South Essex Partnership University NHS Foundation Trust

RWN

Community end of life care

Quality Report

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Date of inspection visit: 29 June 2015 to 03 July 2015
Date of publication: 19/11/2015

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RWN20	Trust Headquarters	Bedford Health Village	MK40 2NT
RWN20	Trust Headquarters	Biggleswade Hospital	SG18 0EL
RWN20	Trust Headquarters	Central Canvey Primary Care Centre	SS8 0JA
RWN20	Trust Headquarters	Thundersley Clinic	SS7 3AT
RWN20	Trust Headquarters	Latton Bush, Harlow	CM18 7BL

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

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

Where applicable, we have reported on each core service provided by South Essex Partnership University NHS Foundation Trust and these are brought together to inform our overall judgement of South Essex Partnership University 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

Contents

Summary of findings

Overall summary

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

- Staff were aware of the processes for reporting any incidents and there was a strong culture of learning from incidents and complaints to improve the quality of the service provided. They were fully aware of the safeguarding policies and procedures and could clearly tell us what they would do if they had any concerns.
- Targets had been met for staff attending mandatory training and staff reported there was good access to further training specific to their roles within the Trust. Staff were able to access external sources of training. We found current risk assessments in place for patients and that these were reviewed as required.
- Patients told us that their pain was under control. We noted that anticipatory drugs were prescribed to ensure pain relief was administered to patients in a timely manner. We did not observe any patients in pain during our inspection.
- Patients and relatives all reported that they found staff caring and supportive. Patients' needs were looked at on an individual basis and the service showed us good examples of responsive care.
- The teams worked closely with other members of the multidisciplinary team in order to ensure patients receive timely access to services. We spoke with one relative who told us they had responded to their family member's needs very quickly when increased pain became difficult to manage.
- Staff were very passionate about their roles and local leadership was good. Staff felt supported in their roles and could discuss any issues they had with senior leaders. Key performance indicators were monitored on a monthly basis which showed the teams were exceeding their targets in most areas. Where targets fell below expected measures, there were plans in place to review and discuss the issues.

However:

- New end of life care planning documentation to replace the Liverpool Care Pathway had been developed by the trust but had yet to be implemented fully across the teams.
- There was no consistent trust wide documentation system. For example, the trust's assessment paperwork varied across the teams.
- The trust's current 'do not attempt cardio pulmonary resuscitation' policy did not reflect national guidance.
- The trust did not have trust wide policies related to the care of a person following their death and for those deceased patients identified as having an infection. This was a potential health and safety risk for relatives, carers and staff.
- Front line staff had not received confirmation of death training.
- The trust did not have a current 'end of life' strategy.
- There was no evident clinical leadership for end of life care at executive level.

Summary of findings

Background to the service

End of Life Care services provided by the trust served the community across both Essex and Bedfordshire. The service formed part of the integrated services directorate and was delivered across various localities closely aligned to clinical commissioning groups and General Practitioners.

Palliative care aimed to achieve the best quality of life for patients and families affected by life limiting illnesses, encompasses the important phase of the end of life care provided by the trust. Guidance issued by the General Medical Council considered patients to be approaching the end of life when they were likely to die within the next twelve months.

End of life care services were being delivered by community nurses, specialist palliative care nurses and Macmillan nurses based at Bedford health village, Biggleswade hospital, central Canvey primary care centre, Thundersley clinic and the Latton Bush centre.

Care was also delivered in the community by a community end of life care consultant and other health professionals such as dieticians and occupational therapists.

Systems were in place to promote collaborative working between this core service and local hospices. The hospice movement in both Essex and Bedfordshire was strong and supportive and provided in-patient beds, day care and hospice at home services.

Our inspection team

Our inspection team was led by:

Chair: Karen Dowman, Chief Executive, Black Country Partnership NHS Foundation Trust

Team Leader: Julie Meikle, head of hospital inspection (mental health) CQC

Inspection Manager: Peter Johnson, mental health hospitals CQC

The team that inspected this core service was a CQC bank inspector and three specialist professional advisors who held senior clinical nurse roles within end of life care services for other NHS trusts.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Why we carried out this inspection

We inspected this trust as part of our ongoing comprehensive inspection programme of mental health and community health NHS trusts.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and trust:

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

Summary of findings

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients using the service.

