Care Quality Commission

The Newcastle upon Tyne Hospitals NHS Foundation Trust

RTD

Community end of life care

Quality Report

Freeman Hospital, Freeman Road, High Heaton
Newcastle upon Tyne, Tyne and Wear, NE7 7DN
Tel:01912336161
Website:www.newcastle-hospitals.org.uk

Date of inspection visit: 19 - 22 January 2016
Date of publication: 06/06/2016

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)
RTD	Geoffrey Rhodes Centre	Equipment Loan Service	NE6 2UZ
RTD03	Campus for Ageing and Vitality	Evening and Night Nursing Service	NE4 6BE
RTD	Arthur's Hill Clinic	Community Specialist Palliative Care	NE4 6BT

This report describes our judgement of the quality of care provided within this core service by The Newcastle upon Tyne Hospitals 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 The Newcastle upon Tyne Hospitals NHS Foundation Trust and these are brought together to inform our overall judgement of The Newcastle upon Tyne Hospitals NHS Foundation Trust

Summary of findings

Ratings

Overall rating for the service	Good	🟢
Are services safe?	**Good**	🟢
Are services effective?	**Good**	🟢
Are services caring?	**Good**	🟢
Are services responsive?	**Good**	🟢
Are services well-led?	**Good**	🟢

Summary of findings

Contents

Summary of findings

Overall summary

Overall rating for this core service Good

Overall, we rated community end of life care as good because:

- Incident reporting was effective across the service. Staff were aware of their reporting responsibilities and there was evidence of learning from incidents.
- Risks to patients were assessed and managed to ensure safe delivery of care. Staff responded appropriately to safeguarding concerns. There were systems and processes for the monitoring of medicines and infection control.
- Staffing levels were adequate to meet patient demands; these were monitored and reviewed daily.
- Documentation and care records were completed appropriately. Do not attempt cardio-pulmonary resuscitation (DNACPR) forms were completed consistently. Equipment was available for patients and appropriate safety checks were in place. There was equipment available in patients' homes and use of anticipatory prescribing of medicines at the end of life.

- The Community Specialist Palliative Care Team provided effective end of life care to patients. The trust had implemented the Care of the Dying Patient document within the community, which was being used as a guide to deliver high quality end of life care.
- The feedback from people who used the service and those who were close to them was extremely positive about the care received by patients nearing the end of life. Staff always considered personal, cultural, social and religious needs when delivering care.
- Care and treatment was planned and delivered in line with current legislation. There was a multi-disciplinary approach to care and treatment within community services.
- Improvements had been made to fast track the discharge of patients at the end of life and all staff were aware of and involved in, supporting patients to be cared for in their preferred place of care.
- There were innovative approaches being implemented to achieve the joined up service within acute and community end of life teams. Local managers were proactive and demonstrated an understanding of the current issues facing the service.

Summary of findings

Background to the service

The Newcastle upon Tyne Hospitals NHS Foundation Trust (NuTH) provides end of life services across the Newcastle region. Specialist palliative care is provided as part of an integrated service across the hospital and community teams. The NuTH Specialist Palliative Care Team (SPCT) is divided into two directorates. The medical staff are in the Cancer Services Directorate and the rest of the team are in Patient Services Directorate. The aim of the NuTH was to provide fully integrated care, in coordination with care provided by other organisations, in hospital and in the community.

There were four separate EOLC clinical teams. The four teams consisted of: Newcastle Community team, Royal Victoria Infirmary (RVI) team, Northern Centre for Cancer Care (NCCC) team and the Freeman Hospital (FRH) team. The four teams work independently from one another. There was one community SPCT covering the Newcastle area. The team comprised of 11 whole time equivalent (wte) specialist palliative care nurses. There was one palliative care consultant employed within the community.

The team provided support and advice for patients in their locality with complex needs and symptom management issues at the end of life. The community team worked jointly with the acute SPCT team and were based at the Geoffrey Rhodes Centre.

