County Durham and Darlington NHS Foundation Trust

RXP

Community end of life care

Quality Report

Darlington Memorial Hospital,
Hollyhurst Road,
Darlington,
DL3 6HX.
Tel: 01325 380100
Website: www.cddft.nhs.uk

Date of inspection visit: 4-6 February 2015
Date of publication: 29/09/2015

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)
RXPCC	Chester-le-Street Community Hospital		DH3 3AT

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

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of this inspection

Detailed findings from this inspection

Summary of findings

Overall summary

Overall community end of life services were good, although there were some aspects of well-led that required improvement. The community specialist palliative care service (CSPCS) provided a safe service. Staff were clear about their responsibilities for clinical safety, operated within clear national clinical guidelines and reported and analysed clinical safety issues and incidents. The service had arrangements in place for reporting and analysing incidents. Staff were aware of current infection prevention and control guidelines and we observed good infection prevention and control practice. Medical support for the CSPCS was provided by one full-time consultant in palliative care medicine. The consultant in post had been absent for several months. The post had been covered by a recently retired consultant who provided cover six sessions per week. A second consultant post was vacant.

CSPCS had been developed in line with national guidance. The service used the palliative and end of life guidelines developed by the North of England Cancer Network. These provided staff with guidance on palliative and end of life care planning, pain management, symptom management and emotional and psychological support. CSPCS staff were appropriately qualified and experienced to give specialist advice and we saw evidence of good multidisciplinary team working as part of the approach to supporting patients in the community. The service had arrangements in place for managing patient’s pain, managing symptoms and supporting their nutrition and hydration needs. The Liverpool Care Pathway had been replaced by guidance developed by the Northern England Strategic Clinical Networks, ‘Guidance for care of patients who are ill enough to die’, June 2014. There was no access to specialist palliative care advice out of hours. There was no specialist or general training programme in place for palliative and end of life care. Some community nursing staff who were coordinating people’s care had not received training in palliative and end of life care.

Patients were treated with dignity, respect and compassion.

The service worked well with other services and had developed services in partnership with the local clinical commissioning group to ensure patients needs were met. Specialist community palliative care staff reviewed the needs of newly referred patients and adjusted their priorities to ensure they provided a responsive service. Any complaints were reviewed and investigated, and any learning from complaints was cascaded to staff.

The service had been without senior leadership for some time. The consultant in palliative care medicine in post had been absent for several months. The post had been covered by a recently retired consultant who provided cover six sessions per week. A second consultant post was vacant. Team leaders had been identified for each of the localities. These were senior nurses who took on operational management responsibilities over and above their clinical caseloads. Staff understood the strategic aims of the organisation and felt involved in the clinical quality improvement framework.

Summary of findings

Background to the service

The community specialist palliative care service (CSPCS) was part of the 'care closer to home' division of the County Durham and Darlington NHS Foundation Trust. The service included doctors who specialised in palliative care, specialist nurses, a Macmillan home care support service and a supporting specialist rehabilitation team. The CSPCS was organised into six locality teams: Durham Dales, Darlington, Derwentside, Durham, Chester-le-Street, Easington and Sedgefield.

Specialist community palliative care staff were based in community hospitals, hospices and other sites in Shotley Bridge, Durham, Chester-le-Street, Peterlee, Bishop Auckland and Darlington.

The community specialist palliative care teams operated from 9.00am until 5.00pm, Monday to Friday. There was no out-of-hours provision for specialist palliative care in County Durham and Darlington. The community district nursing service provided care in the community 24 hours a day and coordinated the care for people receiving palliative and end of life care.

The CSPCS provided four levels of specialist palliative care support ranging from advice and support for other healthcare colleagues supporting the patient at Level 1, to the direct involvement of members of the specialist palliative care team in caring for patients with complex needs at Level 4.

Our inspection team

Our inspection team was led by:

Chair: Iqbal Singh, Consultant Physician in Medicine for Older People.

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission.

The team included CQC inspectors and a variety of specialists: a dentist, doctors, nurses, therapists, a health visitor, district nurses, community matrons, a GP and Experts by Experience (people who had used a service or the carer of someone using a service).

