers of palliative and end of life care, to provide home for home and hospice care, respite care, night sits and welfare advice.
- Concerns about the service were taken seriously and appropriately responded to.
- The Connected Palliative Care partnership was created with private and voluntary organisations, which specialised in end of life and palliative care to provide holistic services for patients deemed to be within the last 12 months of life. Services the partnership identified included: A specialist palliative care team, macmillan therapy team, connected palliative care coordination hub, urgent response team, home from home beds, specialist hospice beds and a day hospice.
- The programme to deliver the contract included the recruitment of new staff including: a team of end of life care facilitators to provide education, awareness and advice to non-specialist teams and additional specialist palliative nurses to enable the service to provide advice and support 24 hours a day, seven days a week.
- Development of the connected palliative care single point of access coordination hub to take all calls and enquiries and manage a CCG wide End of Life Care register.
- Increased availability of end of life care beds (known as home from home beds) within the community with 24 hours a day, seven days a week access.
- A review of day hospice provision that resulted in the closure of Bradbury Day Hospice and the opening of the Heart of Sandwell Day Hospice within Rowley Regis Hospital.

Equality and diversity

- The trust provided an equitable end of life service irrespective of the patient's diagnosis, socio-economic group, ethnicity, gender or sexual orientation. The service monitored access to its services by all groups to show that the service remained accessible to all.
- We observed that staff treated patients with the utmost respect regardless of their race and religion. For example, we observed staff discussed arrangements that had been made for a Muslim patient to be seen by their doctor to ensure that their wishes of burial within 24 hours could be met.
- We asked staff about arrangements to ensure that religious needs such as a burial within 24 hours could be achieved. The consultant told us that they had

Planning and delivering services which meet people's needs

- In 2015, the trust, with clinical leadership from the palliative and end of life care team, won the £3.6 million each year, five-year contract to be the prime provider for all specialist palliative and end of life care services for patients registered with Sandwell and West Birmingham CCG, with a population of around 500,000.



Are services responsive to people's needs?

contacted the person's doctor to ensure they visited and assessed the patient prior to their death enabling their body to be released for burial, to ensure that their religious needs were met when required.

- Staff told us and we saw that translation services were available for patients at the end of life and their relatives. Information leaflets in relation to end of life care were available in a wide range of languages which they could access via the trust intranet when required.
- We observed that disabled car parking was available next to the entrance at Rowley Regis Hospital. A passenger lift was available to take patients to the second floor and disabled toilets were available.
- There were plans in place for the service to work with hard to reach groups. The service was already working with asylum seekers and immigrants who were unable to speak English to ensure that the model was responsive and accessible to individuals.

Meeting the needs of people in vulnerable circumstances

- Staff told us that given the nature of end of life care, this often meant that both the patient and any dependents were vulnerable. Staff gave us examples of how they arranged care for dependents who were under sixteen, had a learning disability, were living with dementia or were in an abusive relationship. This included a single parent with no immediate family in this country to care for the children. Staff told us that the connected palliative care hub had helped them make arrangements in several recent urgent cases.
- We spoke to one person who told us that their preferred place of care when they reached their last few short days of their life was either a hospice or a home from home bed.
- We visited one person in a home from home bed. We were told that they had lived alone and were unable to look after themselves so had agreed to receive care in a home from home bed.
- The connected palliative care hub had agreed arrangements in place with palliative and end of life partnership agencies, to make referrals to other agencies for services such as night sits or for respite care, to assist the patient and their loved ones.

- End of life patients and their loved ones frequently had concerns about finances. The service worked directly with a welfare rights advisor from Age Concern. Staff told us that patients who attended the day hospice could receive advice from this service.