During our inspection, we observed care delivered by SPCT nurses and district nurses. We spoke with 19 members of staff including the palliative care matron, a community palliative care consultant, specialist palliative care community nurses, a physiotherapist and district nurses. We spoke with eight patients and eight relatives and visited patients in their own homes and in community settings. We looked at the records of 16 patients receiving end of life care.

We visited the Community SPCT at Geoffrey Rhodes Centre in Newcastle. We also visited two community-nursing teams based in Arthurs Hill and the out of hour's community nursing team service at the Campus for Ageing and Vitality.

Our inspection team

Our inspection team was led by:

Chair: Ellen Armistead, Deputy Chief Inspector of Hospitals, Care Quality Commission

Team Leader: Amanda Stanford, Head of Hospitals Inspection, Care Quality Commission

The team included CQC inspectors and a variety of specialist nurses in end of life care.

Why we carried out this inspection

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?

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

Before visiting, we reviewed a range of information about the core service and asked other organisations to share

Summary of findings

what they knew. We carried out an announced visit on 19 – 20 Janaury 2016. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people who use services. 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 use services. We met with people who use services and carers, who shared their views and experiences of the core service. We carried out an unannounced visit on 5 February 2016.

What people who use the provider say

Comments from patients, carers and families were positive throughout our inspection. Patients all said that they received compassionate care and staff respected their privacy and dignity.

Good practice

- There was nurse specialist input into 10 care homes that were taking part in the Care Homes Project in Newcastle. The aim was to support the care homes to deliver excellent end of life care.
- Specialist Palliative Care Rapid Assessment was in place where a rapid assessment (within 1 hour) was

offered to patients at home or in a care home to try to prevent unnecessary admission to hospital. The service ran 7 days a week. There was also capacity to work into the Emergency Department and the Assessment Suite at the RVI to facilitate rapid discharge home again if required.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- Ensure that the departmental risk register for End of Life Care accurately reflects the current clinical and non-clinical risks faced by the directorate.

Care Quality Commission

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Community end of life care

Detailed findings from this inspection

Good 🟢

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as good because:

- Staff understood their responsibilities to raise concerns and to record safety incidents. There were systems in place for reporting and learning from incidents.
- There was appropriate equipment available in patients' homes and use of anticipatory prescribing of medicines at the end of life.
- An integrated electronic records system was in use with community SPCT, community nursing teams and many GP practices.
- There were adult safeguarding procedures, supported by mandatory staff training.
- Staffing levels were sufficient to meet the needs of patients.
- We saw that syringe drivers were monitored using appropriate safety checks.

Safety performance

- Safety was managed through the effective reporting of incidents. The trust had an incident reporting and investigation policy and this was embedded within the service. 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 were aware of what should be reported and were encouraged to do so

Incident reporting, learning and improvement

- We reviewed incidents reported between 1 October 2014 and 30 September 2015. Staff from the SPCT had reported five incidents. The severity of each incident was recorded appropriately and indicated the level of harm caused by the incident. Four were recorded as minor with one as insignificant. One incident involved a drug error relating to incorrect dosage for pain relief. We saw this had been reported to the Northern Doctors Urgent Care (NDUC) with notes of observation of the patient's condition and recording of their respiratory rate.
- Minutes from the clinical governance meetings showed incidents and learning was a standing item on the agenda.

Are services safe?

- Staff we spoke with were aware of the Duty of Candour regulations and the need to be open and honest with service users and their families. The trust had an up to date being open (Duty of Candour) policy.

Cleanliness, infection control and hygiene

- The trust had an infection control policy and all staff received training in infection prevention and control. The level of compliance across the community end of life services was 100%.
- An analysis of the hand hygiene audits carried out across community EOL showed compliance of 100%.
- We spoke with staff in home settings. All the staff had a good understanding of infection control practices.
- We observed staff using personal protective equipment appropriately, such as aprons and gloves.

Safeguarding

- All staff on the team received safeguarding training in line with their role. Completion of safeguarding training adults level 2 was 100%, against a trust target of 95%.
- Patients and their relatives we spoke with told us they were encouraged to tell staff if they had any safeguarding concerns.
- Systems were in place to protect people in vulnerable circumstances from abuse. Staff were knowledgeable about their roles and responsibilities in relation to ensuring vulnerable adults and children were safeguarded. Staff understood what constituted a safeguarding concern and could demonstrate the processes to raise a safeguarding alert.