Why we carried out this inspection

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

How we carried out this inspection

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 held about the core service and asked other organisations to share what they knew. We analysed both trust-wide and service specific information provided by the trust and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well-led. We carried out an announced visit from 3 to 6 February 2015.

We held listening events on 26 January and 2 February 2015 in Darlington and Durham to hear people's views about care and treatment received at the hospitals. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who attended the listening events.

Summary of findings

What people who use the provider say

The service had developed a patient feedback questionnaire. The overall patient rating for the service from this questionnaire was 4.8 out of 5.0. We saw the comments received, which were positive. One person said, “I cannot praise the staff too highly. From first contact they have been very caring and supportive to my husband and me.” Another person said there had been “lots of contact and discussion and any assistance required has been provided”.

Good practice

Patients were supported to create memory boxes which consisted of items which were important to the person and would remind family members about them in the future.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- Address the lack of consultant medical staff cover.
- Develop access to out-of-hours advice for healthcare professionals caring for palliative and end of life patients.
- Ensure there is effective leadership and management in place to maintain and develop the service.

County Durham and Darlington NHS Foundation Trust

Community end of life care

Detailed findings from this inspection

Good ●

Are services safe?

By safe, we mean that people are protected from abuse

Summary

The community specialist palliative care service (CSPCS) provided a safe service. Staff were clear about their responsibilities for clinical safety, operated within clear national clinical guidelines and reported and analysed clinical safety issues and incidents. The service had arrangements in place for reporting and analysing incidents. Staff were aware of current infection prevention and control guidelines and we observed good infection prevention and control practice.

Medical support for the CSPCS was provided by one full-time consultant in palliative care medicine. The consultant in post had been absent for several months. The post had been covered by a recently retired consultant who provided cover six sessions per week. A second consultant post was vacant.

Detailed findings

Incidents, reporting and learning

- We saw evidence of learning from incidents. The staff we spoke with were aware of the process for reporting incidents. The trust used an electronic reporting system to record and notify managers about any incidents.
- The community specialist palliative care service were provided with reports which enabled them to analyse the reported incidents. We saw that the service had also reviewed incidents identifying and sharing information to reduce the likelihood of a similar issue recurring. The locality team managers and staff told us that they reviewed incidents at team meetings.
- We saw the agendas for team meetings where the results of investigations into incidents was a regular item for discussion and demonstrated that there was learning from incidents.
- Staff told us there was an open reporting culture and staff reported issues to their manager to learn from incidents and improve the quality of care.

Medicines

- The community specialist palliative care service (CSPCS) used the palliative and end of life guidelines developed by the North of England Cancer Network for managing people's medicines for symptom control, pain management, nausea and other problems.
- We observed a specialist nurse review a person's medicines. The nurse was a trained nurse prescriber and was able to adjust the person's dosage based on the

results of the blood tests they had carried out. The person told the nurse they had been experiencing nausea and the nurse provided the person with advice about their medicines and how these should be taken to reduce the possibility of nausea recurring.
- Staff we spoke with were aware of the trust's palliative and end of life care guidelines for cancer and non-cancer patients and the information these contained about the use of medicines for managing pain, nausea and vomiting, breathlessness and anxiety.
- The community nursing service provided patients with syringe pumps used to administer people's medicines subcutaneously. Palliative care nurse prescribers could prescribe medicines for people; the district nurse was responsible for managing the administration of the medicine. Palliative care nurses who were not prescribers would contact the patient's GP and request a prescription, which the district nurses would administer through the person's syringe pump.

Cleanliness, infection control and hygiene

- Staff were aware of current infection prevention and control guidelines and we observed good infection prevention and control practice.
- Hand washing facilities and alcohol hand sanitising gel available.
- Staff following hand hygiene and 'bare below the elbow' guidance.
- Staff wore personal protective equipment, such as gloves and aprons, while delivering care and treatment.
- Hand hygiene audits were completed showed high levels of compliance.

Maintenance of environment and equipment

- We reviewed the guidance held in a community hospital we visited to make sure the syringe pumps being used for administering people's medicines were being used safely. We found these were being managed in line with the trust's policies. We saw that records of electrical testing on syringe drivers were complete and servicing records were up to date.