Access to the right care at the right time

- The service provided rapid access to advice in relation to end of life and palliative care from a member of the specialist palliative care team 24 hours a day, seven days a week.
- The connected palliative care coordination hub opened in September 2016. The hub was open 8am to 8pm seven days a week and provided a single point of access to palliative and end of life care services. Between 8pm and 8am, calls were transferred to the out-of-hours doctors' service but any end of life calls were referred to the end of life care facilitators and the urgent response team.
- The urgent response team was available 24 hours a day seven days a week. The team provided palliative care nurses to provide treatment to patients and health care assistants who provided personal care such as washing, dressing and toileting on an urgent basis. The team told us about one patient who had deteriorated quickly and required both nursing and social care support. The urgent response team provided care and treatment to the patient and their family over the weekend when no other services were available and avoided a hospital admission. The result was that the patient remained at home which was their expressed wish.
- The urgent response team had seen 686 patients between October 2016 and March 2017 and had undertaken 1105 home visits.
- Information received from the trust for the service between 1 January 2017 and 31 March 2017 showed, the hub contacted 100% of patient within 10 minutes of the request and that 100% of patients received a response within 30 minutes of request from the urgent response team. First contact within one working day of receipt of an urgent (specialist team) referral was achieved for 86% of patients (trust target 85%).
- The target from decision to admit a patient to a hospice or home from home bed for non-urgent patients was within five days. Between 1 January 2017 and 31 March 2017 90% of non-urgent patients were admitted into a hospice or a home from home bed within five days (trust target 60%).



Are services responsive to people's needs?

- The target from the decision for urgent admission to a hospice or a 'home from home' bed was within 24 hours. Between 1 January 2017 and 28 February 2017, 80% of required urgent admissions were made within 24 hours (trust target 75%).
- Community staff told us and we observed that end of life patients were always prioritised within their workload to ensure all patients' needs and wishes were met.
- During our inspection, we were able to follow patients who had been seen by community nurses and community specialist palliative nurses during the day and were seen the same evening and overnight by the urgent response team. We saw this had enabled the patients to receive both new and ongoing treatment in a timely manner.
- We saw a day hospice patient was assessed for additional equipment to enable them to remain in their preferred place of care. The day centre manager told us that they had visited the patient at home the same day and fitted the equipment for them.
- During our inspection, we visited an end of life patient who was experiencing increased pain. The community nurse spoke to the connected palliative care hub who arranged for a specialist palliative care nurse to go to the patient's home, review their pain relief, and provide reassurance to the patient's relative.
- We observed that community specialist palliative care nurses prescribed additional treatment for patients to ensure they were comfortable and their symptoms were controlled.
- End of life patients could be referred to the fatigue and breathlessness (FAB) clinic for advice and treatment management to reduce discomfort. There were plans to move the FAB clinic to the day hospice to assist patients.
- We found staff went above and beyond to ensure patients received care, advice and treatment in a timely way. For example, staff told us about arrangements for the consultant to go out and visit a patient at home following a diagnostic scan. The patient had deteriorated quickly and felt they would be too unwell to attend an outpatient clinic.
- We observed community specialist nurses contacted general practitioners to request home visits for patients when they were concerned about other symptoms. We observed that the GP called back to confirm arrangements for the patient to receive an urgent diagnostic scan.

Learning from complaints and concerns

- Staff told us that if a patient or relative raised any concerns they would try to resolve concerns locally and make their manager aware.
- Community nurses said they discussed how to raise complaints as part of the initial assessment of the patient's needs.
- Written information for people who used the service was included in care records we looked at.
- The manager told us that any complaints received were logged centrally, were investigated and feedback was provided. Learning was highlighted during team meetings and the quality improvement half-day meetings.
- There had been no complaints made about end of life services between 1 April 2016 and 31 March 2017.



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.

We have rated well-led outstanding because:

- Leaders were approachable and supportive. They inspired and motivated staff to deliver a high quality end of life and palliative care service.
- The strategy to deliver an innovative, integrated end of life strategy 24 hours a day with partner agencies in both hospitals and the community was a challenge but had been achieved through the passion and determination of the leaders and staff.
- Governance and performance management arrangements were actively reviewed to identify, understand and monitor risk and meet best practice. Performance issues were escalated to relevant committees through clear structures and processes. There were clear evidence of actions to resolve any concerns
- There were high levels of staff satisfaction. Staff were proud to work for the service and spoke positively about the culture. Staff at all levels were actively encouraged to raise concerns.
- The leadership drove continuous improvement. There was a clear proactive approach to seeking out and embedding new and sustainable models of care.
- The trust had a clear vision and set of values for providing end of life care. The aim for the strategy for 2017 was for the palliative and end of life care service to become 'a beacon of excellence', continue to reduce unplanned hospital admission for end of life patients and research driven best practice.
- A clinical group director, group director of nursing, supported by the nurse manager for palliative and end of life care, led the senior management team for end of life and palliative care.
- The nurse manager and service lead for palliative and end of life care had a direct management responsibility for the lead nurse for palliative care, the end of life care facilitator lead, the therapy lead, the urgent response team lead and the project facilitator.
- End of life had two consultants who oversaw the medical management of end of life patients.
- The lead nurse palliative care (band 8a) had a direct management role of the clinical nurse specialists for palliative care and the day hospice staff.
- The end of life care facilitators were managed by the end of life care facilitator lead (band 7) and the therapy lead (band 7) managed the macmillan therapy team.
- The urgent response lead (band 7) managed the urgent response team.
- The leadership were highly respected by staff.
- The trust had both an executive director and non-executive on the board who had a responsibility for end of life and palliative care.

