

South Tees Hospitals NHS Foundation Trust

RTR

End of life care

Quality Report

CQC Registered Location

The James Cook University Hospital

Tel: 01642 850850

Website: www.southtees.nhs.uk

CQC Location ID

RTRAT

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

Summary of findings

Ratings

Overall rating for End of Life Care		Good	●
Are End of Life Care Services safe?		Good	●
Are End of Life Care Services effective?		Good	●
Are End of Life Care Services caring?		Good	●
Are End of Life Care Services responsive?		Good	●
Are End of Life Care Services well-led?		Good	●

Summary of findings

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Summary of findings

Overall summary

The community specialist palliative care service is part of an integrated service working together with the hospital service provided at the James Cook University Hospital as part of the South Tees Hospitals NHS Foundation Trust.

We found the community specialist palliative care teams provided a safe, high-quality service for people with a life-limiting illness or at the end of life.

The service followed evidence-based guidelines which had been developed by the Specialist Palliative Care Multidisciplinary Team (SPCMDT) and the North of England Cancer Network. The guidelines incorporated the latest guidance from the National Institute for Health and Care Excellence (NICE) and other professional organisations.

There were effective arrangements in place for managing people's pain and the service had made improvements, for example, monitoring people's hydration and nutrition.

Staff were competent and well-qualified to meet people's needs. All staff had completed advanced communications skills training, were able to support people's psychological needs and provide access to services which specialised in helping people cope with the psychological aspects of their condition.

The community specialised palliative teams had developed good working relationships with GP practices, community nurses and nursing homes. In addition to caring for people, staff provided palliative care training for other healthcare professionals.

Throughout our visit we observed that the service was well-led. Staff we spoke with were clear about the development priorities for the service. They told us they felt involved in shaping the future direction of the service and were encouraged to contribute ideas for service development and innovation.

Summary of findings

Background to the service

South Tees Hospitals NHS Foundation Trust runs The James Cook University Hospital in Middlesbrough and the Friarage Hospital in Northallerton, providing district general hospital services for the local population as well as delivering community services in Hambleton, Redcar, Richmondshire, Middlesbrough and Cleveland. The Trust also provides a range of specialist regional services to 1.5million people in the Tees Valley and parts of Durham, North Yorkshire and Cumbria. The Trust employ approximately 9,000 staff and have a purpose-built academic centre with medical students and nursing and midwifery students undertaking their clinical placements on site.

Deprivation in South Tees is higher than average, with some areas of considerable deprivation on a par with the most deprived areas of the country. Significant numbers of children live in poverty, with more than one in four children in Redcar and Cleveland and one in three children in Middlesbrough living in poverty (over 18,000 children across South Tees). There is substantial variation in life expectancy between the most and least deprived areas of South Tees (12.5 years lower for men and 8.5 years lower for women in Redcar and Cleveland; 14 years lower for men and 9.3 years lower for women in Middlesbrough).

The community specialist palliative care service operated as part of an integrated service alongside the hospital-based palliative care team at James Cook University Hospital. The integrated specialist palliative care service was managed within the Specialty Medicine Centre of the South Tees Hospitals NHS Foundation Trust. There were two community specialist palliative care teams serving people living in the Middlesbrough, Redcar and Cleveland

locality, based at the Guisborough Primary Care Hospital and the Hambleton and Richmond locality with staff based in Northallerton. The community teams also provided specialist palliative in-reach care and support for people at the Friarage Hospital in Northallerton and support and advice for the primary care hospitals at Thirsk, Redcar, Richmond, Middlesbrough, Brotton, and Guisborough.

The community service covered a large geographical area and worked closely with hospice service providers, including Herriot Hospice Homecare in North Yorkshire, St Teresa's Hospice in Darlington, Butterwick Hospice in Stockton on Tees and Hartlepool & District Hospice in Hartlepool. There was also a close working relationship with acute and community-based specialist palliative care teams in the neighbouring localities of Durham and Darlington to the West, North Tees and Hartlepool to the North and North Yorkshire to the South, as well as tertiary centres in Newcastle and Leeds.

Community end of life services received 1,173 new referrals in 2013 and had received 843 referrals for the period April to November 2014. The service also had 3,756 face-to-face contacts and 8,939 telephone contacts for the period April to November 2014.