Mandatory training

- The trust's training matrix showed CSPCS mandatory training had been completed or was to be undertaken shortly. This included moving and handling, infection control, fire safety, safeguarding, and Mental Capacity Act 2005.
- Compliance rates for mandatory training ranged from 100% for moving and handling, medicine management and hand wash assessment to 50% for slips, trips and falls training. There were plans in place to complete mandatory training before 31st Match 2015.

Records systems and management

- A CSPCS nurse told us about the service's process for recording patient information as part of an electronic record. They said one of the key benefits of the system was enabling information to be shared with district nurses and the patient's GP. Only a small number of GP practices used a different system.
- The hospitals used a different information system. It was not possible to share information between the hospital and community services and new referrals had to be entered on to the system by clerical or nursing staff. The nurse told us staff obtained the person's consent to record their personal details and clinical information on the system and for sharing this information with other healthcare professionals.

- Referral were received in each of the locality offices and entered on to the system by administrative staff. One of the team leaders we spoke with told us the service was planning to develop a single point of referral to streamline the process.
- Specialist palliative care staff working in the community were able to access patient's pathology test results in the hospital, but other than this patient records were not shared between hospital and community staff.
- Staff showed us the information system they used for capturing patient information. We saw information was held about a patient's religion and whether they lived alone or were cared for by members of their family. There was information about their medicines and any changes to their medicines, a plan for the care they received, and any advanced decisions about the person's future care were recorded, for example, preferred place of death.
- There was a facility for identifying and recording an end of life care plan and the system prompted palliative care staff to notify the out-of-hours primary care service if someone was on an end of life care plan. This meant if someone on an end of life care plan became ill in the evening or at the weekend healthcare professionals

were aware that an end of life care plan was in place. Specialist community palliative care staff made notes of their patient visits and the information was added to the electronic system when staff returned to the office.

- The community palliative care service had developed a home care service for providing people with personal care in their own home. We observed a carer during a home visit and saw they accessed the community nursing notes and recorded details of their visit. This meant there were good written records of visits and the care people received was coordinated effectively.
- We saw examples of 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms in people's records. These had been completed appropriately.

Safeguarding

- We asked specialist community palliative care staff about the arrangements in place for protecting people against the risks of abuse. Staff told us the trust's policy on protecting people from abuse was available on the trust's intranet. This provided advice and guidance for staff who reported concerns. Staff told us any incidents were reported electronically on the risk management system. Incidents were investigated by a senior manager. For example, we saw an incident the lead pharmacist had investigated about a medicines error.
- We spoke with five staff and asked them about protecting people against the risk of abuse. We found staff were knowledgeable about the trust's policies for safeguarding people and they knew how to report concerns and access advice.
- The executive director of nursing was responsible for ensuring there were effective arrangements in place for safeguarding adults and the associate director of nursing was the safeguarding lead within the organisation. We saw the 2013 to 2014 annual safeguarding report, which identified and monitored action plans in response to any safeguarding concerns.
- Fifty-seven per cent of staff had attended level 1 Adults and Children safeguarding training, with plans in place to ensure that all staff completed this training by 31st March 2015.

Lone and remote working

- Community specialist palliative care staff used a phone base lone worker surveillance system, which enabled their visits to be logged and recorded. One member of staff we accompanied on a visit to a person's home told us it helped them feel safe when they were carrying out visits in the community.
- We saw the notes of a staff team meeting where the team leader had reported that more staff were using the service and encouraging other staff to use it.

Nursing staffing

- The CSPCS was provided by 19.7 whole time equivalent nurses. The Macmillan carers team had 13 staff. The Darlington team had a vacancy, which was partly covered by staff from the Durham Dales team. Referrals were picked up and some were added to the Durham Dales team caseloads.

Medical staffing levels and caseload

- Medical support for the CSPCS was provided by one full-time consultant in palliative care medicine. The consultant in post had been absent for several months. The post had been covered by a recently retired consultant who provided cover six sessions per week.
- A second consultant post was vacant. We spoke to the interim service manager about this, who told us the post had been vacant for some time and they were having difficulty recruiting to the post.