Service vision and strategy

- The trust had a clear vision and set of values for providing end of life care. We saw the trust's five Year Strategic Plan, 2013 – 2018. The strategy included development of the palliative and end of life care service and implementation of the supportive care pathway (SCP). The aim for the strategy for 2017 was for the palliative and end of life care service to become 'a beacon of excellence', continue to reduce unplanned hospital admission for end of life patients and research driven best practice.
- Staff had been included, consulted and were fully aware of the vision and strategy. The vision and strategy for the integrated end of life and palliative care service and was detailed within the Palliative Care and End of life Strategy 2013.

Detailed findings

Leadership of this service

- The palliative and end of life care leadership had identified a clear direction for the service to deliver high quality end of life care.
- We found that the leadership team were highly motivated, enthusiastic and inspired staff to provide high quality, safe and effective end of life and palliative care.
- The palliative and end of life service was part of the iCares directorate which is part of the Community and Therapies clinical group



Are services well-led?

- The strategy to deliver a 24 hour service seven days a week for patients in both hospital and the community had been challenging. We found that in the first year since the service was operational, the service was delivering upon its objectives.
- All staff we spoke with were aware of, and understood, the vision and values of the trust and the behaviours that would achieve these values. Staff told us that their vision was to provide high quality end of life care and palliative care to meet the needs and choices of their patients.
- The day hospice manager told us that they had been told to identify excellence in day hospice care and a vision for the service and build the service around that vision of excellence. We saw that the vision had identified and was in place.

Governance, risk management and quality measurement

- Governance and performance management arrangements were reviewed to identify risks and the needs of the service. Information provided by the trust identified there were monthly directorate meetings where governance and quality issues could be escalated either up to the board or down to end of life care staff. There was also an in-depth quality and safety review of the performance of the division, which was undertaken annually
- We asked staff and managers about the risks of the service and found that staff were aware of those risks identified within the risk register
- Staff told us and we saw that there were quarterly service operational meetings, the trust called these meeting quality improvement half days (QIHD). The meetings discussed strategic and developmental quality initiatives within the service, which affected the delivery of end of life and palliative care services. Staff were positive about these meetings and of shared practice and quality initiatives
- The consultants within the team told us they regularly attended trust clinical governance meetings to discuss key developments, audit and governance.
- The acute and community specialist palliative care teams had meetings to discuss day-to-day operational issues.
- We saw that all patient deaths were reviewed as part of the weekly multidisciplinary team meeting. A consultant told us that they reviewed patients who had died to

enable them to share what went well, act upon, and share what may be improved. Staff told us and we saw that a record of these meetings were made to enable staff that were unable to attend an opportunity to read the meeting notes.

- Complaints, incidents and risks were reviewed during the governance meetings which were held every three months. Any findings were then shared with the directorate meeting for further action when required. Staff told us that any outcomes such as learning from complaints or incidents were then shared with them. The outcomes of these meetings were fed back to staff.
- The trust had a lone working policy in place. The policy identified when staff should attend patient visits in twos and actions required to keep them safe.
- The lone working policy identified the use of a lone working device, which should be carried by community staff which tracked their location and could be activated when urgent assistance was required. Staff told us that the trust was introducing a new device in mid-April 2017 and training in its use was arranged before they received it. Staff told us and we observed that they followed the trusts criteria in relation to visiting in twos. Staff told us that their patient visits were identified at their base and they would contact the base before they went home. Staff told us they had a work mobile phone, which they could use if required. They said they would use a coded message to alert their colleagues if they felt in danger.
- The end of life risk register dated 3 March 2017, identified two current risks inherent in the delivery of safe end of life within community services. We saw that the risk register was up to date and reflected the current risks of the service. We saw that there was an identified person to deliver the action plan and appropriate actions had been taken to address these risks.

