

Cambridgeshire Community Services NHS Trust

RYV

End of life care

Quality Report

North Cambridgeshire Hospital
Princess of Wales Hospital
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This report describes our judgement of the quality of care provided within this core service by Cambridgeshire Community Services NHS 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 Cambridgeshire Community Services NHS Trust and these are brought together to inform our overall judgement of Cambridgeshire Community Services NHS Trust

Summary of findings

Ratings

Overall rating for Cambridgeshire Community Services NHS Trust	Good	
Are Cambridgeshire Community Services NHS Trust safe?	Good	
Are Cambridgeshire Community Services NHS Trust caring?	Good	
Are Cambridgeshire Community Services NHS Trust effective?	Good	
Are Cambridgeshire Community Services NHS Trust responsive?	Good	
Are Cambridgeshire Community Services NHS Trust well-led?	Requires Improvement	

Summary of findings

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Summary of findings

Overall summary

Cambridgeshire Community Services NHS Trust delivers community based services to people requiring end of life care and their families, throughout Luton, Cambridgeshire and Peterborough. It provides a range of end of life care services within different care environments including hospice, hospital and care in people's own homes. It also supports people who are being cared for in care homes.

We inspected the regulated activities:

- Diagnostic and screening procedures
- Nursing care
- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury

Services were generally safe. There were arrangements in place to minimise risks to people receiving end of life care and staff working alone in the community. Staffing levels were generally safe in the services we inspected, although staff working in the community often felt under pressure.

Care and treatment were effective, evidence based and focussed on the needs of people requiring end of life care. We saw good examples of collaborative working and innovative practice.

People receiving end of life care and their families felt well supported and involved with their care. They were able to make decisions relating to their treatment and where they wished to die. Staff were dedicated, compassionate, kind and caring.

End of life care services were responsive to people's needs. Services were accessible to people from all communities. We saw evidence of effective multidisciplinary team working to ensure people's end of life care needs were met without avoidable delay.

The service was generally well-led. There was effective decision making at local level, although there was no Trust-wide policy on caring for patients at end of life or after death. The Trust Board and senior managers had oversight of the reported risks and had measures in place to manage them. However, we found that these risks had been overlooked in relation to concerns we found in the mortuary at one hospital. As a result of our concerns, we judged the provider was not meeting Regulation 10, Assessing and monitoring the quality of service provision. We have asked the provider to send us a report that tells us what actions they are taking to meet this essential standard.

Summary of findings

Background to the service

Cambridgeshire Community NHS Trust was first registered on 1 April 2010 and delivers end of life care services throughout Luton, Cambridgeshire and Peterborough. A variety of community and inpatient services are delivered to patients requiring end of life care and their families.

Palliative care aims to achieve the best quality of life for patients and their families who are affected by life limiting illnesses. End of life care is an important part of palliative care and refers to the care of patients and their families throughout the last phase of their life. This could be a period of months, weeks, days or hours.

Palliative and end of life care services were delivered at Arthur Rank House Hospice, North Cambridgeshire Community hospital, Princess of Wales Community Hospital and within people's own homes. During our visit to the Cambridgeshire Community NHS Trust we inspected Arthur Rank House Hospice in Cambridgeshire,

Trafford Ward in Wisbech, the Hudson Macmillan Centre in Wisbech and Welney Ward in Ely. We also visited the mortuary at North Cambridgeshire Community Hospital, Wisbech.

Care is delivered by community GPs, hospital doctors, nurses, community nurses, specialist palliative care nurses health care assistants and allied health professionals.

The inspection team included a CQC inspector, an end of life care specialist nurse and an Expert by Experience. We spoke with four patients, nine relatives, 25 members of staff including nurses, health care assistants, therapists, chaplains, health care assistants and porters. We also spoke with nine members of the specialist palliative care team. We observed patient care and we looked at 11 sets of patient records. We also observed the care that nurses provided in the community.

Our inspection team

Our inspection team was led by:

Chair: Gillian Hooper, Director of Quality and Commissioning (Medical and Dental), Health Education England

Team Leader: Ros Johnson, Inspection Manager, Care Quality Commission (CQC)

The end of life care team included a CQC inspector, a specialist nurse and an expert by experience who was the carer of a person who had accessed end of life care services.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot community health services inspection programme. The focus of wave 2 is on large, complex organisations which provide a range of NHS community services to a local population.

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?

Summary of findings

- Is it well-led?

Before our inspection, we reviewed a range of information we held about the core service and asked other organisations to share what they knew. We carried out announced visits on 28, 29 and 30 May 2014. We also carried out an unannounced visit on 7 June 2014. We visited two community hospitals, a hospice, and saw how care was delivered in people's homes. We spoke with 13

people who used the service, or their relatives, and received comments from people who had attended a listening event prior to the inspection. We spoke with 25 members of staff.

During the visits we held focus groups with a range of staff who worked within the service, such as nurses, therapists and healthcare assistants. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who used end of life care services.

What people who use the provider say

All of the people we spoke with were very positive about the care and treatment they received. People felt safe using the service and they felt they were treated with kindness and compassion.

Good practice

Our inspection team highlighted the following areas of good practice:

- We found good multi-disciplinary team working throughout services providing palliative and end of life care.

- We saw that staff were enthusiastic, compassionate and committed to ensuring patients and their relatives experienced a good end of life care experience.

Areas for improvement

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

Action the provider **MUST** take to improve

- The provider must regularly assess and monitor the quality of all services provided, to include care after death, so as to protect people using the service and others who may be at risk.

Action the provider **SHOULD** take to improve

- The provider should have appropriate policies for staff to follow when supporting patients with end of life care or when caring for patients after they have died.

