

North East London NHS Foundation Trust

RAT

# Community end of life care

## Quality Report

Tel: 0300 555 1200  
Website: [www.nelft.nhs.uk](http://www.nelft.nhs.uk)

Date of inspection visit: 10 October to 12 October  
2017  
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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)
	Chadwell Heath Health Centre	Barking and Dagenham End of Life Care Facilitator	RM6 6RT
	Thurrock Hospital	Thurrock Adults ICT	RM16 2PX
	Mayfield Community Hospital	Inpatient Unit	RM16 2PX
	Grays Court Community Hospital	Barking and Dagenham ICT	RM10 9SR
	Athena Room, Phoenix House	Basildon ICT (ICT)/DistrICT (ICT) Nursing	SS14 3EX
	District Nursing	Redbridge ICT	IG2 7SR
	Wood Street Health Centre	Waltham Forest Children	E17 3LA
	Mellmead House	Redbridge ICT (ICT) (Evening and Night)	E11 2DH
	Langthorne Health Centre	Waltham Forest, ICT (ICT) North	E11 4HX
	Harold Hill Health centre	Havering ICT (ICT)/ DistrICT (ICT) Nursing	RM3 9SU
	Hainault Health Centre	Redbridge, Community Specialist Palliative Care Team	IG7 4DF







This report describes our judgement of the quality of care provided within this core service by North East 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 North East London NHS Foundation Trust and these are brought together to inform our overall judgement of North East 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?		Requires improvement	
Are services well-led?		Good	

# Summary of findings

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# Summary of findings

## Overall summary

We rated end of life care (EOLC) good because:

- There had been a restructure in EOLC in the trust. This meant most specialist palliative care was outsourced and provided by hospice staff. District nurses worked in integrated community teams and were responsible for providing treatment and support to palliative and EOLC patients in the community.
- Staff understood their responsibilities to raise concerns and to record safety incidents.
- There was an open culture in reporting incidents and there were systems in place to learn from incidents and reduce the chances of them happening again.
- There was identification of patients at risk of deterioration and we saw evidence of the use of emergency health care plans in ensuring that all patients had a plan in place should their condition deteriorate.
- There was appropriate equipment available in patients' homes and use of anticipatory prescribing of medicines at the end of life.
- Mandatory training levels were good, with all specialist palliative care team staff.
- An integrated electronic records system was in use across specialist palliative care staff community. Although, in Essex, patients electronic records could be viewed by acute hospital staff and GP practices; and in London, trust staff had access to patients' electronic records, but did not have access to other community providers' records.
- The trust had implemented the 'individual care plan' which was being used as a guide for the delivery of end of life care. We saw that treatment escalation, emergency healthcare plans and advance care plans were in place to support patients and those close to them in making decisions at the end of life.
- There was a commitment to working collaboratively to deliver joined-up care through multidisciplinary working. This was demonstrated through the trust's community services collaborating with hospice staff and staff from local NHS acute trust. There were established links with GPs and local nursing homes.
- The trust were rolling out 'essential to role' EOLC training to all relevant staff.
- Consent practices were embedded across teams providing EOLC.

- Staff demonstrated compassionate care to patients and their families. We observed a commitment to providing care that was focused on meeting the emotional, spiritual and psychological needs of patients as well as their physical needs.
- There was a visible person-centered culture. Staff were highly motivated to offer care that was kind and promoted people's dignity. Relationships between people who used the service, those close to them and staff were caring and supportive. These relationships were valued by people and their families.
- The trust were developing pathways of care to provide care that met people's individual needs.
- There was an open approach to handling complaints.
- There was a vision and strategy that focused on the early identification of patients at the end of life, patients being cared for in their preferred place of care and the use of partnership working to develop services.
- There was end of life care representation and leadership at trust board level.
- There was comprehensive leadership within the palliative care service with clearly defined leadership roles. The director of nursing was passionate about the service and encouraged staff to deliver high quality EOLC. Local managers were proactive and demonstrated an understanding of the issues facing EOLC services.

However, we also found:

- Incident reporting rates for palliative and EOLC were low in integrated community teams compared to specialist palliative care teams.
- Staff were not aware of whether the trust had audited anticipatory medicines.
- Staffing levels had improved in the previous 12 months, but retaining staff was an issue across integrated community teams.
- Waltham Forest had the worst results in England in the national care for the dying audit 2016, for patients achieving their preferred place of care at the end of their life.

# Summary of findings

- Some staff we spoke with told us they were not aware of any audit proposals in 2017, even though there had been an audit of 'do not attempt cardiopulmonary resuscitation' (DNACPR) decisions in 2017.
- Staff at Mayfield inpatient unit had piloted the provision of EOLC in a rehabilitation focused inpatient unit. However, staff felt they had not been fully prepared for the palliative care remit.
- Staff told us they didn't feel connected to other teams across boroughs and there were very few opportunities for staff to meet with colleagues from other directorates across Essex and London to share learning.
- The trust had introduced a new EOLC strategy which aimed to meet patients' needs through direct care, advice, information and education, enabling patients to die in their place of choice. However, across community services staff told us the EOLC strategy was relatively new and teams needed time to embed it.
- Some local managers we spoke with were unaware that there was a specific risk register for EOLC.

## Information about the service

North East London NHS Foundation Trust (NELFT) provides integrated community and mental healthcare services to a diverse population of over 2.5 million people in the London boroughs of Barking and Dagenham, Havering, Redbridge and Waltham Forest. NELFT also provides services in the Essex boroughs of Basildon, Brentwood and Thurrock. The trust employs approximately 6,000 staff. End of life care (EOLC) services are provided by individual directorates based upon London and Essex boroughs. However, there was a NELFT organisational structure to support the individual directorates.

In Essex boroughs NELFT are commissioned to provide community EOLC services through St Luke's Hospice. The community EOLC service provides specialist palliative care to adults in their own homes. Day care services are provided by St Luke's and St Francis Hospices. Patients are also supported by community nursing and district nursing services working in integrated community teams (ICT)) to work with patients in nursing and residential care home settings, as well as working with patients who live in their own homes.

Mayfield inpatient unit provides two specialist palliative care inpatient beds.

St Luke's and Saint Francis Hospices provide a 24 hour advice line, specialist nursing services and out of hours palliative care nursing services. The multidisciplinary team includes physiotherapy, occupational therapy, chaplaincy, clinical pharmacist, complementary therapists and access to medical social workers.

The Redbridge specialist palliative care team is a multi-disciplinary team, which provides expertise in holistic assessment, management of difficult symptoms and patients with co-morbidities.

We visited the specialist palliative care team in Redbridge. We visited district nursing services based in ICT in: Waltham Forest, Barking and Dagenham, Thurrock, Basildon, Redbridge, and Havering. We visited Mayfield inpatient unit in Thurrock. We visited Waltham Forest children's community services. We also visited EOLC facilitators in Basildon and Havering.

# Summary of findings

## Background to the service

North East London NHS Foundation Trust (NELFT) provides integrated community and mental healthcare services to a diverse population of over 2.5 million people in the London boroughs of Barking and Dagenham, Havering, Redbridge and Waltham Forest. NELFT also provides services in the Essex boroughs of Basildon, Brentwood and Thurrock. The trust employs approximately 6,000 staff. End of life care (EOLC) services are provided by individual directorates based upon London and Essex boroughs. However, there was a NELFT organisational structure to support the individual directorates.

In Essex boroughs NELFT provide general community palliative care as part of the integrated care teams (ICT) and St Luke's Hospice provide Specialist Palliative Care to Adults within Essex. Day care services are provided by St Luke's and Saint Francis Hospices. Patients are also supported by community nursing and district nursing services working in ICT to work with patients in nursing and residential care home settings, as well as working with patients who live in their own homes.

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## Our inspection team

**Team Leader:** Max Geraghty, Care Quality Commission

The team included three CQC inspectors and a community nurse specialist advisor.

## Why we carried out this inspection

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

## How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 10-12 October 2017.

## Are services safe?

During our inspection, we observed care being delivered by specialist palliative care nurses and district nurses. We spoke with over 30 members of staff including: senior managers, middle managers, two consultants for older people, specialist palliative care community nurses, district nurses and therapists. In addition we spoke with staff from St Luke's and St Francis Hospices.

We spoke with five patients and six relatives and visited patients in their own homes and in community settings.

We looked at the records of 12 patients receiving end of life care.

### Good practice

- The trust had developed a tiered package of end of life (EOLC) staff training which was being rolled out across community services.
- End of life care (EOLC) in Barking and Dagenham had rolled out training in palliative and end of life care to staff in residential care homes.
- District nurses had received training on the use of a magnet to deactivate implantable cardioverter defibrillators (devices fitted under the skin which regulate abnormal heart rhythms) in the home environment for EOLC patients.