The specialist palliative care multidisciplinary team (SPCMDT) met once a week at the James Cook University Hospital with video-conferencing to the Friarage Hospital to link with the team covering the Friarage Hospital and the Hambleton and Richmondshire locality. The SPCMDT planned people's care with input from a wide range of professionals.

Our inspection team

Our inspection team was led by:

Chair: Sandra Christie, Director of Nursing, Wirral Community NHS Trust

Team Leader: Julie Walton, Head of Hospital Inspection, Care Quality Commission (CQC)

The team included CQC inspectors and a variety of specialists: doctors, nurses, therapists, a school nurse, 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).

Summary of findings

Why we carried out this inspection

South Tees Hospitals NHS Foundation Trust was inspected as part of the scheduled programme of

comprehensive inspections. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

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 carried out an announced visit from 6 to 9 December 2014.

As part of our inspection, we spoke with members of the community specialist palliative care teams, patients and carers, medical staff, ward managers, nursing staff and allied healthcare professionals.

We visited two community hospitals and accompanied a member of the team to a care planning meeting in a GP surgery. We also accompanied a member of staff who provided an in-reach service to the Friarage Hospital and visited three people at home.

We spoke with eight people who had used the service or had been a carer for someone who had used the service. We looked at a range of documents, including the results of audits and five patients' records.

We held a listening event on 2 December 2014 in Middlesbrough 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.

Patients and carers we spoke with told us that all the staff in the palliative care team were caring and considerate. They said they had received a high-quality service.

What people who use the provider say

Patients and carers told us that all the staff in the palliative care team were caring and considerate. They said they had received a high-quality service.

Good practice

- The Sources of Information and Support service directory developed by the Hambleton and Richmondshire Palliative Care Partnership.
- Community specialist palliative care nurses support for the National Gold Standard Framework coordination in GP practices.
- The health and wellbeing clinic at Redcar Primary Care Hospital.
- Support for nursing and residential homes for people with cancer and other life-limiting conditions in the Middlesbrough, Redcar and Cleveland locality.
- Professionalism and compassion of staff.

Summary of findings

Areas for improvement

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

The trust should:

- Consider a common patient record system and database to gather the minimum dataset and achieve a single electronic patient record.
- Review the referral system from the hospital which is by fax, which staff have to scan in to the community information system.
- Ensure there is a sustainable professional advice line accessible across the service.

South Tees Hospitals NHS Foundation Trust

End of life care

Detailed findings from this inspection

The five questions we ask about core services and what we found

Good 

Are End of Life Services safe?

By safe, we mean that people are protected from abuse

Summary

The community specialist palliative care service provided a safe service for people in its care. Staff understood their responsibility for clinical safety, operated within clear national, clinical guidelines and reported and analysed clinical safety issues and incidents. People affected by incidents or mistakes were given an apology, the issues were investigated and the lessons learned shared within the team.

Detailed findings

Incident reporting, learning and improvement

- We saw evidence of learning from incidents. The staff we spoke with were aware of the process for reporting incidents. The trust used the Datix computer-based reporting system to record and notify managers about any incidents.
- The community specialist palliative care teams were provided with reports which enabled them to analyse the reported incidents. We saw that the SPCMDT 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.

- 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.
- Staff told us about an error which occurred in one of the primary care hospitals. Staff were aware of the error and the lessons learned. This had been shared with the rest of the team. A clinical matron had reviewed the incident to see if any further training or competency assessment was required. An education event was also subsequently held.

Duty of Candour

- Staff we spoke with were aware of the Duty of Candour regulations which had been introduced for all NHS providers in November 2014. Staff told us that they had been informed about the new regulations by their managers. We saw a briefing which described how,

under the regulations, staff were expected to contribute to an open culture at all times, inform patients about any serious incidents and provide an honest account of anything that had gone wrong.

Safeguarding

- Staff were aware of the importance of protecting people against the risk of abuse, knew how to report concerns and access advice. We saw an example where staff had contacted the local safeguarding team for advice about observing the person's wishes for end of life care.
- A member of the palliative care team told us about a safeguarding concern they had raised with a person's social worker. As a result, a case conference had been held to discuss the risks and how the services involved could protect the person and their family.
- Staff we spoke with were knowledgeable about the systems to protect people from the risk of abuse.
- Staff visiting people in their own home were also aware of the importance of protecting people from the risk of abuse and provided several examples of how they had acted to protect people, for example, from financial abuse.