Good ●

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

CSPCS had been developed in line with national guidance. The service used the palliative and end of life guidelines developed by the North of England Cancer Network. These provided staff with guidance on palliative and end of life care planning, pain management, symptom management and emotional and psychological support.

CSPCS staff were appropriately qualified and experienced to give specialist advice and we saw evidence of good multidisciplinary team working as part of the approach to supporting patients in the community.

The Liverpool Care Pathway had been replaced by guidance developed by the Northern England Strategic Clinical Networks, 'Guidance for care of patients who are ill enough to die', June 2014.

The service had arrangements in place for managing patients' pain, managing symptoms and supporting their nutrition and hydration needs.

There was no access to specialist palliative care advice out of hours. There was no specialist or general training programme in place for palliative and end of life care. Some community nursing staff who were coordinating people's care had not received training in palliative and end of life care.

Detailed findings

Evidence based care and treatment

- The service used the 'Palliative and end of life care guidelines for cancer and non-cancer patients', which had been developed by the North of England Cancer Network (third edition, 2012).
- The guidelines provided healthcare professionals with advice and guidance on managing pain, breathlessness, restlessness and other symptoms at the end of life. Although, some community staff who coordinated people's care in the community were not always aware of the guidelines.

Care plans and pathways

- Patients referred to the CSPCS were reviewed at a weekly multidisciplinary clinical review meetings. The meetings involved a range of healthcare professionals, who reviewed each patient's needs and agreed the support the person required.
- The service had replaced the Liverpool Care Pathway with guidance developed by the Northern England Strategic Clinical Networks, 'Guidance for care of patients who are ill enough to die', June 2014.
- Specialist palliative care staff were familiar with the guidance and we saw staff use the guidance as part of the care planning process. The guidance set out a number of principles for proving timely, explicit and sensitive communication about dying with the patient and their families. The principles included the patient being seen within 24 hours of referral, identifying and involving people who were important to the patient and developing a plan with the patient's involvement. The guidance being used complied with the requirements of the National Institute for Health and Care Excellence (NICE) quality standard for end of life care for adults [QS13].
- The service had also developed guidance for the application of the regional 'Deciding Right' framework, which we saw staff were using to guide their discussions with patients about making decisions in advance. For example, if the person wished to be resuscitated.
- A specialist palliative care nurse told us GPs reviewed the care of people who had died to assess if aspects of the care could have been improved and to learn any lessons for the future. Specialist palliative care nurses were invited to attend and contribute to the meetings. One nurse said they spent time discussing the care in detail at these meetings to identify areas for improvement and sometimes spent an hour discussing one case.
- We observed a specialist palliative care nurse respond to one person's needs for equipment to support them to remain in their own home. The person was at risk of falling as a result of their condition. There were no aids or equipment in the person's home to help them. We

observed the nurse identify the equipment the person needed and then order what was required. The nurse arranged for the person to receive social care support to help them with activities in the home. The person was also anxious about their condition deteriorating. They said they were due to be admitted for surgery at the specialist centre in Newcastle and if they needed admission to hospital they wished to go to the specialist centre. The nurse contacted the person's consultant and agreed the arrangements, which were put in place to ensure the patient was admitted to the specialist hospital

Pain relief

- The electronic patient information recording system was able to record information about the symptoms and pain the person experienced. This meant the healthcare professionals could monitor the person's symptoms and pain and make adjustments to interventions.
- We observed a specialist palliative care nurse visiting a patient at home. The nurse provided the person with a range of advice and information to help the person manage their pain.

Nutrition and hydration

- Patients nutrition and hydration needs were met. We observed a specialist palliative care nurse review a person's nutritional needs. The person described that they were unable to taste some foods. The nurse talked to the person about mouth care and the type of foods which might be suitable for their needs. For example they described how mint naturally stimulated taste buds. The person told us they found the advice very helpful.