### Areas for improvement

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

##### Action the service **SHOULD** take to improve

- Waltham Forest integrated community teams (ICT) should improve the number of patients achieving their preferred place of care at the end of their life.

- Ensure staff at Mayfield Community Hospital are fully prepared for the palliative care remit.
- Improve staff awareness of the specific risk register for end of life care (EOLC).

Good

## Are services safe?

By safe, we mean that people are protected from abuse

### Summary

We rated safe as good because:

- There had been a restructure in end of life care (EOLC) in the trust. This meant most specialist palliative care was outsourced and provided by hospice staff. District nurses worked in integrated community teams and were responsible for providing treatment and support to palliative and EOLC patients in the community.
- Staff understood their responsibilities to raise concerns and to record safety incidents.
- There was an open culture in reporting incidents and there were systems in place to learn from incidents and reduce the chances of them happening again.
- There was identification of patients at risk of deterioration and we saw evidence of the use of emergency health care plans in ensuring that all patients had a plan in place should their condition deteriorate.
- There was appropriate equipment available in patients' homes and use of anticipatory prescribing of medicines at the end of life.



# Are services safe?

- Mandatory training levels were good, with all specialist palliative care team staff.
- An integrated electronic records system was in use across specialist palliative care staff community. Although, in Essex, patients electronic records could be accessed by acute hospital staff and GP practices; and in London, trust staff had access to patients' electronic records, but did not have access to other community providers' records.

However, we also found:

- Incident reporting rates for palliative and EOLC were low in integrated care teams when compared to specialist palliative care teams.
- Staff were not aware of whether the trust had audited anticipatory medicines.
- Staffing levels had improved in the previous 12 months, but retaining staff was a challenge across community integrated care teams.

## Safety performance

- There had been no never events reported from September 2016 to September 2017 in relation to community end of life care (EOLC) services. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

## Incident reporting, learning and improvement

- Staff we spoke with told us that when an incident occurred it would be recorded on the electronic system for reporting incidents.
- We reviewed incidents reported between 3 August 2016 and 4 January 2017 by the Redbridge specialist palliative care team. The team had reported six incidents in the period related to end of life care (EOLC). The severity of each incident was recorded appropriately and indicated the level of harm caused by the incident. There were no identifiable themes from the incidents reported.
- Staff from other directorates across NELFT informed us they had reported no incidents relating to EOLC, as there hadn't been any. However, this reporting rate was low when compared to the Redbridge

specialist palliative care team's rate of reporting. This may indicate a culture of under reporting of EOLC incidents or staff not identifying when an incident related to EOLC on the electronic system.

- All staff were aware of, and had access to the trust's online incident reporting system. This allowed staff to report all incidents and near misses where patient safety may have been compromised. Staff told us they were encouraged to report all incidents.
- During our inspection staff told us there had been no serious incidents (SI) meeting the STEIS reporting criteria. However, following our inspection the trust informed us there had been one SI between September 2016 and August 2017. This involved an unexpected death in Basildon and Brentwood.
- Some staff said they received feedback from incidents they had raised. One member of staff gave an example of an incident involving controlled drugs missing from a patient's home. As a result, new guidelines had been produced in regards to storage of controlled drugs in patient homes.
- All incidents and any learning from incidents were shared at team meetings and at staff handovers. We saw minutes from meetings, which evidenced feedback to staff regarding local incidents and the actions to be taken. We saw that staff meetings included lessons learnt and details of investigations following incidents.
- Weekly multidisciplinary meetings and monthly management meetings took place during which information from around the trust, including learning from incidents, was shared.

## Duty of Candour

- Staff were aware of their responsibilities in relation to duty of candour and being open with patients when incidents occur and we were given an example of a medication incident where the patient and family were informed.

## Safeguarding

- We viewed the staff training record. This recorded that 100% of EOLC staff were trained to an appropriate level in adults and children's

## Are services safe?

safeguarding. Integrated community teams (ICT) were trained to level 3 in children's safeguarding and trained to level 3 enhanced safeguarding training in adults safeguarding.

- We viewed an incident where staff at the specialist palliative care team had followed the trust's policy following a domestic incident. The team had made appropriate referrals to the trust's safeguarding team and the local authority adults safeguarding team.
- ICT teams had safeguarding link nurses; these were members of staff with a specific interest in safeguarding.
- Staff at the Waltham Forest community children's team received monthly safeguarding supervision. Staff told us they could also receive safeguarding supervision upon request if they were dealing with a child where there were safeguarding concerns.

### Medicines

- Medicines were appropriately managed across NELFT services we visited. Community patients who were identified as requiring end of life care were prescribed anticipatory medicines, these are drugs prescribed for use on an 'as required' basis to manage common symptoms that can occur at the end of life. Having anticipatory drugs available in the home allows qualified staff to attend and administer drugs which may stabilise a patient or reduce pain and anxiety and prevent the need for an emergency admission to hospital.
- We visited a patient in the community who had anticipatory medicines prescribed and these were available and stored safely in their home for when they were required.
- Medicines were prescribed using guidance from the NELFT medicines policy, which was approved in January 2016 and due for review in January 2019. The guidance was available on the NELFT intranet.
- Staff told us there was an adequate number of district nurses who were nurse prescribers. There were also non-medical prescription leads in each borough.
- We viewed a 'quick reference guide' for staff in Redbridge. This gave staff information in an

accessible format on prescribing and how to access further support in regards to EOLC medicines management from the community pharmacy, local acute trust, St Francis hospice and EOLC facilitator.

- We looked at nine prescriptions and administration records in the community and saw they were completed clearly; including the times of administration of medicines prescribed 'as required'.
- NELFT had an up to date formulary and guidelines for managing EOLC medicines, dated April 2015. Staff could access this via mobile working devices. The document provided guidance for staff on EOLC medicines and also gave staff telephone contact numbers to enable them in accessing advice and guidance on medicines or the management of patients EOLC medicines.
- Waltham Forest community children's team worked with medical staff at a London children's hospital. The hospital's palliative care team produced a prescription and delivered any EOLC drugs directly to the child's home from the hospital's pharmacy. Any other drugs were prescribed by the child's GP.
- The trust monitored incidents involving controlled drugs. For example, we viewed the 'controlled drugs occurrence report' dated June 2017 to September 2017. We found there was one documented incident with the Barking and Dagenham ICT. The incident dated 21 July 2017 involved controlled drugs which could not be located in a patient's home. Staff told us about the incident and the subsequent investigation found the drugs had been inadvertently thrown away by the patient's family.
- The trust had undertaken a trustwide controlled drugs audit between April 2016 and March 2017. Overall, the audit found 100% compliance during quarter one and two, 2016 to 2017.
- Staff told us they were not aware of any audits relating specifically to end of life care medicines. This meant the trust did not have up to date data to monitor the safety or effectiveness of anticipatory or end of life medicines.

# Are services safe?

- The team lead at Redbridge specialist palliative care team told us the band 7 nurse managed incident reports as they did not always have time to read them.
- The team lead at Redbridge specialist palliative care team told us they heard about drug errors at the medicines management forum, this was a meeting where directorates medicines practices were reviewed. Staff told us lessons learnt in relation to medicines were shared at the forum.

## Environment and equipment

- Staff told us that they did not experience any issues with obtaining or maintaining equipment for end of life care patients.
- There were different mechanisms across the directorates for ordering equipment. For example, in Essex equipment was sourced from a different private provider from the London directorates.
- Trustwide we found syringe drivers were obtained from an equipment library and these were accessible to community staff out of hours. Specialist mattresses were also available and district nurses could access these as needed.
- Staff were equipped with 'agile working' devices. These were mobile working tablets. Staff told us mobile working allowed them to order equipment for patients on the spot in patients' homes.
- We observed the use of McKinley syringe drivers in the community, and saw that regular safety checks were being recorded.
- Patients had access to occupational therapists and physiotherapists who worked as part of the community team. They would assess patients' needs in relation to their home environment and identify equipment required.
- Staff told us that equipment was accessible within a few hours for patients at the end of life who were being discharged from hospital.
- We found all the equipment in use was clean, had up to date portable appliance testing, and were serviced where required.

## Quality of records

- The trust had implemented 'agile working'. This equipped trust staff with mobile devices in the form of electronic tablets. Staff could access patients' electronic records on their agile working devices. In Essex this meant staff could also access information from the patients GP, as GPs used the same electronic record system as the trust.
- We viewed two patients' electronic patient records at Mayfield inpatient unit. We found one patient did not have clear documentation in regards to the use of anticoagulants; these are drugs used to thin patients' blood and prevent clots. Staff told us they had asked for palliative care plans as the care plans on patients' electronic patient records did not cater to EOLC patients' holistic needs. However, staff did not know if work was in progress on this. The hospital had provided care to a small number of patients. Staff said they were expanding the service and the intermediate care plan document was not geared to the needs of palliative and EOLC patients.

