

Central and North West London NHS Foundation Trust

RV3

Community end of life care

Quality Report

Trust Headquarters
Stephenson House
75 Hampstead Road
London NW1 2PL
Tel: 020 3214 5700
Website: www.feedback.cnwl@nhs.net

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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)
RV3EE	Stephenson House	Community End of Life Care	NW1 2PL

This report describes our judgement of the quality of care provided within this core service by Central and North West London 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 Central and North West London NHS Foundation Trust and these are brought together to inform our overall judgement of Central and North West London 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 rating for this core service Good

We gave an overall rating for end of life care good because :

The specialist palliative care teams were aware of the process for reporting any incidents. Staff we spoke with were able to explain what constituted a safeguarding concern and the steps required to report concerns. There were clear guidelines for medical staff to follow when prescribing anticipatory drugs to patients. A large percentage of staff had completed their mandatory training and that this was updated on a regular basis. We observed that patients' needs were risk assessed and managed on an individual basis.

Clinical staff made a comprehensive assessment of patients when they were referred to the service. Multi-disciplinary meetings were arranged for patients who were approaching their end of life. These effectively arranged services in partnership with other health care professionals and GP's involved in patients care. We looked at 12 DNACPR forms and found that in 5 cases patients had been involved in the discussions, and for the other cases where the patient had been identified as lacking mental capacity, a mental capacity assessment had been undertaken and a best interest decision made.

Throughout our inspection we saw patients being treated with compassion, dignity and respect by staff. We observed staff interactions with patients and families that were professional, sensitive and appropriate at all times. Staff ensured that privacy was maintained when they assisted patients with their needs. Patients told us their clinical nurse specialist would carefully explain pain control and involve them in their care plans.

Patients and families were able to access 24 hour 7 day per week palliative care services. Patients and relatives told us that they were very happy with the service they received and that had information on how to make a complaint. Staff were aware of the diverse needs of all the people who use the service and patients and relatives told us that they had been able to access interpreter services through the teams.

Staff knew the vision and values of the organisation. There was a good governance structure in place and the risk register was used to highlight any issues of immediate risk and these were reviewed on a monthly basis. Staff spoke positively about their team leaders and senior management. Staff felt supported and involved in the delivery of the service.

Summary of findings

Background to the service

The Camden, Islington ELiPSe and UCLH and HCA Palliative Care Service are part of CNWL specialist palliative care service. These services are jointly commissioned through service level agreements with University College Hospital London NHS Trust (UCLH), the Health Corporation of America (HCA), Camden and Westminster Clinical Commissioning Group (CCG) and a contract with Islington CCG.

The Camden, Islington ELiPSe and UCLH and HCA Palliative Care Service provides end of life and palliative care services to adult residents in South Camden, North East Westminster and the London borough of Islington in their own homes. It also provides inpatient services for palliative and end of life care to UCLH and HCA. HCA is a private health care provider and the team provides

specialist palliative care to the Harley Street Clinic, Princess Grace Hospital, the Sarah Cannon Research Institute and to Harley St at UCLH. The specialist palliative care team also provides a 24 hour on call service for patients and responds to urgent referrals.

The Hillingdon palliative care team provides care services to residents of the London Borough of Hillingdon in the community and in their own homes. The team is made up of clinical nurse specialists who care for patients with complex needs in the palliative phase of their life. The team works in partnership with district nurses who deliver day-to-day palliative care. The specialist palliative care team was available from 8.30am to 4.30pm Monday to Friday. Outside these hours a telephone on call service is available provided through a local hospice.

Our inspection team

The team inspecting community health end of life services included a CQC inspector, a specialist advisor and experts by experience. The team worked closely with inspection teams visiting community hospitals and community teams across the trust.

Why we carried out this inspection

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

How we carried out this inspection

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

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

During the inspection visit, the inspection team:

- visited two community palliative care teams and 3 wards at UCLH
- spoke with 30 patients and or relatives and carers who were using the service
- spoke with the palliative consultant nurse manager and team leader for two of the community palliative care teams
- spoke with 19 other staff members; including doctors, nurses, psychologist's, and social workers
- attended and observed two multi-disciplinary meetings.