During the inspection visit, the inspection team:

- Spoke with ten patients who were using these services.
- Met with five carers.
- Reviewed 15 care and treatment records.
- Examined the trust's end of life care policies and procedures.
- Interviewed the managers for each service.
- Spoke with 17 other staff members.
- Attended ten home visits to observe the care and treatment being given to patients with their permission.

What people who use the provider say

Patients and relatives were positive about the palliative support which they received and said staff were kind, caring and respectful. They said that staff were professional.

Patients and relatives were actively involved in their care and treatment. Patients told us that staff always had time for them and were proactive in managing the symptoms of their illness.

Good practice

- The 'partnership for excellence in palliative support' was a good example of innovation used to improve care and treatment for patients and their relatives.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the trust SHOULD take to improve

- The trust should ensure that the new end of life care planning documentation to replace the Liverpool Care Pathway is implemented fully across the teams.
- The trust should ensure that a consistent trust wide documentation system is introduced for this core service.
- The trust should ensure that it's current 'do not attempt cardio pulmonary resuscitation' policy reflects national guidance.
- The trust should introduce trust wide policies for the care of a person following their death and for those deceased patients identified as having an infection.
- The trust should ensure that front line staff receive confirmation of death training.
- The trust should introduce a current 'end of life' strategy.
- The trust should ensure that there is clear clinical leadership for end of life care at executive level.

South Essex Partnership University 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 community health services for end of life care as good for safe because:

- Staff were aware of the process for reporting any incidents and what to do with the information. There were effective systems in place to learn from any incidents.
- Arrangements were in place to minimise risks to people receiving the service and this was managed on an individual basis.
- Staffing levels were generally good across the services. One team told us it was difficult to recruit specialist band 7 nurses so they had developed an in-house competency programme for internal development of band 6 nurses. We heard good reports of cross cover and supportive teams.
- Mandatory training rates were good. Patient records were completed properly and no issues were identified with records storage or any breaches of patient confidentiality.

However:

- Some staff were concerned about their individual caseloads and had fed this back to their managers.

Safety performance

- Performance monitoring took place within this core service. For example, through trust wide and local safety audits. Evidence was seen of learning from these being disseminated throughout the trust during team meetings and via all staff emails.
- There had not been any never events (serious largely preventable patient safety incidents that should not occur if proper preventative measures are taken) in the end of life care services within the past 12 months.
- The trust had a current incident reporting policy and the staff were aware of the required reporting processes. Staff were positive about incident reporting as they saw this as a way of improving the service that they provided for patients. For example we noted discussions regarding the incidence of pressure sores within the service.
- Learning from incidents was a regular agenda item at staff meetings. Staff described to us how case studies were developed in response to certain incidents and lessons learnt were cascaded through regular meetings and via email.

Good

Are services safe?

Safeguarding

- The trust had had a robust safeguarding system in pace. We saw local policies and procedures in place in relation to safeguarding adults and children.
- Staff told us they had received appropriate training and were confident in reporting concerns to the relevant teams. The trust target for mandatory safeguarding training was 90% and all the teams had exceeded that attendance target.
- Staff were able to explain what constituted a safeguarding concern and the steps required for reporting on these concerns. Staff told us they had an excellent, supportive response from the safeguarding team.
- Staff were involved in learning from safeguarding incidents and in learning from safeguarding reviews.

Medicines

- Most of the Macmillan nurses we spoke with were able to prescribe independently and were fully trained nurse prescribers. The trust's non-medical prescribing policy was in the process of being reviewed so necessary updates could be made.
- Staff used a combination of national and local guidelines when prescribing. We observed medicines being prescribed appropriately to prevent nausea and vomiting. Syringe driver conversion charts were in regular use to ensure the correct amount of medication was dispensed.
- The management and administration of medicines in end of life care was simplified as much as possible to prevent any undue pain or distress. Arrangements were in place to ensure the secure storage of medicines within the home environment.