Medicines

- Medicines were well managed. Community patients who were identified as requiring end of life care were prescribed anticipatory medicines: anticipatory medicines are 'as required' medicines that are prescribed in advance to ensure prompt management of increases in pain and other symptoms.
- 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.
- There were guidelines on the trust intranet (NHS North of England Cancer Network) for medical staff to follow when prescribing anticipatory medicines. Medical staff we spoke with were aware of the guidance and how to access the SPCT for advice should they need it.

- Prescriptions and administration records we looked at in the community were completed clearly, including the times of administration of medicines prescribed 'as required'.

Environment and Equipment

- Staff said that they did not experience any issues with obtaining or maintaining equipment for end of life care patients. Syringe drivers were obtained from a trust wide 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.
- The trust used a number of syringe drivers , which were in line with the NPSA Rapid Response Report; Safer ambulatory syringe drivers (NPSA/2010/RRR019) published in December 2010. This advised that all healthcare organisations that use ambulatory syringe drivers should change over to devices with specific safety features.
- Staff told us that equipment was accessible within a few hours for patients at the end of life who were being discharged. Records showed equipment had been safety tested and serviced where required.

Quality of Records

- The Community SPCT used an electronic record system that enabled sharing of patient information within the team and with other health care professionals for example GP practices. District nurses told us they used the same electronic record system. However, staff working across the acute services did not have access to the system community colleagues were using.
- Currently, patients' notes were updated onto the electronic system once staff returned to their base site. Staff told us there was occasions when patients notes were not updated immediately as going back to the base office was not always practicable at the end of a shift. However, staff told us paper records at peoples homes' were updated at the time of the visit and electronic records were updated the following day where required. There was a pilot project of mobile devices to access the electronic system and therefore update patients' notes without the need to go back to the base site.
- During our inspection, we looked at the care records of 16 patients across the end of life care services. The records were well organised and information was easy

Are services safe?

to access. Records were complete and up to date and included records of capacity and consent. There was evidence of discussions with patients about their condition, advanced care planning and their resuscitation status was clearly documented.

- Information governance training was part of the annual mandatory requirement for all staff and the SPCT were up to date.

Mandatory training

- The trust had a training target of 95%. We found that 100% community specialist care staff based at Geoffrey Rhodes Centre had completed the trust mandatory training. This training included information governance, consent to care, health and safety, infection prevention and control, and moving and handling level two.
- The Community SPCT and community nursing staff we spoke with confirmed they had received training in the use of syringe drivers.

Assessing and responding to patient risk

- The trust used the Northern England Strategic Clinical Networks guidance on caring for the dying patient and care planning document. The guidance 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.
- Staff assessed and managed patient risk as part of an ongoing holistic assessment process. We observed good use of general risk assessments for patients receiving end of life care. This included the assessment of risk in relation to nutrition and hydration, pressure ulcers and falls.
- Nursing, medical and therapy staff recorded daily changes to patients' conditions in their notes. In the community, advice and support regarding deteriorating patients was available from the SPCT.
- We observed a community SPCT meeting and saw that risks to patients were discussed as part of a routine review of their care and ongoing evaluation.

- Where a patient was being cared for at home, relatives we spoke with were aware of how to access help and support should the patients condition deteriorate.

Staffing levels and caseload

- Staffing levels were sufficient to ensure that patients received safe care and treatment. End of life care was provided in the community seven days a week. Specialist palliative care was provided from 9am to 5pm seven days a week. Out of hours, a general Palliative Care Helpline that was nurse led and situated at Marie Curie Hospice was available.
- In Newcastle, there were 11 whole time equivalent (wte) specialist palliative care nurses. There was one palliative care consultant employed within the community.
- Staff we spoke with told us their caseloads were manageable and they had sufficient staff to deliver good quality end of life care.
- Each of the end of life care teams discussed caseloads each morning. The needs of each patient, details of new patients, changes both expected and unexpected to the patients 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 patients. We saw staff were unhurried and willing to spend time explaining procedures and health issues with them.