Risks identified were :

- Patients and other clinicians may not be aware to contact the hub and patients may be missed.
- Potential risks included insufficient staff to provide a 24 hours service.

Culture within this service

- We found staff were passionate and highly committed to provide excellent palliative and end of life care service demonstrating a strong patient focused culture.



Are services well-led?

- Staff spoke positively about working within palliative and end of life care and would recommend it as place to work.
- Staff told us that they felt respected, valued, supported and that their achievements were recognised.
- Staff told us there was a culture of openness and transparency and they felt able to challenge poor practice if required, whilst being supported by other staff and managers. Staff told us that the team were supportive and they were “always listened to.”
- Several staff told us they were proud of the team, its development and the care they delivered seven days a week. One clinical nurse specialist said, “The urgent response team is responsive and enables us to give high quality care to end of life patients in the community 24 hours a day.”
- Staff told us they felt proud of the care they provided giving patients control with their treatment options, where they wanted to receive their care and their preferred place to die.
- Staff we spoke with said they were able to raise concerns and they were always listened to.

Staff told us that concerns had been identified by community nurses in relation to effective working alongside the end of life service. Staff told us managers had met with community nurses to discuss their concerns and clarify working arrangements, such as was it appropriate to contact the named palliative care nurse direct and timely sharing of information of patient death with the team. Staff we spoke with said that they felt this meeting had been valuable and that the specialist nurses and urgent response team had been valuable for end of life and palliative care.

- We found that staff sickness rates across community end of life services in February 2017 was 3.8%. This is below the national average of 4.1%.

Public engagement

- We saw information on the trust web site and in local media that showed there had been widespread public engagement to both identify and shape end of life and palliative care service and the day hospice.
- We saw that there were ongoing press releases to show the public about developments of the end of life and palliative care service at Sandwell and City Hospitals Trust, such as use of the supportive care plan and information about the connected palliative care hub.

- We saw the end of life service continued to seek patient survey information about the service they provided. The nurse manager told us it that it could be difficult to get feedback at such a difficult time, but they reviewed and shared all information received including comments made by the patient and their loved ones.

Staff engagement

- Staff received regular key messages from the organisation via email, which updated them on what was going on within the trust. In addition, a pod cast had been set up and was accessible on a lap top for all staff to see.
- Staff received a copy of the Heart Beat magazine along with their payslip, which contained information about the trust.
- There were monthly staff meetings in all palliative and end of life care teams to ensure they were kept up to date on new initiatives and when improvements were needed following incidents and any complaints.

Innovation, improvement and sustainability

- Information provided by the service identified it had recently presented at a Department of Health Roadshow and received positive comments with requests to mirror the service elsewhere.
- The service has been nominated for the national council for palliative care award within the previous 12 months.
- The service delivered a partnership model with third sector organisations. The partnership provided a patient focused, individualised, holistic service that was able to provide respite, domestic support and specialist hospice beds in addition to the specialist palliative care.
- The urgent response team was available 24 hours a day, seven days a week, which enabled the service to respond to patients rapidly when they most needed support. This enabled patients the choice to die at home with their symptoms controlled.
- The home from home beds provided patients with an extra level of support if they were unable to remain in their own home.
- The end of life register, with increased awareness in its use from end of life facilitators had enabled end of life patients to be quickly identified, and receive timely and appropriate care and treatment in their preferred place of care.



Are services well-led?

- Care plans for end of life care had been reviewed and relaunched and were available trust wide (the supportive care plan).
- The service was working with a local university to provide full evaluation including qualitative analysis with patients, carers and staff of the service provided.
- There were appropriate systems in place to review and develop service delivery and, when needed, ensure that lessons were learned and appropriate actions taken to provide excellence in end of life and palliative care.
- The service recommended a number of improvements from the results of their audit of why end of life patients preferred place of death (PPD) was not achieved between 1 April 2016 and 31 October 2016. This demonstrated the service were keen to constantly improve the service they provided to end of life patients.