Environment and equipment

- Staff told us that they were able to access equipment seven days per week. Robust processes were in place to ensure the equipment was safe and fit for purpose. For example, we saw completed maintenance records.
- Staff did not express any concerns with the trust's equipment contract and were satisfied that it was a safe and effective service.
- Whilst accompanying staff on home visits we observed appropriate equipment was available for the end of life care patient. We noted that the trust used ambulatory syringe drivers. These were being monitored regularly by staff.
- However, the trust procedure for the use of the syringe driver needed updating as it still referred to the Liverpool Care Pathway which was no longer in use.

Quality of records

- Care and treatment records had been completed sensitively and with sufficient detail to outline the personalised care given to patients. Staff told us that these templates were regularly reviewed to ensure they were effective as possible.
- A yellow folder containing relevant information and patient care records was being developed on Harlow prior to be being rolled out across the trust.
- Electronic and paper based records were produced by staff. Paper based records were kept in patients' homes to ensure safe handovers of care.
- The trust carried out trust wide record keeping audits and these findings were shared with the relevant manager.
- Managers told us that these audits were discussed at team meetings.

Cleanliness, infection control and hygiene

- We found good levels of infection control with appropriate use of hand washing and the application of alcohol gel. Where we had any concerns about the levels of hand hygiene, we identified these to the relevant staff member and this was addressed.
- Staff wore personal protective equipment such as gloves and aprons when delivering personal care.
- The trust did not have trust wide policies related to the care of a person following their death and for those deceased patients identified as having an infection. This was a potential health and safety risk for relatives, carers and staff.

Mandatory training

- Staff confirmed that there was good access to mandatory training study days and profession specific training. A variety of topics were discussed at these sessions included safeguarding issues, infection prevention and control, medicines management and health and safety.

Good

Are services safe?

- Staff training records confirmed that staff had attended their mandatory training opportunities. We noted that staff were booked onto further training sessions where required. For example, mandatory training rates provided by the Canvey Island integrated team showed a consistently high level of compliance at over 90% of staff completing the training. Other staff teams had good access to mandatory training and felt supported by their managers in being able to access it.
- Managers confirmed that training needs were discussed during staff supervision and appraisals.

Assessing and responding to patient risk

- Those care and treatment records reviewed showed us that risk assessments were completed on a regular four weekly basis or as required. These included risk assessments for the management of pressure ulcers and nutritional safeguards.
- The Macmillan nurses had developed a distress tool to assess level of psychological intervention required. This offered nurse led first line guidance which included individualised support to families and carers. If it was assessed that the need was greater than the support on offer, a referral to a psychologist was made.

Staffing levels and caseload

- Staff self-reported a good level of staffing throughout this core service. Vacancy rates were below 2% for the teams inspected. Short term staff absence was covered from within the staff team.
- One team told us it was difficult to recruit specialist band 7 nurses so they had developed an in-house competency programme for internal development of band 6 nurses.
- Staff told us that the demand for these services was high and the system was 'stretched' but we heard good reports of cross cover and supportive teams.
- Staff reported robust handover procedures and we found that local hospice services supported end of life care services as required.
- There were nine Macmillan nurses across the Bedfordshire area aligned to GP localities. Each team held a caseload of patients with complex specialist palliative care needs.
- However, the Macmillan nurses told us they were concerned about their designated caseload of four patients per day which they felt unable to achieve in a working day. They had fed back to the managers and were currently doing a time and motion study every 15 minutes to more accurately capture their working day.

Managing anticipated risks

- The trust had a trust wide emergency contingency policy and procedures. Staff told us they worked closely as a team to address anticipated risks such as flooding. This ensured that people were provided with the care they needed. For example, we saw alternative road routes had been identified to ensure care continuity.
- On the week of the visit, the country was experiencing exceptionally high temperatures. The trust sent out a series of emails encouraging staff to take care of themselves and to be more aware of the needs of vulnerable patient
- Staff told us they managed anticipated risks such as heatwaves by knowing the individual needs of their patients and risk assessing them accordingly.

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 community health services for end of life care as good for effective because:

- Services were meeting the needs of the people requiring end of life care and their carers and relatives. We saw examples of very good multidisciplinary working and effective partnerships with the local GPs and hospices.
- Patients told us that their pain was under control. We noted that anticipatory drugs were prescribed to ensure pain relief was administered to patients in a timely manner. We did not observe any patients in pain during our inspection.
- Staff were clear on how to identify and assess those who lacked mental capacity and how to make best interest decisions. Care plans had been developed taking into account the five priorities of care for the dying person as established by the 'leadership alliance for the care of dying people'.