Summary of findings

We also:

- looked at 12 patients DNACPR's.
- looked at 9 patient records.
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider say

Patients and relatives told us that the care and support provided by the palliative care teams in the community and hospital was good and they had access to services

when they needed them. Patients said they could access the service when it was needed. Relatives told us that they were given information and included in decisions about the care being provided.

Good practice

- In response to concerns from a group of people with a learning disability the Islington ELiPSe team and the Camden palliative care team worked with the group giving them advice, information and support about the decisions they could make regarding their care at end of life.
- The Hillingdon palliative care team worked closely with nursing homes to improve the end of life care for people in the home which had resulted in an increase in people dying in the homes rather than in hospitals.
- The 'transform end of life project' will run for five years to educate, mentor and train clinical and medical staff in end of life care. New documentation was being piloted which incorporated five key tools to improve communication between patients, families and clinical staff that will also roll out across the community Camden, Islington ELiPSe palliative care services.

Central and North West London 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 safe as **good** because:

The specialist palliative care teams were aware of the process for reporting any incidents. Staff we spoke with were able to explain what constituted a safeguarding concern and the steps required to report concerns. There were clear guidelines for medical staff to follow when prescribing anticipatory drugs to patients. A large percentage of staff had completed their mandatory training and this was updated on a regular basis. Patients' needs were risk assessed and managed on an individual basis.

Detailed findings

Incident reporting, learning and improvement

- There have not been any never events (serious largely preventable patient safety incidents that should not occur if proper preventative measures are taken) in the specialist palliative care services in the past 12 months.
- The specialist palliative care teams were aware of the process for reporting any identified risks to patients or staff. All incidents, accidents, concerns and near misses were reported through a trust-wide reporting system.

We looked at two incidents that had been recorded and saw that they had been followed up, and there was an action plan in place to prevent further occurrence with learning from the incident to be disseminated to staff.

- Staff from the Islington ELiPSe palliative care service told us that they would also report to Islington Social Services when patient equipment for end of life patients was not delivered or delayed.
- We saw that incidents that had been reported by the Camden and Islington services in December 2014 had been discussed at the Camden senior management team meeting in January 2015.
- The specialist palliative care teams held regular team meetings. Staff told us that team managers would feedback from the trust and that incidents and the learning from incidents were discussed.

Duty of Candour

- The Trust had promoted duty of candour amongst staff. Staff we spoke with were aware of their

Are services safe?

responsibilities under duty of candour. Staff told us that they felt supported and if they had any concerns these could be raised, and there was support from the trust for staff when they made a mistake in the delivery of care.

- Staff were also able to raise concerns at the weekly multi-disciplinary team (MDT) meetings.

Safeguarding

- Staff confirmed that they had completed adult safeguarding training in the last twelve months. They had a sound understanding of safeguarding processes and policies. The specialist palliative care teams told us that safeguarding training was mandatory. Mandatory training records confirmed that a large percentage of staff had completed safeguarding training.
- Staff were able to explain what constituted a safeguarding concern and the steps required to report concerns.
- Staff also knew about the whistleblowing policy and how to report concerns if they had them.
- Patients and relatives told us that they were very happy with the care and support they received from the community specialist palliative care teams. Relatives we spoke with told us they knew how to raise concerns and felt they would be taken seriously.

Medicines management

- There were clear guidelines for medical staff to follow when prescribing anticipatory drugs to patients.
- The Camden, Islington ELiPSe and UCLH and HCA Palliative Care had a standard operating policy in place for prescribing and advising on medications.
- Clinical nurse specialists told us they worked closely with patients' GPs and that requests for anticipatory medications will normally be authorised the same day and that out of hours they had access to medics if emergency prescriptions were required.

Safety of equipment

- Hillingdon palliative care staff told us that they were able to access equipment 7 days per week and that a pressure relieving mattress could be delivered the same day.
- The Islington ELiPSe team told us that they were able to access special equipment for patients from Islington out of hours or at weekends.

- Patients and relatives we spoke with told us specialist equipment arrived when expected and they were shown how to use it. However one relative told us that equipment was delivered and assembled the same day.

