Calderdale and Huddersfield NHS Foundation Trust

RWY

Community end of life care

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RWY07	Todmorden Health Centre		
RWY01	Huddersfield Royal Infirmary		
RWY02	Calderdale Royal Hospital		

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

Summary of findings

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Summary of findings

Overall summary

Overall we rated the service as good. We rated the end of life service in the trust as good for safe, effective, caring responsive and well-led. The service understood how to identify safety concerns and risks to patient safety. Incident reporting was embedded in the service and learning from incidents was shared across the service to ensure improvements were made.

Medicines were effectively managed and improvements from incidents were used to improve care and treatment of patients.

Patients could access services out of hours staff worked well with GP practices to ensure patients who were receiving end of life care and their relatives were cared for and supported in the last days of life.

Staff worked within multi-disciplinary teams to allow co-ordination of care and there were meetings held with every GP practice in the area where the team provided end of life care.

There was a 24 hour telephone service and referrals to the service were acknowledged within 10 minutes of referral and contacted by telephone within one hour of the referral. Patients and their relatives were contacted by the service within 3 hours.

There was a clinical educator post within the service to co-ordinate and provide training and staff had access to specialist training. Staff had one to ones with their manager and yearly appraisals. Staff understood their roles and responsibilities for providing end of life care.

Care was provided based on national guidance such as The National Institute for Health and Care Excellence (NICE). The trust had developed and was implementing an Individual care of the dying document (ICODD) which was based on the five priorities of care document in the community.

The service had developed an end of life dashboard and they monitored patient outcomes. Information about patient care and outcomes were shared with the trust and commissioners of the service to continue to improve patient care.

The service had a vision for the service which was understood by all staff and staff felt the service was well managed and patient care was a priority for all staff.

Summary of findings

Background to the service

Information about the service

Calderdale and Huddersfield NHS Foundation Trust (CHFT) employed Clinical Nurse Specialists (CNS) based at Overgate Hospice in Elland to support patients and their families in the community in Calderdale. The CNS worked Monday to Friday 9am to 5pm.

The Overgate team delivered an education programme to nurses, doctors and allied health professionals. Community patients were contacted to arrange a mutually convenient time for a telephone assessment and /or a face-to-face assessment and support.

There was also an out of hours palliative care team who worked 8pm to 5am seven days per week based at the Horne Street Health Centre in Halifax.

The service provided specialist palliative care advice to patients and their carers and to nursing and medical staff from hospital and community settings, including care homes. Consultant palliative medical advice was provided for health care professionals through switchboards at the trust and at a neighbouring NHS trust by eight Consultants in Palliative Medicine who covered the areas of Calderdale.

There was a 24 hour telephone service at Kirkwood Hospice and Overgate Hospice that operated a 24 hour/ 365 days a year telephone advice service.

We spoke with 27 staff, we visited and spoke with four patients and their relatives, we listened to five telephone calls and we looked at 14 patient records.

Our inspection team

Our inspection team was led by:

Chair: Ellen Armistead, Care Quality Commission

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission

The team included CQC inspectors and a variety of specialists: including consultants, specialist nurses, community nurses, therapists and a nurse director.

Why we carried out this inspection

We inspected this core service as part of our comprehensive acute hospital trust and community health services inspection programme.

How we carried out this inspection

To get to the heart of patients' experiences 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?

The inspection team inspected the following eight core services at Huddersfield Royal Infirmary and Calderdale Royal hospital:

- Urgent and emergency care
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and family planning

Summary of findings

- Services for children and young people
- End of life care
- Outpatients and diagnostics

The community health services were also inspected for the following core services:

- Community adult services
- Community end of life
- Community children's services

Before the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the hospitals. These included the clinical commissioning group (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), royal colleges and the local Healthwatch.

We held stalls at Calderdale Royal Hospital and Huddersfield Royal Infirmary on 29 February and 1 March 2016 and provided comment cards and boxes at a number of locations across the organisation. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection.

Focus groups were held with a range of staff in the hospital, including nurses and midwives, junior doctors, consultants, allied health professionals, including physiotherapists and occupational therapists. We also spoke with staff individually as requested. We talked with patients, families and staff from all the ward areas, outpatient services, community clinics, and in patients' homes when visiting with District nursing teams. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' personal care and treatment records.

What people who use the provider say

- Patients and their relatives were positive about staff. They felt staff treated them with dignity and respect.
- The service took part in the National Service evaluation of bereaved relative's satisfaction with patient's end of life care 2014. The results showed 86% of families were very satisfied or satisfied with the emotional support provided to the patient by the palliative care team.