## Cleanliness, infection control and hygiene

- The trust had an infection control policy and all staff received training in infection prevention and control (IPC). The level of compliance across the community end of life services was above the 85% target set by the trust.
- We viewed a sample of the hand hygiene audits carried out across NELFT community services. We found most teams offering EOLC met or exceeded the compliance target of 98% across all services. For example, Redbridge quarterly infection prevention and control audits dated from 1 April 2017 to 1 July 2017 demonstrated 100% compliance for the period with hand hygiene and equipment cleaning.
- We viewed the Thurrock ICT quarterly clinical audit report dated January to April 2017. We found 100% compliance with hand hygiene and the use of personal protective equipment (PPE).
- We spoke with staff in clinics and in patients' home settings. All the staff had a good understanding of infection control practices.
- We observed staff using PPE appropriately, such as aprons and gloves.

## Mandatory training

## Are services safe?

- The trusts had a target of 85% for mandatory training. We found that specialist palliative care staff had completed 100% of the trust mandatory training. This training included: moving and handling (88%); basic life support (BLS) (88%); prevent (training in recognising people that may be drawn into terrorism) (89%), equality and diversity (100%), mental capacity act and deprivation of liberty safeguards (DoLS) (88%), infection prevention and control (89%) and information governance (100%).
- All nursing staff we spoke with confirmed they had received training in the use of syringe drivers.
- All staff received mandatory training in EOLC medicines. There was a three year rolling programme of update training for staff. Staff would also update training in medicines in the event of a medicines error.
- The trust were rolling out a programme of tiered EOLC training to all trust staff. There were three tiers to the training, with staff completing the level of training that was essential to their role. We found across community services boroughs staff were at different levels in their EOLC training. Some staff had completed level 3, whilst other staff had only completed level 1. Managers told us the training was a work in progress and staff were working towards achieving their appropriate level.
- Some staff told us the tier 3 training took three hours and staff were having to take a staggered approach to its completion, as they did not have a block of three hours in their work schedules where they could complete the training.

### Assessing and responding to patient risk

- Specialist support was available with hospices operating a 24 hour service.
- There was a palliative care consultant on call service seven days a week together with a 24 hour palliative care helpline which was nurse led at St Luke's and Saint Francis Hospices and the Margaret Centre.
- Thurrock and Waltham Forest had developed a 24-hour rapid response and assessment service (RRAS) to get supportive and specialist care to end of life patients, reduce hospital admission where appropriate and enable the patient to stay in their

place of choice. We did not visit RRAS during the inspection. However, district nursing staff were positive about the service and said they took some of the pressure from district nursing teams as they could respond quickly to a patient who appeared to be deteriorating.

- St Luke's Hospice provided a 'One Response' service that provided advice on care and management and had clinical nurse specialists who could visit patients to support district nursing staff. One Response also had an on-call oncologist available 24 hours a day to advise or signpost staff.
- The trust used 'individual care plan' on caring for the dying patient and care planning document. The care plan included identifying patients at the end of life, holistic assessment, advance care planning, coordinated care, involvement of the patient and those close to them and the management of pain and other symptoms.
- We saw that changes in a patient's health or vulnerability was recorded and any additional preventative measures were put in place such as pressure reducing mattresses or therapies to improve mobility or combat eating or other disorders.
- Symptom control was managed by the specialist palliative care team, who also provided advice to families and professionals. Symptom control was dependant on patients and family choices.
- We observed district nurses using appropriate moving and handling techniques with a palliative patient during a home visit. We saw that the patient had turning charts in place and these were in order and up to date. We also saw nursing staff offering advice to a relative of a patient, when the relative reported that the patient had redness on their foot. The district nurse provided advice on administering cream to the area and the frequency or this to the relative.
- We spoke with relatives who were aware of how to access help and support should a patient's condition deteriorate when they were being cared for at home.
- The trust had implemented a long-term conditions meeting. This gave staff the opportunity to discuss

## Are services safe?

patients and gave the clinical team the opportunity to look at the overall plan of care, and incorporate a range of potential treatments patients may benefit from. The meetings also enabled advance care planning meetings where a care coordinator was identified to begin conversations with the family about patients' individual needs and EOLC preferences.

- The long term conditions meetings identified patients in the last year of their life. A letter was sent to the patient's GP suggesting the patient went on to the EOLC register. In Havering the meetings were called palliative care meetings and were held monthly.
- Staff at the Waltham Forest community children's team demonstrated how the trust's electronic records system alerted staff to a child who was receiving end of life care. The team used a symptom management and emergency plan which was provided by a London children's hospital. Children's emergency care plan's included 'do not attempt cardiopulmonary resuscitation' DNACPR forms. Staff told us the hospital always completed children's DNACPR with the child's family. Work was also in progress on the team adopting the hospital's advanced care plan tool for children.

### Staffing levels and caseload

- There had been a restructure in end of life care (EOLC) in the trust. This meant most specialist palliative care was provided by St Luke's and Saint Francis hospice staff, except in Redbridge where there was a dedicated community palliative care service. District nurses worked in integrated community teams (ICT) and were responsible for providing treatment and support to palliative and EOLC patients in the community.
- Staff in the ICTs told us staffing levels across community services had improved, but retaining staff was an issue. There were no specialist palliative care nurse vacancies and there had been no specialist palliative care nurse turnover in the previous 12 months.
- Most staff we spoke with told us they had sufficient staff to deliver appropriate end of life care. However, there were directorates based on borough

boundaries that experienced staffing challenges. For example, Waltham Forest ICT had a vacancy rate of 17% which was high. However, the trend was improving from a vacancy rate of 30% in 2016.

- The Waltham Forest community children's team told us they had a "lean period," in 2016 in regards to staffing due to staff on maternity leave and a member of staff on secondment. However, the team was fully staffed and had no vacancies in October 2017.
- Staffing levels in the Redbridge specialist palliative care team were in accordance with guidance produced by the Association for Palliative Medicine of Great Britain and Ireland, Consultant Nurse in Palliative Care Reference Group, Marie Curie Cancer Care National Council for Palliative Care, and the Palliative Care Section of the Royal Society of Medicine. This guidance recommends at least two whole-time equivalent community-based consultants in palliative medicine and at least five specialist palliative care nurses per 250,000 population.
- In Thurrock ICT there were six whole time equivalent (WTE) Band 5 nurse vacancies and one WTE health care assistant (HCA) vacancy. Basildon ICT had 14 band 5 nursing vacancies. Redbridge out of hours district nursing team had 0.5 WTE qualified district nursing vacancy and one HCA vacancy.
- Vacant shifts in ICTs were covered by the use of the trust's bank nursing staff.
- Staff told us staff left due to positive reasons, such as receiving a promotion. For example, we were told staff in Essex could move to the London boroughs and receive London weighting payments and this also acted as an incentive for staff to leave and take up roles with London NHS trusts.
- Staff at a focus group told us the board had introduced quality visits from the board for any services where the vacancy rate reached 30% or above, the visits involved board members looking at reasons for vacancy rates and reviews of caseloads.

## Are services safe?

- A consultant in palliative medicine worked 0.4 whole time equivalent (WTE) for the commissioned Redbridge specialist palliative care team. The consultant provided one session a week as strategic medical lead for end of life for NELFT.
- The acute trust and hospices provided 24 hour on call consultant cover for advice.
- Caseloads were discussed each morning and at evening handovers by all teams responsible for the provision of end of life care. The needs of each patient, details of new patients, changes both expected and unexpected to the patient's health or circumstances were discussed which then allowed an appropriate response to be planned from the most suitable member of staff.
- Staff in all areas we visited during the inspection told us they were busy, but they felt they had sufficient time to provide a meaningful and quality experience for their palliative and EOLC patients. Patients told us that with very few exceptions, staff were unhurried and willing to spend time explaining procedures and health issues with them.
- The Thurrock ICT team quarterly clinical audit report dated January to April 2017. We found 100% compliance with catheter insertion and catheter care.
- The trust had a lone worker policy that was known to staff. We visited different teams with a responsibility for delivering EOLC. We found each team followed the trust's lone working policy. The Redbridge out of hours ICT explained their lone worker policy and said they didn't have any difficulties contacting the manager or other members of staff in the evening.

### **Major incident awareness and training (only include at core service level if variation or specific concerns)**

- Major incident and winter management plans were in place. Senior staff had access to action plans and we saw that these included managers working clinically as appropriate, staff covering from different areas and prioritisation of patient need. Staff from all services told us they had business continuity plans. The plans documented a list of service contingencies, which, in the event of an emergency, would ensure continuity of service delivery.