Records and management

- The palliative care teams used an electronic system to record patient information. We looked at eight patient records, we saw that initial assessments had been written up and where paper assessments had been completed these had been scanned into the records. The patient notes had details of the name of the person making the entry, their job title and time the entry was made.
- We found that patient notes had been completed sensitively and detailed the discussions that had taken place with patients and relatives.
- We looked at 12 do not attempt cardio pulmonary resuscitation (DNACPR) forms at UCLH and in peoples home and found that 10 out of the 12 had been completed correctly. Where one of the DNACPR's had been completed incorrectly following discharge from a local hospital the community nurse specialist completed another form following discussion with the patients relative. The form was left with the nursing home staff for the GP to countersign.

Cleanliness, infection control and hygiene

- The Islington ELiPSe team had personal protective equipment packs which they carried with them that contained a plastic apron, gloves, alcohol gel, soap and towel.
- The palliative care nurses that worked on the wards at UCLH wore clean uniforms with arms 'bare below the elbow' and personal protective equipment was available for use by staff in clinical areas.

Mandatory training

- Mandatory training records provided by CNWL confirmed that a large percentage of staff had completed their mandatory training and that this is updated on a regular basis.
- Staff confirmed that their mandatory training was updated regularly.

Assessing and responding to patient risk

- Patients were able to access palliative care services out of hours. In Hillingdon patients, relatives and carers were

Are services safe?

able to access out of hour's telephone advice, and there was also a 24 hour consultant on call service for health care professionals to contact. The Camden, Islington ELiPSe and UCLH and HCA palliative care service provided a 24 hour on call service which provided telephone support and face to face support.

- We observed at the MDT meeting patients' needs were risk assessed and managed on an individual basis. At UCLH arrangements were made for an older patient who was distressed and at risk of falling to have a psychiatric assessment and have a "special" (an extra nurse) to sit with the patient.

Staffing levels and caseload

- There were vacancies in the community palliative teams in Camden and in Hillingdon. The vacancies for a clinical nurse specialist and occupational therapist in Camden had been flagged on the Camden provider services risk register. There were plans in place to address the shortfall in staffing levels to ensure that the posts were covered.

- The team lead in Hillingdon had recently been promoted and was still carrying a caseload whilst actively seeking to recruit. The team was supported by 1 WTE community consultant which was covered by 3 consultants who also worked as part of the 24 hour consultant on call rota for palliative care. Staff told us that they carried case loads of between 30 – 35 patients.
- The Islington ELiPSe team told us that they had recently had posts reduced from 6 to 5 WTE clinical nurse specialists. A consultant, occupational therapist, physiotherapist and social worker also worked as part of the team. Staff told us carried a caseload of between 25 – 30 patients and that this was manageable but the team felt under pressure when colleagues were sick or on annual leave.

Managing anticipated risks

- Staff told us that they worked very closely with their own teams to address anticipated risks such as bad weather. We were told that people were provided with the care they needed.

Are services effective?

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

Summary

We rated effective as **good** because:

Clinical staff made a comprehensive assessment of patients when they were referred to the service. Multi-disciplinary meetings were arranged for patients who were approaching their end of life. These effectively arranged services in partnership with other health care professionals and GP's involved in patients care. We looked at 12 DNACPR forms and found that in 5 cases patients had been involved in the discussions, and in the other cases where the patient had been identified as lacking mental capacity, a mental capacity assessment had been undertaken and a best interest decision made.

Detailed findings

Evidence based care and treatment

- The use of the 'Liverpool care pathway' had been replaced with 'excellent care in last days of life'. The transform end of life team were piloting new documentation which incorporated five key enablers to improve communication between patients, families and clinical staff. This included the amber care bundle, advanced care planning, coordinate my care (CMC), rapid discharge checklist, and excellent care in last days of life which was being trialled at UCHL. These were all tools and approaches to guide the support given when the person may not have long to live. The transform project will run for five years to educate mentor and train clinical and medical staff in end of life care. It is anticipated that the documentation will also roll out across the community Camden, Islington ELiPSe palliative care services.
- The current strategy had been revised to take account of national guidance of the "five priorities of care" which included a number of strands such as a recognition that a patient was dying, advanced care planning decisions, symptom management, food and drink, involvement of the patient and their family and consideration of the patients' religious and spiritual needs.
- We were told that since the introduction of the amber care bundle to the care of the elderly wards for the

period of August to December 2014 there had been a decrease in the number of older people being readmitted to hospital from 45% to 8% as plans were put into place to support people to receive end of life care in their home.