Good practice

- The palliative care team won the multidisciplinary section of the international Journal of Palliative Nursing awards for their nurse training programme to help them validate and record expected death.
- The end of life care pathway aimed to reduce Accident and Emergency (A&E) attendances and admissions and GP callouts by increasing community capacity to safely and effectively care for people approaching the end of life in their own home, and by improving the identification and coordination of care for patients approaching the end of life.
- Between April 2015 and December 2015 the pathway had avoided 201 admissions to hospital and 102 GP call outs.
- There had been a pilot at Heathstones Learning disability home where qualified and unqualified staff from the home had completed End of Life Care training sessions to enable staff to provide and look at providing end of life care in a more holistic manner.
- The service also used Dis DAT a disability distress assessment tool for patients to help identify distress cues for patients who had severely limited communication skills to ensure the service was meeting the needs of these patients.

Calderdale and Huddersfield 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

We rated end of life care as good because:

- Staff knew how to report incidents and safety was a priority. Staff took an active role in reporting and learning from incidents. Learning was shared at team meetings and by email.
- There were systems in place for safeguarding adults and children. Staff knew when and what to report. They had completed safeguarding training and PREVENT training.
- The service was appropriately staffed and reviewed staffing levels to ensure people were safe and had their needs meet in a timely manner.
- Medication and oxygen were available patients receiving end of life care.
- Staff had access to specialist equipment seven days per week.

Safety performance

Incident reporting, learning and improvement

- There were no never events or serious incidents reported for community end of life care within the last 12 months.
- The trust had an incident reporting policy and staff knew how to report incidents. Staff were encouraged to report incidents and they were used to help improve services provided. Staff knew how to recognise and report incidents on the trust incident reporting system.
- Staff gave us examples of incidents they had reported including pressure ulcers and the access to pharmacies that hold anticipatory drugs (ACP) available for the out of hour service. Staff told us there had been an incident when staff did not know which pharmacists held ACP drugs. Following the incident staff were given a list of pharmacies that hold ACP drugs.
- Learning from incidents from across the trust was discussed at team meetings. Case studies were also developed and discussed at team meetings to ensure the service continue to improve. In November the service had shared case studies about the verification of death for a 93 year old patient and a 69 year old patient diagnosed with bowel cancer how the care provided by an integrated team approach involving his GP, District Nurses, OOH District Nurses, Community Palliative Care Team and the OOH Palliative Care Team had supported the patient and their partner to allow the patient to have a good death in their preferred place of death.

Duty of Candour

Good

Are services safe?

- Duty of Candour is a requirement for all trusts to be open and transparent with patients when things go wrong. Providers of healthcare services must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.
- Staff understood the requirements of the duty of candour and told us they would share information with patients and their relatives if there was an incident which resulted in severe or moderate harm.

Safeguarding

- The trust had policies and procedures in place for safeguarding adults and children. Staff had completed their safeguarding training. The trust target was 95% and all the teams had achieved 100% in March 2016.
- In March 2016 86% of staff had completed PREVENT training. PREVENT training is central to the Safeguarding agenda and should be detailed within safeguarding policies, procedures and training. The Prevent agenda requires healthcare organisations to work with partner organisations to contribute to the prevention of terrorism by safeguarding and protecting vulnerable individuals who may be at a greater risk of radicalisation and making safety a shared responsibility.
- Staff were able to explain when they would raise a safeguarding concern and what steps were needed to be taken to report concerns.
- Safeguarding was discussed at team meetings and lessons learned were shared.

Medicines

- The palliative care team worked with GPs and the community district nursing team to provide the management and administration of medication for patients who were approaching the end of life.
- Medication was available for patients and regularly reviewed. Syringe drivers and conversion charts were available to ensure patients received medication properly.
- The service used electronic prescribing for anticipatory control drugs. Staff told us it worked well because the system was available for district nurses and GPs who could see what had been prescribed.
- We observed medicines being prescribed appropriately to prevent nausea, vomiting and pain. We observed discussions with a GP to review a patients medication needs and ensure appropriate medication was available for the district nursing teams visiting the patient in their own home.
- Some palliative care nurses were able to prescribe independently and were fully trained nurse prescribers. Staff had access to a 24 hour advice line at the hospice and GPs and consultants provided professional advice. The service had quarterly education forum and bi-monthly peer case reviews where medicine management would be reviewed.
- We saw oxygen was prescribed and available for patients. We observed oxygen was reviewed for a patient and extra oxygen was arranged to be delivered during the visit.

Environment and equipment

- Staff were able to access equipment seven days per week. Staff did not have any concerns about accessing equipment such as syringe drivers. There were no incidents relating to the lack of availability of equipment.
- We observed appropriate equipment was available when we accompanied staff on home visits.
- The trust used the Mckinsey syringe drivers and all staff had had appropriate training. Staff completed training as part of the end of life training. In March 2016 100% of palliative care staff had completed the Mckinsey Syringe driver training.