Medicines management

- We observed a member of the team, a trained nurse prescriber, reviewing one person's medicines for managing pain. They discussed proposed changes to the person's medicines, the reasons, risks and possible side effects. The majority of professional staff within both the Middlesbrough, Redcar and Cleveland team and the Hambleton and Richmond team were trained nurse prescribers. These were nurses specially trained to independently prescribe from a set range of medicines.
- A relative told us, "The palliative care nurse helped to sort [the patient's] drugs out. [The patient was] all mixed up and very confused about what they were taking. They were asleep all the time but, within 24 hours of the nurse changing their medicines, they were able to talk to us".
- Another person told us, "The nurse arranged an increase in the dosage of my medicine which has helped ease my pain and has no bad side effects. I am so relieved".
- We spoke with a nurse providing care for one person in a community hospital who demonstrated a good understanding of pain management and medication.

- Staff we spoke with were aware of the trust's palliative and end of life care guidelines for cancer and non-cancer patients, which contained information about the use of medicines for managing pain, nausea and vomiting, breathlessness and anxiety.
- The trust had recently replaced equipment for administering people's medicines using an electronic pump in response to a patient safety alert (RRR019) from the Department of Health. Staff told us that a training programme had been developed which all staff attended. Staff demonstrated competence and knowledge about the use of syringe drivers and pumps.
- The service's audit plan showed that an audit to ensure that the new syringe driver equipment was being used correctly had been completed. This was part of audit carried out across the trust during 2014. We reviewed the records relating to the administration of medicines in the community hospitals using syringe pumps and found that these were well-maintained with changes to medicines or dose recorded.
- We observed that one person in a community hospital was receiving their medicine through an electronic pump. Their care plan showed they were receiving end of life care. Procedures for monitoring the administration of the person's medicines were being followed in accordance with trust guidelines.
- We reviewed the controlled drugs register at one community hospital and saw the records were complete and signed in accordance with legal requirements. Staff were knowledgeable about managing pain and the procedures for administering controlled drugs.
- Staff arranged anticipatory medicines, those a person could take if they wished to ease their symptoms, which were available for people at home. There were protocols for staff to follow for prescribing and monitoring the use of these medicines.
- Incidents including medicines errors were reported via the trust's incident reporting system and investigated to identify any possible concerns about clinical practice. There were processes for addressing any competency issues which could be addressed through the training and staff supervision processes if appropriate.
- There were systems in place to access medicines quickly to support people's rapid discharge home from one of the community hospitals.

Safety of 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.

Records and management

- The SPCMDT had developed guidelines for recording discussions with patients. These were based on a wide range of published research and national guidance – for example, NICE guidelines – and met the standards for good practice. Staff were aware of the guidelines and told us these were followed.
- Community specialist palliative care staff shared information with GPs and with other community staff to coordinate the care people received. Palliative care community staff were following the National Gold Standards Framework, a set of national standards for providing high-quality care to people at the end of life. GP practices kept electronic records about the care people received and most GP practices were able to share the information they held with community palliative care staff because they used the same information system. This meant community palliative care staff and GPs were able to share information and coordinate people's care in the community. However, it was not possible to share information with all GP practices. Some GP practices used a different system which could not share information with the community system.
- Community palliative care staff told us that sharing electronic records with GPs had improved the quality of service people received and further improvements could be achieved if information could be exchanged with all GP practices and hospital services. Electronic links to the hospital would make it easier to refer patients and enable a common patient record to be used by all healthcare professionals. There were no current plans for this to be introduced.
- The community palliative care teams received referrals from the hospital by fax; staff had to scan the faxes in to the community information system. Staff told us they were aware of the GP practices they needed to contact by phone to discuss patients' care.
- The service had incorporated recently published NICE guidance (QS13 and CG140) about managing people's

care at the end of life. The new approach had been tested and was due to be implemented across the trust early in 2015. The service was using a 'preferred priorities of care' planning tool to enable people approaching the end of life to identify their preferences and priorities for care. We saw that the tool's planning process was being used in GP practices and across specialist and general community services.