Pain relief

- At UCLH there was UCLH trust guidelines in place for pain control in palliative care which the hospital palliative care team coordinated. There were also guidelines for pain control for the community teams to coordinate, these included the setting up and use of an anticipatory syringe driver for palliative care patients by trained staff.
- We observed the palliative care teams MDT's meeting where of the best use of medication for patient care was discussed and prescribed with consideration to patients choice and religious beliefs.
- We looked at two prescription charts at UCLH and saw that all medication was given in a timely manner and 'just in case' medication was also documented. A relative told us that their relative was given pain relief as soon as it was needed.
- We spoke with 16 patients and their family. All the patients told us that they were involved in discussions about their pain management and gave us positive feedback about the quality of care they received. Patients told us that if required they could contact the 24 hour on call service to have their pain management reviewed.
- We observed palliative care nurses discussing pain relief with five patients providing them with good pain management support and advice. One patient told us that the palliative care nurses explained in terms that they understood about symptom control and gave suggestions about what may help but left it to them to make the final decision.

Nutrition and hydration

- We observed community nurse specialists discussing with patients their nutritional and hydration needs during home visits. We saw that staff routinely provided advice on hydration and nutrition.

Are services effective?

- In multi-disciplinary team meetings (MDT) patients nutritional and hydration needs were discussed, this included referring patients to speech and language therapists and dieticians to ensure that patients were supported appropriately.
- A relative of a patient under the palliative care team at UCLH told us that it was helpful to be able to eat with their relative. They also commented the food was really good.

Outcomes of care and treatment

- The Hillingdon palliative care team's clinical nurse specialists had worked closely with care and nursing homes in the area to support staff in looking after older people at the end of their life. For the period 2010 to 2014 the number of older people in care and nursing homes dying in hospital had fallen from 31.90% to 22.80%, with numbers of people dying in their preferred place of care increasing from 67.5% to 81.20% and deaths in usual place of residence increasing from 50.5% to 66.80%.
- The Camden, Islington ELiPSe and UCLH and HCA Palliative Care Service for the period November 2013 to December 2014 92% of patients died in their preferred place of choice.
- UCLH participated in the national care of the dying Audit 2013/2014 and achieved three out of the seven organisational key performance indicators.

Competent staff

- There was a full training programme in place for clinical and nursing staff who worked in the palliative care teams. This included staff attending university based modules and study days at the Royal Marsden and Kings College.
- A member of staff who had recently joined the palliative care team in Hillingdon told us that they had regular teaching/clinical sessions and that they had been booked onto further training in palliative care later this year.
- The Camden, Islington ELiPSe and UCLH and HCA palliative care service also had in place an educational and clinical governance programme. All staff were expected to attend the weekly sessions which were held each Wednesday.

- Staff had received regular supervision and annual appraisals and they had been appraised in the current financial year. The palliative care services had 100% completion rate for appraisals.

Multi-disciplinary working and coordination of care pathways

- Each of the palliative care teams had weekly multidisciplinary team meetings (MDT). We observed two MDT meetings. At UCLH the team consisted of twelve palliative care clinicians including doctors, nurses, psychologist and the chaplain and this was led by the consultant. At Hillingdon the MDT meeting was led by the consultant with input from the palliative care nurses and psychologist. At these meetings new referrals, complex patients and patients on going care included pain control, care plans, and preferred place of care were discussed.
- At UCLH the team had access to chaplaincy services that could provide spiritual support for all religions and beliefs. This service was available 24 hours a day, seven days per week. Religious beliefs were discussed at the MDT meeting.
- The Hillingdon palliative care team met with district nurses who provided the day to day support to patients in the community on a monthly basis to discuss patients who were receiving end of life care.
- Patients who had died the previous week and bereavement plans were discussed with members of the teams who were allocated to follow up with the families. The Hillingdon palliative care team advised that they were only able to offer one bereavement follow up session to families due to funding restraints.
- The palliative care teams used the electronic record 'coordinate my care' to coordinate services for patients who were approaching end of life with other health care professionals and GP's involved in patients care.