- The provider should ensure effective infection prevention and control policies and procedures in place in all areas of the service.
- The provider should ensure that staff are supported in escalating concerns and that incidents identified by contractors and external agencies are incorporated into the Trust's risk reporting.
- The provider should ensure that confidential records and papers are kept securely and can be located promptly at all times.
- The provider should ensure that staff are up to date with mandatory training.

Cambridgeshire Community Services NHS Trust

End of life care

Detailed findings from this inspection

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

Good 

Are End of Life Care Services safe?

By safe, we mean that people are protected from abuse

Summary

We found that services were safe. We saw that there were arrangements in place to minimise risks to people receiving end of life care and to community based lone workers. Staffing levels were generally safe in the services we inspected although staff working in the community reported they often felt under pressure.

There was awareness amongst staff to identify and consider serious incidents, incidents, near miss incidents and risks and what to do with that information. There were effective systems in place to learn from incidents and we saw that staff shared incidents so that learning could take place. There was consistency in incident reporting at ward level but we found some concerns over incidents that had not been reported in the mortuary.

Patient records were completed properly and generally stored safely, although in one location we found confidential papers and records in an unsecured and unused room. Overall, there were good standards of

cleanliness and infection control. However in one hospital these were not met in the mortuary. As a result of our concerns, the Trust took immediate action so that any risks were removed.

Detailed findings Incidents, reporting and learning

There had been no reported 'never events' within palliative or end of life care services between 2012 and 2014. Never events are classified as such because they are so serious that they should never happen.

The Trust had an up to date incident reporting policy which clearly outlined the arrangements for reporting, managing, analysing and learning from incidents. Most staff were clear and positive about reporting incidents and all of the staff we spoke with knew how and under what circumstances they should report incidents. Some staff were able to give examples of times when they had reported incidents and gave examples of lessons that had been learned as a result. For example, one staff member told us of an incident relating to the failure of a bed rail, leading to the injury of a patient. The investigation resulted in changes to the management of patients requiring bed rails. We could see

Are End of Life Care Services safe?

that a root cause analysis had been undertaken and that lessons learned had been detailed within an action plan. Most of the staff we spoke with told us they received feedback on the outcome of incidents they had reported.

Not all staff raised concerns when they should have done. One hospital had a small mortuary and we found concerns about the conditions there. We asked staff whether similar concerns had been raised previously and found that although some staff were aware of the issues and that external agencies had mentioned problems, these had not been escalated in the correct way. Staff working for sub-contracted services did not report incidents through the Trust's incident reporting system and the Chief Nurse did not know how any concerns they raised were incorporated into the Trust's risk reports.

Cleanliness, infection control and hygiene

The locations we inspected had effective infection control procedures in place at ward level. The ward areas within the hospice and the hospital were visibly clean and staff demonstrated a good understanding of infection control procedures. Personal Protective Equipment (PPE) in the form of gloves and apron was readily available and we saw staff wearing these when delivering personal care. We saw that staff adhered to guidelines relating to 'bare arms below the elbow' in clinical areas. Hand washing facilities were readily available and we observed staff washing their hands between interventions. The patients we spoke with told us they always saw staff wearing gloves and aprons and that they washed their hands regularly.

We observed that where patients were being nursed in isolation because of infection, staff followed infection prevention and control procedures. For example, we saw that patients were being nursed in a side room and that staff were using appropriate PPE on entering the room. We also saw that staff washed their hands before they left the room.

The Trust did not have a Trust-wide policy relating to the care of a person following their death and there was no transfer policy for deceased patients identified as having an infection. A member of staff with responsibility for transferring deceased patients to the mortuary could not adequately explain the procedure that should be followed in the event that a patient had an infection. This was a potential infection risk for both patients and staff.

One hospital had a small mortuary, where we found serious concerns with the standards of cleanliness and infection control. There was no effective monitoring of these standards. We were told the contractors were last in the building at least three weeks prior to our inspection. The refrigerated storage area was clean, but there were several areas in the mortuary that needed cleaning and repairing in order to minimise risk. We raised our concerns immediately with the Trust's Chief Nurse and the palliative care lead who assured us of immediate action taken to remedy the situation. When we visited unannounced ten days later we found the area had been cleared and the mortuary was closed, with alternative arrangements in place for managing deceased patients.

Maintenance of environment and equipment

We observed that the ward areas had sufficient moving and handling equipment to enable patients to be cared for safely. This equipment was maintained and checked regularly to ensure it continued to be safe for use. We saw that equipment was also clearly labelled to indicate when it was next due for a service. We checked the resuscitation equipment on the hospital ward and found it to be stocked in accordance to their check list.

The hospice and the wards we visited had access to specialist pressure relieving mattresses and equipment. These were being used appropriately according to patients' assessed needs. Resuscitation equipment was checked on a daily basis and trolleys were well stocked according to their checklist.

The Trust used ambulatory syringe drivers for patients who required a continuous infusion to control their symptoms and these met the current NHS Patient Safety guidance. This meant that patients were protected from harm when a syringe driver was used to administer a continuous infusion of medication because the syringe drivers used were tamperproof and had the recommended alarm features.

Medicines

Medicines were stored safely and pharmacy staff carried out regular safety audits. We spoke with pharmacist technicians who visited the inpatient areas regularly and replenished medicines as required. Medicines were stored at the correct temperature so that they were fit for use.

Are End of Life Care Services safe?

Controlled drugs (CDs) were managed according to legal requirements and emergency medicines were in date and fit for use. Keys for the medication cupboards and trolleys were always kept with the nurse in charge for the shift.