Quality of records

- The patient record was a combination of an electronic and paper record. Care records were completed in the patient's home and also information was stored on the electronic system.
- The electronic system was available to GPs, community nursing teams, out of hour services and 111 services. If the GP was on another system there were arrangements in place for 111 services to update the GP with any changes in care.
- A red folder was used to store relevant patient care information provided by the CNS team with the patient held district nurse record in the patient's home.
- All the records we looked at had completed risk assessments and care plans to allow staff to provide the required clinical care needed. We looked at 14 patient

records and found evaluation sheets for symptom management had been completed and evaluated. For example in one set of records we found that there had been a change in medication following the review.
- The service completed record keeping audits and findings were shared we staff at team meetings and individually if required. The audit had identified concerns about the documentation of DNACPR and GP letters and the service had implement stickers to be attached to records to remind staff they needed a DNACPR completing. We looked at team meetings and found findings from audits were a standing item on the agenda. Staff told us audits were discussed at team meetings.

Cleanliness, infection control and hygiene

- There was trust infection prevention and control policy and staff had a good understanding of infection prevention and control practices. We observed staff adhering to bare below the elbow guidance, washing their hands or using hand gel after providing care to patients. Patients and their relatives also told us staff washed their hands before and after they provided care.
- Staff had access to personal protection equipment (PPE). We observed staff wearing PPE when providing care to patients in their homes. Patients and their relatives told us PPE was always available for use in the home.
- 100% of palliative care staff had completed their infection control and hand hygiene training in March 2016

Mandatory training

- Mandatory training provided by the trust included infection control, dementia awareness, safeguarding, health, safety and welfare and conflict resolution.
- Training was delivered through e-learning with some face to face training.
- We looked at mandatory training for community end of life care staff and 100% of nursing staff had completed training infection control, dementia awareness, safeguarding, health, safety and welfare and conflict resolution

Assessing and responding to patient risk

- The care records we looked at had completed risk assessments and were regularly reviewed. Patients were reviewed daily and their care records were updated. We looked at 14 patient records and found risk assessments for pressure care, food and fluid had been reviewed at least once a day, district nurses and palliative care nurses had completed four hourly reviews for patients
- The service was implementing an individualised Care of the Dying Documentation (ICCOD) which included sections on good communication, hydration and nutrition assessments of patients' psychological and spiritual needs and assessment needs of relatives. The service had reviewed the use of the ICCOD for 20 patients. For patients on the ICCOD the duration of supported care was 50 hours and the review felt this indicated that families had time to prepare for the death of their loved one.

Staffing levels and caseload

- The CNS team based at Overgate Hospice had one full time band 7 nurse and three full time band 6 nurses. There was also a band 4 support worker who provided training in the hospital and in the community.
- The band 7 and band 6 CNS staff were aligned to GP practices across the locality. Each CNS managed their own caseload of patients with complex specialist palliative care needs.
- The CNS team based at Overgate Hospice worked 9am to 5pm Monday to Friday. Staff told us they did not have enough staff to provide a seven day service but were hoping to expand the service to introduce this in the future.
- There were three band 6 CNS nurses out of hours who were based at Horne Street Health Centre. They provided a seven day service 8pm to 5am. This had been extended from 11:15pm to 6am by the CCG commissioners. Two CNS staff worked each evening and the service was able to achieve this. They were hoping to provide the service from 8pm to 8am in the future. Annual leave was covered within the team
- Palliative care nurses had a monthly average caseload of 36 for 2014/2015 and between April 2015 and December 2015 the average monthly caseload was 56. The service completed quarterly reviews with the CCG to review capacity and demand.

Managing anticipated risks

- The trust had a trust wide business continuity policy and procedures. These had been implemented during recent floods and disruption in December 2015.

Good

Are services safe?

- Staff told us how they had managed the service during the floods in the district in December 2015. Staff had contacted patients by telephone and arranged alternative routes if a visit was required.
- The service had a lone working policy. Staff were kept safe at night two staff completed end of life visits to patients. Alerts were put on the electronic system if there were concerns about safety. Staff would ring the office at the beginning and end of visits.

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

We rated end of life care as good because.

- Patients care and treatment was in line with current legislation and best practice guidance.
- There was a multi –disciplinary approach to care and treatment.
- There was proactive engagement with other health and social care providers. Referral, discharge and transfer was planned to ensure the patient had access to timely care.
- Staff received an induction and had access to a comprehensive training plan.
- Staff understood the requirements of the mental capacity act 2005 and the deprivation of liberty safeguards.