- We visited two of the community hospitals (Lambert Memorial and Redcar Primary Care Hospital) and saw examples of do not attempt cardio-pulmonary resuscitation (DNA CPR) forms in people's records which had been correctly completed. The trust had undertaken an audit of DNA CPR forms in 2014. This had identified the need to: ensure there was a full discussion with the person and their family about their wishes for the end of life; document the wishes in the person's records; and complete the DNA CPR document appropriately. Staff told us they had been provided with guidance for improving practice and we saw the trust's plans to re-audit practice during 2014/15.
- A record-keeping audit had been undertaken in each of the specialist palliative care team localities. This was an annual audit aimed at improving the quality of record-keeping across the trust.
- Staff told us that identifying people's spiritual needs and determining and recording their preferred place of death had been identified as requiring improvement by an audit of the end of life care pathway in 2014. As a result, an education programme was planned for staff across the service for 2015.

Mandatory training

- We saw the staff training matrix for the community teams and saw that staff training was up to date, or that plans were in place to ensure this was completed. The staff training matrix was on display in one of the team bases. This provided the manager and staff with a visible, accessible record of staff training.

Assessing and responding to patient risk

- We spoke with specialist healthcare professionals who were part of the integrated service based in community teams. One healthcare professional was employed by the local authority, seconded to the integrated team to support people who needed special equipment to enable them to return or continue living at home. They

told us they carried out assessments in the person's home to see what equipment they needed, identify risks in the home and recommend any changes needed to improve the person's environment.

- Another healthcare professional provided support and advice for people who were at risk of malnutrition or dehydration. A risk assessment tool had been developed to help staff identify those people at high risk so that they could receive specialist assessment and advice.
- We saw that the healthcare professional had also developed an easy-to-use tool to identify people with a risk of developing a complex condition which resulted in them losing body weight which was difficult to reverse. They said they wanted to encourage healthcare professionals to identify the risk as early as possible and the assessment tool was designed to provide staff with specialist advice about this risk.
- We saw that the palliative care team could access the risks assessments completed by district nurses on the shared information system. This meant there was good coordination between the services supporting people.

Staffing levels and caseload

- Both community specialist palliative care teams were led by a community team leader reporting to a nurse consultant in palliative care. There was a total of 12.5 whole time equivalent (WTE) nursing staff for both teams, the majority of whom were band 7 nurses with medical input from a part-time (0.6 WTE) consultant for the Middlesbrough, Redcar and Cleveland team and a 0.5 WTE speciality doctor in palliative medicine of which 0.4WTE of their time was deployed for the Hambleton and Richmondshire team.
- Both teams had access to psychology services and occupational therapy. The Hambleton and Richmondshire team had dedicated input from a dietician.
- At the time of our inspection, there was one vacant consultant post (0.5 WTE). One nurse provided an in-reach service to the Friarage Hospital in Northallerton.

- Staff told us that one of the challenges they faced was providing a service to such a large, rurally dispersed population. This was particularly the case for the Hambleton and Richmondshire locality team, providing a service to an area of 1,000 square miles. Staff told us the teams worked flexibly to provide cross-cover and ensure efficient service delivery. Staff also said they worked closely with district nurses and GPs to ensure that people's needs were met.
- Specialist palliative care nurses were available Monday to Friday during normal working hours. An out-of-hours advice service was provided by consultant medical staff. The service had developed plans for an advice line for professionals provided by specialist nurses which was due to commence in January 2015. The out-of-hours advice line would operate from 4.30pm until 11.00pm on weekdays and at weekends.

Managing anticipated risks

- We saw that risk assessments had been undertaken for people in the last days of life. This included identifying the risk of malnutrition and dehydration, falls and pressure sores.
- The service had developed a Patient Passport which contained information about the person, their condition, (for example, the medicines they were taking), the support they preferred in the event of an emergency, and who to contact. The passport had been designed to provide ambulance staff and other professionals with information to help them in an urgent situation to decide the most appropriate approach to supporting the person, for example, if they did not wish to be admitted to hospital. This meant the person's wishes were known to healthcare staff at all times and the person's wishes could be respected in an emergency. The Patient Passport was in the process of being implemented throughout the community palliative care localities.

Are End of Life 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

The care provided by the community specialist palliative care teams was built on evidence-based guidelines which had been developed by the SPCMDT and the North of England Cancer Network.

Detailed findings

Evidence-based care and treatment

- The care provided by the community specialist palliative care teams was built on evidence-based guidelines which had been developed by the SPCMDT and North of England Cancer Network.
- We observed that new service developments used evidence-based guidance – for example, the health and wellbeing clinic at Redcar Primary Care Hospital which was based on the Department of Health survivorship initiative.
- The service used a pathway to support end of life care planning. They had developed a new approach to planning end of life care (in response to the independent review of the Liverpool Care Pathway and national recommendations). The new approach had been tested by staff across the trust. We saw that the new approach would be used across the trust in January 2015.