We saw that anticipatory medication [medicines that are prescribed just in case they are required] was prescribed appropriately. We reviewed Medication Administration Record (MAR) charts in the areas we visited and saw appropriate prescribing. Staff told us they were aware of the Trust's protocols for handling medicines and followed this so that risks to people were minimised. We found no discrepancies with the storage, recording or administration of medication. All of the medication we looked at was within its expiry date.

Detailed findings

The trust had policies and processes in place in relation to safeguarding adults and children and we saw that safeguarding procedures were clearly displayed. Staff told us they had received appropriate adult safeguarding training and were confident in reporting concerns. The Trust target was for 95% of staff to have undertaken adult safeguarding training; 94% of staff in the service had undertaken this training by the end of April 2014. There was a lead for safeguarding who staff could contact for guidance. The staff we spoke with were able to tell us who this person was and how they could be contacted.

The nursing and therapy staff we spoke with in the hospice and on the ward had a good understanding of the Trust's safeguarding policy. Staff were able to explain what constituted a safeguarding concern and the steps required to report such concerns. A member of staff working on one of the wards was able to give a recent example of when they had used the Trust's safeguarding policy. We looked at the documentation regarding this alert and were reassured that the alert had been raised and managed appropriately. This demonstrated that staff had a good understanding of possible safeguarding concerns and how those concerns should be escalated.

Records

All of the staff we spoke with told us they had received information governance training as part of their mandatory training, and that this training was refreshed annually. When we looked at information submitted by the Trust, we could see that only 54% of staff working in palliative care were up-to-date with their information governance training

by the end of April 2014. Information submitted by the Trust indicated that there had been five incidents between April 2013 and March 2014 concerning confidential information. This meant that confidential information had not always been protected.

In the ward areas, the Trust used paper records to record care planning, delivery and evaluation. There were additional electronic records which allowed sharing of key details about a person who is nearing the end of their life to ensure their wishes are upheld. This would include their preferred place of care and death. This meant there was a single place where all relevant information about an individual was recorded and shared with relevant people, so that care was better co-ordinated.

Paper records were stored securely in order to ensure they could not be accessed by people who did not have the authority to access them. In addition we saw that consent had been obtained to allow staff to keep some written records at the end of patients' beds and to share relevant information with other health and social care professionals as appropriate.

We looked at Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms within the hospice and the hospital ward and found that all had been completed in line with General Medical Council (GMC) national guidance. The forms indicated that the decision had been made and recorded by the appropriate clinician. We saw evidence that discussions around DNACPR had been undertaken as appropriate with patients and their families.

We saw that documentation was clear, comprehensive and was maintained in line with Nursing and Midwifery Council (NMC) guidelines. Care plans detailed on-going discussions with patients and their families and treatment plans were written up and maintained in line with patient choices. A multidisciplinary team (MDT) approach had been adopted and we could see that patient records had been updated by all members of the MDT. Charts were used to monitor a patient's general health and wellbeing such as food and fluid intake and skin condition. We saw that patients had been formally assessed and that charts were accurately completed. Staff therefore had an accurate assessments of a patient's condition, for example, if they were adequately hydrated.

We saw that where appropriate, the clinical nurse specialist had undertaken discussions in relation to preferred place

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for care and preferred place for death with patients and their families. Decisions were documented in the patient's medical records, discharge plans and their nursing discharge letter. We saw documentation in relation to on-going liaison with the district nursing team. When a patient was transferred home from the ward, the palliative care consultant also sent a discharge letter to the patient's GP.

In a part of North Cambridgeshire hospital we found confidential papers and records, some of which related to patient care in a room that was not secured. These records could be accessed by non clinical staff and contractors. We were concerned that there were not systems in place to ensure patient records remained confidential. When we visited unannounced ten days later we found that action had been taken to clear the records and papers from the room.

We also found that although there were systems in place to release deceased patients from the mortuary there were inadequate systems in place for recording the details of patients who had been transferred to the mortuary. We immediately raised our concerns with the Trust's Chief Nurse and the palliative care lead. We were assured that immediate action would be taken to remedy the situation. When we visited unannounced ten days later we found the mortuary was closed and there were alternative arrangements in place for the care of deceased patients.

Lone and remote working

Lone working policies were in place for staff working in the community and staff told us they followed them. All staff were aware of what they should do to keep safe when working in the community. Staff told us they carried a mobile alarm device that was linked to a call centre for emergencies. Staff also told us there was a procedure for checking in and checking out when they had arrived at and were leaving a patient's home. The computerised record system used by staff in the community had a mechanism for alerting staff about any potential risks when carrying out visits. Staff told us that if a visit was deemed to be a high risk, they would go in pairs rather than go alone. The staff we spoke with told us they had also received conflict resolution training. We saw that 71% of staff working in palliative care had completed this training.

Adaptation of safety systems for care in different settings

End of life care took place in different settings. Some patients were being cared for in their own homes, whilst others were being cared for in hospital or in the hospice environment. Teams operated local risk assessment protocols to reflect the type of service and where care was being delivered.

We found that systems were in place to monitor and respond to risk. We saw that staffing levels and skills mix supported safe practice in the areas we inspected. Risk assessments had been conducted to ensure staff and patient safety. The Trust had implemented The Quality Early Warning Trigger Tool (QEWT) in 2012. In all of the areas we inspected, managers were aware of local risks within their area and had raised these through the Trust's incident reporting system or through the QEWT.

Assessing and responding to patient risk

In line with the Trust's deteriorating patient policy, staff used a recognised early warning tool known as the Modified Early Warning Score (MEWS) to record patients' physiological observations. This was used as part of a 'track and trigger' system whereby an increasing score indicated escalation. On the wards we inspected medical and nursing staff were aware of the appropriate action to be taken if a patient scored higher than expected. We looked at completed MEWS charts and saw that staff had taken appropriate action and repeat observations were taken in the necessary timeframes.