### **Managing anticipated risks**



# 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:

- The trust had implemented the 'individual care plan' which was being used as a guide for the delivery of end of life care. We saw that treatment escalation, emergency healthcare plans and advance care plans were in place to support patients and those close to them in making decisions at the end of life.
- There was a commitment to working collaboratively to deliver joined-up care through multidisciplinary working. This was demonstrated through the trust's community services collaborating with hospice staff and staff from local NHS acute trust. There were established links with GPs and local nursing homes.
- The trust were rolling out 'essential to role' end of life care training to all relevant staff.
- Consent practices were embedded across teams providing end of life care.

However, we also found:

Some staff we spoke with told us they were not aware of any audit proposals in 2017, even though there had been an audit of 'do not attempt cardiopulmonary resuscitation (DNACPR) decisions in 2017.

## Evidence based care and treatment

- The trust used the NELFT individual care plan on caring for the dying patient and care planning document. The plan included identifying patients at the end of life, holistic assessment, advance care planning, coordinated care, involvement of the patient and those close to them and the management of pain and other symptoms.
- The individual care plan documentation was based on national guidance from sources such as the Leadership Alliance for the Care of Dying People, the Department of Health End of Life care Strategy, and the National Institute of Clinical Excellence (NICE).

- The individual care plan document had been implemented to replace the Liverpool Care Pathway which had been discontinued in 2014. This was in response to the Leadership Alliance for Care of Dying People following the Neuberger report on the Liverpool Care Pathway, which recommended that organisations develop person centred end of life care (EOLC) plans. The NELFT end of life care plan was originally piloted in Havering in 2015 and extended to all boroughs in 2016.
- Staff at the out of hours team explained how 'individual care plans' were based upon the priorities of care for the dying patient.
- The trust has implemented 'agile working'. This was an initiative providing community nursing staff with tablets for mobile working. Staff told us they could access the trust's policies and procedures as well as clinical guidelines from NICE and Royal Colleges whilst they were with patients in their homes.
- In June 2016, the trust had undertaken an audit of NICE (QS13) Statement 2: People approaching the end of life and their families and carers are communicated with, and offered information, in an accessible and sensitive way in response to their needs and preferences. This includes conversations about resuscitation.
- As part of the QS13 audit the trust audited inpatients with 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms. The audit found DNACPR forms were generally completed accurately, meeting the record keeping standard of having demographic details and NHS number on each form and correct GP details. However, the audit identified that there was no standardisation of DNACPR across NELFT. In response the trust had developed a universal DNACPR form.
- A member of staff accessed EOLC policies which were on a shared drive on the trust intranet. The three policies we viewed were: the 'Quick Reference Guide' for palliative care we found was in date, but due for review

## Are services effective?

in October 2017. We found the EOLC chaplaincy team strategy was out of date and due for review in June 2017, and the EOLC strategic group terms of reference were in date and due for review in April 2018.

- Staff from St Luke's Hospice told us the director of nursing had been supportive in sharing trust policies and procedures with the hospice, and this had enhanced joint working between hospice staff and the trust's staff.
- The trust had introduced a tiered package of training for EOLC. This was a three tiered model of training. The training packages on offer were based on best practice guidance from the Leadership Alliance for the Care of Dying People (2014), End of Life Care Core Skills Education and Training Framework (Skills For Health, 2016), Leading Change, Adding Value, a Framework for Nursing, Midwifery and Care Staff (NHS England 2016) NHS Constitution (Department of Health 2013).

### **Pain relief (always include for EoLC and inpatients, include for others if applicable)**

- We saw guidance available for staff on symptom management including the need for anticipatory prescribing of medication at the end of life. Patients who were considered to be in the last days/weeks of life were appropriately prescribed anticipatory medicines for these symptoms including pain.
- Patients we spoke with told us their pain was well managed and that staff were quick to respond to requests for additional medicines when pain occurred.
- The Redbridge specialist palliative care team supported patients by liaising with GPs and district nurses regarding best practice in relation to care and treatment including pain management.
- Mayfield inpatient unit staff used a pain scale which was widely used in the NHS as part of patients overall pain management plan for people with dementia.
- We observed district nurses and specialist nurses assessing patients' pain levels in the community and saw that they assessed the type and duration of pain as well as factors that made the pain better or worse.

- Where patients received pain relief medication through syringe drivers which delivered measured doses of drugs at pre-set times; all qualified nursing staff were trained in the syringe drivers use.

### **Nutrition and hydration (always include for Adults, Inpatients and EoLC, include for others is applicable)**

- During home care assessments we saw malnutrition universal screening tool (MUST) risk assessments were undertaken to identify patients at risk of malnutrition. Where required, food and liquid intake was recorded and patient weight was monitored.
- The 'individual care plan' document included an assessment of patient's nutrition and hydration needs and guidance about the patient's choice to eat and drink, also considering if they had swallowing difficulties.
- During the home visits we attended, we saw staff spend a significant amount of time during the visit reviewing and discussing the patient's needs including nutritional needs. All the patients and relatives we spoke with felt the patient's nutrition had been managed appropriately.
- There was a culture of meeting patients comfort requirements at the end of life and staff we spoke with were clear that nutrition and hydration needs were based upon the patient's view of their nutritional needs.

### **Technology and telemedicine (always include for Adults and CYP, include for others if applicable)**

- The trust had implemented a new mobile working system for use across community service that was aligned with the trust electronic records system used by community teams. This enabled staff to access patient records and communicate details of patient care in real time with other disciplines.

### **Patient outcomes**

- Staff we spoke with told us they were not aware of any audit proposals in 2017 although there had been audits of DNACPR, use of the 'care for the dying patient', and a baseline audit of dementia and EOLC in October 2016 and an audit of NICE quality standard (QS13) in 2017.
- In July 2017, the trust had undertaken an audit of the use of the SSKIN bundle, this is a five step resource pack for the assessment and prevention of pressure ulcers.





## Are services effective?

The audit was in response to findings from pressure ulcer root cause analysis which indicated that gaps in data quality in completion of the SSKIN bundle designed for pressure ulcer prevention may have contributed to harm to patients. However, the audit found overall the SSKIN bundle was consistently being implemented across London. But, there were variations and weaknesses in the re assessment of patients once the bundle had been implemented. There was an action plan in place to address the shortfalls and a re-assessment of the SSKIN bundle was scheduled to take place in August 2018.

- The trust had undertaken a re-audit of EOLC planning in June 2016. The audit found conversations about end of life care were not routinely recorded in the patient records with omissions and poor care planning in general end of life care. For example, there was little use of the 'End of Life Care Plan for the Dying' a year after its introduction. In response the trust had produced an action plan and had introduced a new 'individualised care plan'. We saw that all the patients we visited had 'individualised care plans' in place.
- The action plan outlined the need for presentation of the findings of the audit to district nursing leads across London and a thorough consultation with district nurses on the use of an end of life care plan in NELFT to engage them in how they could move forward in achieving the priorities for care.
- We found the trust were addressing actions identified in the audit. For example, district nursing staff had been consulted in regards to the EOLC strategy. There was a revised 'care for the dying' leaflet for relatives and significant others.
- Staff at Waltham Forest told us they were unable to complete national EOLC audits due to a lack of specialist palliative care nurses. Staff told us the lack of specialist palliative care nurses was on the local risk register.

### Competent staff

- The trust had introduced an 'End of Life Training Programme' in 2017. We viewed an action plan for the training rollout in 2017. We saw that the trust were on target to meet the actions identified in the plan in the required timescales.
- The EOLC training was split into three tiers of training. Trust staff were in the process of completing the level of training appropriate to their role. All staff completed tier one training. Community nursing staff band 2 to band 8, with limited contact with EOLC patients, completed tier 2 training, Nursing staff band 2 to band 8, with lots of contact with EOLC patients, completed tier 3 training. All community nursing staff completed tier 3 training.
- Specific training courses were designed around the needs of different staff groups, for example newly qualified nurses and health care assistants. Feedback from healthcare assistants included comments around the value of specific practical aspects of care such as symptom control and supporting the spiritual and emotional needs of patients and their families.
- The education lead for the trust told us work was in progress for a roll out of 'difficult conversations' training to staff across NELFT.
- Essex had EOLC facilitators who supported the generic workforce to provide care at the end of life by providing an expert resource for health and social care professionals. This included visiting patients to discuss end of life care if the attending staff did not feel confident or competent to discuss these issues.
- The EOLC facilitators supported staff in advance care planning, including preferred place of care and DNACPR. The facilitators provided education and support for health and social care staff supporting initial facilitation of gold standards framework (GSF) meetings and providing education and support around advance care planning including the DNACPR process. However, staff in Redbridge told us they did not have an EOLC facilitator and the team felt disadvantaged. A member of staff from a hospice told us there was a difference in the quality of patient experience where staff had access to an EOLC facilitator.
- Members of the specialist palliative care team had specialist training in palliative care including degree modules. In addition, the palliative care nursing team had completed advanced communication skills training or were scheduled to attend.
- The out of hour's team manager had completed a university module on palliative care symptom control.