Evidence based care and treatment

- Patients received care according to NICE guidance 'Care of the dying adults in the last days of life' published December 2015. The service had developed an Individual care of the dying document (ICODD)which had been reviewed to ensure it adhered NICE Guidance
- The service had implemented an Individual care of the dying document (ICODD) which was based on the five priorities of care document. The five priorities of care was developed by the Leadership Alliance for the Care of the Dying to ensure high quality care in the last few days and hours of life.
- Staff had received training and had a good understanding of the documentation and used the document effectively.
- The service carried out audits on the use of the ICODD. The service had completed an audit report in December 2015 against NICE QS13 End of Life Care, statement 2: Communication and patient information. The service found Information about local resources was offered to 94% patients but written information was not being offered to patients. The service had plans to repeat the audit for patients deceased in one month in 2015.
- The service also used a disability distress (Dis-DAT) assessment tool for patients. Dis-DAT is used to identify distress in people with severe communication difficulties. Meaningful communication with patients who have profound communication difficulties depends on the ability of carers to recognize and translate many different verbal cues. Dis-DAT allows carers to document a wide range of signs and behaviours of distress to help them recognise when a patient is in pain. The use of the tool allowed staff to know when a patient was contented and when the patient was distressed.

Pain relief

- Pain relief was available for patients, we found pain relief was prescribed correctly and reviewed for effectiveness.
- We observed staff reviewing pain relief for patients and changes were made to meet the needs of individual patients. We observed staff reviewing a patient who was unable to take medication by mouth. Staff completed an assessment of the patients' needs and assessed a syringe driver was appropriate. A syringe driver was arranged and provided following the assessment. There was also a discussion with the patient's GP who attended a home visit whilst the CNS staff were at the home.
- Syringe drivers were available for patients who needed continuous pain control.
- We observed anticipatory drugs were prescribed to ensure pain relief was administered appropriately.
- We observed a discussion between a GP and the CNS to ensure a patient had access to pain relief during the last days and hours of life. The GP reviewed the medication and arranged for IV medication to be available.
- The service took part in the National Service evaluation of bereaved relative's satisfaction with patient's end of life care in 2014. The results showed 86% of families were very satisfied or satisfied with how effectively the palliative care team managed the patient's symptoms.

Nutrition and hydration

- CNS worked with families to understand the nutrition and hydration needs of the patient.

Good

Are services effective?

- Staff talked with carers about the changes in the patient's food and fluid intake when they were at the end of life. The ICODD was used to document nutrition and hydration discussions with the patient and their families.
- We observed an assessment of a patient's nutrition and hydration during a home visit. The staff provided advice about the patient's hydration and nutrition needs during the last days of life.
- We observed a specialist nurse speaking with a family who's loved one was at the last days of life. The nurse explained they were not concerned the patient was not eating because they were in the dying phase of their life.

Patient outcomes

- The trust completed the National Care of the Dying Audit but this only looked at inpatient hospital services and did not include community end of life care.
- CNS from Overgate Hospice attended 'gold standard framework' (GSF) meetings with their GP practices. The GSF is a systematic, evidence based approach to optimising care delivered by care staff to patients approaching the end of life. The GSF meeting will assess the patients' needs and those of their carers develop a plan for their care.
- The community palliative care service had developed a performance dashboard for recording key performance indicators. We looked at the preferred place of death indicator and found for December 2015 100% of patients during the year to date had died in their preferred place of death. In September 100% of patients and in October 2015 90% of patients, in November 2015 87.5% and in December 2015 100% of patients died in their preferred place of death.
- In December 2015 the service had supported 28 patients to avoid admission to hospital and due to support from the service 21 GP callouts had been avoided. The service had verified 60 deaths during 2015.
- The service completed annual audits of patient information, clinical records and outcomes. It had been identified spiritual needs assessments were not always completed. Training was developed which included input from the chaplaincy from the local hospice. In 2013 0nly 88% of patients had spiritual needs assessment completed. In 2014 88% of patients had spiritual needs assessment completed. The service had continued to improve the completion of spiritual needs assessment and 100% of patients had had an assessment completed in 2015.
- The service reviewed and audited the caseload for palliative care every two months and had agreed quality standards to identify gaps and to maintain standards. The audit looked at completion of notes, was information about end of life care services offered to patients and their relatives and was letters sent to GPs. They had identified gaps in GP letters and had introduced stickers to act as an aid for staff to when completing the patient record.