Within the wards we visited, we saw there was NHS Patient Safety Thermometer (PST) information. This provided up-to-date information about the ward's current status relating to common avoidable "harms," namely falls, catheter acquired urinary tract infections, pressure ulcers and new venous thromboembolism's or blood clots (VTEs). This information was presented in a format that could be easily understood by the general public.

Staffing levels and caseload

We had no concerns about staffing levels in any of the locations we inspected. On the day of our inspection, the hospice inpatient unit and the hospital ward were calm and there appeared to be enough staff, of an appropriate skill mix to enable the effective delivery of care and treatment. Nursing numbers were assessed using a recognised tool. Staffing levels were clearly identified and displayed in the areas we inspected. Staff reported that although they were busy they were rarely short staffed.

Are End of Life Care Services safe?

We saw that there were vacancies for a full time and a part time nurse on the hospital ward we inspected. The sister on the ward told us these vacancies had already been filled. On the hospital ward, there was one registered nurse to ten patients, with the support of five health care assistants. In addition there was a clinical nurse specialist for end of life care based at the hospital, Monday to Friday, who could be called upon for specialist advice. Out of hours, ward staff could contact the hospice for support.

On the hospital ward, patients were seen once a week by a consultant. A GP with a specialist interest in palliative and end of life care visited the ward for two hours each day. There were also out of hours nurse prescribers on site. If medical advice was required out of hours, the nurses told us they could contact medical staff at the hospice.

At the hospice, there was 24 hour consultant cover, supporting a team of training doctors and there was a registrar or GP registrar present during weekdays. An out of hours consultant was available as well as doctors with specialist interest in palliative medicine. We were told there was an on call rota and a doctor could always be contacted out of hours. However, the therapists at the hospice expressed concern that due to their workload, patients sometimes had to wait longer than expected for their therapy. They said this was because they were undertaking general therapy interventions rather than the specialist interventions for which they had been trained.

We observed nurse handover in both the hospice and the hospital ward. The information given was holistic, pertinent and covered all aspects of patient care. Patients were referred to with dignity and respect and appropriate further actions were handed over to the in-coming shift of staff.

Deprivation of Liberty safeguards

Staff told us they received mandatory training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) and that this was refreshed annually. Data from the trust indicated that 82% of staff who worked in end of life care services had completed Mental Capacity Act training.

Staff understanding in relation to the MCA and DOLS was variable. Whilst some had in depth knowledge, more junior members of staff's knowledge was limited. However this was sufficient for their job role and they told us they would seek further guidance and information if required. We did not see any patients who were being deprived of their liberty [not being inappropriately restricted of their freedom] within any of the wards we visited throughout our inspection.

Managing anticipated risks

We saw the Trust had an electronic system for reporting risks. Risks were escalated to the Chief Nurse and reported to the board. This enabled the Trust Board to have an overview of the risks that might affect the safe running of the service. We looked at information relating to some risks that had been identified and could see that controls had been put in place to manage the risks. We could see that learning had taken place following serious incidents. This was being used to provide the Board with assurance that safe care was being delivered throughout palliative and end of life care services. We were told that there was no formal risk register for End of Life Care and that when required; risks were added to each unit or ward's risk register.

Major incident awareness and training

We saw the Trust had a major lock down policy for dealing with major incidents. Some staff had undertaken risk management training and the majority of staff had undertaken fire safety training. The staff we spoke with were aware of escalation procedures if a risk was identified.

Are End of Life Care 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

Overall services were effective, evidence based and focussed on the needs of people requiring end of life care and their families. We saw examples of very good collaborative work and innovative practice.

Staff were mostly up-to-date with mandatory training and effective clinical supervision arrangements were in place across the service, together with regular team meetings being held throughout the service.

Detailed findings

Evidence based care and treatment

We saw that the Trust did not have a Trust-wide end of life care policy or a care after death policy. We asked the Trust to tell us how staff providing end of life care were informed about the processes for delivering end of life care. We were told that although they didn't have an end of life care policy, they used their associated end of life care programme board, factsheets, initiatives and collaborative working with the five different palliative care teams to inform their practice.

We saw that care was based on the National Institute for Health and Care Excellence (NICE) quality standard for best practice within end of life for adults. The Trust had responded to the national withdrawal of the Liverpool Care Pathway (LCP) following an independent review and had developed their own personalised care plan for the last few days of life. We saw this was a holistic tool which promoted collaborative working and all aspects of planning and discharge, to enable people to be cared for and die in their preferred place. The personalised care plan for the last days of life was being piloted on three in-patient wards to ensure staff were familiar with it prior to the withdrawal of the LCP. We saw that there was clear guidance for using the care plan and that staff were encouraged to feedback any comments about the plan.

Pain relief

We did not observe any patients to be in pain throughout our inspection. We saw that patients were assessed for pain

and that pain care plans were in place. Pain was monitored on an on-going basis, although one relative we spoke with at the hospice told us they had to administer pain relief to their relative once or twice a day.

The specialist palliative care team had developed guidance for ensuring anticipatory medication was prescribed, and to ensure pain relief was administered to patients in a timely manner. The specialist palliative care team could also be contacted for advice about appropriate pain relief if required where symptoms were more complex.

Nutrition and hydration

The Trust had a policy in place to ensure staff were aware of their responsibilities concerning nutritional screening and taking action to prevent malnutrition. We saw that the Malnutrition Universal Screening Tool (MUST) was used to assess patients and that appropriate action was being taken when patients were identified as being at risk of malnutrition. We saw when patients had been prescribed nutritional supplements they were receiving these in line with their prescription.

