

# Bridgewater Community Healthcare NHS Foundation Trust

RY2

# Community end of life care

## Quality Report

Bevan House, Beecham Court, Smithy Brook Road,  
Wigan, WN3 6PR  
Tel: 01942 482630  
Website: <http://www.bridgewater.nhs.uk/>

Date of inspection visit: 31 May – 3 June 2016  
Date of publication: 06/02/2017

# 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)
	Bevan House		






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

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

Where applicable, we have reported on each core service provided by Bridgewater Community Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of Bridgewater Community Healthcare 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?	Good	
Are services responsive?	Good	
Are services well-led?	Requires improvement	

# Summary of findings

## Contents

### Summary of this inspection

	Page
Overall summary	5
Background to the service	6
Our inspection team	6
Why we carried out this inspection	6
How we carried out this inspection	6
What people who use the provider say	7
Good practice	7
Areas for improvement	7

---

### Detailed findings from this inspection

The five questions we ask about core services and what we found	8
Action we have told the provider to take	27

---

# Summary of findings

## Overall summary

We rated end of life service as requires improvement overall. This was because:

- There was no vision or strategy in place across the trust for end of life services. When we visited there was no end of life steering group in place that could develop a strategic vision and monitor the trust's progress towards the vision. The trust had recently changed the executive lead responsible for the trust and we were informed that the first end of life steering group was meeting in June 2016. Given this, it was unlikely that a trust vision would be developed in the next few months.
- The trust did not strategically plan its services for end of life care across the trust. This occurred at local government borough and CCG level. This meant that service provision gaps in different areas could not be identified.
- There was no consistent medicines management for end of life across the trust. We saw different standards of documentation and practice with regards to medicines management. In one area, Widnes we identified a prescribing and administration practice that gave rise to confusion and was not safe. The documentation used in Widnes was confusing in that it contained prescriptions for medication administered via syringe drivers and other routes. We also identified

two episodes of GPs prescribing end of life medications for a wide dose range, which enabled district nurses to increase the dose significantly without medical review. Staff confirmed that this was accepted practice and that they had not been trained in end of life medications.

- Incidents were not monitored for end of life patients. Incidents were being reported for end of life patients within community adults teams, but there was no system in place to identify these incidents as specific to end of life. This meant that themes could not be identified in relation to end of life care and learning could not take place and be disseminated across the trust.
- The individual care plan to replace the Liverpool care pathway was not embedded into practice in all locations.
- Complaints were not collated for end of life services, which was a missed opportunity to identify themes for service improvement and development.

However,

- End of life services were planned and organised well at local level. Care was delivered by highly skilled, dedicated practitioners who considered the complex needs of all patients in their care.

# Summary of findings

## Background to the service

Bridgewater Community Healthcare NHS Foundation Trust provides end of life services for patients through specialist palliative care services, district nursing service and a specialist nurse within a heart failure service. The service is spread over a very wide geographical area and is organised around the local government boroughs of Halton, Warrington, St Helens and Wigan. There are different models of service provision in each of the boroughs, depending upon the commissioning priorities of each of the local clinical commissioning groups. The trust provides specialist palliative care nursing teams in Warrington and Halton. In Wigan it provides a specialist palliative care allied health professional team, called the complex cancer & palliative care allied health professional service. The specialist palliative care nursing teams in Wigan and St Helens are provided by both NHS

and other providers. The trust also funds some specialist palliative care medical services in Warrington, Halton Wigan and St Helens. Data provided to us from the trust indicates that from April 2014 to March 2015 specialist palliative care nursing team had 564 referrals, of these 524 were for patients who had a cancer diagnosis.

We spoke with a range of staff including specialist palliative care teams, allied health professionals, district nurses, heart failure team, specialist palliative care medical staff, service managers, area managers and executive directors. We reviewed 31 sets of patient records, across a variety of teams providing end of life care. We were able to speak with six patients and relatives.

## Our inspection team

Our inspection team was led by:

**Wendy Dixon:** Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists including a nurse and a therapist.

## Why we carried out this inspection

We carried out a comprehensive inspection of this service as part of a routine programme of inspections and to rate the service.

## How we carried out this inspection

To get to the heart of 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 visiting, we reviewed a range of information we hold about the core service, performance information received from the trust and asked other organisations to share what they knew.

We carried out an announced visit from 31 May 2016 to 2 June 2016.

As part of the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors and therapists. We observed how care and treatment was provided.

# Summary of findings

## What people who use the provider say

As part of our inspection we spoke with patients and carers and asked their views of the service received, we also saw feedback given to community nurses displayed in nurse bases.

People who used the service said:

“They looked after my mother with utmost dignity and respect, I will be forever grateful.”

“Without the team I could not have had my husband at home. I can’t thank them enough. He had the best possible outcome. He died happy where he wanted to be.”

“The nurse assistant is here for me, I can ask anything and really appreciate her coming, she understands what is happening and I can ask her anything, I have no fear, I have confidence in her that she’s not hiding anything from me, she is outstanding.”

## Good practice

The development of an AHP complex cancer & palliative care allied health professional service was an example of outstanding practice in this service.

## Areas for improvement

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

The trust **MUST**

- The trust must ensure that there is a trust wide vision for end of life services, which is in line with national guidelines and recommendations.
- The trust must ensure that there is a trust wide strategy for end of life services.
- The trust must ensure that there are trust wide governance systems to monitor progression towards national targets.

- The trust must ensure that an individual plan of care is embedded into all documentation for patients at the end of their life.
- The trust must ensure that there is a safe and consistent system of documentation for end of life medication across all services.

The trust **SHOULD**

- The trust should monitor all incidents that relate to end of life services and patients.
- The trust should monitor all complaints that relate to end of life services.

## Bridgewater Community Healthcare NHS Foundation Trust

# Community end of life care

## Detailed findings from this inspection

Requires improvement 

### Are services safe?

By safe, we mean that people are protected from abuse

#### Summary

We found that safe required improvement because:

- The systems and processes for medicines management across the trust were not standardised and subject to an unacceptable level of variation with regards to risk. Some boroughs were using confusing documentation to authorise prescriptions for end of life patients and not complying with trust policy for this documentation.
- We found that, in one location, there was a practice in operation of GPs prescribing an unacceptably wide range of doses for end of life medications and district nurses titrating the medication dose upwards without medical review.
- There was no system in place for identifying incidents that related to end of life services or patients.
- This was no opportunity to identify issues occurring for end of life patients and themes that could drive forward service improvements.
- We identified that the records of the district nurse team in Widnes were of a poor standard in that they were not complete, in one instance contained details of a

documentation audit which included confidential details from other patients and in another contained post-it notes containing important information which was undated, unsigned with no patient identifiers.