However:

- The trust had not implemented a trust wide end of life care strategy leading to lack of consistency across the services for core documentation and evidence based care policies and procedures. The trust's framework for 'do not attempt cardio-pulmonary resuscitation' (DNACPR) did not reflect current national guidance.

Evidence based care and treatment

- The trust did not have a trust wide current end of life care strategy. For example currently, there was no standard documentation used throughout the trust.
- We spoke with managers of the local teams and they informed us about the processes for delivering end of life care based on the core principles of good care as outlined in the "five priorities of care." This included a number of strands under the headings: 'recognise, communicate, involve, support and plan and do'.
- The use of the 'Liverpool care pathway' had been replaced with new documentation that was being developed in the Canvey Island locality, the documentation was called the 'care of the dying patient plan' and was being piloted in two areas where the Gold Standard Framework (GSF) was working well. (The GSF framework aimed to improve the quality, coordination and organisation of care leading to better patient outcomes).
- The care plans were holistic in approach and care was based on the National Institute for Health and Care Excellence quality standard for best practice within end of life care for adults.
- There was a lack of consistency across the services for evidence based care policies and procedures.
- There was limited evidence of trust wide work on equality and diversity around the end of life care. We were told that a new black and minority ethnic (BME) worker had been employed by the hospice in Bedford and the Macmillan Nurses anticipated working closely with them on their findings to help deliver personalised and effective care.
- One team showed us their audit plan. Staff told us they were involved in audits. However, the majority of services did not undertake regular audits specific to end of life care either at a local or national level.
- The trust's 'summary decision making framework for DNACPR' did not reflect current national guidance from the British Medical Association (BMA) as a result of the High Court judgement made in July 2014 that patients must be consulted in relation to advanced DNACPR decisions. Managers told us that this under review by the trust.

Pain relief

- We found that patients received good pain relief. Patients told us that their pain was under control. We noted that anticipatory drugs were prescribed to ensure pain relief was administered to patients in a timely manner. We did not observe any patients in pain during our inspection.
- Staff used pain assessment tools and we found that patients had pain management care plans in place.
- We observed a 'just in case' box was in one patient's home containing the relevant medications, prescription, record sheet, needles and syringes. The family told us they felt reassured the pain would be under control during the last hours of life.

Good

Are services effective?

- Specialist palliative care advice for pain control was available at all times across the areas inspected. However, there was no trust wide policy in place for pain control in palliative care.

Nutrition and hydration

- Staff were aware of their responsibilities concerning nutritional screening. We saw that the malnutrition universal screening tool was used. They were aware that the goal during late end of life care was not weight gain or reversal of malnutrition but to improve the quality of life.
- Staff told us they had worked hard to control a patient's symptoms of diabetes so they could enjoy ice cream as a particular favourite food.
- Patients were encouraged to drink during the extreme hot weather. We found that each patient had a drink available and within easy reach.

Patient outcomes

- Staff regularly attended the 'gold standard framework' meetings based in GP practices. We were told that these reviews ensured that the assessed needs and wishes of patients were being reviewed and met as a priority.
- Key performance indicators were monitored on a monthly basis which showed the teams were exceeding their targets in most areas. Where targets fell below expected measures, there were plans in place to review and discuss the issues.
- We reviewed the 'preferred priorities of care' document. This was used within the service as an advance care plan to document the patients priorities, preferences and wishes.
- We found that the most recent results of the 'preferred place of death' (PPD) target achieved was 71% in one area and 88% in another out of a target of 85%. If the PPD had not been achieved, the information was reviewed at locality meetings.
- The audit on 'advance care plans' in one locality had identified that although advance care planning took place, it was not being recorded correctly on the electronic system. This was being addressed with staff.