Managing anticipated risks

- The trust had a 'Maintaining Services during Adverse Weather Conditions and Public Transport Disruption' policy, which set out the responsibility of the employee and managers.
- Staff had been provided with lone working devices. All staff managed their diaries on the computer system to indicate where they were. Staff signed in and out of bases.
- Staff told us visits were conducted in pairs if there was an identified risk.
- All staff conducting home visits carried mobile phones.

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:

- Within the community, we saw end of life care guidance. This had influenced the development of the caring for the dying patient document that had been rolled out across community services.
- End of life care services were well resourced and we observed effective assessment, planning and delivery of care and treatment to patients within the community.
- There was multi-disciplinary work across acute and community settings. There were established links with GPs, district nurses, local nursing homes and the local Hospice. Community SPCT delivered a seven-day service. At the weekend the community team would be based at the trust hospital sites and provided a 1 hour referral which involved an initial call back within an hour, but in many occasions, they would go out on the ward in the hospital.
- We observed good practice in terms of pain assessment and management and all patients we spoke with told us their pain was well managed.
- The community SPCT used a holistic approach to provide effective discharge and transfers to community services from acute services.
- Consent practices were embedded across the community end of life team. Staff were supported in relation to best interest decisions for patients who did not have capacity to make decisions about care and treatment.
- Community SPCT were delivering a seven-day service with specialist support available.

Evidence based care and treatment

- The Community SPCT delivered care in line with evidence-based guidance such as the 'North East Cancer Network Palliative and End of Life Care Guidelines'.
- The Care for the Dying Patient (CDP) document had been implemented to replace the Liverpool Care Pathway that had been discontinued in 2014. We saw

the document implemented within the community and staff confirmed this. We were told the acute side of the trust had not implemented the CDP document across all hospital sites, but were using interim guidance.

- We saw that the CDP documentation had included 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 for Health and Care Excellence (NICE).
- Various audits of End of Life Care delivered to patients their relatives and carers were carried out. Areas reviewed included length of stay from admission to death, communication, resuscitation status and care after death. Action taken because of audits included, improved documented conversations regarding hydration/nutrition with patients and families, improved medical review at weekends, and documentary evidence of last offices being performed.
- The trust has implemented the 'Deciding Right' initiative. This was a northeast initiative for making care decisions in advance. The initiative included recognising the individual with capacity as key to making care decisions in advance and the needs of the individual who lacked capacity to have decisions made in their best interests.
- We saw the personalised care plan for the last days of life incorporated within the community. A care plan was prepared in consultation with the patient if possible and involving their relative/carer regarding investigations, treatments, and options for symptom control. Any medication or equipment was identified to ensure availability and discussed with the patient and their relative/carer.

Pain relief

- Patients who were considered to be in the last days/ weeks of life were appropriately prescribed anticipatory medicines for their symptoms.
- Staff told us there were adequate stocks of appropriate medicines for end of life care and that these were available as needed both during the day and out of hours.

Are services effective?

- We found that patients received good pain relief. Patients and relatives told us that their pain was under control and we saw that pain relief was administered in a timely manner.
- Patients and relatives we spoke with told us that the community nursing staff supported them well in managing their pain.
- 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. For example, we saw a patient in their home being assisted by community nurses so the patient was able to use a portable syringe driver. We saw the nurses take their time so the patient was comfortable and both the patient and their family were able to have the correct information about the way the syringe driver was being used and how the patient managed their pain relief.

Nutrition and hydration

- Nutrition and hydration was assessed and monitored. Patients were routinely assessed using the 'Malnutrition Universal Screening Tool' (MUST) which is used to identify nutritional risks.
- The CDP document was used and nutrition and hydration needs at the end of life were assessed. Assessments included patient choice and comfort and for patients without mental capacity to make their own decisions. We saw prompts to assist staff to make decisions in the best interests of the patient.
- During home visits, we saw staff spend a significant amount of time during the visit reviewing and discussing the needs (including nutritional needs) of the patient. All the patients and relatives we spoke with felt that nutrition was appropriately managed.
- Specialist palliative care regularly provided advice to community staff about nutrition, hydration and mouth care.