Outcomes of care and treatment

- The trust had taken part in the 2013/14 National Care of the Dying Audit, where it had not achieved six out of seven organisational key performance indicators. The trust performed well in the use of clinical protocols for the prescription of medications for the five key symptoms at the end of life. The trust performed below the England average and failed to meet all of the 10 clinical key performance indicators.
- We viewed a draft action plan that aimed to address issues raised following the audit, including the recruitment to an end of life care educator post, the appointment of a non-executive director to take the lead on end of life care, and the implementation of regional 'guidance for care of patients who are ill enough to die'.
- At the time of our inspection the 'guidance for care of patients who are ill enough to die' had been implemented in July 2014 but other actions had been delayed. Members of the specialist palliative care team told us that delays had been due to structural and staffing issues as well as the end of life steering group being newly established.

Competent staff

- Staff had relevant experience and qualifications to enable them to carry out their roles effectively.
- Palliative care nursing staff were trained to provide people with psychological support. Staff had received appropriate training to assess and support people's psychological needs. Specialist palliative care staff told us they were able to refer to counsellors at a local family therapy service for people with more complex needs.
- Community nursing staff had received training in end of life care, which included developing care plans and dealing with emergencies in the community. They said the community teams had expanded to provide a 24-hour service. New community nursing staff who had been recruited had not received end of life training. They told us it had not been possible for specialty palliative care staff to provide training for all new community staff.

- We found staff had completed advanced communications skills training to help them discuss palliative care and end of life decisions with the patient and their family.
- A workforce development group was chaired by one of the palliative care consultants. This looked at staff training and development needs. A Macmillan educator was due to be appointed to develop an education programme.
- Clinical supervision was in place and should take place every six to eight weeks. Staff said these had not always been taking place in recent months because of the workload pressures on senior staff. They said these sessions provided a helpful opportunity to speak with a professional colleague about the care they provided, to raise any concerns and seek advice and guidance on their clinical practice.

- Experienced clinical professionals were available within the service to speak to if they had concerns. They told us there were also arrangements in place to access advice and guidance from GPs.

Multi-disciplinary working

- The specialist palliative care team had access to a range of healthcare specialists who could provide advice, for example: dieticians, physiotherapists and a therapy technician who could provide complimentary therapy.
- We spoke with community nursing staff, who worked closely with the specialist palliative care teams. They told us they were the patient's key worker, which meant they coordinated the care the patient received. They said they accessed advice from members of the specialist palliative care team in the first instance and there was good communication between the teams. Community nursing staff told us they were able to access specialist therapy staff, for example, physiotherapists and occupational therapists when needed.

Referral, transfer, discharge and transition

- GPs were informed electronically when a person had been referred to the community specialist palliative care service. However, not all GPs used the same system as the community palliative care service.

- We saw the community specialist palliative care service discussing new referrals. Referrals from the hospital were faxed and scanned on to the community specialist palliative care team information system. Most referrals from GPs and community staff were received electronically.
- The team met daily to review the referrals received and to prioritise and allocate the staff to providing care for people.

Availability of information

- The care plans we saw contained the records of multidisciplinary assessments, including risk assessments. Care plans contained information relevant to the person's needs.
- We saw that some people had been identified as being in the last few days of life, which resulted in staff assessing and monitoring the person's symptoms according to the service's end of life guidelines. There were prompts for assessing and monitoring the effectiveness of interventions. Medical staff also reviewed and recorded the person's care daily. This meant that staff were able to monitor changes in the person's condition.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Information about a patient's capacity to make decisions had been assessed. There were also manual and electronic records of people's consent to treatment and for sharing information with other professionals.
- We saw examples of mental capacity assessments which had been completed, and were recorded, on their electronic patient record. This included DNACPR documentation. This meant staff were informed about someone who might not be able to make decisions, for example, understanding why they should take their medicines.
- Where a person was not able to give consent to treatment because they lacked capacity, the service could make decisions in a person's best interests. Decisions could only be made in a person's best interest if healthcare professionals complied with the requirements of the Mental Capacity Act 2005. The electronic patient record system enabled members of the specialist palliative care team to record the results of a mental capacity assessment or to access information about a mental capacity assessment, which had been completed.
- We saw advice and guidance was also available to members of the specialist palliative care team who could access the regional guidance 'Deciding right' and Department of Health guidance on the Mental Capacity Act 2005. This meant the service was compliant with the laws on mental capacity and protected people's rights.