Competent staff

- All new staff were provided with a comprehensive induction period. A lecturer practitioner from the Bedford hospice worked closely with the trust to develop clinical competency training.
- One locality had developed a competency framework for supporting band 6 staff to progress to band 7. This underpinned the skills required to deliver high quality end of life care.
- Another team had developed an 'end of life care education' programme encompassing the five core competencies outlined in the 'national end of life care programme'. All eligible staff without basic training in end of life care were automatically enrolled on a one day course. The course was evaluated and staff reported an increased level of confidence in end of life care following attendance.
- We saw a robust training programme open to all relevant staff including allied health professionals (AHPS). One AHP told us they attended one day training in advanced communication skills which they found very helpful in their work. Trust provided DNACPR training had been booked for all relevant staff in West Essex to attend.
- The majority of staff we spoke with were very positive about the training received. However, some staff felt there was not enough time to attend all of the training opportunities available.
- Care home staff were given training in the 'foundations of end of life care' developed as a national programme for non-registered staff such as care assistants.
- Staff received annual appraisals and regular supervisions. They told us they could identify training needs within these sessions. Some staff had attended advanced training such as the 'advanced clinical examination and independent prescribing course'.
- One team felt they needed more senior clinical leadership within the service and this was shared with senior managers during the inspection.

Multi-disciplinary working and coordinated care pathways

- There were good local working arrangements with hospice provider organisations. Each team worked in an integrated and multidisciplinary way. The local multidisciplinary team meetings (MDTs) held at GP practices and local hospitals were well attended by community nurses, specialist palliative care staff, hospice services staff and hospital staff as relevant. These meetings were very productive to ensure improved communication and coordination of patient care. Staff felt the multidisciplinary way of working was very strong and effective across this core service.

Good

Are services effective?

- We observed shared care with a local private chemotherapy provider. We saw good working relationships had been established to ensure an effective coordinated approach to end of life care.
- We spoke with some end of life coordinators at West Essex CHS. This team consisted of five staff at band 6 level working across three localities. They work with the patients at the point of diagnosis, coordinated the necessary care, and attend the multidisciplinary meetings and the gold standard framework meetings at GP practices. This model was effective and one patient said the coordinator had been a lifeline.
- Staff in one team had a good working relationship with the community end of life care consultant who worked two days a week at the hospital and three days a week in the community. This offered good links between the services. Patients and families were very positive about the care received from this service.

Referral, transfer, discharge and transition

- The service offered a single point of access for referral. We saw one new urgent two hour referral was met by the team.
- The discharge from hospital into the community service was good. Examples were given of effective co –ordination with the local acute hospitals. For example, all end of life care patients referred to the Bedfordshire teams were offered a referral into the 'partnership for excellence in palliative support' (PEPS) service. This service provided a single, 24-hour telephone point of access for palliative care services. The service was included as a best practice case study example by the 'national end of life care' programme report. Both patients and staff spoke highly of this service.

Access to information

- The teams used an electronic system for recording information. Other clinicians, allied health professionals and the ambulance service were able to access the records.
- Handover systems between services were effective. For example information was shared between professionals at the gold standard framework meetings.
- The PEPS service in Bedfordshire used the trust's electronic system so access to information on patients was available at all times.
- A 'light' version of the patient's records was kept in the patient's home. This meant that other agencies such as the private providers of end of life care could access the information. The Harlow teams were piloting a 'yellow folder' containing all the necessary information for patients and relatives and carers such as out of hours contact numbers.
- Information leaflets were available to patients and their relatives. These could be translated if required.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff had received training on the Mental Capacity Act (MCA) as part of their mandatory training. This was well attended and up to date. Staff were aware of the MCA and the implications for their practice.
- We reviewed some MCA forms on the electronic system and were shown good examples of when they had been used appropriately.
- We saw the Deprivation of Liberty Safeguard (Dolls) form on the electronic system. Staff were able to explain how these were used, for example in the use of cot sides.
- Managers confirmed that the trust's use of restraint practices was being monitored and action taken to minimise its use where required.
- We had mixed feedback on the discussions held with patients when completing 'DNACPR' forms. There was no trust wide policy in place to add clarity to the process.

Good

Are services caring?

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

Summary

We rated community health services for end of life care as good for caring because:

- Patients were being treated with compassion, dignity and respect by all staff. Everyone we spoke with told us they had positive experiences of this service.
- Staff were not familiar with carers' assessments although we observed good care of families and carers during our observations. All staff we spoke with were passionate about their work and acted in a professional and sensitive manner at all times.