We observed that all patients had access to drinks and these were within their reach. In the hospice we observed one person's bed side table was out of their reach. However the person's relative was present and could reach things from the table if required. Patient's fluid and nutrition intake was accurately recorded when it needed to be and in circumstances that were appropriate for the patient. We saw that fluid balance charts were maintained and these were accurately totalled. This meant they could be used to make clinical decisions where required. Patients told us they felt they had enough to eat and drink.

We saw that mealtimes were protected on the hospital ward. This meant that patients could eat their meals without interruption and staff could focus on providing assistance to patients who were unable to eat independently. The hospice had a flexible approach to meal times. so that if a patient was sleeping or wasn't hungry, their meal would be served at a more convenient time. Snacks and drinks were available between meals if patients felt hungry during the day or night

Are End of Life Care Services effective?

Patient outcomes

The care and treatment provided achieved positive outcomes for people who used the service. Patients and their relatives expressed they were happy with the services provided.

The Trust reported that in Cambridge City and South Cambridgeshire between September 2012 and August 2013 interventions involving the Arthur Rank Hospice at Home service enabled 96% of patients to die in their own home and in accordance with their wishes. This service alongside interventions from the Hudson Macmillan Centre had contributed to the avoidance of hospital admission and enabling people to live as independently as possible.

The Gold Standards Framework (GSF) is a framework to improve the supportive and palliative care of patients nearing the end of their life. We attended a meeting at a GP practice in Peterborough which included a discussion around patients who were on the GSF register and the plans that were in place for end of life care and ongoing care requirements. There was also a discussion of a recent audit which indicated that out of 33 patients who had expressed a preference to die at home, 31 had died in their preferred place.

Performance information

Performance information was included in the Trust's quality monitoring dashboard system. This included information about patient safety, safeguarding, infection prevention and control, staffing issues and patient experience. This information was shared with staff through the Trust's weekly communication cascade along with action plans to improve performance.

Competent staff

Staff were appropriately qualified to carry out their roles safely and effectively. Staff told us their training needs were identified through supervision and appraisal. They felt supported and encouraged to attend training. On one ward a nurse had been identified as a link nurse for end of life care. They were waiting to attend training and were planning on using their knowledge to educate other members of staff on the ward.

All new staff were provided with an induction period in which they undertook mandatory training. All staff we spoke with confirmed they had received a period of induction on starting at the hospital. Staff told us they

received annual appraisals and, one to ones and supervisions took place every four to six weeks. Staff working within the specialist palliative care team had clinical supervision to support them in their role. Nursing staff on the hospital wards and in the community displayed good knowledge about the needs of patients who required end of life care. All of the staff we spoke with told us they could get support from the specialist palliative care team if they needed to. Staff at the hospice also told us they had monthly debrief sessions with the multi-disciplinary team which was led by the chaplain.

We saw there was a comprehensive education programme run by the education department at the hospice. Staff throughout the Trust were able to access this training. Staff were supported with their continuing professional development. One nurse told us that they had wanted to increase their knowledge in spiritual care with a view to sharing their knowledge with their colleagues. This was discussed in their appraisal and as a result they were currently undertaking an education programme in spiritual care. A health care assistant told us the Trust was supporting them to undertake a foundation degree so that they could enter nurse training.

Use of equipment and facilities

Equipment and facilities were generally fit for purpose. We looked at equipment used for resuscitation and found it to be clean. Single-use items were sealed and in date, and emergency equipment was dated to indicate it had been serviced. We saw that equipment had been checked daily by staff. This meant the equipment was safe and ready for use if required in an emergency. We observed the availability of pressure relieving equipment to be sufficient in all areas.

Within the locations we inspected we saw that same sex accommodation was adhered to in order to safeguard patient's privacy and dignity and comply with the Government's requirement to eliminate mixed-sex accommodation.

One location we inspected had a small mortuary that could accommodate five people after death before collection by an undertaker. This facility was inadequately maintained and not fit for purpose. We escalated our concerns with the

Are End of Life Care Services effective?

Chief Nurse who reassured us that immediate action would be taken to remedy the situation. When we visited nine days later the Trust had taken action to close the mortuary down.

Multi-disciplinary working and working with others

The specialist palliative care team worked in a collaborative and multi-disciplinary manner. This was particularly noticeable within the hospice setting. They shared information efficiently and were proactive in meeting people's needs. We saw that multidisciplinary team meetings took place on a weekly basis and that all communication was written and shared in the multi-disciplinary team folder.

The community nurses we spoke with in Peterborough told us that the district nurse sisters took the lead on liaising with GPs, Macmillan nurses and had discussions with families. They also told us that the community nurses attended GSF multidisciplinary team meetings at GP practices on a monthly basis. These meetings included input from social workers, Macmillan nurses, occupational therapists, physiotherapists and the falls team. We saw evidence of this when we attended a meeting at one of the GP practices in the community.

All staff reported that there was an effective multidisciplinary team working and decision making approach to end of life care. We saw good collaborative

working on the hospital ward when a district nurse who had been visiting a patient at home came into the ward to show the ward nurses how she had been dressing the patient's wound. The district nurse was going to visit again the following day to support staff whilst they dressed the wound and in order to ensure continuity of care for the patient.

Co-ordinated integrated care pathways

An integrated care pathway is a multidisciplinary way of working to ensure people receive their care in a timely manner. We saw examples of excellent holistic integrated care pathways. These clearly detailed anticipated care that had been drawn up by the multidisciplinary team and were patient and family focussed. We saw that patients were supported by members of the multi-disciplinary team who worked together to ensure care was integrated.