Seven Day Services

- The service was provided five days a week, Monday to Friday from 9am until 5pm. Specialist community palliative care staff had looked into the possibility of extending the service into the evenings and over the weekend, however, there was no medical out-of-hours cover to support a nurse on-call system.
- One patient we spoke with said it would be helpful to know they could access the service out of hours. They said, "It's important to know you are talking to a team who know you, rather than a stranger."

Good ●

Are services effective?

- Out-of-hours care for palliative and end of life patients was provided by the community district nursing service, which operated 24 hours a day. The CSPCS also worked closely with the Marie Curie Cancer Care rapid response service, which was able to provide nursing and other services for patients in an emergency. Patients could also access out-of-hours care from the urgent care centres provided by the GP-led clinical commissioning groups. There were informal arrangements in place for hospices to provide healthcare professionals with advice.

Good ●

Are services caring?

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

Summary

During our inspection we observed community specialist palliative care staff treating people with sensitivity and compassion. We saw examples of staff involving and supporting patients and their families in discussions about the care provided. Patients and carers we spoke with told us that all the staff in the palliative care team were caring and considerate. They said they received a high quality service.

Detailed findings

Dignity, respect and compassionate care

- Patients were treated with dignity, respect and compassion.
- We observed a specialist palliative care nurse conduct a patient review. The nurse engaged with the person, supported them when they found it difficult to speak and showed compassion.
- The nurse asked about the person’s family, their religious views and preferences. The person described how their condition had worsened and discussed their future treatment. The nurse provided reassurance and asked if they needed any help to organise their personal affairs. The nurse offered access to legal and financial advice and provided emotional support when the person spoke about a recent family loss they were particularly upset about. The nurse offered the person time to reflect on their discussion, which they said they could return to whenever the person wanted.
- We observed the care provided for one person in their home. The person told us, “I think the care and attention I have had at home is better than anything I have experienced before, including hospital.” They said, “I know when they come they will take time to do things properly. They listen to me and aren’t rushing about trying to see to everybody at once and I really appreciate that.” They said, “[The carers] always make sure I am comfortable. They know I like them to come before lunch so that I am washed and dressed and ready for lunch and I feel so much better once they have been.” They told us they had been admitted to hospital with pressure sores and had been glad to get home and that the pressure sores had healed.

Patient understanding and involvement

- We visited and spoke with one person whose relative had been supported by the CSPCS. They said they were “pleased [their relative] had been able to stay at home, which was where they wanted to be”. They told us the service had organised a bed for their relative, which had arrived the next day and was taken away just as quickly when it was no longer needed.
- Written information was available and given to patients to help with understanding of their conditions.

Emotional support

- Family support services were available at Willowburn Hospice, St Cuthbert’s Hospice and St Teresa’s Hospice to provide patients and their families with emotional support, counselling and bereavement support. CSPCS could also refer patients requiring psychological support to the community mental health team through the patient’s GP. The service received referrals by fax and by telephone.
- We observed a specialist community palliative care nurse discuss resuscitation with one person’s family. The person’s family had not wished to discuss this, however, the nurse sensitively made the family aware that their relative was in the last days of their life and the time was right to consider whether they would wish to be resuscitated or supported to die in their preferred place of death.
- The specialist palliative care team told us they would speak to the family bereavement support team in the home, although we noted there was no information available on bereavement support. The specialist palliative care nurse spoke with the family about completing a 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) form, which meant healthcare professionals would not attempt to resuscitate the person if their heart stopped. We asked staff about access to spiritual support. They told us they were not aware of a service they could access for patients in the community. They told us they provided bereavement support by telephone and visited the family a few weeks after the person had died.

Good ●

Are services caring?

Promotion of self-care

- The specialist palliative care service encouraged and empowered people to manage their own physical and emotional health while receiving palliative care.

Good ●

Are services responsive to people's needs?

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

Summary

The service worked well with other services and had developed services in partnership with the local clinical commissioning group to ensure patients needs were met. Specialist community palliative care staff reviewed the needs of newly referred patients and adjusted their priorities to ensure they provided a responsive service.