Competent staff

- We spoke with a new member of staff who told us they had completed an induction and had been supported by their manager. The induction included a competency framework for delivering end of life care. Staff completed the training to ensure they were able to provide high quality care to meet the needs of the patient.
- Staff were provided training in end of life care in the acute and community services. There was a band 4 support worker who co-ordinated training.
- There was a training matrix for qualified and non-qualified staff. Qualified staff completed End of Life Care Training, Respiratory training, Dilemmas in care at the End of Life, DNACPR, the role of SPCNS, ICODD, and Communication Skills training.
- Non-qualified staff completed End of Life Care Training, training to improve communication skills which they did with 3 patients, Respiratory training. ICODD and Personal Care after Death training.
- The Overgate CNS team delivered an education programme to nurses, doctors and allied health professionals. For example the team at Overgate Hospice had completed advanced communications training and advanced course in pain and symptom management.
- The team provided training on the validation and verification of death. Staff had completed competency based training for verification of death which included a theoretical session and a simulated session.
- Staff had yearly appraisals and we found the appraisal rate for the palliative care teams was 86%.

Good

Are services effective?

- Staff had access to monthly clinical supervision at the hospice and staff would choose their own clinical supervisor. Staff we spoke with found supervision was available and useful.
- Palliative care community staff felt they had access to training and it was expected if staff attended a training event and would share the learning at the next team. The service had introduced a quarterly forum for disseminated learning and skills. Staff told us they found the session informative and relevant.

Multi-disciplinary working and coordinated care pathways

- Clinical Review Meetings were held each week to discuss all referrals made to the hospital and community specialist palliative care teams. Staff told us they found the meetings were well attended and ensured they were informed about needs of the patients
- The palliative care team met with GPs to discuss patients who were identified as being end of life.The service provided specialist palliative care advice to patients and their carers and to nursing and medical staff from hospital and community settings, including care homes.
- Consultant palliative medical advice was provided for health care professionals through switchboards at CHFT and neighbouring providers of end of life care including the local hospices and other providers of community NHS care by eight Consultants in Palliative Medicine who covered the areas of Calderdale.
- There was a 24 hour telephone service at Kirkwood Hospice and Overgate Hospice that operated a 24 hour/ 365 days a year telephone advice service.
- The palliative care network included all patients in the community including residential care homes
- We observed three multi-disciplinary meetings and saw there were good local working arrangements with all staff. These meetings ensured there was sharing of information and co-ordination of care provided. Staff told us they felt the MDT working worked well and they allowed the patients to be provided with high quality care.

Referral, transfer, discharge and transition

- The service had a single referral point for the community palliative care team. Staff felt this worked well and allowed them to contact patients and their relatives promptly.
- Community patients were acknowledged within 10 minutes of the service receiving the referral and contacted by telephone within one hour of referral by staff.
- Community patients were contacted within three working days to arrange a mutually convenient time for a face-to-face assessment and support.
- The community service was able to access a fast track service for equipment to allow a patient to be transferred home. The Fast Track Response team who would provide equipment within two hours.
- There was an end of life care ambulance provided by Yorkshire Ambulance Service available to allow patients to be discharged quickly. There were no concerns about accessing transport for end of life patients.
- There were fast track arrangements for continuing healthcare funding but this was not always available when needed due to the lack of local authority carers' availability.

Access to information

- Information was available on the trust intranet for staff to access there was information on palliative and end of life care.
- The service had a checklist of information available for patients and their relatives. Information was available in other languages. There was information and booklets for children.
- Information also included information on dementia, heart disease and lung disease.
- The service completed an annual clinical audit of case notes. In 2015 97% of patients had been offered information and this had been documented in the patient's notes.
- The service took part in the National Service evaluation of bereaved relative's satisfaction with patient's end of life care 2014. 71% of families were very satisfied or satisfied with information given about how to manage the patient's symptoms (e.g. pain, constipation).

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff completed training on MCA and DOLS as part of their mandatory training and they were up to date with their training. Staff we spoke with had an understanding of MCA and best interest meetings. We attended a best interest meeting attended by a Quest Matron, GP and Care Home manager to review treatment of a patient.

Good

Are services effective?

- We saw staff asking patients consent and explaining what they were doing. Patients were given the opportunity to ask questions when staff were providing care.
- We looked at four Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms. The forms were kept at the patient's home.
- The service completed an audit DNACPR forms completed between September 2015 to December 2015 54 deceased patient notes were reviewed and all patients had a DNA CPR form completed before they died. Out of the 54 completed, 20 forms were completed solely by the Community Palliative Care team. Discussions with patients and their families were documented in the patient record.
- We found patients and their carers had been involved in making the decision and discussions were recorded in the patient's notes.

Good

Are services caring?

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

Summary

We rated end of life care as good because:

- Staff treated patients and their relatives with dignity and respect.
- Staff were caring and compassionate.
- Staff explained what to expect and what was happening at the different stages of end of life.
- Staff responded to pain discomfort, emotional distress in a timely and appropriate manner.
- Staff involved patients and their relatives in decisions about their care and treatment.
- Feedback from patient's families was positive and they felt supported emotionally by staff during the patient's last days of life.