Community health care assistants at Peterborough told us there were sometimes delays in social care packages being arranged for people ready to be discharged from hospital. They explained that this sometimes meant delays to patients receiving palliative care. One health care assistant said "Our palliative care patients can't come out of hospital and time isn't on their side". They told us that 'continuing care' packages sometimes had a negative impact on their palliative care case load.

Are End of Life Care Services caring?

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

Summary

Everyone we spoke with told us they had positive experiences of end of life care services throughout the Trust. Patients and their families felt well supported and involved in their care and treatment. Patients were actively encouraged to make decisions and care was person-centred. Advance care plans were communicated to all associated health care professionals effectively. We saw that staff displayed compassion, kindness and respect at all times. They showed a good understanding of the policies and procedures relating to their practice and were respectful of the cultural diversity of the communities they worked in. All of the staff we spoke with were passionate about their work and were proud of what they did.

Detailed findings

Compassionate care

We found the care and treatment of patients and support for their families, within all services we inspected to be empathetic and compassionate. Staff and volunteers across the service promoted and maintained dignity and respect of all patients and their families. We saw that each person's culture, beliefs and values had been taken into account in the assessment, planning and delivery of care. Staff always ensured that confidentiality was maintained and we found that patients, their families and staff had developed trusting relationships that were focussed on ensuring the patient was at the centre of all decisions made.

The staff we spoke with were passionate about their job and expressed how privileged they were to be able to support people at the end of their life. One of the community nurses told us "We are really proud of how we deliver palliative care. We are involved from the point of diagnosis to post bereavement. You give a little piece of yourself to everyone and that is a real privilege." A community health care assistant we spoke with told us, "caring is something that is drummed into us from day one. We are passionate about what we do. We do a lot of end of life care and the patient and their families are our focus". One of the nurses on the ward told us "palliative care is excellent because as soon as we get a referral we begin

work to ensure they [the patient] and all of their needs are met. We never just support patients, it's always families too. All the staff here love the palliative element of our work and embrace it."

We saw a large number of thank you cards displayed on one of the wards. These contained positive comments received from families whose loved ones had been cared for on this ward. The families we spoke with could not praise the quality of care highly enough. The family of one patient told us "The staff here are wonderful, they don't only care for the patient but they care for families too. We have been offered massages by the Macmillan nurse. We have been offered bereavement support. They sent a pack out to us. Everyone has been wonderful. It's just like a family. Even the agency staff have been fantastic as well. We feel extremely lucky that he [their father] has got a bed here." Another relative told us "The care is phenomenal, we feel so privileged to have been able to get a bed here."

We saw evidence and families told us they were encouraged to bring personal belongings such as photographs in. The ward sister told us of a time when the relatives of a patient nearing the end of their life brought the patient's pet dog in to the ward. This meant that patients were enabled to be close to things that mattered to them when they died in hospital.

Dignity and respect

Throughout our inspection we saw patients and their families being treated with compassion, dignity and respect. We observed staff interactions with patients and their families to be positive, respectful and person-centred. We saw that all patients were able to reach their call bell with ease, in order to attract the attention of a member of staff if they needed to. Call bells were answered in a timely manner and that curtains were drawn and privacy respected when staff were supporting patients with personal care. Each of the areas we inspected had a room where discussions could be held in private when required.

We looked at patients' records. We found they were completed sensitively and detailed discussions had been held with patients and their families. We saw that patients and their families had been given time to understand information before making decisions. Patients' care plans

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demonstrated that systems were in place to ensure patients were comfortable and that their symptoms were controlled. We saw that intentional ward rounds took place regularly to ensure patients were comfortable and to tend to any needs the patient had for example mouth care and repositioning.

Patients who were nearing the end of their life were cared for in single rooms where their privacy and dignity could be maintained. We saw that restrictive visiting times were waived for relatives and friends of patients who were nearing the end of their life in order that they could spend time with their loved ones. Families were encouraged to stay overnight if they wished. Families we spoke with told us they were happy that staff always preserved the privacy and dignity of the patient.

Patient understanding and involvement

We found that staff delivered person-centred care within all of the palliative care services we inspected, and that patients and where appropriate their families were involved in and central to all decisions about their care and treatment. We saw evidence of this when we looked at patient records. One relative commented, "Very good care, I'm seeing the palliative doctor to discuss my mums case. She was put on antibiotics for a chest infection but I'm uncertain what Mum's future is, I'll know more when I talk to the doctor".

We observed interactions between staff and patients and we saw that staff offered patients choices and provided them with information to allow them to make informed decisions. We also saw staff asking patients for their consent prior to supporting them with their care needs.

We saw that information leaflets were available about a range of end of life care subjects such as pain control and bereavement support. The leaflets were available in other formats and languages if required.

There were systems in place to ensure patients who did not have the capacity to consent to end of life care were treated in their best interests by staff. We looked at patient records and found some examples of documented discussions with patients and their relatives about treatment decisions where appropriate.

Full discussions were recorded that had taken place with patients and their families regarding care, treatment, prognosis, discharge, preferred place of care and preferred place of death. We saw where patients had been assessed as not having capacity to make decisions, best interest decisions had been made and where appropriate care options had been discussed with their next of kin. When we looked at records we saw there was evidence of patients and/or their relatives being involved in the development of their care plans. As a good example of person-centred care, there was a 'getting to know me' document which was completed by patients and their relatives in order that staff were aware of what was important to the person.