Any complaints were reviewed and investigated, and any learning from complaints was cascaded to staff.

Detailed findings

Service planning and delivery to meet the needs of different people

- The service worked well with other services such as Marie Curie Cancer Care and the Admiral Nurses service, which supported people with dementia, to plan and deliver patient services.
- Community specialist palliative care staff supported a local nursing home to provide care for two people at the end of life. There were two beds available to care for people at the end of life. The specialist palliative care team identified people they thought were suitable and contacted the home to see if a bed was available. This meant some people could continue to be supported close to home rather than being admitted to hospital in the event. For example, if there was a problem with home care support.
- Staff at the nursing home told us it was very helpful for the specialist palliative care nurses to be able to prescribe because they did not have to wait for a prescription from the GP surgery and they were able to ensure patients received a service which responded quickly to their changing needs.
- The service had been developed in partnership with the local clinical commissioning group because of the lack of hospice services in the area.

Access and flow

- Specialist community palliative care staff told us they reviewed the needs of new referrals and adjusted their priorities to ensure they provided a responsive service.
- We observed one member of the specialist palliative care team who had a full caseload make arrangements for a person to receive a blood transfusion at a local hospital. They said administrative staff recorded all new referrals onto the patient information system and members of the team picked up referrals depending on the number of patients on their caseload, where they lived and the person's symptoms.
- The specialist palliative care team provided four levels of service according to the person's needs and was based on guidelines from the regional North of England Cancer Network (third edition, 2012). Level 1 consisted of advice and information offered to professional colleagues, for example, by directing healthcare professionals to the end of life care guidelines. The team were not in direct contact with the patient. A person who was assessed as requiring a Level 2 service received a visit from the specialist palliative care team together with another healthcare professional, for example, a district nurse. Specialist palliative care staff provided a Level 3 service when the person was assessed as needing short-term interventions to address specific problems which had arisen, for example, complex symptom control. The intention of this level of support was to withdraw once the specific issues were resolved. A Level 4 service was provided if the person had complex issues extending over a significant period of time, requiring continuing regular assessment. For example, if they required very complex medicines or were experiencing particular distress.

Meeting people's individual needs

- CSPCS staff told us the service was able to offer people therapies to help them cope with anxiety. The therapies available included acupuncture, aromatherapy and massage. We saw a review of the aromatherapy service, which had gathered some very positive comments from patients. Staff told us they were also able to refer people to the complementary therapy service at the James Cook University Hospital and the Maggie's Cancer Care Centre in Newcastle.
- The Macmillan personal care team had designed their own electronic patient records for recording information about the care provided. The service aimed to provide a same day response for a six week care package. The service had won a trust recognition award.

Good ●

Are services responsive to people's needs?

Learning from complaints and concerns

- Minutes of staff team meetings showed that team leaders provided staff with feedback on the nature and outcome of complaints.
- We spoke with one of the locality lead managers, who told us they reviewed all complaints and ensured that learning from complaints was cascaded through the staff teams.
- We visited and spoke with one person whose relative had been supported by the CSPCS. We asked if they knew how to complain. They told us that any issues they raised with staff were taken seriously and resolved there and then.

Requires improvement ●

Are services well-led?

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

Summary

The service had been without senior leadership for some time. The consultant in palliative care medicine in post had been absent for several months. The post had been covered by a recently retired consultant who provided cover six sessions per week. A second consultant post was vacant. Team leaders had been identified for each of the localities. These were senior nurses who took on operational management responsibilities over and above their clinical caseloads.

Staff understood the strategic aims of the organisation and felt involved in the clinical quality improvement framework.

The trust was in the process of implementing the 'Deciding right' initiative, developed by the regional 'North of England Cancer Network', which was aimed at integrating the principles of making advance care decisions and, bringing together advance care planning, the requirements of the Mental Capacity Act 2005, cardio-pulmonary resuscitation decisions and emergency healthcare plans.

The team were involved in the commissioning-led strategy for 'Improving palliative and end of life care' working alongside colleagues from the clinical commissioning groups, local authorities and charities.