Pain relief

- We saw the guidelines which had been developed for managing pain at the end of life. These provided staff with guidance for managing pain at the end of life for a range of conditions, including renal failure. These were based on published research and NICE guidance.
- There were evidence-based guidelines for the assessment and management of pain. These included advice on medicines, complementary therapies, depression and anxiety. We saw the service had provided training events for GPs on symptom management in November 2014.

- Staff told us they used a pain assessment tool and we saw examples of these which had been completed for people being cared for in the community hospitals. This meant staff were able to monitor the person's pain over time and adjust the care being provided.

Nutrition and hydration

- During a visit to a community hospital, we observed a clinical team discuss the care plan for a patient who had recently been admitted from the James Cook University Hospital. The team discussed the person's family and social situation as well as undertaking a full clinical assessment. As part of the assessment, they saw that the person had experienced a recent significant weight loss and referred the person to the dietician.
- We saw examples of nutrition and hydration monitoring charts in people's records in the community hospitals we visited. This meant that systems were in place to protect people from the risk of dehydration and malnutrition.

Outcomes of care and treatment

- The trust had participated in the National Care of the Dying Audit in 2013. They had performed better than the England average in seven out of 10 clinical indicators and lower or equal to all seven organisational indicators. The trust had reviewed the results and identified areas for improvement, such as the assessment of nutrition and hydration as part of their review and revision of end of life care guidance. The service had performed well in multidisciplinary recognition that the patient was dying, and in discussions with the patient and their relative.
- The multidisciplinary team had self-assessed the specialist palliative care service against national peer review measures, which resulted in a compliance score of 72%. The service had met 18 of the 25 relevant national requirements. This meant the service was achieving a high level of compliance against national standards.
- The service was not contributing data about end of life care to the national minimum dataset and was not

Are End of Life Services effective?

using the end of life quality assessment tool, but had contributed to the 2014 National Care of the Dying Audit. The end of life quality assessment tool was based on NICE end of life care standards (QS 13). These standards had been developed to help organisations assess progress towards achieving the quality standards and compare that progress with other, similar organisations.

- Improving access to clinical trials had been identified as an area for improvement in 2014/15 by the SPCMDT.
- A patient and carers group had developed an experience survey which had provided valuable feedback for the service, resulting in the development of an emergency healthcare plan designed to make communications with healthcare professionals easier in an emergency. The group had identified that patients and carers were asked for information about their condition and the treatment they had received. They were often asked for the same information several times. The document enabled healthcare staff to quickly and reliably access essential patient information.

Competent staff

- Staff had completed advanced communications skills training to help them discuss palliative care and end of life decisions with the patient and their family. Senior staff in both community palliative care teams had completed level 2 psychological therapies training, including cognitive behaviour therapy, to enable them to support people experiencing anxiety or depression.
- An SPCMDT education action plan had been developed for 2014/15. Many educational events had been delivered in 2014. These included training for GPs, community nurses, nursing home staff and community hospital staff on topics including symptom control and advanced care planning.
- The service had developed micro-education events undertaken when community specialist palliative care staff attended routine monthly palliative care meetings in GP surgeries.
- The service had an active training and education programme for specialist palliative care staff, community staff and GPs providing palliative care. We saw a number of training sessions had been held during 2014 and more were planned for 2015 for end of life

care. The sessions completed included symptom control, advanced care plans and training for non-specialist staff on caring for people in the last days of life.

- Staff told us it was sometimes difficult for ward staff to be released for training. Steering group members were aware of this problem and were looking at ways of ensuring that staff were able to attend training events.
- There were professional supervision arrangements in place for the community specialist palliative care teams. These were monthly group supervision discussions with input and support from a psychologist. Staff told us they found these sessions very helpful for obtaining professional support.

Multidisciplinary working and coordination of care pathways

- The specialist palliative care team worked with a wide range of healthcare professionals – for example, district nurses, GPs, community hospitals and nursing homes – who used the National Gold Standards Framework, an evidence-based approach to providing care for people approaching the end of life.
- One community-based healthcare professional we spoke with told us, “We will occasionally visit and assess a patient together. On one occasion, we had also had a psychologist from the specialist palliative care team because it’s not all just about physical symptoms”.
- We found there were strong links with other cancer teams in the hospital, with good referral and communication flows in both directions. Staff told us there were also good links between the community-based teams of the specialist palliative care service and community nursing teams and community hospitals.