However:

- There was evidence of learning and examples given of changes made following incidents.
- Mobile devices were in use in Wigan for accessing patient health care records. This meant that current information could be accessed and updated by all staff caring for the patient. Current guidance and procedures were also available to assist staff whilst in the community.

#### Incident reporting, learning and improvement

- There were no never events or serious incidents linked to end of life care occurring at the trust between 1 February 2015 and 31 January 2016.
- The trust had an electronic system in place to record incidents. All staff that we spoke with understood how to report an incident and staff were able to give us examples of incidents they reported.



## Are services safe?

- There was no agreed strategy, across the trust, regarding how to record and deal with incidents occurring at the end of life. Each area managed the process in a different way.
- There were no incidents recorded across the trust for either end of life services or for patients at the end of their life. This does not mean that incidents involving patients at the end of life have not occurred, but rather that the trust does not have a system to identify incidents as attributable to end of life services or patients. When we asked staff about incidents they believed that incidents had occurred but were recorded as relating to district nursing services.
- 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. We raised this with managers in one locality who readily agreed that this was both an omission and a lost opportunity to improve end of life services across the trust.
- In St Helens, we were told of a medication incident and the subsequent actions taken. Staff were retrained, and lessons were cascaded among district nurse teams. In Wigan, after an issue was raised at an inquest, changes were made to a drug administration form in order to clarify the process followed by staff. An additional 'drug wasted' column was added to the form. This is an example of learning taking place from incidents.
- We were told by district nursing staff that in some localities incidents were discussed at handover, locality meetings and monthly band 7 meetings. However, such learning from incidents did not always take place across the trust. In another locality staff who reported incidents told us that they never received feedback for the incidents that they reported.
- In response to an additional data request the trust identified 129 incidents that were attributable to patients at the end of their life. The majority of these incidents related to pressure ulcers and had been reported by the district nursing teams.
- 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.
- A clinical manager demonstrated a thorough knowledge of the duty of candour and gave an example of when it had been used.

### 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 Warrington and Halton had completed their safeguarding training. The trust provided evidence that 100% of cancer and palliative staff and between 87% and 100% of district nurses had completed adult safeguarding to level 2. We saw evidence that 98% of district nurse staff in St Helens were trained in safeguarding children to level 2.
- In Wigan and St Helens staff were able to explain their understanding of the safeguarding process. District nurses and a community matron gave us examples of their experiences.

### Medicines

- Anticipatory medicines were prescribed for patients in the community, identified as requiring end of life care. These are medicines that may be required and can be prescribed in advance to ensure prompt responses to the management of symptoms that could occur in the last days or hours of life.
- The trust used the prescribing guidelines from the 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. Anticipatory medicines were usually prescribed by the patient's general practitioner (GP) or via the hospital when the patient was discharged. Medicine reviews were completed and inappropriate medication was discontinued. We were told that availability of anticipatory medicines was good.

### Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

## Are services safe?

- There appeared to be some confusion among district nurses as to where emergency stores of medication were kept. During inspection we were informed that in St Helens an emergency supply of medication was stored at the GP out of hours office. District nurses knew which pharmacies in the community kept stock of required medication. In St Helens we were told that an emergency supply of anticipatory medication was stored at the GP out of hours office and therefore available at all times. Following our inspection the provider challenged this, stating that stocks of controlled drugs are held in Warrington out of hours office only.
- There was no consistent documentation of medicines across the trust for patients at the end of their life. Different types of prescribing documentation were used in different geographical locations and we found a variation in the safety of the different systems.
- In Widnes when we were reviewing a patient's district nursing notes we found that a GP had prescribed end of life medications as and when required (PRN) using an inappropriately broad range. It was then left to the district nurse caring for the patient to titrate the doses using her own professional judgement. This meant that medication doses could be increased without medical review. We saw no further discussion with the GP noted in the medical records. From the patient's medical record we were able to identify that the district nurse administered all medications at an appropriate dose. We saw a second example of an inappropriately large range of dosage for PRN medication. When we discussed the matter with the district nurses they confirmed that what we had seen in the notes was the normal practice and that they did titrate the dose upwards using their own judgement. They also reported that they had not had training in EOL medications. This practice was unsafe because it was open to mistake or abuse and consequently was escalated immediately to trust management and additional safety measures put in place .
- In addition, the prescribing advice documentation used in Widnes was confusing. This was because the way in which the prescription was written made it unclear the medication was to be administered PRN or over a 24 hour period. We found that there was a single documentation sheet for two routes of medication administration; subcutaneous syringe driver and other routes. Having the two processes on the same sheet created a needless opportunity for confusion. Indeed we saw instances where the wrong drug had been put in the wrong column on three occasions, although the prescriber had always corrected themselves.
- There was a trust policy for syringe driver prescription advice medication to be prescribed on a pink sheet of paper. We found that this was not adhered to in every location, in Widnes where a white sheet was used.
- In other areas there were separate sheets for syringe driver medication which was safer practice because it was clear and did not give rise to confusion.
- In some areas the prescribing guidelines were included on the prescription sheet and in others this was not the case.
- From medical records we noted that syringe driver volumes were regularly checked and we noted them to be accurate.
- There was a system in place across the trust for checking the drug stock and two nurses carried out this check. In most instances this check was completed, however, we saw one instance where although it was written that the check had been completed, the check was not completed in line with requirements.
- The care records we inspected contained, prescription charts and controlled drug logs. Regular stock checks were evident in all cases. Prescriptions were completed clearly, including times of administration of medicines prescribed 'as required'.
- Advice regarding medication was available to nursing teams via the specialist palliative care teams based in the local hospice. Staff also told us that they would contact the patient GP.

### 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.
- A rapid discharge scheme operated for each borough which enabled end of life patients to receive essential equipment the same day as discharge. In St Helens and Wigan this service was provided by a third party provider and there was a service level agreement in place agreeing levels of service provision. Staff found this service to be highly beneficial to ensuring that patients were discharged to their preferred place of care in a timely manner.