Patient outcomes

- The trust supported patients to achieve their preferred place of death either through rapid discharge to home, hospice or nursing home or by ensuring appropriate care for patients who wished to die at the hospital.

- The trust used a metric where patients were given the opportunity to discuss their wishes and preferences as appropriate during their illness. The preferred place of death was monitored in a twice-yearly end of life real time audit.
- More recently, the trust had been accepted into the national minimum data set pilot hosted by Public Health England. The pilot included a question asking about patients' wishes and preferences. The data was collected at the beginning of a hospital admission or beginning of community spell of care. Between October 2015 and December 2015, out of 154 patients, 53% of patients preferred place of death was at home, and 22 (27%) of these patients died at home.
- PaCA (Palliative Care Assessment) Outcome Data was collected by all four (three hospital, one community based) specialist palliative care teams at the trust. PaCA is a symptom-scoring tool and gives numerical data to help quantify the success of palliative care interventions. The symptom or problem is left blank for staff or patients to identify the main issues causing distress. The PaCA outcome data for 2014 confirmed the positive impact the specialist palliative care teams made on patients problems (both physical and non-physical).
- The Specialist Palliative Care service delivered a Rapid Assessment service to enable a 1-hour crisis response in the Community and at the RVI 7 days a week. In the 9 months from September 2014 of the 63 patients seen, only three ended up as hospital admissions.

Competent staff

- Members of the SPCT told us they had received 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 community SPCT told us they had received an annual appraisal, and we were told that training, and development plans were aligned to this process. To date 82% of the community staff had completed their annual appraisal.
- Members of the SPCT across the trust attended monthly group supervision sessions where there were opportunities to reflect on their practice. We saw minutes of those meetings.

Are services effective?

- District nurses had opportunities to develop their end of life care skills and knowledge. Staff told us they were actively encouraged to work alongside the community SPCT.
- Staff had completed additional training which included conflict resolution, blood transfusion administration and prevention of patient falls.

Multi-disciplinary working and co-ordinated care pathways

- Community SPCT liaised and communicated with community nursing teams reviewing end of life care as and when required for patients.
- The Community SPCT worked closely with local hospice services and we saw evidence of agreed local pathways, with patients moving between services effectively.
- The trust told us they met as a whole (both acute and community services) twice a year to discuss the strategy and vision of the service.

Referral, transfer, discharge and transition

- Patients were referred appropriately. The planning of discharge to an alternative place of care involved both the acute and community teams as well as support agencies who were involved in providing end of life care to patients at home.
- Staff told us patients could be discharged home with appropriate support from the community nursing team by using the RAPA service.
- During 2014/2015, there were 800 referrals to the community SPCT. In the whole of Newcastle there were 1685 deaths in the year 2015.
- There were clear models of palliative care provision and support for non-cancer patients, where appropriate in line with relevant Outcomes Strategies and the National Service Framework. In 2014/15, annual referrals in the Community for non-cancer patients were 13%.
- The Palliative Care Rapid Assessment Project (SPRAT) provided referral criteria for patients with identified palliative care diagnosis with specialist needs. Referrals were received from band 6/7 community nurses who

had made a face-to-face assessment of the patient. The response time was one hour or as negotiated with the referrer or patient. There were clear assessment outcomes with management plans.

Access to information

- Community SPCT used an electronic patient record system. Local GP's and the community nursing teams could access this. However, staff told us staff who worked on the acute wards used a different electronic system. Staff found this was not an effective way of working.
- The CDP document, which was used in the community, 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.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Do not attempt cardio-pulmonary resuscitation (DNACPR) forms were completed consistently. We reviewed six DNACPR forms. The forms were kept in the front of patient notes, had clearly documented decisions with reasoning and clinical information and had been signed by a consultant. They also recorded discussions with patients and relatives.
- In the community, DNACPR forms were kept in a yellow envelope to be easily accessible to community staff and family members and could be sent with the patient in the event of a hospital admission.
- For patients at the end of life who did not have capacity to make decisions about care and treatment, we saw prompts on the Caring for the Dying Patient (CDP) document relating to best interest decisions, for example, about nutrition and hydration.
- The specialist palliative care team told us they had completed consent and Mental Capacity Act training and this was repeated annually in mandatory training.