Referral, transfer, discharge and transition

- Patients were able to access the palliative care services through self-referral, hospitals, district nurses and GP's.
- The Camden, Islington ELiPSe and UCLH and HCA palliative care service allocated new referrals on a daily basis. Performance information for the period November 2013 to December 2014 showed that 99% of

Are services effective?

non-urgent referrals were followed up within 48 hours and 100% of urgent referrals were followed up in 24 hours. New referrals were seen by the hospital palliative care team within 4 hours or 2 hours if urgent.

- The Hillingdon palliative care team allocated new referrals on a daily basis and followed up non urgent referrals within 48 hours and urgent referrals within 24 hours. There was no waiting list.
- Clinical nurse specialists gave us examples of how they would ensure that patients' wishes accommodated for example making appropriate arrangements for a patient who wanted to leave their body to medical research.

Availability of information

- The palliative care teams used an electronic system for recording information. This meant other clinicians and allied health professionals were able to access and update the records.
- The Islington ELiPSe team told us that the district nursing teams they worked with were unable to access CNWL patient records as they were employed by another NHS health trust. Staff told us that they worked closely with the district nurses and ensured that they kept each other up to date by using the telephone and exchanging emails. The link district nurse also attended the Islington ELiPSe team MDT meeting.
- The palliative care teams also used 'coordinate my care' (CMC) an electronic record to record patient wishes which other health care professionals, emergency and out of hours health services were able to access. GP's and district nurse are also able to input data which helped with communication between clinical professionals.

- When we looked at the electronic patient notes and CMC, it was not always easy to determine whether or not a DNACPR was in place.

Consent

- In MDT meetings we observed that patients' mental capacity and ability to consent to treatment was discussed. Staff would also update colleagues on patients DNACPR status.
- In the community we observed that community nurse specialists would check patients consent and recheck whilst discussing treatment and ongoing support.
- The father of a child we spoke with expressed his relief of the patience of the clinical staff and that they had listened and respected concerns about a procedure affected by a religious belief. The clinical team worked over several days with the family to explain the seriousness of the patient's condition and avoided obtaining a court order by the family agreeing to the transfusion.
- We looked at 12 DNACPR forms across at UCLH and in peoples home and found that in 5 cases patients had been involved in the discussions, and in the other cases where the patient had been identified as lacking mental capacity a mental capacity assessments had been undertaken. One of the DNACPR forms checked was for a young person under the age of 16 years, we saw that the decisions were fully documented and the young person and parents had their decisions taken into account.
- Staff had received training on the Mental Capacity Act as part of their mandatory training and this was up to date. Staff we spoke with said this included training on Deprivation of Liberty Safeguards (DOLS) and were aware of the implications for their practice.

Are services caring?

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

Summary

We rated caring as **good** because:

Throughout our inspection we saw patients being treated with compassion, dignity and respect by staff. We observed staff interactions with patients and families that were professional, sensitive and appropriate at all times. Staff ensured that privacy was maintained when they assisted patients with their needs. Patients told us that community nurse specialist would carefully explain pain control and involve them in their care plans.

Detailed findings

Dignity, respect and compassionate care

- Throughout our inspection we saw patients being treated with compassion, dignity and respect by staff on the hospital wards and in the community in people's homes.
- The palliative care teams used an assessment tool to develop individual plans so that patients nutritional and hydration, symptom control, and psychological, social and spiritual needs were identified and responded to.
- We observed clinical and community nurse specialist using a patient outcome scale (POS) to quickly establish patients concerns and changing needs. For example during a home visit the clinical nurse specialist used the POS to assess the pre-planning of the patients care, going at their pace and respecting their wishes.
- Staff ensured that privacy was maintained when they assisted patients with their needs.
- We observed staff interactions with patients and families that were professional, sensitive and appropriate at all times. Always allowing the patient or their relative's time to discuss their issues and concerns, offering practical and psychological support.
- The patient and relatives we spoke with were very happy with the care they or their family members received. Patients told us the palliative care teams were very good.