## Are services safe?

- In Wigan the physiotherapy team reported that the range of equipment available in the area meant that individualised assessments could be made and the most appropriate aids supplied for patients' comfort.
- Newton hospital in Newton-le-Willows also held an equipment store which could be accessed out of hours if it was required.
- One brand of syringe driver was used across the hospital and community, which ensured a consistent approach to the care of patients requiring a subcutaneous infusion (a subcutaneous infusion is an injection of fluid under the skin). All clinical staff received training in the use of the driver as part of their End of Life care (EOL) training package.
- Community district nursing teams each held a stock of syringe drivers and the out of hours district nursing services in each area also had their own stock of syringe drivers. The syringe drivers were regularly serviced and an electronic log was kept centrally.
- We were told that district nurses supplied and transported sharps bins to and from the patient's home. Sharps bins were used to dispose of syringes, needles and opened ampoules. Unused medicine was disposed of using a controlled drugs destruction kit.

### Quality of records

- We reviewed 31 sets of patients records. Some of these records were district nursing notes of deceased patients and some of them were the records of specialist palliative care teams. All teams used paper records, apart from the Wigan district nursing and allied health professional team where electronic records were used across the borough.
- We observed that the standard of documentation of all the specialist palliative care teams was high. All entries into the records were legible, signed appropriately and contained all relevant information.
- The quality of district nursing records for end of life patients was variable across different locations. In Widnes we reviewed 10 sets of district nursing records and from these records we observed that the standard of documentation was poor in this location in all 10 sets of notes. In two sets of notes we observed that although risk assessments for pressure ulcers and nutritional status had been carried out because there were comments in the notes referring to them, we could not find the risk assessments. There were loose pieces of paper inside some of the notes, some had no patient

identifier at the top of the sheet, which meant it was difficult to be sure if the page belonged in the notes that we found it in. In one set of notes we found audit documentation, which contained information from other patients. In another set of notes there was a post-it note stuck on a district nurse referral form sent by the acute hospital. The post-it note was querying medication levels and suggesting alternative dosage. This note did not have a signature on it nor a date. The potential for confusion that such a note could give rise to presented a risk to patients. This was raised with the district nursing manager at the time of our inspection, who commented that the level of administration support the team received had been decreased over the past months and this had impacted upon the quality of the team's documentation.

- We saw evidence of documented discussions taking place with patients regarding their preferred place of care/death and resuscitation status. These documented discussions involved other family members.
- We reviewed seven sets of health care records in St Helens and four in Wigan. We found all the notes to contain evidence of named staff involved in the patients care, documented ceilings of care and evidence of family involvement. Individualised plans of care were seen in five of the records, though one was incomplete as the patient had died within 48 hours of discharge from hospital.
- All notes that we reviewed were legible and signed and dated appropriately.
- All health care records in Wigan were on an electronic system that was accessed by staff via secure log in. This meant that district nurses could access the system and review records before going into the patients' home. Updates were immediate so information regarding care was current. We were told that there was only a small geographical location that had poor internet signal in the borough and access there was limited. District nurses were initially reluctant to use the system but now appreciate its value. All healthcare professionals involved in patient care can access the system, for example GPs, AHPs etc. Paper records of essential documentation were still kept in the patients home, such as the DNAR, IPOC, prescription and administration sheets.

## Are services safe?

- Record keeping audits were performed in Wigan. We were told that two sets of notes were randomly selected each month and assessment of quality was performed. However, the records sampled were taken from all available records, not exclusively end of life patients.

### Cleanliness, infection control and hygiene

- Staff undertaking community visits had adequate supplies of gel hand sanitiser and personal protective equipment (PPE). The patients with whom we spoke commented that all staff washed their hands before and after treatments.
- We were told that there was a standard procedure in place to decontaminate syringe drivers between each use.

### Mandatory training

- There was an annual mandatory programme in place for all trust staff. This programme was completed through e-learning and classroom based learning. The mandatory training programme included basic life support, safeguarding patients, infection control, medicines management and moving and handling.
- There were no end of life modules on the mandatory training programme.
- We were provided with information which indicated that all specialist palliative care staff in Warrington and Halton had completed this programme for this year. This information was confirmed by staff during our inspection. All Wigan AHP staff had completed their annual mandatory training programme.

### Assessing and responding to patient risk

- From case notes 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. In some instances we could see from the case notes that risk assessments had been carried out, but could not find the risk assessment tool itself.
- We saw evidence that patients with an intravenous infusion in place had their infusion site checked on a

daily basis. A visual infusion phlebitis score was taken for patients, which assessed whether patients infusion site was red, swollen or patients were experiencing any pain arising from the site of the infusion.

- 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.
- There was a district nurse out of hours service in the different boroughs which provided emergency care to patients outside of Monday to Friday 8.30am - 5pm. We noted that relatives and carers had access to contact numbers for help and advice.
- In the event of a rapid discharge, district nursing staff are able to access anticipatory medication out of hours from a supply kept with out of hours GP service.

### Staffing levels and caseload

- There was an adequate level of specialist palliative care nurses in Halton and Warrington. In Warrington the specialist palliative care nursing team consisted of 4.6 whole time equivalent (WTE) clinical staff and 0.48 administrative staff. This team comprised of a nurse manager, three band 7 specialist nurses and administrative support.
- In Halton there were 3.5 WTE specialist nursing staff at band 7 and one administrative member of staff. A band 6 specialist nurse had been appointed but had not yet commenced in post.
- St Helens and Wigan did not have a specialist palliative care nursing team. The specialist palliative care nursing team in these areas were provided by another community trust and a charitable hospice respectively.
- There were adequate levels of specialist palliative care medical staffing across the trust, when we visited. These posts were trust appointments but shared posts with local hospices. All medical staff provided specialist input into community clinics. One member of medical staff was planning to change their working arrangements and take up the medical director post at Willowbrook hospice. This would reduce the specialist medical input into palliative care clinics but had been agreed by the trust board. How this would impact on community clinics had not been risk assessed.
- In Warrington there was a well staffed heart failure team providing end of life care to heart failure patients. There

## Are services safe?

was also a specialist palliative care heart failure nurse based in St Helens. She was responsible for a clinical list of palliative patients and provided specialist knowledge to district nurses managing patients with heart failure.