Are services caring?

Good ⬤

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

Summary

We rated caring as good because:

- Patients and their relatives spoke positively about the care they received in the community. We observed interactions between staff and patients and saw that these were kind, caring and compassionate.

- Staff were highly motivated and inspired 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 strong, caring and supportive. These relationships were highly valued by people and their families.
- Patient satisfaction surveys showed the majority of patients or their relatives were satisfied with the SPCT service.
- Patients and their families were involved in decisions about their care and received emotional and psychological support.

Compassionate care

- In the SPCT Report of Patient and Carer Satisfaction Survey 2015, we saw 20 responses. The results showed all patients were satisfied with the service provided by the SPCT.
- The SPCT carried out patient and carer satisfaction surveys. The 2015 survey showed the majority of patients felt highly supported, involved in decisions affecting their care and 100% stated they felt satisfied with the service overall.
- The Family's Voice: helping family or friends in the last days of life, preliminary report March 2015 showed that 95% of family were being supported in a sensitive way.
- We attended eleven home visits during our inspection; we witnessed caring and compassionate staff who were not hurried while undertaking home visits. On one occasion, the palliative care nurse discussed a patients treatment. The patient was concerned about the delay in the response from the results of tests and this was causing them some undue worry. We saw the nurse telephone the consultant to establish when the follow up contact with the patient would be made. We saw the nurse take time during the visit to arrange a follow up appointment for the patient.

- Patients and their relatives spoke highly of the staff and told us they were supportive. If there were any issues staff would contact the right people and try to ease the worry of patients. For example, we saw during our visit an issue with medication. A patient was worried about being able to access their local pharmacist as their relative was on holiday. We saw the nurse contact the local pharmacist to ensure they had the correct medication in stock and arrange delivery.
- 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.
- 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, staff were treated almost as family by patients and their relatives or carers.

Understanding and involvement of patients and those close to them

- Patients and family members we spoke with told us they felt involved in the care delivered.
- Staff discussions with patients and relatives about care issues were clearly recorded in patients' notes.
- The caring for the dying patient document used by the trust included prompts for discussing issues of care with patients and relatives.
- Guidance literature was available for patients and their relatives. This included an end of life booklet informing what patients might expect to happen.
- We saw documentation about advance care planning and saw that patients were asked about their advance wishes and these were recorded and accessible to all staff involved in their care.
- The SPCT used The Family's Voice diary. This was given to relatives or friends of dying patients inviting them to be part of the care. This included questions about pain, sickness, agitation, breathlessness and whether the staff were treating the dying person with dignity and sensitively and whether the relative or friend was included and involved in the care.

Are services caring?

Emotional support

- Staff told us they felt they had the time to spend with patients and provide the emotional support to meet their needs.

- We observed community and specialist nurses assessing people's emotional needs as a matter of routine when visiting them at home.
- Support was available from chaplaincy and psychology teams and staff we spoke with told us this was readily available to patients and their relatives at the end of life.

Are services responsive to people's needs?

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

Summary

We rated responsive as good because:

- The delivery of services in the community focussed on meeting the needs of patients, including patients in vulnerable circumstances.
- Community end of life care services were very responsive to the needs of individual patients and to the needs of the local community. They worked closely with commissioners and other external providers to review, design and deliver high quality end of life care.
- There were low levels of complaints in Community EOLC. Any concerns were taken seriously, responded to in a timely way and listened to. Improvements were made to the quality of care because of complaints and concerns.