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 team 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.



Are End of Life Services effective?

- The team met daily to review the referrals received and to prioritise and allocate the staff to providing care for people.
- We observed staff organise one person's discharge from the Friarage Hospital. They had transferred from the James Cook University Hospital. A member of the community specialist palliative care team who provided an in-reach service to the Friarage Hospital discussed the person's wishes with them and their family and made arrangements for the person to be discharged that day. This included organising medicines and a brief stay in a local hospice before the person returned home.
- The community specialist palliative care service provided care for adults. There were separate services for children. Staff told us they were involved in the care of a young adult and were working closely with healthcare professionals from the teenage and young adult's service.

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 observed a meeting of hospital and community-based healthcare professionals reviewing the quality of care provided for people the service was currently

supporting and for relatives of those who had recently died. Improvements to decision-making and record-keeping were discussed – for example, recording more information about a person's nutrition and hydration.

- 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 and deprivation of liberty safeguards

- The records we reviewed contained accurate details of people's decisions – for example, consent and decisions made by the service in the person's best interests – following a two-stage mental capacity assessment.
- We observed a clinical team discussing the decision-making process for completing a DNA CPR form for one person whose condition had deteriorated. We observed them discussing the person's wishes with their relative and taking advice about making a decision in the person's best interest before completing the DNA CPR form.

Are End of Life Services caring?

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

Summary

Staff treated people with dignity and respect. We observed staff being sensitive, compassionate and caring and we saw examples of staff involving patients and their relatives in discussions about the care provided. Patients and carers told us that all the staff in the palliative care team were caring and considerate. They said they had received a high-quality service. Staff told us the advanced communication skills training they had undertaken helped them to discuss people's wishes and support them to make plans for the end of life.

Detailed findings

Dignity, respect and compassionate care

- Patients and carers told us that staff respected people's wishes and showed compassion when people experienced pain or received bad news.
- One person told us about their relative who had wanted to fulfil a certain wish before they died. They said the specialist palliative care team got in touch with colleagues and arranged it very quickly. The relative said it was really important the family had been able to spend time together, sharing the experience with them.
- Another person told us that a close relative who lived some distance away was due to visit someone whose condition had deteriorated. They told us the nurse had contacted the relative who had been able to visit shortly before the person died.

Emotional support

- The service provided people with support at the end of life and helped relatives with bereavement. The team also referred people to a psychologist or to the community mental health team for support.

Patient understanding and involvement

- We met one person who was reluctant to take a medicine recommended by a member of the specialist palliative care team. They said they were happy to carry on with the medicine they were familiar with and did not understand why the other medicine was being suggested. We observed the specialist nurse carry out an assessment of the person's pain by asking them about the level and type of pain, peaks and troughs. They explained the limitations of the medicine they were currently using and the benefits to the person of trying the one suggested. The person said, "Now I understand – why couldn't anyone else explain this to me?"
- Other people told us that staff were good at explaining things to them and involving them in making decisions about their care.

Promotion of self-care

- The specialist palliative care team developed a health and wellbeing clinic aimed at empowering people to manage their own physical and emotional health while receiving palliative care.

Are End of Life Care Services responsive to people's needs?

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

Summary

The community specialist palliative care team aimed to respond to all urgent referrals within 24 hours, and within 48 hours for less urgent referrals. Patients and carers told us the service had responded very quickly and everything they needed had been identified and swiftly put in to place.

The service operated from Monday to Friday, with access to an out-of-hours telephone advice service provided by consultants in palliative medicine. A new advice service for healthcare professionals was planned for January 2015, with advice being provided by specialist nurses. A daytime care triage advice service was also provided for healthcare professionals in the Middlesbrough Redcar and Cleveland locality.

The service supported people who needed care in a community hospital bed, residential and nursing homes. A health and wellbeing clinic had been set up at Redcar hospital to support people living with a life-limiting condition.

Staff were able to put arrangements in place to enable people to be cared for at home or in a local community hospital. They also ensured that families were supported with pain and symptom management, psychological and social support. Staff also worked closely with hospices within the localities and around the borders to support people's access respite care, complementary and other therapies.