- The allied health professionals employed in Wigan were based at the local hospice. There was a team of nine staff of physiotherapists, dieticians, speech and language and occupational therapists and administrative support. The team cared for palliative and cancer patients in their home and also arranged outpatient clinics at the hospice for people from the

Wigan area. A need for an additional dietician had been identified on the risk register. We were told that funding had become available and plans were in place to recruit.

### Managing anticipated risks

- The trust had a major incident plan, which was available on the intranet. Staff we spoke with in Warrington and Halton had considered how a major incident might impact on their service.
- All staff were trained in basic life support skills as part of the annual mandatory training programme.

# 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 required improvement because:

- The individual care records for end of life patients were not being consistently used across the trust.
- There was no formal pain assessment tool being used consistently, across the trust, to assess the pain levels of patients at the end of their life. In addition there was no formal pain tool being consistently used across the trust to assess the pain of non-verbal patients.
- Not all district nursing staff had received training on the use of anticipatory medications for end of life patients.

However:

- We were provided with audit information for Wigan which demonstrated that over a 12 month period an advanced care plan was completed in case notes between 87% and 99% of occasions.

## Evidence based care and treatment

- The SPCTs used the clinical guidelines from the Cheshire and Merseyside strategic clinical network for end of life patients, which were based on national guidance set out in One Chance to Get it Right and Priorities of Care for the Dying Person.
- There was no trust wide individual plan of care to replace the Liverpool care pathway, which was withdrawn in 2013. There were three different care plans in operation, which had each been developed within geographical locations using the borough based clinical networks that existed. All the care plans that we saw were based on national guidelines.
- In Warrington, Halton and St Helens the individual care plan for end of life patients was called 'Care and Communication Record'. We were told that this was initiated by the district nurse who saw the patient. In Wigan the individual care plan was called the 'Individual plan of care for the dying person in the last days of life (IPOC)'.  
 • We found conflicting evidence regarding the use of the individual plan of care in the different boroughs. In the District Nursing Care of Dying Quality Indicator Audits for 2015/16, which were carried out on a quarterly basis,

there was a high level of use of the individual plans of care across all the boroughs. In Warrington the audit identified that the percentage of patients with an individual care plan ranged between 66% to 71% over the previous four quarters of the year. The same audit carried out in Halton 2015/16 indicated that an individual plan of care was in place between 67% and 95% over the previous four quarters of the year. In St Helens the audit indicated that an individual plan of care was in place between 96-100% over the previous four quarters. In Wigan the audit identified that uptake of the new IPOC document was poor and ranged between 5% and 12% over the last four quarters of 2015/6. However, an advanced care plan that had previously been developed by the Wigan Borough End of Life task force was also audited and between 87% and 99% of records checked over the last 12 months had a plan in place.

- The quality audit findings were not supported in the review of the district nursing notes that we carried out during inspection. We did not see any evidence in the 10 district nursing records that we reviewed that the care plan was being used in Warrington. Staff that we spoke with in Warrington and Halton reported that it had not been embedded into practice. In Wigan we saw the IPOC being used on two occasions and three completed plans in St Helens.
- We investigated the cause of the poor use of the individualised plans of care in the notes that we saw on inspection. Managers, district nurses and facilitators all stated that it was due to the lack of involvement of general practitioners (GPs). GPs were reluctant to sign the new document and there had been difficulty resolving this issue. An SPC consultant told us of a regional audit that had been undertaken regarding the uptake of the IPOC document, however the results of the audit were not available.
- Although the audit results were positive in terms of numbers of patients placed on the individual plan of care and this was a total case sample, rather than the small number we looked at on inspection, staff reported that the take up of the IPOC was poor.

## Are services effective?

- We were told in Wigan that all patients that have been identified as entering the last stages of life, have a 'Statement of Intent' form completed by the GP. Any death without a statement of intent completed has to be investigated by police and the coroner.
  - We saw evidence recommended prescribing guidelines included in case notes, which were based on the prescribing guidelines of regional clinical networks.
  - We saw evidence in case notes of a unified do not attempt cardiopulmonary resuscitation (DNACPR). These were initiated either in hospital or by a GP, travelled with the patient and stored in a prominent place in the patients' notes.
  - The gold standard framework (GSF) sets out a framework for patients cared for in primary care at the end of their life. It increases coordination between services and agencies and assists staff working with patients identifying their care preferences as patients approach death.
  - We saw evidence that the care provided by staff was based upon the GSF, with patients being placed on a GSF register when identified as at the end of their life and travelling through different stages of the framework as they progressed towards death.
  - The Warrington heart failure team provided effective treatment for heart failure patients using nationally recommended guidelines. We saw evidence of individual care plans being used for heart failure patients at the end of their life.
  - We were told about the introduction of sub-cutaneous furosemide injections administered by district nurses, via a syringe driver, to relieve symptoms of heart failure and prevent hospital admission. This off-licence use is appropriate when prescribed and monitored by the palliative care consultant which was the criteria in Bridgewater.
- cases the anticipatory medications were prescribed in line with national guidelines. We found two occasions where the range of anticipatory medications prescribed were too wide to be used without medical review, but were within the recommended guidelines.
- In Warrington the locality based group had developed credit card size prescribing guidelines and computer mouse mats with guidelines printed on them. They reported that all staff caring for patients at the end of their life found these readily available guidelines very helpful.
  - In Warrington and Halton we were told that staff did not use a formal pain tool to assess patients' pain levels and there was no pain tool used to assess the pain of those patients who were not able to respond to verbal questions about pain.
  - We saw evidence in health care records of pain score tools used in both Wigan and St Helens. We saw daily entries relating to patients responses and evidence of staff training to use the tool. We saw the Abbey pain tool used that had a visual guide to measure pain in people with dementia who cannot verbalise their pain.
  - We saw evidence in case notes that syringe driver medication was reviewed and recorded at each visit to ensure the correct volume and ensure that patients' pain was controlled.

### Nutrition and hydration

- We saw evidence in case notes that the nutritional needs of patients were assessed using the malnutrition universal screening tool (MUST). In every record we reviewed, we found evidence that the patient's nutritional status had been assessed. We could not always find the assessment but the score was always in evidence. We saw evidence of referral to dietician for specialist advice where required.
- We saw evidence of consideration of patients' fluid intake in case notes.