Detailed findings

Vision and strategy for this service

- Specialist palliative care staff told us: "[We] feel we made a difference to the quality of people's end of life care." They said they were proud of the positive feedback they received from patients and their families. They said their role was to "help people achieve their preferred place of care and preferred place of death and contribute to a peaceful death". We found community specialist palliative care staff understood the importance of their role supporting patients and as an important service within the care closer to home division and the wider organisation. Representatives of the service were actively contributing to the end of life steering group and the end of life strategic commissioning group.

Governance, risk management and quality measurement

- There were risk management and governance processes in place and the service had a risk register.
- There was wide support and engagement from staff in the clinical quality improvement framework and we saw the results of the assessments which had been carried out by individual teams. The framework had been developed to assess standards of safety, effectiveness, care, responsiveness, professional development and leadership. Staff also spoke positively about the work that had taken place to improve advance care planning through the 'Deciding right' initiative.
- We saw references in the notes of team meetings to progress rolling this out across the service. Staff told us they felt the trust had made a strategic commitment to improving advance care planning, which would benefit patients. 'Deciding Right' was a north-east-wide initiative, which aimed to integrate the principles of making advance care decisions by bringing together advance care planning, the requirements of the Mental Capacity Act 2005, cardio-pulmonary resuscitation decisions and emergency healthcare plans.

Leadership of this service

- The service had been without managerial and clinical leadership for some time. Staff we spoke with told us this had been challenging for the teams.
- The consultant palliative care medicine in post had been absent for several months. The post had been covered by a recently retired consultant who provided cover six sessions per week. A second consultant post was vacant.
- Team leaders had been identified for each of the localities. These were senior nurses who took on operational management responsibilities over and above their clinical caseloads. Team leaders we spoke with told us the responsibilities had been difficult at first, but there were aspects of the role they had enjoyed, including being more involved in discussions about developing the service.

Are services well-led?

- The team leaders met frequently as a group to share information and work together to resolve issues. Staff in the teams told us things had improved since the team leaders had taken on these roles.

Culture within this service

- The culture in the service was open and positive. Staff spoke openly about the challenges the service faced and how difficult it was to try to move forward without a manager.
- Staff told us their view on the importance of having clinical and managerial leadership had been heard and they believed the appointment to these new posts was positive. Staff told us they continued to be concerned about the lack of consultant cover and felt a solution needed to be found.
- When we spoke to the locality lead and interim manager they said they had engaged with staff to identify solutions to managing the service more effectively and staff had responded positively. They also recognised the importance of resolving the issue of consultant cover, confirming this was the service's highest risk on the risk register.
- The CSPCS nurses we spoke with told us there were good support mechanisms in place for staff in the specialist community palliative care team. They told us their manager was very supportive and they could access counselling and other support if they were affected by aspects of their work.

Public and staff engagement

- The service had developed a questionnaire for obtaining feedback from people who used the service. These asked patients whether they were happy with their involvement in their treatment plan and to rate their experience from poor to excellent.
- We saw the feedback had been analysed to identify patient satisfaction levels. The results were on display in locality team offices, together with the comments received from patients.
- Specialist palliative care staff we spoke with were aware of the feedback received from patients about the service provided by their team. We saw examples of feedback which had been analysed for each team. These showed the majority of patients (85%) were happy with communications but there was still some scope for improvement (17%).
- The overall patient rating for the service was 4.8 out of 5.0. We saw the comments received, which were positive. One person said, "I cannot praise the staff too highly. From first contact they have been very caring and supportive to my husband and me." Another person said there had been "lots of contact and discussion and any assistance required has been provided".

Innovation, improvement and sustainability

- A Macmillan home care support service was provided for patients in the Easington locality, which was being extended to two other localities within the community.
- Patients were supported to create memory boxes which consisted of items which were important to the person and would remind family members about them in the future.

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	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Address the lack of consultant medical staff cover in community end of life services.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision (1)(a)(b) (2)(a)(b)(c) Develop access to out-of-hours advice for healthcare professionals caring for palliative and end of life patients within the community. Ensure there is effective leadership and management in place to maintain and develop the community end of life service.