Compassionate care

- Patients were treated with compassion, dignity and respect throughout our inspection.
- Staff communication with patients and their families was generally good. However, we found that some improvements could be made in communications of sensitive subjects such as DNACPR.
- Patient choice was fulfilled where possible, taking into account a person's culture, beliefs and values. A trusting relationship had been established with the patients and their families. We received a number of positive comments from relatives.
- Patients were positive about the care they were receiving. Relatives told us that staff respected the patient's wishes wherever possible.
- However, the national bereavement survey for 2012 and 2013 provided mixed results. For example the Essex and Bedfordshire health economy areas were in the bottom 20% for 'respect and dignity always shown' and 'support for carers'.

Understanding and involvement of patients and those close to them

- Time was given to patients and relatives to discuss their concerns. During a home visit we saw that the community nurse specialist took time to discuss the changes in medications with the relative and ensured there had been a good understanding of the reasons why.
- Staff delivered person-centred care and knew the patients and families well. There was information available for families and carers from the PEPS service such as the bereavement service leaflet. We saw examples of a variety of information leaflets available to families and carers.

Emotional support

- We observed a good assessment of emotional needs during a home visit. One family told us they had received good emotional support and were as well prepared as possible for the final days and hours of their relative's life.
- We found that most staff were not aware of carers' assessments that are outlined in the 'end of life care' NICE quality statement. However carers told us that they were happy with the level of support provided by trust staff.
- We observed care and support given to families and carers but this was on an individual basis rather than a trust wide policy for good practice.
- We noted examples of the availability and signposting of counselling services and psychological support where required.

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 community health services for end of life care as good for responsive because:

- Patients and families were able to access 24 hour help and advice for end of life care. Staff were aware of individual diverse needs and an interpreter service was available if needed. Figures were collected on the patients preferred place of death by the local clinical commissioning groups (CCG) and were followed up by the service when preferred preferences had not been met.
- Each team worked well with the local hospice to make the best use of day care and hospice at home services in response to patient need. Patients and relatives told us they were very happy with the service provided and knew how to make a complaint if necessary.

However.

- Nurses were not able to confirm a death and no policy was in place for after death care specific to end of life.

Planning and delivering services which meet people's needs

- Managers confirmed that services were planned in partnership with the commissioners of services. For example, we saw evidence of robust partnership arrangements with local GP practices and the local hospice movement.
- Services were delivered in people's homes by the integrated care teams, including specialist nurses, community nurses and therapists.
- Palliative Care was delivered in nursing homes by 'care home practitioners'.
- The PEPS service was developed in response to patient and family feedback regarding effective discharge planning and communication. This was now widely recognised as an example of best practice.
- Staff told us about the 'virtual ward' initiative in the West Essex service. Daily meetings were held to discuss all patients within the virtual ward to establish any changes to their care needs. Care needs were re-assessed where applicable following these meetings.
- Staff had not received confirmation of death training and were not able to confirm death which meant which meant relatives might have to wait longer than necessary for this. Under best practice guidance, national end of life care programme (2012) this was demonstrated as an extended skill that could have increased the quality of care offered.

Equality and diversity

- Staff had received training in equality and diversity. The hospice in Bedford had just recruited a BME worker to look at the needs of the local community for end of life care support. The staff we spoke with were aware of the benefit this would bring to the team in better responding to patient's needs from the BME communities.
- Staff had access to an interpreter service if required. One staff member had recently accessed the service to help translate for a Russian patient. They said the service was very efficient and helpful.
- Spiritual support were discussed with patients and families. Staff had good access to local resources.

Meeting the needs of people in vulnerable circumstances

- Staff in some teams were due to attend 'psychology assessment skills training' to be able to better support patients and families with first line psychological support.
- Staff told were able to access wider trust services to support patients with learning difficulties and those living with dementia. For example, the learning disability community and the older people's mental health community teams. This had helped avoid unnecessary hospital admissions.
- The care home practitioners worked in partnership with other multi-disciplinary teams to help reduce falls. They also looked at tissue viability and nutritional care.

Access to the right care at the right time

- The teams told us they worked closely with other members of the multidisciplinary team in order to ensure patients receive timely access to services. We saw an example of staff responding to an urgent referral within the target time of two hours.