### Patient outcomes

- Patient outcomes for end of life patients were monitored for the boroughs of the trust. In Warrington there was a quarterly district nurse care of the dying quality indicator audit carried out. This audit reviewed a number of key indicators for end of life patients. The audit indicated that in Warrington between 93% and 100% of patients discussed their preferred place of care

### Pain relief

- The trust had prescribing guidelines and algorithms in place for medications to address the five key end of life symptoms of pain, breathlessness, nausea, respiratory secretions and restlessness. These guidelines were based on the regional palliative care network audit group guidelines, which are based on nationally recommended best practice.
- We found evidence of prescribing for anticipatory medications in case notes and all patients had an adequate stock of anticipatory medication. In most

## Are services effective?

with a professional over the previous four quarters of the year. Patients' preferred place of care at death was achieved between 97% and 98% of the time over the previous four quarters of the year.

- In Halton the annual district nursing care of the dying quality audit for 2015/16 indicated that between 81% and 100% of patients discussed and recorded their preferred place of care with a professional over the previous four quarters of the year. Patients' preferred place of care at death was achieved between 76% and 100% of the time over the previous four quarters of the year.
- In Wigan an adapted form of the national care of the dying audit was carried out for 2015/16. This audit identified that of the patient records reviewed between 83% and 97% had an advanced care plan in the notes over the four quarters of the year. Patients' preferred place of death was indicated in notes for 80% to 87% of patients over the four quarters of the year.
- In January 2016 an audit was published that measured outcomes and included actions and learning to make improvements. The Audit of the Individual Plan of Care for the Dying Person in the Last Days of Life within the Wigan Borough collected data over a seven month period and demonstrated a significant assurance level of 82% that quality care is being provided. The results included 100% of patients had an individualised plan based on evidence and best practice. 96% of patients had a multi-disciplinary team assessment and 92% of Wigan patients died in their preferred place. Actions included improvement in the initial assessment process for patients on a rapid discharge from hospital and improvements to the bereavement support, as only 35% of relatives received a bereavement leaflet.
- An additional audit was undertaken by the audit team regarding the Wigan electronic record system. They found that all elements of a patient's care that were recorded electronically could be cross matched with the paper plan.
- We were told by the AHP staff that patient outcomes are monitored when patients are given a course of acupuncture treatment. A questionnaire is completed before, during and after treatment. The results were requested by the inspection team but not received. Following inspection we were informed by the provider that no patient audits of this service were undertaken.

### Competent staff

- Specialist palliative care nursing and medical staff were highly trained. All were trained to postgraduate level education, specialising in the care of the dying patient. SPCT in Halton were all independent prescribers and able to prescribe anticipatory end of life medications.
- In Wigan and St Helens the clinical managers and facilitator provided a comprehensive four week training package for new staff to the team including specific end of life information. The staff were supernumerary until the training was completed and competencies assured. The training included advanced care planning, controlled drugs, individualised care plan documentation, equipment training and communication.
- The facilitator based in Wigan kept records of all staff involved in end of life care, who had completed annual updated training and other external courses. These included: end of life care for children and young people, dementia and oncology and role specific training for allied health professionals.
- District nurses received training in syringe driver competency from the named trainer in their team. Competency updates were performed annually. District nurses were qualified to prescribe non-medical items such as dressings.
- All staff caring for end of life patients had been trained in foundation level Sage and Thyme communication skills and some staff were trained to advanced level communication skills.
- There were end of life care facilitators who provided training for staff in care homes based on the national education programme for end of life care, six steps to end of life. The end of life care facilitators joined with the SPCT to provide training to district nurses based on the six steps programme. However, we spoke with a group of five district nurses in Widnes, who reported that they had not had training on anticipatory medications for end of life patients.
- Training was provided on the care plan which replaced the Liverpool Care Pathway for district nursing staff, but it was reported to us that the take up of the training was poor.
- All staff we spoke with had received annual performance review, during which they were able to identify forthcoming training needs. 96.4% of staff providing end of life care had received an appraisal.



## Are services effective?

- There was no individual clinical supervision provided to the SPCT but group supervision was provided every two months.
- There were two district nurses who had completed university modules in Advanced Practice in EOL and Professional Practice in Palliative Care.
- Staff who worked out of hours told us they have access to end of life specific training modules via the internet and can continue their education within their working hours.
- We saw evidence of gap analysis performed by managers to assess staff competencies and arrange specific training.
- The AHP team had additional training in acupuncture, advanced communication and a head and neck cancer care to assist speech and language and told us they were encouraged to develop their skills.
- The specialist palliative heart failure nurse delivered training to other teams on an ad hoc basis. She provided training at the end of life champions meeting, to practice managers at an end of life nursing home forum and on a case by case basis to district nurses.
- We saw evidence of the Wigan borough palliative and end of life care committee meetings that included representation from the trust, GPs, hospital, hospice, local authority and ambulance service and took place every two months.

### Referral, transfer, discharge and transition

- We were provided with referral criteria for the SPCTs in Warrington and Halton. These referral criteria emphasised that the majority of care for end of life patients was carried out by district nurse teams and the specialist basis for referral to SPCT.
- There was a rapid discharge policy in place with each acute hospital and the clinical commissioning group (CCG) . We were told that district nursing staff and the patients GP would visit the patient on the day of discharge. Specialist palliative care staff visited within 24 hours of referral. We did not see evidence of any audit of this operational policy.
- Staff told us there was good communication channels between the local hospital, the hospices and themselves regarding the care of the dying patient. A specialist palliative care consultant told us that she would visit patients in the hospital as well as the community to provide ongoing care.

### Multi-disciplinary working and coordinated care pathways

- There was good evidence of multidisciplinary working across the trust when providing care for end of life patients. This working was supported by robust local clinical networks that had developed around GP clinical commissioning groups (CCGs).
- In each area there were regular multidisciplinary meetings where a range of staff came together to discuss patients in receipt of palliative care.
- From the notes that we reviewed, we saw input from a range of professionals.
- Although we saw evidence of good multidisciplinary working, we did not see consistent evidence of coordinated care pathways being used in district nursing notes.
- In Wigan and St Helens, where specialist palliative care staff were employed by a different provider, there was evidence of good communication between teams. Regular meetings took place and staff told us they had a good relationship with the team.

### Access to information

- We observed a whiteboard in each St Helens and Wigan base with current end of life patients identified by initials, which was called the patient status at a glance board. The board contained information pertinent to end of life care such as DNACPR, end of life medication, preferred place of care and GP initials. This meant information was accessible to all relevant staff who may need to respond quickly. The board was updated daily and information discussed at staff handover..
- In the case notes we reviewed we saw evidence of communication between different staff groups. We noted SPCT input and advice was clearly placed in patient notes and saw evidence of communication of relevant patient information on discharge.
- We saw evidence of referrals to different agencies and advice given. Patient notes also contained information provided by other agencies such as the Halton borough end of life team. All this information assisted staff to provide seamless care to patients at the end of their life.