Compassionate care

- Patients and their relatives were positive about staff. They felt staff treated them with dignity and respect.
- We observed staff speaking with patients and their relatives in a respectful way. Staff explained what was happening and listened to concerns and questions from relatives.
- We observed staff being honest and open with a patient and their relatives about the patient's needs and dealing with their concerns in a compassionate manner.
- Staff we spoke with understood time was important and they supported the patient and their relatives with care or treatment. Staff helped relatives to change a patient and make them more comfortable.

Understanding and involvement of patients and those close to them

- We observed patients and their relatives were involved in decisions. We case tracked and visited one patient who was provided support from the palliative care team during the day and out of hours. We observed staff spoke with the patient and their relatives in a calm and thorough way to discuss choices and preferences of care during the last days of life.
- Patients and their relatives were provided with contact details of the service so they could ask questions about the care and treatment including preferred priorities and what happens with the verification of death.
- We observed the needs of the relatives were also discussed during this time. Staff talked to relatives about increasing the use of oxygen and the use of a syringe driver to provide medication to make the patient more comfortable.
- We looked at four sets of records and found staff had discussed and documented they had spoken with relatives and explained the patient was deteriorating and what relatives could expect.

Emotional support

- Patients were given timely support and information. We observed one patient had been reviewed by the out of hour's service. The patient and relatives had been provided with information to help them cope with the care and treatment and deterioration of the patient at home.
- Staff looked at the needs of relatives to ensure support and wellbeing were managed and relatives were able to link with local services. Staff always considered the needs of the relatives including support for children. The service was able to refer into a voluntary sector organisation for emotional and post bereavement support.
- Staff could refer patients and their relatives to services at the local hospice and those services provided by the voluntary sector. Relatives were able to be referred to counselling and bereavement services. For example they were able to refer children through the local authority to a local group called Noah's Ark for support.
- Staff told us how they would support patients to write letters for their relatives who were left behind when they died.
- The service completed an annual clinical records audit and in 2015 100% of patients and their relatives had an assessment of their physical needs, social and occupational needs, psychological and well-being assessments completed.
- The service took part in the National Service evaluation of bereaved relative's satisfaction with patient's end of life care 2014. The results showed 86% of families were very satisfied or satisfied with the emotional support provided to the patient by the palliative care team.

Good

Are services responsive to people's needs?

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

Summary

We rated end of life care for responsive as good because:

- The service understood the different needs of the population it served and it designed the service to meet the needs of the population.
- The service implemented changes to the out of hour's services to meet the needs of patients and their families.
- Patients and their relatives were supported to access care at the right time
- Patients did not have to wait long for services, treatment or care.
- The service had a complaints policy and families were given information about how to raise concerns.

Planning and delivering services which meet people's needs

- Services were planned and information was collected to inform local commissioners how services were delivered.
- The service had implemented a dashboard which collected information about care for patients who were on the end of life pathway. The information collected included the potential for patients to be cared for and die in their preferred place of choice.
- The end of life care pathway aimed to reduce Accident and Emergency (A&E) attendances and admissions and GP callouts by increasing community capacity to safely and effectively care for people approaching the end of life in their own home, and by improving the identification and coordination of care for patients approaching the end of life.
- Between April 2015 and December 2015 the pathway had avoided 201 admissions to hospital and 102 GP call outs. This had allowed the service to achieve potential cost savings of £138,339 in admission avoidance and £79 per GP callout and improve care for patients who wanted to stay at home at their end of life.
- Staff from the service had met with commissioners to review the service and ensure the service was meeting the needs of the people of Calderdale. It had been identified there was a gap in the provision of out of hours palliative care. An Out of hours service had been provided between 11:00pm and 7:00am but after a six month review the service was increased to provide care from 8:00pm to 5:00am.
- The service reviewed the caseload for palliative care every two months and had agreed quality standards to be reviewed to ensure the service is providing a responsive service.

Equality and diversity

- Mandatory training included equality and diversity training within the service 100% of staff had completed equality and diversity training in March 2016.
- Interpreting services were available and staff told us they knew how to access them.
- Quest Matrons provided support to patients in care homes to ensure they had access to services. Quest matrons would attend MDT meetings and would liaise directly with care home staff. They would hold clinics for residents to attend at care homes one day a week.
- The service completed a project to raise awareness of services offered by the Calderdale Specialist Palliative Care Team, the Hospices and Calderdale and Halifax NHS Foundation trust to raise awareness amongst South Asian Communities in Calderdale. The project identified the need for a key worker to work with the community
- The educational facilitator was working with the community Asian women's groups to improve
- Understanding and access for the community.
- The service is also looking at linking in with the Homeless basement café to improve links with the homeless community.
- Staff discussed spiritual support and needs as part of the ICCOD. There was access to a Chaplin at the hospice which patients and their families could access.