## Are services effective?

- A health visitor at Waltham Forest community children's team told us they had completed a university training module in the care of children with life limiting conditions. All qualified community children's nursing staff had completed training in syringe drivers.
- All staff we spoke with told us they had received an annual appraisal and we were told that training and development plans were aligned to this process. Staff across the trust attended clinical supervision sessions.
- Staff told us the trust training was good and they were very positive about the trust supporting them to attend. However, some managers told us most training was at the trust headquarters. This meant some managers could only release staff one at a time, due to the travelling time involved in staff getting to the trust's headquarters. Managers told us they sometimes struggled to ensure all staff received update training. The managers told us they thought basic life support training should be offered at each borough to enable a number of staff to attend the same session.
- Staff in Thurrock ICT told us the team were taking newly qualified Band 5 nurses. Newly qualified nurses were supported with preceptorship, based on a local acute trust's preceptorship model and involved newly qualified nurses being closely supported by an experienced community nurse mentor.
- Staff in Thurrock ICT had received 'advanced communication skills' training from specialist palliative care staff at St Luke's hospice to enhance their skills in communicating with patients. Staff had also attended a two day palliative care course which was delivered by the hospice staff.
- Nursing staff in Essex had received advanced care planning training from the specialists palliative care staff at St Luke's hospice.
- All qualified nursing staff band 5 to band 8 were trained in syringe drivers. This included both classroom based training and competency assessments.
- Some band 6 to band 8 staff had completed verification of expected death training. This included classroom training, competency assessments, and completion of a workbook.
- Staff at Thurrock ICT had attended a 'Dying Matters' awareness week in May 2017. This had involved link nurses producing information for staff on EOLC. For example, how to speak with patients and families about end of life care.
- We viewed the schedule for a two day EOLC workshop which was being rolled out between August 2017 and April 2018. The trust expectation was that all community staff would attend a workshop. The workshop would cover legal aspects of EOLC, spiritual needs, advanced care planning, and communication skills.
- The trust was also rolling out 'sage and thyme' workshops commencing in July 2017, these were workshops which specifically addressed communication skills in EOLC. Some of the staff we spoke with told us they had attended the workshops.
- Waltham Forest Children's Community Nursing Team had link nurses for EOLC. Staff told us EOLC was a small part of children's services remit. Staff had also received training in EOLC from staff at a London children's hospital on EOLC.
- Staff at the out of hours team told us they had always had any request for training approved. Staff told us they could access extra training as long as it was relevant to their role.

### Multi-disciplinary working and coordinated care pathways

- The specialist palliative care team had worked closely with community services, including GPs, district nurses and the community palliative care team at St Luke's Hospice.
- The community teams attended a weekly specialist palliative care multi-disciplinary team (MDT) meeting. The MDT meeting was attended by staff from a variety of disciplines including medicine, nursing, physiotherapy, social work, occupational therapy, psychology services and the chaplaincy. Staff told us the MDT promoted positive links between the services. The electronic record system in Essex was also an effective link between community colleagues and local GP practices that used the same system.
- Staff had worked on a pilot project with staff from an acute trust and staff from St Luke's Hospice 'Hospice at Home' team on a project of removing patients tubes at

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home in the final hours. Staff from the hospice told us the pilot had been successful as a result of the joint working between the NHS staff and staff from the hospice.

- Thurrock ICT attended all gold standards framework meetings (GSF) at local GP surgeries. GPs, St Luke's Hospice and the ICT team used the same electronic records systems; this facilitated electronic communication between the services and sharing of patient information where patients consented.
- Barking and Dagenham staff had supported all care homes in the area with clinical commissioning group (CCG) funded GSF training, as well as supporting two care homes to achieve GSF accreditation.
- MDT working was an integral part of the aims and objectives of the specialist palliative care team. Members of the specialist palliative care team participated in MDT meetings and worked with other specialists and district nurses to support patients end of life care across the community.
- Senior managers told us there was a long-term conditions meeting which identified patients who were in need of palliative care. The meeting informed the patients GP that the patient had been identified as needing palliative care. Staff told us the trust were working with GPs due to having identified inconsistencies in GPs approaches to integrated EOLC working.
- Thurrock ICT district nurses were aligned geographically to GP practices. All district nurses were also linked to a specific residential care home to promote continuity of care for patients.
- Waltham Forest Children's Community Nursing team staff worked closely with staff from Haven House and Richard House children's hospice staff, and had been involved in joint training with hospice staff.
- Staff at Saint Francis Hospice told us where directorates had EOLC facilitator in place communication was improved. Staff at the hospice said EOLC facilitators at the trust were key in driving the EOLC improvement agenda.

### Referral, transfer, discharge and transition

- The trust had a rapid response assessment service (RRAS) for palliative care. The primary aim was to introduce a community-based service that would work between hospital and community provision to enable patients at the end of life to stay in their place of choice and access specialist input. Other aims included preventing avoidable admissions to acute care and assisting rapid discharges from acute hospitals.
- Patients were referred and transferred appropriately. The planning of discharge to an alternative place of care was an MDT process, which included the input of hospital and community staff, as well as support agencies who were involved in providing end of life care to patients at home.

### Access to information

- Directorates had different electronic patient record system (EPRS) across community. Services in Essex told us EPRS facilitated co-ordination and integration of care, eliminating and improving data collection. However, staff in London told us EPRS was not linked to GP practices and didn't facilitate data collection.
- The trust had implemented 'agile working.' This involved staff being equipped with mobile working devices in the form of a tablet computer. Staff could access patient electronic records whilst on-site at patients' homes. This meant other trust staff would have rapid access to the most current patient information. Staff could also use the devices to access trust policies and procedures whilst on home visits.
- The 'individual care plan' document provided a clear guide to clinical staff in the assessment and identification of patients' needs. Information was recorded in a clear and timely way so that all staff had access to up to date clinical records when caring for and making decisions about patient care.
- Paper based records were held in people's homes so that everyone had access to records that were needed. Care plans and medicine administration records were kept in people's homes.

### Consent, Mental Capacity act and Deprivation of Liberty Safeguards (just 'Consent' for CYP core service)

- The trust had developed a 'do not attempt cardiopulmonary resuscitation' (DNACPR) form based

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upon the Resuscitation Council model form. These record patients' decisions in regards to resuscitation. Both Essex and London had a recognisable DNACPR which was transferable across acute, ambulance and community services. However, staff at Waltham Forest told us they had different arrangements, as separate DNACPR forms were required for acute and community services due to Waltham Forest having acute care provision from a different NHS trust.

- Patients DNACPR forms were held in their homes, this had recently been introduced for all teams.
- Where DNACPR forms were in place, we saw that the patient was involved in discussion about the decision where they had capacity to make decisions, or that an assessment of their capacity had been recorded in their medical notes and decisions were made in their best interests.

- Staff at Waltham Forest community children's team were aware of Gillick competence, in medical law this allows children and young people, who are able, to consent to their own medical treatment without the need for parental consent or knowledge. However, staff told us they would always involve families in end of life care decisions.
- We viewed assessment documents for patients identified as being at end of life. We saw prompts for guidance for staff to follow in relation to best interest decisions for patients who did not have capacity to make decisions about care and treatment, including in relation to nutrition and hydration.
- The specialist palliative care team and integrated community teams completed consent and mental capacity act training as mandatory training.

# 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:

- Feedback from people who used the service and those who were close to them was positive about the care received by patients nearing the end of life. We saw that staff were motivated to meet patient's needs.
- Staff demonstrated compassionate care to patients and their families. We observed a commitment to providing care that was of a consistently good standard and focused on meeting the emotional, spiritual and psychological needs of patients as well as their physical needs.
- Partnership working with patients and those close to them was evident. There were systems and processes embedded to record patients' wishes relating to their treatment and care and advanced care planning. End of life care services provided additional support to families and consistency to patients and families who were facing stressful life events.
- There was a visible person-centered culture. Staff were highly motivated to offer care that was kind and promoted people's dignity. Relationships between people who used the service, those close to them and staff were caring and supportive. These relationships were valued by people and their families.

## Compassionate care

- We attended six home visits during our inspection; we saw staff consistently treating patients with compassion and kindness.
- Patients were treated with dignity, kindness and compassion. Patients and relatives we spoke with told us that staff were professional, supportive and kind. We observed care being provided and saw that patients were treated with compassion, dignity and respect. Staff told us they "go the extra mile" for patients at the end of life. For example, staff at the Thurrock ICT told us about a band 6 nurse who had worked out of their normal

hours to pick up equipment for a patient. Staff also told us they had attended patient funerals in their own time as this was important to both families and the staff who had provided care for the patient.