Planning and delivering services which meet people's needs

- The service received 1,173 new referrals in 2013 and had received 843 referrals for the period April to November 2014. The service also had 3,756 face-to-face contacts and 8,939 telephone contacts for the period April to November 2014.
- Staff told us they aimed to respond to urgent referrals within 24 hours, and 48 hours for all other referrals. The nurse consultant told us they were not routinely monitoring the service's response times but they were confident they were responding to all urgent referrals within 24 hours.

- The target for achieving patients' preferred place of death was 100%. The service achieved 96% for patients preferred place of death for the quarter ending March 2014 and 90% at the end of June 2014.
- The specialist palliative care team had set up a specialist advice line to provide support to healthcare professionals caring for people receiving palliative care. This was operated by the Macmillan specialist nurses with back-up from consultants in palliative medicine. An audit of the service found that the advice had improved the support provided, including avoiding sending some people to hospital.
- The service had developed plans for an advice line for professionals provided by specialist nurses which was due to commence in January 2015. The out of hours advice line would operate at weekends and bank holidays between the hours of 08.30 and 16.30 and 16.30 to 23.00 on week days. The service, proposed for commencement in January 2015, was a pilot out of hours helpline across all community services provided by a nurse for healthcare professionals.
- District nurses told us community palliative care staff were accessible and responsive to the needs of patients and staff working in the community. They said the daytime care triage advice service meant there was one telephone number they could call to obtain advice. The daytime specialist triage service was provided to the Redcar, Middlesbrough and Cleveland locality team for healthcare professionals. There was not a similar arrangement in Hambleton and Richmondshire.
- The Hambleton and Richmondshire locality extends across an area of 1,000 square miles. Staff told us it sometimes took the majority of the day to visit people in the most remote areas. They said they worked closely with community nurses and GPs to make sure that people's care was well-coordinated. They said they felt they had access to support when needed.
- Each of the trust's community and primary care hospitals had palliative care beds. Staff told us they were usually able to access a bed when someone needed one.

Meeting the needs of people in vulnerable services

Are End of Life Care Services responsive to people's needs?

- We spoke with one member of the community specialist palliative care team about the support they provided for people at the end of life who lived in nursing and residential homes. They told us they provided the care homes with advice and support for people with a wide range of health conditions. The service provided support for nursing and residential homes in the Middlesbrough, Redcar and Cleveland locality. There were around 120 care homes in the area. The clinical nurse specialist provided education and practical support for staff. An example of this was the End of Life Competencies for Care Homes programme.
- One person told us their relative had been seen by the specialist palliative care dietician because of weight loss. They said they had arranged food supplements quickly. They said their relative had put weight on and felt much better.
- We saw a directory of services which had been developed by the Palliative Care Partnership for Hambleton and Richmondshire. The Sources of Information and Support directory was maintained by members of the partnership group to ensure that it was up to date. The booklet contained a comprehensive list of organisations people could contact for advice and information about cancer and other life-limiting conditions. For example, it included contact details for

young people whose parent had cancer and an organisation which explained how the law operated for people to make advanced decisions if they wished to refuse treatment.

- We also saw patient information leaflets explaining the role of the community specialist palliative care teams. The service had developed leaflets to support people experiencing grief and loss, what to do when someone dies and what to tell children.

Complaints handling and learning from feedback

- We saw examples of information leaflets which highlighted how people could raise concerns and make a complaint. The Palliative Care Partnership group also undertook surveys of people's views about the service. Staff told us how they had responded to the issues raised. An example of this was the development of the Patient Passport which contained information about the person to be used in an emergency.
- We observed a meeting of hospital and community-based healthcare professionals reviewing the quality of care provided for people, including those who had recently died. The quality of care provided was reviewed, incidents and areas for improvement discussed.
- We saw examples of complaints which had been handled in line with the trust's policy. Substantiated complaints were reported to the quality assurance committee and the Trust Board.

Are End of Life 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

Throughout our inspection we observed that the community specialist palliative care service was well-led.

We saw evidence of effective multidisciplinary team working within the service and effective relationships with partners in the community.

A steering group led by a member of the Board had been set up to provide strategic leadership for palliative care and end of life across the trust.

Considerable progress had been made on integrating community and acute services.

The SPCMDT led the development of professional practice within palliative care and worked closely with other clinical teams across the trust.