Emotional support

Staff developed trusting relationships with patients and their relatives by working in an open, honest and supportive way. Throughout our inspection we saw that staff were responsive to the emotional needs of patients and their relatives. The specialist palliative care team had received training to enable them to have difficult discussions with patients and their families. The specialist palliative care team, the chaplaincy, nurse specialists and psychologists provided emotional support to patients and relatives. We saw there were quiet rooms where emotional support could be provided. A visiting family member told us they felt their emotional needs had been well supported. They said they had been staying overnight with their relative and were always kept up-to-date about their relative's condition.

Promotion of self-care

Care plans gave guidance for staff in supporting people to remain as independent as possible for as long as possible. We saw that patients within the hospice were encouraged and enabled to look after and take their own tablets/ medicines where possible.

Families were encouraged to be involved in care whenever possible. One nurse in the hospice told us that where patients have specialist equipment such as feeding tubes, the hospice staff support families and teach them how to use the equipment themselves.

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

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

Summary

We found that end of life care services were responsive to people's needs and that people from all communities could access services. Effective multidisciplinary team working, ensured patients and their families were provided with care that met their needs, at the right time and without avoidable delay. Overall we found effective systems were in place to ensure people who were dying, their relatives and those close to them received the support they needed in the community, the hospice and in hospital depending on their wishes.

Detailed findings

Service planning and delivery to meet the needs of different people

We saw that end of life care took place in a number of different settings such as community hospital, hospice and people's own homes. We observed an integrated approach to the delivery of care in all of the areas we inspected. We observed that all staff were committed to ensuring patients and their families received person-centred care.

We saw that 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. staff told us that interpreter services were easily accessible if they were required. We saw that staff had undertaken training in dementia awareness to enable them to better understand and provide care for patients who had dementia.

The specialist palliative care team and staff working on the hospital ward were aware of the importance of respecting the cultural and religious beliefs of different members of society. The chaplaincy presence in the multidisciplinary team worked closely with local representatives of various denominations.

Access to care as close to home as possible

We found that the Trust was committed to ensuring people received their end of life care in their preferred place. We saw that staff had discussed preferred place of care and preferred place of death. The specialist palliative care team

could facilitate a rapid discharge home for people who had identified a wish to be cared for in their own home. Staff told us they could access medicines in a timely manner to ensure discharge was not delayed.

We saw that multidisciplinary team "board rounds" were undertaken on a daily basis in each of the locations we inspected, where plans relating to appropriate discharge were discussed. Community nurses visited people in their own home to ensure they were able to receive the care required. The hospice also ran a hospice at home service to provide 24 hour care to patients who chose to die at home and, support for their families. This meant that patients and their families could be cared for in their preferred place by specialist nurses and support staff who were committed to providing high standards of palliative care in the community.

Access to the right care at the right time

We found that palliative care services delivered good, safe and coordinated care throughout all of the locations we inspected. In all the areas we inspected we found that care arrangements met the needs of patients who required end of life care and their families. We found effective communication between specialist palliative care teams and staff working at ward level in addition to effective communication between all members of the multidisciplinary team. The Trust used an electronic recording system to enable the recording and sharing of people's care preferences and key details about their care. This ensured care was co-ordinated and delivered in the right place, by the right person, at the right time.

Flexible community services

As well as the hospice and the community, end of life care was delivered within community hospital settings. The wards we visited had a set number of palliative care beds. The sister on one of the wards told us they had three palliative care beds but if they had empty rehabilitation beds they would accept patients requiring end of life care. We saw evidence of flexibility on another ward where they had two palliative care beds. at the time of our inspection there were three patients receiving end of life care.

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We also saw evidence of flexibility in the hospice where a patient being cared for at the hospice had identified that they wished to die at home. The patient then decided they would rather die in the hospice. Staff at the hospice agreed to the patient's wishes to enable the person to die where they preferred.

There was a day unit within one of the community hospitals which was run between 08.30 and 16.30 by a Macmillan nurse. A consultant ran a clinic here once a week and oncology patients could be seen at the service for their outpatient appointments. Patients could have their bloods taken and could have intravenous medications given as well as blood transfusions. The unit offered day therapy, symptom management support and psychological support. The service offered therapies such as reflexology and massage. This service was also offered to relatives. The clinical nurse specialist also supported patients on the wards with discussions around end of life care. The service demonstrated flexibility as they would often move services around to accommodate patients who perhaps required a blood transfusion prior to a bank holiday weekend, in order to prevent them being admitted to hospital.

Meeting the needs of individuals

We saw that when a patient had been identified as being at the end of their life relatives were able to offer their help by coming into the ward and providing some sort of care for their loved one. For example they could help the person to eat their meal or provide personal care.

We also saw that individual needs were met by the clinical nurse specialist on the day unit who took pride in ensuring patients continued to be cared for in their preferred place. The nurse told us, "I really love the preventative element of my job. Keeping people at home is so rewarding. I am proud of keeping my patients as well as possible. My job isn't about end of life, it's about quality of life."

Moving between services

Wherever possible patients and their families had been involved throughout their care pathway and their wishes had been considered. We saw that discussions had taken place to ensure the best outcome for patients and that relatives and, where possible, patients had been asked about their wishes for transfer to the acute hospital should their condition deteriorate. This was important to avoid unnecessary trips to hospital if the patient did not wish to be treated for acute deterioration.

Complaints handling (for this service) and learning from feedback

Within the locations we visited we saw numerous letters and cards expressing positive remarks about the services provided. We saw there was a complaints procedure and people were encouraged to complete a patient experience questionnaire. Relatives we spoke with told us they would know how to raise a complaint if they needed to but none of the people we spoke with felt the need to complain. We saw that complaints were handled in line with the Trust's policy and action plans were in place to address complaints and concerns.

Are End of Life Care 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

The service was generally well led at a local level with effective decision making and strategic planning. There were risk management systems in place across the service and staff largely had a clear oversight of risks and quality in the organisation. The service engaged well with people requiring end of life care and their families. Staff felt well supported and valued by the service.