- A patient told us about the support they had received from the team. They told us the team was always available and would respond to any request or get in touch with the right person who could resolve the problem. A typical response from a palliative care patient in the community was, "the communication from the district nurses is fantastic. They do what they say they will do and always get back to us within a couple of hours if we contact them. Just wonderful."
- We observed staff caring for patients in a way that respected their individual choices and beliefs and we saw that records included sections to record patient choices and beliefs so that these were widely communicated between the teams.

## Understanding and involvement of patients and those close to them

- We saw that nursing staff spoke with patients about their care so that they could understand and be involved in decisions being made. Patients and relatives all told us they had been fully involved in the care provided and had a clear understanding of what was happening at all times. Patients told us that their medication and treatment had been explained to them, including any possible side effects and the benefits they might see from taking medication.
- We saw a district nurse explaining a patient's agreed plan for symptom management. For example, the district nurse explained the role of the palliative care consultant in managing the patients' symptoms and the role of the occupational therapist (OT) in the provision of equipment.
- Patients preferred place of care and their individual choices and preferences featured as a primary focus when planning care. We saw that the 'individual care plan' document used by the trust included prompts to assist staff talking through key issues with patients and their relatives. For example, one patient's preferred

## Are services caring?

place of care record noted that the patient was aware that they were receiving palliative care, “but doesn’t want to think about their preferred place of care at the moment.”

- There was evidence of patients and/or their relatives being involved in the development of their care plans. For example, we saw advanced wishes were discussed with patients and their relatives and recorded within the care plan.
- The trust EOLC patient experience report dated August 2016 to July 2017 recorded 99% of patients found staff introduced themselves to patients when they met.
- In the same survey 98% of patients responded that they felt they had been involved in their care as much as they would have liked.

### Emotional support

- Staff told us they felt they had the time to spend with patients and provide the emotional support to meet their needs.
- Throughout our inspection, we visited patients at the end of life care in their homes and in inpatient areas. We saw that staff were polite and courteous; patients appeared genuinely pleased to see staff and in respect of home visits.
- We asked staff if they assessed relatives’ emotional needs prior to the patient’s end of life. Staff told us that when the nurse met the patient for the first time, they undertook an assessment of the emotional needs of family members using a pre-bereavement checklist. This allowed the nurse to determine what level of support might be needed in the post bereavement stage.
- Throughout our inspection we saw that staff were responsive to the emotional needs of patients and their relatives. The palliative care team, the trust chaplaincy, local registered charities, clinical psychologists and psychiatrists were all available to provide appropriate psychological support to patients, relatives and staff.
- Bereavement support was provided by St Luke’s and St Francis Hospices and the Margaret Centre for relatives of patients in the community. The specialist palliative care team informed us that emotional support was also available from the trust chaplaincy upon request.
- During home visits we saw nurses take an active interest in the patient’s social needs and made suggestions to assist patients to engage in social activities even when the symptoms of their illness may have restricted them.



# 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 requires improvement because:

- Staff at Mayfield inpatient unit had piloted the provision of EOLC in a rehabilitation focused inpatient unit. However, staff felt they had not been fully prepared for the palliative care remit.
- Waltham Forest told had the worst results in England in the national care for the dying audit 2016, for patients achieving their preferred place of care at the end of their life.

However, we also found:

- Community end of life care services were responsive to the needs of individual patients and to the needs of the local community overall. The trust had partnership working with local hospices and local NHS acute trusts.
- Specialist support was available seven days a week from specialist palliative care consultants and specialist nursing services.
- The trust were developing pathways of care to provide care that met people's individual needs.

## Planning and delivering services which meet people's needs

- Staff told us the end of life care (EOLC) strategy was in the process of being rolled out alongside a revised service delivery model. Staff were very clear that the key priority was ensuring patients were cared for in their preferred place of care wherever possible. Staff told us the trust had completed a lot of work in regards to the planning of EOLC services in the previous 12 months. This included restructuring, outsourcing and training packages for staff.
- The directorates were based on geographical borough boundaries. Staff told us care provision was different in each directorate depending on the commissioning arrangements in each borough.
- The trust had restructured EOLC services in 2017. This had resulted in services provided by external consultant led specialist palliative care hospice providers. St Luke's Hospice were in the process of becoming the lead

provider for NELFT EOLC services. This had led to a reduction in the palliative and EOLC services the trust provided directly. Most of the trust's community EOLC remit was delivered by district nurses in integrated community care teams. However, the trust's community nursing teams worked closely with medical and clinical nurse specialist staff from the hospices.

- There was a three year pilot with Saint Francis Hospice and Redbridge clinical commissioning group (CCG) to provide a new model of EOLC. This included enhanced district nursing services 24 hours a day, seven days a week, Hospice at Home services until 9.00pm, and clinical nurses specialists offering a second on-call service to support district nurses.
- Staff told us there were differences across the directorates in the way EOLC services were commissioned. For example, Waltham Forest did not have a specialist palliative care nurse. This meant staff at Waltham Forest did not have a specialist nurse with advanced skills in providing care for the dying patients. However, Redbridge had a specialist palliative care team. This meant that NELFT patients received different levels of specialist care dependent upon their postcode.
- As a result of the restructure all district nursing teams were remodelled as integrated care teams (ICT). These teams offered district nursing and therapy services to mainly housebound patients or patients in residential care homes. Staff told us the restructure had not effected EOLC provision as the model of care had remained the same and was based on the 'priorities of care for the dying.' Most staff we spoke with were positive about the integrated team model saying that it improved joint working between nursing and therapy staff.
- Staff told us it was easier to monitor service delivery in Essex than it was in London. Staff said this was due to Essex and London using different electronic systems and analysts finding it easier to collate information from the system used in Essex than the system used in London.
- Essex had two EOLC facilitators based in Basildon and Brentwood. The facilitators had recently transferred to

# Are services responsive to people's needs?

St Luke's hospice, as part of the hospice commissioning services. The facilitators acted as a resource to support the generic workforce in the provision of care at end of life. This included supporting and promoting the advance care planning process for people approaching end of life and advocated the use of the National End of Life Care Tools as recommended in the Department of Health End of Life Care Strategy, 2008.

- St Luke's Hospice provided a day hospice offering patients the opportunity to attend on a weekly basis while living in their home environment. In addition, patients could be seen by a palliative care clinical nurse specialist or palliative medicine consultant at home.
- Mayfield inpatient unit piloted the provision of one EOLC bed. The pilot of the hospital providing palliative care commenced in February 2017 in collaboration with the specialist community palliative care team. However, staff said they felt that Mayfield inpatient unit had not been fully prepared for the palliative care remit. Although staff said they had only provided the service to two patients and thought service delivery would improve as staff developed their understanding of palliative care provision.
- Marie Curie operated a night sitting service that was available for the last two weeks of a patient's life. The service operated between 10pm and 7am. Marie Curie also offered a sitting service in care homes. We were told that nurses were also sometimes available on request from Marie Curie, but not always. Staff told us the Marie Curie service was essentially to enable relatives to have a break. St Luke's and Saint Francis Hospices also provided an overnight sitting service for the last two weeks of a patient's life and would also go to residential care homes to provide the service.

## Equality and diversity

- Equality and diversity training was delivered to all staff as part of their induction to the trust.
- Staff told us the trust's communications team would produce information on request for patients who did not speak English as a first language. Staff told us they could also access a telephone interpreting service for any language patients may speak.
- Specialist palliative care teams and integrated community teams provided information for patients

and their families when patients came into their care. Guidance leaflets and information about health issues relative to people's diagnosis were available. Written information was available for patients and their families and although these were written in English, staff were able to obtain the information in other formats such as large print and audio as well as in different languages.

- The 'individualised care plan' included the assessment of patient's spiritual needs.
- Work was in progress on a NELFT EOLC conference for autumn 2018 'Different Endings' – to be facilitated by EOLC facilitators. The conference was intended to showcase and draw on the expertise of NELFT staff on the EOLC pathways for minority groups, to include non-cancer, travellers, dementia, secure units, homeless people, and lesbian, gay, bisexual, and transgendered and transsexual patients (LGBT).

## Meeting the needs of people in vulnerable circumstances

- Community services provided access to support and advice for caring for patients living with dementia and learning disabilities with the availability of the learning disability nurse and the community dementia services.
- Staff told us information was available in 'easy read' format from the trust's communications team and this would be provided on the same day a request was submitted via email.
- Personalised, 'individual care plans' ensured that care met the needs of the individual at the end of life.
- Emergency health care plans, treatment escalations plans and advance care planning were all seen to be in use. The wishes, choices and beliefs of individuals were seen to be incorporated into all plans and we saw evidence of recorded discussions with patients and their families about their care at the end of life. For example, Thurrock ICT told us they tried to respect patients preferred place of care decisions as much as possible, including supporting families in the last days of a patient's life.