## Are services effective?

- Trust specialist palliative care consultants that were based in local hospices were unable to access trust IT systems, which created difficulties communicating about patients.
- We noted that DNACPR were in place and signed appropriately.
- In Wigan, the electronic patient record system allowed all staff to have instant access to the most recent patient information so that treatment and care could be optimised.
- District nursing staff in Wigan could access the trust intranet via their laptops. This allowed access to all policies and procedures, and the most current guidance and best practice whilst in the community.

### **Consent, Mental Capacity act and Deprivation of Liberty Safeguards**

- The trust had a written policy in place governing DNACPR. This policy included advanced decisions, lasting power of attorney, mental capacity guidance and the use of independent mental capacity advocates.
- All staff received mandatory training regarding mental capacity and deprivation of liberty safeguards as part of safeguarding training.
- We saw evidence of DNACPR in case notes and these were completed either by a GP or when patients were in hospital, by a consultant.
- We saw two completed capacity assessments in the healthcare records we inspected. They were completed appropriately and in full.
- A district nurse co-ordinator told us that verbal consent before treatment was sought by all staff visiting a patients home. We asked patients from St Helens and Wigan who confirmed this.

## Are services caring?

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

### Summary

We rated end of life services were good for caring because:

- Staff considered the emotional and physical needs of patients, families and bereaved relatives at all times.
- We were told by patients and family that staff treated patients at the end of their life with compassion and empathy.
- We were told that staff were sensitive, kind and compassionate. We spoke to six patients and relatives and all said they were treated with dignity and respect and their wishes were acknowledged. Staff were sensitive to the emotional needs of patients and those close to them and mindful to respect their wishes.

### Compassionate care

- Patients were treated with dignity, kindness and compassion. Relatives we spoke with told us that staff were professional, supportive and kind. Staff were sensitive to their needs.
- We spoke with patients and relatives from St Helens and Wigan boroughs and all were positive about the compassionate care they had received. We were told that nurses were always polite and pleasant, asked about nutrition and pain levels and always respectful when providing care. Plans and wishes for the future had been discussed.
- We were told all the nursing staff visiting patients homes were “brilliant, wonderful” and “superb”. A recently bereaved wife told us “Without the team I could not have had my husband at home. I can’t thank them enough. He had the best possible outcome. He died happy where he wanted to be”.
- In one of the district nurse bases, we were shown a display of feedback from relatives/ carers that the staff had received. The manager arranged cards with quotations on a wall-mounted board so that all staff would see the responses. Quotes included “care has been brilliant” “really appreciate all they do, things were explained thoroughly” and “they looked after my mother with upmost dignity and respect, I will be forever grateful”.
- A staff member told us she felt it was a privilege to be a district nurse and be a part of a persons life event.

- We heard from two sources, an instance where a district nurse team demonstrated sensitive care and compassion for the family of a bereaved patient. The staff ensured that the patients dignity was maintained and the family were not distressed by the traumatic death in the home. The family appreciated what the staff had done and contacted the team to thank them personally. One of the nurses involved wrote a reflective piece of work so that other staff could learn from her experience.

### Understanding and involvement of patients and those close to them

- A patient with memory issues due to his condition, told us that the nursing team had recognised when he needed additional support and helped him understand the care and treatment he required. He was supported to write information in a book and helped to keep a diary with appointments and health incidents and any questions to be discussed.
- We saw a personalised note in a healthcare record that ensured staff communication was sensitive to the dying person. The entry stated “Billy doesn’t like the word morphine”.
- During the inspection, we overheard a phone call between a palliative patient and nurse in the DN office. She was kind but practical and supportive and assessed the patients needs. She arranged a visit in the following 24 hours even though the patient was unknown to the service as they had moved to the area.
- An end of life champion nurse told us that when she delivers training she always reminds staff that they are a guest in that persons home and an intimate part of their life.

### Emotional support

- The specialist palliative care teams we spoke with reported that providing emotional support to patients, families and bereaved relatives was a key part of their role.
- District nurses told us that they like to initiate the conversation about advanced care planning as they have a rapport with the palliative patient and know the patients situation. When the patient has been identified

## Are services caring?

as at the end of life, the district nurse teams take over the all the care aspects of the patient from the local authority in order to support the patient and family at the most critical time and provide four visits each day.

- We saw evidence of specialist nurses assessing patients' emotional needs in their records. Staff had advanced communication training to help them have the difficult conversations with patients and family.
- We spoke to a patient who told us how much he was supported by the service. He said the staff spoke to him "like he was normal" and "she is here for me, I can ask

anything and really appreciate her coming, she understands what is happening and I can ask her anything, I have no fear, I have confidence in her that she's not hiding anything from me."

- Two further patients told us they had received calls since their loved one had passed away. One said she felt they genuinely cared and the other relative said she had personally thanked the staff in the newspaper.
- We were told that a patient had been supported by the physiotherapists to remain independent. Advice and guidance had been given to them to manage to remain as mobile for as long as possible.

# Are services responsive to people's needs?

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

## Summary

Services were rated as good for responsive because:

- End of life services were planned well at a local level. This planning was underpinned by strong borough based clinical networks.
- Each borough based service was responsive to the needs of individual patients, including patients with very complex needs. Services were responsive to the individual needs of patients. We observed that staff cared passionately about the needs of all end of life patients and responded with dedication to all patients, including those with complex needs.
- Each borough had rapid discharge procedures in place to assist the facilitation of a patient's discharge to their preferred place of care.
- Alternative therapies and treatments are offered to patients to provide comfort at the end of their life.
- The trust audited the number of patients who had a discussion about their preferred place of death and the number who actually died in their preferred place of death and these numbers were high.

However,

- The trust did not strategically plan end of life care across all geographical areas. Although there was excellent local planning, based around local authority boroughs and local CCGs, there was no consideration of patients needs on a trust wide basis, which allowed gaps in service provision and quality to go unidentified.
- EOL complaints were not collated and reviewed on a trust wide basis. This meant that the opportunity to learn from complaints and improve service delivery in response to complaints was missed.