The Trust did not have a unified vision or strategy for end of life care. There was no Trust-wide policy on end of life care or on caring for patients after they have died. The Board and senior managers had oversight of the reported risks and had measures in place to manage these risks at ward level. However, risks in the mortuary had not been monitored and had been overlooked.

As a result of our concerns, we judged the provider was not meeting Regulation 10, Assessing and monitoring the quality of service provision. We have asked the provider to send us a report that tells us what actions they are taking to meet this essential standard.

Detailed findings

Vision and strategy for this service

The Trust did not have a unified vision or strategy for end of life care. The palliative care lead for Luton told us that a strategy was written for Luton in 2012 and was largely still relevant but needed to be re-newed. We saw that some sections of the strategy were out of date. We saw the hospice had developed a new vision and strategy that would be implemented with the development of the new hospice. Trust staff contributed to the local Clinical Commissioning Groups' end of life care strategies.

When we met with the leads for palliative care they told us that the Liverpool Care Pathway was no longer being used throughout the Trust and an individual care plan for the dying had been written. Guidance had been provided and it was up to teams to develop their own care plans. The wards providing end of life care were currently piloting a care plan which we saw on one of the wards we visited.

We looked at the NHS staff survey results for 2013 and saw that the levels of staff satisfaction with the Trust were

better than average when compared with other community trusts. All of the staff we spoke with were passionate and committed to ensuring patients received the best end of life care they could give them. Staff demonstrated the Trust's commitment to patients and the values of the organisation they worked for. Throughout our inspection we saw mutual respect between staff. Staff were keen to talk about their role and how they felt about supporting people at the end of their life. They were also keen to share their experiences and how they were going to put their learning into practice.

Governance, risk management and quality measurement

The ward sisters demonstrated a good awareness of governance arrangements. They were able to explain the actions taken to monitor patient safety and risks. For example they spoke about incident reporting, risk registers and undertaking audits. We also saw examples of where root cause analysis had been undertaken and learning had taken place following incidents. We were told by the leads for palliative care that there were no identified risks on the risk register for end of life care.

The Trust did not have Trust-wide policies in place for staff to follow when supporting patients with end of life care or when caring for patients after they have died. In North Cambridgeshire hospital, there was no guidance for staff responsible for transporting deceased patients to the mortuary and staff told us they had received no training to prepare them to undertake this role. The Trust could not provide evidence that risks had been managed, or that quality of service had been monitored in the mortuary. There were no procedures or schedules in place for cleaning and minimising the risk of infection to people who were deceased or to staff. The senior staff and palliative care leads we spoke with told us they had never visited the mortuary despite care after death being an important part of end of life care. This meant that the Trust had overlooked the mortuary and potentially put staff and

Are End of Life Care Services well-led?

patients at risk. We raised these concerns at the time of the inspection and the Trust took immediate action to close the mortuary and put in place alternative arrangements for the care of deceased patients.

Leadership of this service

The NHS Staff Survey 2013 saw the percentage of staff in the Trust reporting good communication between senior management and staff as better than average when compared with other community Trusts.

One of the leads for palliative care told us that end of life care services were represented by the medical director at Board level. None of the staff we spoke with knew who this was. All of the staff we spoke with knew who the nursing leads for palliative care were and how they could contact them. The staff we spoke with felt the leads for palliative care had a strong presence in the service. We saw there was a strong leadership at a local level. All were passionate about ensuring patients and their families received a good end of life care experience.

The ward areas and the hospice we inspected were well led. Most staff reported good support from their line manager and spoke positively about leadership at ward level. On one ward a member of staff told us, “The manager is on the ball, she works us very hard but its what’s needed to keep the place running so well”.

Culture within this service

Staff told us of their commitment to provide safe, caring and person-centred care for people requiring their services. Staff morale was positive as represented by the staff survey 2013. All of the staff we spoke with spoke passionately about the patients they supported and the care they provided. Staff within the specialist palliative care service were passionate about their job role and the quality of end of life care provision.

Staff working on an inpatient ward thought highly of the hospital. They spoke positively about the service they provided and likened the hospital to a family community. They described good, supportive working relationships with the specialist palliative care team. There was a culture of sharing knowledge between specialist palliative care and other services through formal and informal teaching opportunities. Staff reported positive working relationships and we observed that staff were respectful towards each other, not only in their specialities, but across all disciplines.

Public and staff engagement

Staff recognised the importance of the views of the people using their service. We saw minutes from meetings where the views of people using the service had been shared. This meant that staff were sharing the views and that lessons could be learned where needed. We saw that patients and their families were asked for their views about the care they received. They were asked to complete a patient experience questionnaire.

Staff we spoke with told us that team meetings were held regularly. They said that any updates or changes in relation to the provision of end of life care was discussed during these meetings. Staff felt they could raise concerns at any time and that they would be supported and listened to. All staff said that their managers were approachable and they would have no worries about raising concerns.

Innovation, improvement and sustainability

Core members of the palliative care multidisciplinary care team had undertaken specialist training, for example, advanced communication skills, acupuncture and hypnosis. The hospice was being relocated and plans had been drawn up for a new building.

Compliance actions

Action we have told the provider to take

The table below shows the regulations that were not being met. The provider must send CQC a report that says what action they are going to take to meet these regulations.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision</p> <p>How the regulation was not being met:</p> <p>In relation to end of life care and care after death, the provider did not have effective systems to regularly assess and monitor the quality of services and to identify, assess and manage risks to people using the services and others at risk.</p> <p>Regulation 10(1)(a) & (1)(b).</p>