Patient understanding and involvement

- There was information available for families and carers from about the palliative care service in Hillingdon and Camden. Patients and families also had access to information about coordinate my care.
- Patients told us that clinical nurse specialists would carefully explain pain control and were encouraged to seek more analgesia if their pain was not in control and they involved them in their care plans.
- During a home visit we saw that the community nurse specialist took time to build trust with the patient who was frightened and had concerns about their pain relief. The nurse obtained verbal consent from the patient for the nurse to contact their GP to review their medicines and prevent a hospital admission.
- The palliative care nurses ensured that patient choice was fulfilled.

Emotional support

- One person told us that they received a lot of emotional support from the specialist nurse and they phoned them regularly. Another relative told us that staff go out of their way to support them and the patient.
- A relative told us that their relative was extremely well looked after and that the support for the whole family was fantastic. Their relative had been able to die at home which was their wish. They said it was an 'outstanding service'.
- At the MDT at UCLH the clinical team discussed a plan of action to support hospital staff that were supporting a family with complex family issues. The patient's family lived overseas and staff spoke with their relatives through interpreters on the telephone.

Promotion of self-care

- We found staff supported and promoted patients to undertake greater self-care. During one of our visits we observed a nurse talking to an elderly patient about the importance of keeping themselves warm in the cold weather and encouraging them to keep the heating on. We also witnessed nurses discussing what patients had been eating and drinking and where patients had loss of appetite gaining consent to contact their GP's to obtain supplements.

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 responsive as **good** because:

Patients and families were able to access 24 hour 7 day per week palliative care services. Patients and relatives told us that they were very happy with the service they received and that had information on how to make a complaint. Staff were aware of the diverse needs of all the people who use the service and patients and relatives told us that they had been able to access interpreter services through the teams.

Detailed findings

Planning and delivering services which meet people's needs

- In Hillingdon the clinical commissioning group had block funded 10 beds in a nursing home through continuing care funding for patients who needed enhanced care and their life expectancy was less than 12 weeks. The patients were supported by the palliative care team and the palliative care consultant visited once a week. The staff in the nursing home had been supported with extra training on medication and management of dying patients. At the MDT meeting we observed that current patients and potential referrals were discussed.
- The Islington ELiPSe team had new funding from the clinical commissioning groups (CCG) awarded to develop a volunteer bereavement service to signpost families to services.

Equality and diversity

- Staff had received training in equality and diversity. Patients and relatives told us that they had been able to access interpreter services through the teams.
- In Hillingdon we saw that the leaflet on the palliative care service provided by the trust was available in other languages on request.
- Staff told us that they will make sure arrangements were in place for relatives so that they could obtain death certificates for Muslim burials as soon as possible.

Meeting the needs of people in vulnerable circumstances

- In 2014 the Islington ELiPSe team and the Camden palliative care team together with a social care housing provider won the Linda McEnhill award for outstanding end of life care for making positive difference to the end of life care for people with a learning disability. The palliative care team worked with a group of people with a learning disability giving them advice, information and support about the decisions they could make regarding their care at end of life.
- The Camden, Islington ELiPSe and UCLH and HCA palliative care service was working with the dementia memory clinic to offer people who have been diagnosed with dementia the opportunity to discuss future needs as part of the advanced care planning project.
- In Hillingdon the nursing homes project had a significant impact on the number of people from nursing and care homes dying in hospitals. Since 2010 there had been a 9% decrease in people dying inappropriately in hospital and 13.7% increase in people dying in the homes. Community nurse specialists worked closely with nursing homes and visited them on a regular basis. Where it was anticipated that people had less than 12 months to live the specialist nurses could ensure that DNRCPR, sealing of care documentation and anticipatory medicines were in place.
- One patient we spoke with told us that they didn't like people coming to their home and that the palliative care nurse would always contact them before the visit to let them know when they would be arriving.

Access to the right care at the right time

- The Camden, Islington ELiPSe and UCLH and HCA palliative care service had a 24 hour 7 day per week on call system with specialist nurses as the main point of contact. Palliative care consultants also operated a 24 hour 7 day per week on call rota which specialist nurses and clinicians were able to access. The on call service was able to provide home visits out of hours.
- In Hillingdon patients had access to an out of hour's telephone service which was operated through a local hospice. There was also a 24 hour consultant on call

Are services responsive to people's needs?

service for health care professionals to contact. The palliative care team linked with the twilight district nurse service for patients who needed to be visited at night.