## Access to the right care at the right time

- There were pathways in place to ensure EOLC patients were referred to appropriate services. In Havering, specialist palliative care services were referred to Saint



# Are services responsive to people's needs?

Francis Hospice, the pathway included patients who consented to onward referral who required a specialist services due to complexity of need, either at home or via a hospice bed. In addition, day hospice was available to patients at St Luke's Hospice. Patients also had access to Hospice at Home. Thurrock referred patients to the palliative care team at St Luke's Hospice. St Luke's

- Redbridge specialist palliative care team received referrals from any appropriate provider via specialist palliative care referral form which would be sent by NHS mail, secure fax or post.
- Across both Essex and London staff told us EOLC patients were prioritised. Staff told us most referrals were from GPs or the acute hospital. Staff told us district nurses prioritised end of life care patients and would see them on the same day. For example, referrals in Thurrock ICT went through the 'Thurrock First' which was a joint integrated single point of access service between the local authority, NELFT and another Essex based NHS trust. Patients were referred to the Thurrock ICT where they were triaged. Patients would then receive an initial assessment visit from ICT staff. Staff told us the team had a two day response rate to referrals from the single point of access, but EOLC patients would be prioritised and visited on the same day.
- Waltham Forest referrals were via a GP or the single point of access. EOLC patients were referred to the specialist palliative care nurses based in a local NHS trust hospital. In Basildon, specialist palliative care was provided by an NHS trust hospital team
- The Redbridge specialist palliative care team responded to referrals from consultants, GPs, community staff and acute hospital staff on the same day or the following day if the referral had been submitted in the latter part of the day.
- Staff in the out of hours team told us work was in progress on producing formalised pathways for EOLC referrals, as the current method of referral was by telephone or fax.
- Of the total number of palliative care patients known to community services, 76% of patients in Havering were referred to specialist palliative care services provided by Saint Francis Hospice. In Redbridge 25% of patients were referred to specialist EOLC services. Following our inspection the trust informed us that this was due to

Redbridge district nursing services managing most of the uncomplicated palliative cases, and 25% representing the complex EOLC patients who were referred to Redbridge community palliative care team.

- The Redbridge specialist palliative care team provided a seven day 9am to 5pm service. Out of hours was covered by the Saint Francis hospice telephone advice service and Redbridge evening and night district nursing service. The team engaged with patients as early in their treatment as they could to make the initial assessment and liaise closely with GPs, district nursing teams and other health providers in an advisory and support capacity. They provided a range of interventions both in people's homes and in community settings.
- Specialist support was available with hospices and hospitals operating a 24 hour service. Across the trust there were palliative care consultants on call service seven days a week together with 24 hour palliative care helplines.
- Out of hours services were provided trustwide by district nursing teams. These were supported by Saint Francis Hospice specialist community and crisis support service. In Waltham Forest out of hours patients were supported by medical and clinical nurse specialists at the Margaret Centre. Overnight nursing was provided by Marie Curie nurses. In Barking and Dagenham out of hours services were provided by district nurses.
- Waltham Forest children's services did not provide an out of hour's service due to the small number of children receiving EOLC. However, care was provided out of hours where syringes driver changes were needed on an ad hoc basis where the team felt it was appropriate.
- The trust EOLC patient experience report dated August 2016 to July 2017 recorded 97% of patients found it easy to get care, treatment and support from EOLC services.
- Staff told us the CCG, acute trust, and community services had responded to patients place of care issues. Staff told us it had been recognised by the clinical commissioning group (CCG) and local NHS acute trust that action was needed to improve. As a result there was a trust initiative to work with GPs and care homes in Waltham Forest to improve patients receiving their preferred place of care. This included the local acute NHS trust offering enhanced training packages to care

# Are services responsive to people's needs?

home staff. The CCG had also introduced an EOLC 'task and finish group,' to improve communication between the local NHS acute hospital, community health staff and social care providers.

- We requested the percentage of patients across directorates who achieved their preferred place of care. In Thurrock the preferred place of care was being recorded; however, the level of reporting was low as the electronic patient record system did not offer the option of recording this data. Between July 2016 and June 2017 3432 patient deaths were recorded in Thurrock in the period and 16.7% of these had either their preferred place of care or preferred place of death recorded.
- We viewed a dashboard recording the percentage of patients who achieved their preferred place of death for the specialist palliative care team. The dashboard did not provide an overall figure. However, between April 2016 and March 2018 18% of patients died in a care home, 7% in a hospice, 27% died in hospital, 5% were recorded as "null" (this was 23 patients), 0% were recorded as "other" (this was one patient), 42% died in their own home, and 1% died in a voluntary hospice (six patients).
- In Barking, Havering and Redbridge ICT between April 2016 and March 2017 an average of 86% of EOLC patients died at home, with 100% of EOLC patients in Redbridge dying at home in the period.
- Staff in Waltham Forest told us the service had the worst results in the country in the national care for the dying audit 2016, for patients achieving their preferred place of care at the end of their life. However, staff told us these results had been skewed due to staff not recording when a patient was receiving EOLC on the system. As a result the trust had adapted their electronic system to ensure staff had to complete a tick box to identify preferred place of care data and palliative care discussions with patients. Staff also said there was a

rapid turnover of staff in care homes in London and this had exacerbated the issue, as care home staff would refer patients to the acute trust if the patient began to deteriorate. Staff said they did offer to support and train staff in care homes, but often found staff they had trained had left soon after the training and new care home staff had been recruited. Hence, the care home staff lacked confidence in caring for patients in their final days and hours and would refer patients to the acute trust.

- The trust told us they acknowledged preferred place of care recording was an area for improvement and confirmed the trust were addressing the issue of reporting through the EOLC strategic plan. This included any failures to meet preferred place of care or death being captured within patients clinical records as well as discussions with family members or those close to the patient.

## Learning from complaints and concerns

- Staff at the specialist palliative care team told us very few complaints were received by the team.
- Between July 2017 and October 2017 there had been four complaints relating to EOLC across community services. All complaints had been dealt with in accordance with the trust complaints policy and timescales. Two of these complaints related to patient care, one complaint related to multidisciplinary working, and one complaint related to a delay in out of hours provision of care.
- Complaints and concerns were listened to and learning was used to improve services. For example, the trust had introduced an EOLC newsletter to share learning from EOLC complaints across community services. We viewed the first edition of the newsletter and this carried a case study of a complaint regarding staff communication.

## 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:

- There was a vision and strategy that focused on the early identification of patients at the end of life, patients being cared for in their preferred place of care, and the use of partnership working to develop services.
- There was end of life care representation and leadership at trust board level.
- There was comprehensive leadership within the palliative care service with clearly defined leadership roles. The director of nursing was passionate about the service and encouraged staff to deliver high quality end of life care (EOLC). Local managers were proactive in regards to EOLC and demonstrated an understanding of the issues facing EOLC services.
- Staff appeared to have respect for each other within teams.

However, we also found:

- Some staff told us they didn't feel connected to other teams across boroughs and there were very few opportunities for staff to meet with staff from other directorates across Essex and London to share learning.
- The trust had introduced a new end of life care (EOLC) strategy which aimed to meet patients' needs through direct care, advice, information and education, enabling patients to die in their place of choice. However, across community services staff told us the EOLC strategy was relatively new and teams needed time to embed it.
- Some local managers we spoke with were unaware that there was a specific risk register for EOLC.

### Service vision and strategy

- The trust's EOLC strategy's purpose was to ensure there was a shared vision for end of life care for both adults and children, and to outline what the trust aimed to

achieve between 2016 and 2021. The strategy was designed to work with trust partners in diverse communities to deliver the best possible joined up and personalised care for people.

- The end of life strategy aimed to identify all patients with palliative care needs and ensure those needs were met through direct care, advice, information and education, provide a comprehensive, joined up palliative care service to patients and their families in all settings, enable patients to die in their place of choice, offer emotional and practical support to patients, carers and family members and to provide specialist input where needed. However, local managers and staff told us the EOLC strategy was relatively new and teams needed time to embed it.
- The trust was clear that they were committed to providing EOLC in the patient's place of choice. Teams worked with other departments, such as district nursing, psychology and other palliative care providers to deliver care and provide patients with a seamless service. Palliative care providers included St Luke's Hospice, Saint Francis Hospice and the Margaret Centre. However, senior managers told us some directorates were still disjointed and acknowledged that the EOLC strategy was a work in progress. For example, staff at Mayfield inpatient unit told us they were aware that there was an EOLC strategy, but said there had not been any groups at Mayfield inpatient unit where the strategy had been explained to staff.
- In Waltham Forest, a gap analysis was completed in 2017 by all EOLC stake holders in partnership with a private company. A model for integrated EOLC had been designed and work was in progress on sharing the model with all organisations involved in EOLC including the acute hospital with a view to the model being adopted across Waltham Forest services.
- This strategy was based on the 'Ambitions for Palliative and End of Life Care; A national framework for local action', the 'Five priorities for the care of dying people'

## Are services well-led?

and 'Together for short Lives – standards framework for children's palliative care 2015'. The principles of the strategy spanned both adult and child pathways for EOLC.