Meeting the needs of people in vulnerable circumstances

- Staff had completed basic dementia training. The quest team could provide mental health assessment and support for patients in care homes.

Good

Are services responsive to people's needs?

- Staff could refer to specialist for patients who had a learning disability. The service used the ICCOD documentation for all patients including those with a learning disability or living with dementia.
- There had been a pilot at Heathstones Learning disability home where qualified and unqualified staff from the home had completed End of Life Care training sessions to enable staff to provide and look at providing end of life care in a more holistic manner.
- The service also used Dis DAT a disability distress assessment tool for patients to help identify distress cues for patients who had severely limited communication skills to ensure the service was meeting the needs of these patients.
- There was a community support group for stroke patients.
- Staff were able to verify an expected death and were positive about verifying death as it reduced the time a relative had to wait for a doctor to visit and verify death. It could be several hours before a doctor was able to visit and verify death. Staff had access to interpreting services and information was available in other languages such as Urdu and Hindi. Information was also available on DVD and CD.

Access to the right care at the right time

- The community service had received 506 referrals between April and December 2015. In September 2015 the service had received 73 referrals in September; 49 referrals in October; 46 referrals in November and 56 referrals in December. The service monitored referrals and provided commissioners with a monthly update. The service and commissioners had a joint escalation plan to ensure an early warning system was in place to cope with fluctuating demand. Also information about referrals would inform future modelling of the service.
- The community CNS staff were available Monday to Friday 9:00am to 5:00pm. There was an Out of Hours service from 8:00pm to 5:00 am seven days a week. We found evidence that the OOH contact number had been given to the relatives and the information was documented in the notes.
- Community staff attended Gold Standard Framework meetings with all GPs in the areas they covered. As part of the meeting they would review patients who were in their last year of life. Also patients who had accessed the palliative care team would be reviewed.
- Staff told us support from GPs for end of life care was generally good. We observed at a home visit a discussion with the local GP about the end of life care of a patient and were responsive to ensure the patient had the correct medication for a syringe driver.
- We also observed oxygen was increased for a patient and the oxygen supplier was contacted by the palliative care nurse to organise an urgent delivery of oxygen. The supplier contacted the delivery team who responded whilst we were at the home visit.
- We looked at the End of Life Care Dashboard and in September100% of patients and in October 2015 90% of patients, in November 2015 87.5% and in December 2015 100% of patients died in their preferred place of death. The average for the year to date 2015-2016 for patients dying in their preferred place of death was 91.9%.
- The service had a target of 90% of patients to be contacted within 10 minutes to acknowledge referral request. Between September 2015 and December 2015 100% of patients received an acknowledgement within 10 minutes. The average for the year to date 2015-2016 was 95.6% for patients to receive an acknowledgement.
- The service had a target of 95% of patients to receive a response within one hour of the referral. Between September 2015 and December 2015. 100% of patients received a response from the palliative care team within an hour. The average for the year to date 2015-2016 was 98.6% for patients to receive a response within one hour of the referral.
- The team demonstrated 100% compliance with Regional Referral Response Time Standards. The audit is to be repeated in December 2016.
- The service had rapid discharge processes in place and staff told us there was not a problem and patients were discharged in a timely manner. However the service did not collect information about rapid discharge and the time taken between the decision to discharge and transfer to preferred place of care was not captured.

Learning from complaints and concerns

- There was a trust policy for managing and dealing with complaints. There were no complaints relating to end of life care received between July 2015 and March 2016. Staff understood the process for reviewing complaints.

Good

Are services responsive to people's needs?

- Patients and their carers were provided with information on how to complain. Patients and carers we spoke with felt they would know how to complain if they needed to.
- Lessons learned from complaints were discussed in team meetings and action would be taken to improve the quality of care provided. Staff told us lessons learned were shared at team meetings.

Good

Are services well-led?

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

Summary

We rated end of life care for well led as good because:

- There were clear governance arrangements in place for the cascading and sharing of information with all staff.
- End of Life care risks were included in the adult community risk register.
- The services had regular team meetings which looked at performance, referrals, incidents, complaints, compliments and audits.
- There was an End of Life Dashboard which was shared and discussed with staff.
- Staff were enthusiastic about the service they provided.
- Patient care was seen as a priority by the staff.
- Patients were asked for their views and feedback about the service.
- Staff felt part of the trust and information was shared through the internet by email and newsletter.
- Staff told us they felt involved in the planning and delivery of the service.