Planning and delivering services which meet people's needs

- Services were planned and delivered within the community to meet patients and relatives needs. Staff were very clear that the key priority was ensuring patients were cared for in their preferred place of death wherever possible.
- The trust met with commissioners andother providers to review, design and deliver end of life care to meet the needs of patients. The aim of the SPCT service was to "provide a comprehensive, joined up palliative care service to patients and their families in all settings". A particular focus for this was to assist rapid discharge from acute care and to prevent avoidable admission to hospital.
- The service worked with the Northern Strategic Clinical Networks NHS England (formally the North East Cancer Network) to test areas such as the Family's Voice project.
- An out of hours service was in place provided by the local hospice for patients and staff to access.

Equality and diversity

- Patients receiving end of life and palliative care were treated as individuals.
- All staff, as part of their induction to the trust, received equality and diversity training.

- The chaplaincy service provided support and pastoral care for people of all faiths. We were told that chaplaincy staff were able to access leaders of different faiths in order to meet the spiritual and faith needs of patients and their relatives.
- A multi-faith prayer room was available for patients on the community in-patient ward. The multi-faith room included washing facilities and spiritual books for different faiths.
- Individual end of life care teams provided information for patients and their families as and when patients came into their care.
- The trust provided a service for staff to access interpreting services for patients whose first language was not English.

Meeting the needs of people in vulnerable circumstances

- Staff told us they could access support and advice from the trust's learning disability nurse or the community dementia services. We saw that a member of the community SPCT had taken part in a regional dementia group working with the trust's commissioners. The aim of the group was to improve delivery, joint working and communication around end of life care for patients with dementia living in care homes in the region.
- Emergency Health Care Plans (EHP) were in use across the community in the event of a health care emergency to ensure patient need and good standards of communication were met. The plans were designed to be used for patients who did not have the mental capacity to make decisions so that their care could be planned within a best interest process.

Access to the right care at the right time

- The community SPCT responded to referrals from consultants, GPs, community staff and acute hospital staff.
- The end of life care team engaged with patients and they provided a range of interventions both in people's homes and in community settings enabling patients to receive treatments.

Are services responsive to people's needs?

- Specialist support was available with Community SPCT operating a seven-day service, and also a 24 hour Palliative Care Helpline, which was nurse, led and situated at the Marie Curie Hospice.
- Community SPCT worked closely with local ambulance teams to facilitate the transfer of a patient from hospital to their usual place of residence. For example, an agreement with North East Ambulance Service and the trust enabled an ambulance to be made available on the day of transfer so the patient did not have to wait to go home once discharged.

Learning from complaints and concerns

- The service told us they received low numbers of complaints. Staff told us they tried to address any issues and concerns at a local level before they became complaints.
- Staff told us that they received more compliments than concerns but that complaints were discussed at team meetings.

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:

- End of Life was part of the trust's patient services strategy and there was an integrated strategy and vision across the four teams. Staff knew and understood the vision, values and strategic goals.
- Community SPCT leadership was effective with staff commenting on having confidence in them.
- There was a clear sense of pride and belonging amongst staff at all levels within the end of life care teams. Staff felt proud of the care they were able to give and there was positive feedback from nursing and care staff as to the level of support they received from the specialist palliative care team.
- Governance structures were in place. The quality of services was monitored through audit, incidents, complaints and patient/carer experiences. However, the risk register did not always reflect the key risks in the directorate.
- There was some evidence of patient engagement and innovation.

Service vision and strategy

- There was a vision and strategy for end of life care. This centred on care that was available at the point of need at any time during the patients management pathway. The trust's aim was to provide fully integrated care, in coordination with care provided by other organisations, in hospital and in the community.
- Community SPCT staff were aware of the end of life strategy and were confident of how this linked in with the community nursing team.
- Community SPCT confirmed they met with the acute staff twice yearly to discuss the vision and strategy.
- The Community SPCT worked very closely with other departments to deliver care: community nursing, the hospice, pharmacy, GP's and acute staff.
- The Palliative and End of Life Care Strategy Group met three times a year and was accountable to the Trust

Board to deliver palliative and end of life strategies. There was representation from all directorates, paediatrics, chaplaincy and the Assistant Director of Patient Services.