- The strategy was underpinned by a vision of 'providing the best care at the end of life by the best people.'
- A palliative care strategy group was in operation to guide the trust in delivering effective palliative and end of life care. Membership of the group included key staff and representatives from a variety of specialities including medical representatives from hospices and acute hospitals. This helped to ensure that responsibility for end of life care did not solely sit with the specialist palliative care and ICT teams.
- The strategy group were responsible for driving the EOLC strategy, which included the rolling out of EOLC training across the trust. A directorate lead told us, "we need time to embed the strategy and time to focus on delivering quality outcomes for patients."
- Each directorate had a responsibility to feedback on EOLC in their borough to the trustwide palliative care strategy group.
- Senior managers told us the strategy was what bound EOLC services together across the trust.
- Staff were aware of the trust's overarching vision and this was consistently articulated by staff we spoke with.

### Governance, risk management and quality measurement

- The director of nursing lead EOLC strategically, reporting to the chief nurse, executive director, who was the EOLC executive lead on the Board.
- Operational services delivered EOLC within their respective directorates. There was an EOLC lead for each directorate who was a member of, and reported to, the EOLC strategy group.
- Weekly and monthly team meetings took place in all the teams we met with. Standing agenda items included incidents, complaints, and policy updates. Staff at all levels told us the meetings were a useful source of information and enabled learning to be passed across the directorate. We viewed minutes of meetings and saw that what staff had told us was reflected in the notes.
- Internal quality measurements included place of death data and use of other metrics including patient feedback and analysis of patient activity. Senior managers told us teams were benchmarked against national guidance such as priorities of care for the dying. Where directorates had an EOLC facilitator the facilitators had produced their own benchmarking for EOLC.
- The trust had a national clinical audit schedule in place for 2016 and 2017. We saw that audits had been completed or were scheduled to be completed.
- The trust had established a mortality review group which was aligned to existing learning from unexpected death governance meetings and exports. The purpose of the group was to methodically review cases of mortality as specified in the group's policy. The palliative care consultant attended the group.
- There was a specific risk register for EOLC. However, staff we spoke with were mostly unaware of a register for EOLC. Some local managers told us there were local risk registers and any risks including EOLC risk would be added to the local risk register. However, this meant the divisions could not monitor any themes relating to EOLC across all of community EOLC.
- The EOLC risk register identified 11 risks relating to EOLC. Three risks were assessed as moderate and eight risks were assessed as low. We saw that the risk register had been reviewed regularly and the dates for the next scheduled review were recorded. Any actions the trust had taken to mitigate risks were also recorded on the risk register. For example, the risk of not having a specialist palliative care nurse in Waltham Forest was on the risk register. Initially the risk had been rated as a high risk. However, this was downgraded upon review as actions had been recorded to mitigate the risk, including use of the out of hours GP for advice, support from staff at St Joseph's Hospice for advice, and the Waltham Forest EOLC champion to visit with the trust's EOLC facilitator. We spoke with the EOLC champion who confirmed they had visited with the EOLC facilitator and support from the facilitator was on-going.
- The service produced an annual EOLC report to the trust board. We viewed the report for 2016 to 2017. The report

## Are services well-led?

fed back to the board on progress with the EOLC strategy and identified key areas for improvement in 2017 and 2018. For example, and are for improvement was improved data capturing.

- Managers at a focus group told us risks were measured against the trust strategy. Staff told us risks were always discussed at local multi-disciplinary meetings.
- Staff at Waltham Forest community children's team told us EOLC was on the local risk register due to a lack of specialist EOLC nurses. However, this risk had been mitigated by staff receiving training from both the trust and staff at a specialist children's hospital in London on EOLC.

### Leadership of this service

- The director of nursing and personal assistant to the director of nursing managed operations and resources to deliver the end of life care (EOLC) service aims. The service leadership was responsible to the palliative care strategic group. The group included senior trust staff from related services.
- The director of nursing reported directly to the lead nurse for EOLC, who was the trust board representative for EOLC.
- Community team leads reported to the director of nursing. The director of nursing told us their remit was to ensure the trust had the highest standard of EOLC nursing in community services and to provide nursing leadership to the service.
- Staff told us they didn't feel connected to other teams across boroughs. Staff told us there were very few opportunities for staff to meet with staff from other directorates across Essex and London.
- The director of nursing was knowledgeable about the EOLC service and encouraged staff to deliver high quality care.
- Every directorate had an end of life lead that was either a band 8a, 8b or 8c.
- Staff told us they generally felt that the trust was committed to the ongoing development of EOLC services.
- Overall, staff told us directorate leads were visible and accessible. For example, two staff told us they had

breakfast on their birthday with the CEO. A team manager told us they had emailed the CEO and they had visited. However, another team manager said the board "tended" to visit when there were issues. A few staff also told us they would not recognise any leaders above their directorate leads.

- Most staff were positive about local leaders. For example, staff at Waltham Forest integrated community team (ICT) told us the team manager was pro-active and supportive. Staff in Basildon ICT told us, "we get great support from the team lead and managers."

### Culture within this service

- There was evidence that the culture of end of life care (EOLC) was centred on the needs and experience of patients and their relatives. Staff told us they felt able to prioritise the needs of people at the end of life in terms of the delivery of care.
- We found there was a disconnect between new staff and staff who had worked in their teams for a long period. Newer staff told us the corporate induction gave them a sense of identity and belonging with the trust. However, a few longer serving staff told us they had experienced a number of restructures and service changes and as a result they tended to identify with their teams rather than the trust. A member of staff described themselves as being, "change fatigued."
- Staff we spoke with demonstrated a commitment to the delivery of good quality end of life care. All ICTs had EOLC link nurses, these were staff with a specific interest in EOLC, who would attend meetings and extra training in EOLC and cascade this back to their teams.
- Most staff told us that monthly team meetings were held in which staff were able to contribute their views or concerns. Most staff reported being proud of the service, their teams and their jobs.

### Public engagement

- The trust EOLC patient experience report dated August 2016 to July 2017 recorded that 98% of patients thought the EOLC service met their expectations.
- We viewed the executive summary from the Patient Experience Annual Report dated 25 October 2016. This



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recorded actions the trust were taking in regards to monitoring patient experiences of trust services. There was a patient experience strategy which was mapped to the strategy's key principles.

- Patients could volunteer to support the trust in a number of ways. For example, by joining the trust's patient experience group, becoming involved in interviewing new staff candidates, and become involved in consultations on trust policies.
- Each month a senior member of staff from each service contacted a minimum of five randomly selected patients/ carers by telephone to ask them five key questions about their experience of care.
- A carers' representative for Havering was a member of the strategic end of life group to ensure carers' views were heard. There was also a patient representative in the group to ensure patients were engaged and involved in the design and running of services.

### Staff engagement

- Overall, staff told us there had been improvements in senior and middle managers engagement with staff.
- The trust had launched an end of life care newsletter to share learning from serious incidents and complaints in EOLC with staff. We viewed the first edition of the newsletter and saw this covered communication with patients and learning from trust investigations into pressure ulcers. The newsletter had been emailed to staff. Staff told us the EOLC newsletter was intended to be a regular way of the trust communicating learning to staff.
- We spoke with directorate leads who told us the director of nursing and clinical director held regular staff

engagement meetings, which staff were encouraged to attend. We spoke with two staff who told us they had attended staff engagement meetings. Following our inspection the service informed us the EOLC engagement meetings were held to benchmark CQC standards and develop an improvement plan.

- Two new members of staff told us they had been visited by the CEO during their corporate induction and the CEO had asked for feedback on whether they felt the induction was an effective introduction to the trust.
- Waltham Forest community children's team had support in place for staff dealing with EOLC, this included team debriefings. Staff told us they had asked for ad hoc psychological supervision to be provided by the trust's psychological services. However, staff said psychological services had informed them they were unable to provide ad hoc sessions

### Innovation, improvement and sustainability

- The trust had invested staff time and energy in reviewing and formulating a new strategy for EOLC. Overall, staff were positive about the trust's EOLC strategy and told us they welcomed the trust's initiatives, but, some staff recognised the strategy was a work in progress and staff told us it needed time to become embedded.
- The trust had developed a tiered package of EOLC staff training which was being rolled out across community services.
- District nurses had received training on the use of a magnet to deactivate implantable cardioverter defibrillators (devices fitted under the skin which regulate abnormal heart rhythms) in the home environment for EOLC patients.