Service vision and strategy

- The service had a draft end of life strategy and a trust vision for the community palliative care service.
- Staff we spoke with were aware of the vision for palliative care and the provision of high quality care for patients and their relatives was important.
- The service was implementing an ICCOD documentation for patients to ensure they had care plans to assess and support them at the end of life. They had piloted the use of the ICCOD in two community areas within Calderdale.
- The service was part of the transformation project for care closer to home. Staff had an understanding of vanguard working and the upper valley region was part of the vanguard closer to home transformation project. The aim of vanguard working is to develop patient centred care. Care to be moved from hospital and delivered in community and GP settings to provide a wider range of services in the local area. The upper valley of Calderdale has gathered views from GPs, health professionals and had engagement with patient representatives when designing models of care.

Governance, risk management and quality measurement

- There were clear governance arrangements in place. Staff understood their roles and who they were accountable to.
- There were clear arrangements for the cascading and sharing of information with all staff. For example there had been an incident with a mobile phone when at the end of shift a member of staff had forgotten to transfer the phone to the next member of staff and the following day was not on duty. The staff member realised the following day and made staff aware. They later highlighted the risks with other staff and the directorate is now looking at working in hubs and having access through a single point of access portal to reduce the risk. There was a risk a patient or their family may not be able to contact the palliative care team on duty.
- There wasn't a separate risk register for end of life care; end of life care risks were included in the adult community risk register. Also risks were reviewed in the monthly service report provided to commissioners. Risks included lack of referrals from A&E the service had held meetings with A&E and the End of Life team were to contact A&E on each shift as a reminder to A&E staff.
- The services had regular team meetings which looked at performance, referrals, incidents, complaints, compliments and audits. There was an End of Life Dashboard which was shared and discussed with staff. Information included caseload information, preferred place of death, advanced care planning and admissions and GP callout avoidance.

Leadership of this service

- The palliative care service was part of the community health directorate. There was a manager who had day to day management of the service. The leadership team was clearly defined and all staff told us managers were supportive and available.
- There were community walkabouts by senior managers including a member of the board.

Good

Are services well-led?

- We observed a team meeting with the manager of the Out of Hours Palliative care service. Staff confirmed that the manager would work with them at least one night every six weeks.
- Staff understood and felt involved in the development of the service. Staff told us they had met individually with commissioners to share what went well and not so well within the service.
- There was a Non-Executive Director on the board who had responsibility for end of life care,

Culture within this service

- Staff were enthusiastic about the service they provided. Patient care was seen as a priority by the staff.
- Staff were encouraged to raise any concerns they had about patient care and there was an open culture to report incidents.
- Staff worked well together and well with other disciplines we observed good working with District nurses, GPs and allied health professionals.

Public engagement

- Patients were asked for their views and feedback about the service. Information from feedback was shared at the team meetings. Information from the clinical notes audit and compliance with discussion of patient and relatives was shared, The service scored 100% for discussions with patients.
- We observed patients and relatives being actively involved in the decision making about their care and treatment.
- The service took part in the National Service evaluation of bereaved relative's satisfaction with patient's end of life care 2014. 39 Questionnaires were sent and 21 returned achieving a response rate of 53.8% which was higher than 2013 (43%). 71% of families were very satisfied or satisfied with the way the family was included in treatment and care decisions.
- The Community Integrated Nursing Services collected Family and Friends information and in August 2015 93.6% of patients would recommend the service to family and friends.
- The service had Patient/Carer Satisfaction Survey for November referrals had been completed but the results were still to be reviewed and shared with the service.

Staff engagement

- Staff felt that senior managers were available and would attend team meetings. We saw evidence in the team meeting minutes that manager attended them. Staffing was discussed at the team meetings and updates on the filling of vacancies were discussed.
- Staff felt part of the trust and information was shared through the internet by email and newsletter.
- Staff told us they felt involved in the planning and delivery of the service. They told us they had met with commissioners to discuss the service and what they thought went well and what needed to improve.
- Out of hours staff told us how they had met with commissioners and after discussions the service hours had been increased to cover the early evening ay 20:00pm rather than commencing the service at 23:00.
- Feedback was given at team meetings and the team manager for the out of hour's service would work with the team at least once a month. We observed the team leader working with the team in the evening and sharing learning from incidents at a team meeting. Staff confirmed that the team manager worked a whole shift once per month.
- There were a bi-monthly Team Forum where staff shared learning. For example staff would share learning from attending palliative care training with GPs. Staff have used the forum to share learning about ICODD and have looked at oncology emergencies in the community.
- Staff told us they were encouraged to complete the staff survey and results from the survey were discussed at team meetings.The staff survey found access to training was within expectation. Staff told us they had access to training and staff were completing masters qualifications for palliative care.

Innovation, improvement and sustainability

- The palliative care team won the multidisciplinary section of the international Journal of Palliative Nursing awards for their nurse training programme to help them validate and record expected death.
- The service had developed a dashboard to collect information about end of life care provided.