Governance, risk management and quality measurement

- In line with trust clinical governance policy, the quality of services was monitored through clinical audit, feedback from incidents, complaints, and patient/ carer experiences.
- Weekly governance MDT meetings took place within the Community SPCT. Staff at all levels told us the meetings were a useful source of information, encouraged staff to engage with issues and enabled learning to be passed across the teams and the trust.
- Feedback from incidents and complaints was discussed at monthly business meetings. Important issues around patient safety requiring further action was discussed at community team meetings. Minutes and service improvements were sent to the whole team.
- The lead nurse for palliative care held the risk register. This was reviewed annually. Each team held a risk assessment file and there was a trained risk assessor for community. The lead nurse for palliative care was the identified risk lead. We discussed the risk register with the senior management team who told us there were no risks identified. However, an EOL and palliative care report identified a loss of funding for AHP staff which 'represented a significant risk to patient care', however, this had not been identified on the risk register.
- Staff attended patient safety briefings and the briefing summary discussed at the team business meeting.

Leadership of this service

- EOLC reported to the Nursing and Patient Services Director and had a direct link into the Trust Board.
- The SPCT was subdivided into four teams covering the 4 key areas – Newcastle Community team, Royal Victoria Infirmary (RVI) team, Northern Centre for Cancer Care

Are services well-led?

(NCCC) team and Freeman Hospital (FRH) team. The four teams work independently for day-to-day clinical work, with the ability to cross cover when teams were busy. Strategically the teams worked as one joined up service.

- The End of Life Care team was interdisciplinary; including Consultants in Palliative Medicine, band 6 and 7 Nurse Specialists and administrators. In addition, there was an advanced Macmillan Specialist occupational therapist and physiotherapist on a four year Macmillan funded project based at the hospital sites.
- SPC line management was divided between cancer services directorate (all medics) and the patient services directorate (all other staff).
- Community SPCT staff told us they generally felt that the trust was committed to the ongoing development of end of life care services. Staff spoke positively about the effectiveness of the MDT meeting, which was held weekly.
- Staff confirmed they met with colleagues from the acute teams twice yearly to discuss service developments but were in contact regularly about patient care needs.

Culture within this service

- The trust provided emotional support for staff as they recognised this was an important aspect in caring and provided staff with an outlet facilitating them to maintain their ability to continue caring for patients with complex needs and their families.
- Staff we spoke with demonstrated a commitment to the delivery of good quality end of life care. There was evidence that staff felt proud of the care they were able to give and there was positive feedback from nursing and care staff as to the level of support they received from the SPCT.
- There was evidence that the culture of end of life care 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 observed good joint team working across the community SPCT and district nursing teams. Staff told us there were opportunities to learn and that the delivery of high quality end of life care services within the community was a priority.

Public engagement

- Relatives were encouraged to participate in the Family Voice Diary. The diary was intended to improve communication between family / friends and health professionals during end of life care.
- Bi-annual audits of end of life care were conducted across the community setting, to monitor standards. Views of relatives and staff providing end of life care were included in the data collection process. Audit results continued to provide evidence of compliance with the priorities for care outlined in 'One Chance to Get it Right'. Carer feedback was very positive.
- Patient Centred Outcome Measured (PCOMS) were collected using the Palliative Care Assessment tool. The data was reported annually to CCG leads.

Staff engagement

- The Community SPCT teams had regular monthly meetings and these gave team members the opportunity to share information, ideas and learning.
- Staff we spoke with told us they felt they had an opportunity to feedback to management and that they felt listened to.
- Staff told us they felt valued by the management of the trust and that the service they provided was seen as an integral part of the work being undertaken by the trust as a whole.

Innovation, improvement and sustainability

- The trust had implemented the Palliative Care Rapid Assessment Project. A 1-hour referral service either where a SPCT staff member would contact face to face or telephone contact a patient who had been identified as a palliative patient.
- The Care for the Dying Patient (CDP) had been fully implemented within the community setting.
- An integrated model of palliative care for cystic fibrosis has been introduced which was shortlisted for an award.