- Patients and relatives we spoke to told us that when they contacted the out of hours services that the staff were always willing to help and listen. Patients told us they were not rushed and that nurses would visit.
- The palliative nurse specialists ensured that anticipatory medication was in place for those patients who might require it. On home visits we saw this was checked by the nurses to ensure that the medicines were in place.
- The palliative care team at UCHL had in place a rapid discharge home process that was part of the 'excellent care in the last days of life' documentation. This was

used for patients where it was recognised that the patients preferred place of care had been established as home or nursing home. This enabled the team to make sure that appropriate arrangements were in place so that the patients and relatives wishes could be met.

Complaints handling and learning from feedback

- In Hillingdon we saw that where complaints had been made that these had been investigated and resolved satisfactorily. The complaints had been discussed in MDT meetings with action points to prevent further reoccurrence.
- Patients and relatives we spoke with told us they had information on how to make a complaint. Patients and relatives told us that they were very happy with the service they had received.

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 well led as **good** because:

Staff knew the vision and values of the organisation. There was a good governance structure in place and the risk register was used to highlight any issues of immediate risk and these were reviewed on a monthly basis. Staff spoke positively about their team leaders and senior management. Staff felt supported and involved in the delivery of the service.

Detailed findings

Service vision and strategy

- CNWL NHS Foundation Trust did not have a strategy for end of life care in place. We were advised that there were plans to develop a strategy for the trust.
- We found that Hillingdon NHS trust had a strategy in place for end of life which incorporated the work of the Hillingdon community palliative care team.
- The two palliative care service worked independently of each other, however both services thought there would be further opportunity to work together particularly in policy development.
- We saw that there were operational policies in place for the Camden, Islington ELiPSe and UCLH and HCA palliative care services which set out the policy for each of the teams and these were reviewed on a six monthly basis.
- The Trust had a policy and procedure in place for staff on the 'management of expected death' which provided guidance for staff to follow when patients die on CNWL premises.
- Staff we spoke with were aware and understood the trusts vision and values.

Governance, risk management and quality measurement

- The Camden, Islington ELiPSe and UCLH and HCA palliative care services risk register was used to highlight any issues of immediate risk and these were reviewed on a monthly basis.

- The operational policies for the Camden, Islington ELiPSe and UCLH and HCA palliative care services set out the governance framework for the services.
- We found that key performance indicators were monitored on a monthly basis across all the Camden, Islington ELiPSe and UCLH and HCA palliative care services which showed that the teams were consistently achieving or exceeding in their targets in the community.

Leadership of this service

- We found the teams well lead. Team leaders and senior management were visible during the day to day provision of care and treatment and they were proactive in providing support. Staff spoke positively about their team leaders and senior management. They felt supported and involved in the delivery of the service.
- Palliative care consultants were part of the teams and provided clinical support and leadership on a day to day basis.
- There were arrangements in place for staff when lone working with a person in each team identified to ensure that all team members were accounted for at the end of the day. There was also a procedure for staff to follow if they found themselves in a potentially threatening or dangerous situation.

Culture within this service

- The culture in the teams was open and encouraged staff to bring forward ideas for improving care.
- The palliative care teams linked to primary care services in the role as expert. They provided a range of master classes for GP's, district nurses and clinicians on end of life care and DNACPR.

Public and staff engagement

- There was no evidence of public or staff engagement specific to end of life. During our inspection we were told that there was little involvement from patients or relatives about the development of the service. Senior management were aware that this needed to be addressed.

Are services well-led?

Innovation, improvement and sustainability

- In response to concerns from a group of people with a learning disability the Islington ELiPSe team and the Camden palliative care team worked with the group giving them advice, information and support about the decisions they could make regarding their care at end of life.
- The Hillingdon palliative care team worked closely with nursing homes to improve the end of life care for people in the home which had resulted in an increase in people dying in the homes rather than in hospitals.
- The 'transform end of life project' will run for five years to educate, mentor and train clinical and medical staff in end of life care. New documentation was being piloted which incorporated five key tools to improve communication between patients, families and clinical staff that will also roll out across the community Camden, Islington ELiPSe palliative care services.