We saw evidence of good leadership at locality team level and the professionalism and pride the teams felt about providing high-quality care.

There was a strong track record of service development, innovation and patient and carer engagement. Support to nursing homes, for GPs with the National Gold Standards Framework and the health and wellbeing clinic were examples of innovation.

Detailed findings

Service vision and strategy

- An end of life steering group had been set up and a work programme had been developed to look at the provision of care in the last year of life, care in the last days of life, education, staff support and board engagement and assurance.
- A board director was responsible for leading the trust's strategy for end of life care.

Governance, risk management and quality measurement

- Specialist palliative care reported within the structure of the speciality medicine directorate.

- The SPCMDT guided the development of palliative care across hospital and community services, following national guidelines.
- The SPCMDT had produced an operational policy to direct the membership and work of the group, in line with national requirements for specialist palliative care services. The operational policy stated that the team's role was to "oversee the delivery of national standards for specialist palliative care to patients, families and carers, indirect patient care through advice and education of generalist colleagues, direct patient care where palliative care needs are complex and cannot be met by generalist teams, evidence-based palliative care education, quality assured patient information, development of evidence-based palliative care through evaluation of patient pathways, patient and carer partnership working".
- Managers responsible for community palliative care services attended meetings of the specialist palliative care directorate. Minutes of those meetings showed that managers met and discussed a range of operational issues with palliative care managers from the hospital, the directorate manager, nurse consultant and clinical director.
- We saw evidence that complaints, incidents, audits and patient experience were reviewed and that action was taken as a result. For example, we saw that, based on the feedback received from community staff and patients, the service was developing an out-of-hours advice service.
- We saw from the end of life work programme and the change action report from the National Care of the Dying Audit that there were action plans to develop and improve the end of life care services across the trust.

Leadership of service

- We spoke with the managers of both community teams and saw that they provided effective managerial and professional leadership for their teams. Staff told us they felt involved in shaping the future direction of the service. They also said they were encouraged to contribute ideas for service development and innovation.

Are End of Life Services well-led?

- There was strong professional leadership for the community specialist palliative care team, led by the nurse consultant, with input from consultants in palliative care, psychologist, occupational therapy and a dietician.
- Community hospital staff, district nurses and GPs all told us the community palliative care teams provided valuable advice and support and promoted the adoption of best practice standards in the community – for example, the National Gold Standards Framework and advanced care planning.
- We were told the community specialist palliative care team provided active support across all the community hospitals and in GP practices through the monthly National Gold Standard Framework coordination meetings they attended. Palliative care nursing staff from the community teams had each been assigned to support GP practices across the Hambleton and Richmondshire and Middlesbrough, Redcar and Cleveland localities.
- We saw the service had developed and tested a new approach to supporting people at the end of life. This followed the recommendations of review of the Liverpool Care Pathway for end of life care. The service had achieved significant progress towards meeting the recommendations by setting up an integrated acute and community service. The service was implementing a new approach to end of life care planning. We were told a series of education events had taken place and further events were planned for early 2015 to support the implementation of the new approach. Staff told us it had taken longer than expected to develop the new approach, but they had felt involved in its development and felt confident this would lead to improvements in care.

Culture within the service

- Staff were very positive about the quality of care they were able to provide. They felt involved in developing services, supported by their managers, medical staff and other members of their teams.
- We met members of the Palliative Care Partnership for Hambleton and Richmondshire who praised the services highly. Members of the partnership we met had all cared for relatives at the end of their lives. They told us the manager and staff involved them in developing the service and listened and responded to any issues they raised.

Public and staff engagement

- The Palliative Care Partnership group provided the service with formal feedback on the service in the form of an experience survey the group designed and analysed annually. The group had also developed a service directory which reflected the experiences of people who used the palliative care service and carers. The group maintained the directory updating contact information to ensure that carers always had access to services they needed.
- A bereavement survey was in place to ensure ongoing feedback from relatives to provide information on the patient experience and ensure that good care and areas for improvement were identified.
- We saw that the trust had appointed a patient/carer representative to the end of life steering group.

Innovation, improvement and sustainability

- The SPCMDT was using national guidance and tools to develop the service.
- The service had secured funds to pilot a specialist nurse on-call service to provide advice to healthcare professionals in the evenings and at weekends.
- A health and wellbeing clinic had also been set up in the Redcar Primary Care Hospital to support people with help and advice for maintaining their physical and emotional health.