Good

Are services responsive to people's needs?

- We reviewed the service's monthly key performance indicators and these showed us that the service was meeting their relevant standard for referral to assessment and then to care and treatment.
- We spoke with one relative who told us that staff had responded to their family member's needs very quickly when increased pain became difficult to manage.
- Staff referred into the hospice at home service regularly. We saw that the hospice at home team being contacted so that the patient had access to overnight care.
- The 'preferred place of death' (PPD) achieved varied from team to team, we noted that if the target of 85% was not achieved, the information was reviewed at locality meetings.
- Patients and relatives told us they had contacted the service out of hours and were given the right advice when they needed it.

Learning from complaints and concerns

- Staff were aware of the trust's complaints process. One team told us that their complaints had been reviewed and an analysis done as to the main reasons for the complaints. A full debrief was done with the team with recommendations for learning from the complaints. Following this, all staff were due to attend an advanced communication skills course.
- Patients and relatives told us they knew how to make a complaint if required. However, those spoken with were happy with the service they had received.

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 community health services for end of life care as good for well led because:

- Staff knew the vision and values of the organisation although they felt slightly disconnected from the organisation as a whole. Staff felt involved with their service at a local level.
- There was a good governance structure in place and the risk register was used to highlight any immediate areas of risk to be reviewed on a monthly basis. Managers of the service were aware of the risk register and how it related to end of life care. All staff spoke positively of their team leaders.
- However there was a lack of senior leadership both clinically and managerially at executive level to champion this service. There was no Trust wide strategy for end of life care.

Service vision and strategy

- Staff knew the vision and values of the organisation although they felt slightly disconnected from the organisation as a whole. Staff felt involved with their service at a local level.
- The trust's' end of life' strategy was out of date and a new strategy had yet to be commissioned. Staff felt more representation and leadership was needed at executive level to progress the end of life vision and strategy.
- The teams were clearly able to articulate their own particular service area's service delivery model.

Governance, risk management and quality measurement

- We found that service based audits were limited and not many were specific to end of life care in order to improve the quality of the service.
- Staff told us that complaints, incidents, learning from incidents, safeguarding and policy reviews were discussed at team meetings. This was supported by those minutes seen.
- Key performance indicators were monitored on a monthly basis which showed the teams were exceeding their targets in most areas. Where targets fell below expected measures, there were plans in place to review and discuss the issues.
- There were limited trust policies and procedures specifically related to end of life care.

Leadership of this service

- Staff spoke positively about their team leaders and senior management. One team felt they needed more senior clinical leadership.
- Staff said they felt supported and could discuss any issues. We saw one team were having their workload reviewed proactively by senior management in response to raising concerns that the workload was too high.
- Local managers were proactive and came from a clinical background. They demonstrated an understanding of the current issues facing the service.

Culture within this service

- We found the culture was very positive within the local teams and staff felt empowered to do their job and be involved in the service delivery.
- We considered that this culture encourage candour, openness and honesty. Systems were in place to promote staff safety including a trust wide lone working policy.
- The teams worked collaboratively with their local partners and stakeholders and there was a great level of respect for other services involved in end of life care such as the hospices and advice lines.
- Staff were passionate about their roles and this promoted a caring culture within the service.

Public engagement

- The trust were hosting public feedback sessions called "take it to the top" in June and July 2015. These had been organised by the trust patient experience team.
- Managers told us that this feedback would be used to inform future service developments and trust direction.

Good

Are services well-led?

- There were ten responses in February and March 2015 and nine in April and May 2015 to the trust's friends and family test in respect of this service. 100% and 89% respectively said they were extremely likely to recommend the service.

Staff engagement

- Staff told us that they felt engaged with by the trust.
- The NHs staff survey 2014 showed that the trust performed better than the national average for questions relating to staff recommending the trust as a place to work or receive treatment and agree that feedback from patients is used to make informed decisions in the department. 75% of staff felt able to contribute towards improvements at work (compared to the national average of 72%).

Innovation, improvement and sustainability

- The PEPS service was a good example of innovation used to improve care and treatment for patients and their relatives. We found that staff used their extended knowledge and skills provided a quality service.