## Planning and delivering services which meet people's needs

- We found very strong clinical networks based around GP localities. 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 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. For example there was a night sitting service provided by Marie Curie in Halton. Halton Borough Council provide a service called End of Life care service, which supports the work of district nurses in the Halton area.

- Although we found excellent planning systems at local levels, 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. An example of this is that end of life patients in Wigan had access to a dedicated specialist palliative care allied health professions team, because Wigan CCG had identified this as a priority. There was no 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.
- Each borough had processes in place to facilitate the rapid discharge of patients from hospital to their preferred place of care. However, only Wigan borough had developed written procedures to support these processes.
- Information about patients, who are potentially in their last hours, were faxed between teams so that knowledge was shared if the staff were needed urgently. This meant that out of hours teams were informed at the start of their shift and could be prepared. Information regarding overnight care was also faxed back to the team in the morning.
- The allied health professionals (AHP) team were made up of nine staff who provided physiotherapy, dietician, speech and language and occupational therapy, the team visit patients in their home and at an outpatient clinic in the hospice in Wigan. The team were passionate about the work they performed and were disappointed that they could only provide services to patients from Wigan. A patient told us how much she had benefitted from the input of the physiotherapist.

## Are services responsive to people's needs?

- The AHP team offer acupuncture to patients as an alternative therapy treatment. Macmillan had funded the four day training course for the staff, but the service is offered to patients in the community. We were told the treatments are popular and in demand.

### 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. It provided translation services for 120 languages.
- 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 services we visited demonstrated that they met the needs of people in vulnerable circumstances. In Halton the specialist palliative care team had developed a Men's Shed scheme, to meet the emotional needs of bereaved men. It was identified by a team member that the emotional needs of bereaved men were not being addressed. Funding was sought for a Men's Shed scheme, specifically for those men who have been bereaved. A programme of activities and support had been developed, targeted to this client group. The men we saw were very appreciative of the service. This service had received a number of awards.
- In St Helens a community matron gave us an example of how she responded to the complex needs of a patient at the end of their life who was also drug and alcohol dependent. This patient had very particular social and environmental needs and the matron was able to respond to meet these needs by working in collaboration with other agencies.
- Services were responsive to the needs of end of life patients with complex needs such as dementia and learning difficulties. District nursing and specialist palliative care nurses worked closely with other specialist services and agencies to meet the needs of these patients. The facilities at Wigan and Leigh hospice that were used by the AHP team for the outpatient clinic was purpose built and suitable for larger patients and people living with dementia.

- We saw evidence of best interest meetings taking place in Wigan to discuss individual cases, which were attended by the trust safeguarding lead. A holistic approach to patient care was taken and access to MCA/DoLs coordinator and family welfare for patients with learning disabilities was good. A matron told us she attended regular meetings with a provider of drug and alcohol assistance.

### Access to the right care at the right time

- Specialist palliative care teams also held regular triage meetings to prioritise patients and responded to referrals within 24 hours.
- We were told that patients at the end of their life were identified as a priority by all district nursing teams. We found evidence to support this prioritisation in patient case notes.
- The District Nurse Care of the Dying Quality Indicator Audit results indicated that the percentage of patients who had discussions about their preferred place of care/death recorded in their notes was high, between 95-100%. The percentage of patients who died in their preferred place of care/death was also high, between 89-97%.
- District nurse handover meetings were held on a daily basis and patients were discussed and triaged according to need. District nursing teams provided regular visits multiple times a day, if required. We were told by two separate patients that the same nurse would attend if possible at a pre-arranged time. If the nurse is going to be late, the patient will receive a phone call informing them in advance.
- We were given examples of where patients had requested emergency out of hours visits for pain relief and a syringe driver alarm and district nurses attended within 10 minutes.
- Patients and families were given 24 hours a day contact numbers in order that they could request help and advice quickly, if they should need it.
- We spoke to a relative of a patient who had been treated by a physiotherapist in Wigan and were very positive about their experience. She had assessed the patients property and equipment then ordered more suitable items. When delivered, she then demonstrated best posture and coping mechanisms. We were told this greatly reduced the patients pain and allowed him to stay active for longer.

## Are services responsive to people's needs?

- Staff in Wigan had laptops during their working day and could access their emails and any urgent requests for visits. They could reschedule their day and have patients records available without returning to base, this improved staff efficiency and reduced waiting time for patients.
- We saw locally produced information leaflets in a clinic base. A district nurse told us they were given to patients/ carers when appropriate. Leaflets included the use of syringe drivers and information about controlled drugs, The language and information was appropriate for relatives/carers, however review dates for the leaflets had expired (January and September 2014).

### Learning from complaints and concerns

- There were no complaints or concerns identified for end of life patients at trust level. The trust did not collate complaints and concerns specifically about end of life services. It was reported to us that end of life complaints would go to adult community services. This meant that the opportunity to learn from complaints and develop services from them was missed.
- A clinical manager gave us an example of a complaint regarding an end of life patient. The complaint related to the amount of controlled drug audits the nurses had done and the provision of personal care. The matter was handled appropriately and the family were satisfied with the response.

# Are services well-led?

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

## Summary

We rated end of life services as requiring improvement in well-led because:

- There was no vision or strategy for end of life services across the trust. There was no end of life strategy group to provide governance for end of life services and measure progress towards national targets.
- The trust leadership for end of life services was not clearly identified in that the different branches of end of life services came under different aspects of community services. This lack of clarity meant that it was very difficult to identify the risks that existed for end of life services.

However,

- There was a very strong, supportive culture in evidence within specialist palliative care and district nursing teams. These teams worked collaboratively with other trust teams and external agencies to provide services to patients at the end of their life.
- Staff were supported to progress their education and co-ordinators ensured a continuous service with end of life patients as a key priority.

## Service vision and strategy

- The trust did not have a strategy for end of life services. We found that the trust did not have an end of life strategy group. The trust accepted our findings and commented that the first trust strategy group was set up for June 2016.
- There was no trust vision for end of life services. We found evidence of strong local vision regarding end of life services, led by clinicians and other agencies in each of the localities.
- Local clinicians also articulated how they would like end of life services to develop, that is with a greater degree of integration with other agencies and social services.

## Governance, risk management and quality measurement

- There were no robust governance systems in place for end of life services at trust level. By this we mean that there was no end of life steering group setting targets and measuring progress towards these targets, for end of life services.
- Staff providing services for end of life patients operated within the general performance and quality governance systems of the trust. We could not find evidence that these systems addressed the governance of end of life issues.
- Risks to the end of life service were not fully identified. An example of this is that the up and coming change to a consultant's role meant a decrease in medical service provision, but this was not identified as a risk to the service. Another example of the poor governance for end of life was that we found that the medical consultants undertook each other's annual personal appraisal.

## Leadership of this service

- The trust leadership for end of life services changed in April 2016 from the medical director, who had left the trust, to the chief nurse.
- There was no clear line of leadership and accountability for the progress of end of life services towards implementation of national guidelines.
- The trust had recently undergone a change in management structure which affected the community district nursing team and the specialist palliative nursing team. However, these structural changes did not have an impact on day to day service provision.
- A number of staff commented to us that the trust frequently changed the middle management structure. One member of staff commented that she had had three line managers in the last six years, with the most recent change being March 2016.



## Are services well-led?

- At local level, district nursing teams were clear about their roles and structure of the team. Staff told us their leaders were visible and approachable and regular team meetings were held within each team base, where staff were supported.
- There were regular meetings between clinical managers from the four boroughs in the trust. This facilitated some information sharing and the lack of a trust wide strategy had been discussed. We were told that the meetings provided peer support for the managers.
- Local managers understood the needs and challenges of the service and had produced an analysis of unmet needs and were addressing the issues, as a team, to improve performance.
- The AHP team do not have line managers based at the hospice, but stated they still felt supported. Monthly team meetings took place and regular one to one meetings. The team leader had resigned last year and their administration and planning role had been shared among the team. The team had managed the service but felt the additional work had impacted on clinical time available.
- A clinical manager gave us an example where staff reported violence and aggression from a patient but didn't wish to report officially. The manager supported the staff and used trust policy to work with the staff and patient to sort out the issues.

### Culture within this service

- In all the locations we visited, staff we spoke with articulated a very positive culture, dedicated to providing the best care possible to end of life patients.
- Most staff reported working in supportive and collaborative teams and feeling supported by their immediate line managers.
- A significant number of staff we spoke with indicated that they felt isolated from the trust and considered themselves to be more part of the service from where they were based, than a trust employee. Staff could not identify the trust lead for end of life services. Some staff identified the medical director and other staff identified the executive nurse, but nobody was entirely sure. Most staff had not seen either the chief executive officer or the executive nurse. There were very few meetings outside of the locality where staff could share experiences and knowledge.

- We noted that staff providing services to patients were very happy with the quality and openness of their line management arrangements. However, as seniority increased there was an increasingly frequent reporting of difficulty in management relationships.

### Public engagement

- The trust introduced a 'talk to us Tuesdays' scheme. This scheme involved district nurses taking comment cards out on visits with them and asking patients for their views of the service. This scheme was not valued by the staff asked to participate in it as they felt it was inappropriate for patients at the end of their life.
- The trust participated in the NHS friends and family test (FFT). All geographical borough areas scored highly on whether they would recommend the service to friends and family, with between 95% and 100% of patients across the trust recommending the service.
- Staff told us a phone call was made to the relative/carer to offer any additional support that may be needed after their relative has deceased. A bereavement card was sent to the family from the team that had cared for the patient following their death. One member of staff suggested that the comment/feedback card may be more appropriate being sent to the family after care has ended.

### Staff engagement

- There was good engagement with staff within the specialist palliative care team. Knowledge was shared at the regular team meetings.
- There was limited management meetings with managers of clinical services. There had recently been a change in management across community services and managers of clinical services did not receive one to one management meetings with senior managers. A number of managers commented that they would appreciate one to one meetings and the group level meetings were not sufficiently supportive.
- When district nurses had a challenging case, joint visits with SPCT staff were arranged for peer support. A debrief and reflections session took place with the whole team to learn from experiences. Counselling services were available for staff via occupational health services.

## Are services well-led?

- We saw several examples for district nursing staff receiving a trust 'Star of the Month' award. One example given was for a nurse who climbed through a window to assist a palliative patient who had deteriorated whilst alone.
- A 'wall of praise' was displayed in nurse team bases so that all staff could see the compliments received.
- Staff told us they were encouraged to continue their education. A community matron had completed a clinical diagnostics course and AHPs had undertaken a master class in head and neck cancer care.
- Staff told us they had met the chief executive officer for the trust and found him very approachable.

### Innovation, improvement and sustainability

- An end of life, grab and go bag had been introduced and placed in each of the district nurse bases. The bag contained items that would need to be prescribed and dispensed from a chemist such as catheters, dressings etc. Baby toothbrushes were introduced as a softer and more palatable option than sponge swabs. The bag was ready to be taken to the home at all times, saving valuable time putting together items in the clinic and delays at the chemists.
- A recent project, undertaken by the district nurse coordinators, aimed to make efficiencies and had

- resulted in better weekend cover and an addition of 20 hours district nurse time in normal working hours. The team had been awarded Clinical Team of the Year 2016 for the Bridgewater trust.
- We were also told of other future plans for EOL services in Wigan. There were plans in progress for a completely integrated service within the Wigan borough. An integrated care nurse therapy team made up of hospital, community nurse and social services staff was to be implemented in October 2016. This would include a single point of contact for patients with a single referral form and the local hospital will have access to community computer system. The locations of integrated teams were already arranged.
- There were plans in place to train district nursing staff in verification of death training in Wigan. This would fall in line with other trusts in the Greater Manchester area.
- The Wigan district nurse teams were the pilot site for the mobile system and staff were really happy with the results. Data could be extracted for auditing purposes and the Warrington weighting tool was used to plan staffing. We were told that evidence from the electronic system had been submitted for Coroner's evidence and was accepted.
- The AHP team have identified the value of head and neck work to improve speech and language in patients post-surgery and radiotherapy. They have established links with Greater Manchester Cancer Group to develop a pathway in Wigan.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

Regulation 12 Safe Care and Treatment

12 (1) Care and treatment must be provided in a safe way for service users.

(2) without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include-

(g) the proper and safe management of medicines;

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

Regulation 17 Good Governance

(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.

(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to-

(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

This section is primarily information for the provider

## Requirement notices

(b) assess, monitor and mitigate the risks relating to health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

(f) evaluate and improve their practice in respect of the processing of the information referred to in subparagraphs (a) to (e).

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.