

Cheshire and Wirral Partnership NHS Foundation Trust

RXAX2

Community end of life care

Quality Report

Redesmere
Countess of Chester Health Park
Liverpool Road
Chester
CH2 1BQ
Tel: 01244 364186
Website: www.cwp.nhs.uk

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RXAX2	Redesmere, Countess of Chester Health Park	Community End of Life services	CH2 1BQ

This report describes our judgement of the quality of care provided within this core service by Cheshire and Wirral Partnership 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 Cheshire and Wirral Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Cheshire and Wirral Partnership NHS Foundation Trust

Summary of findings

Ratings

Overall rating for the service	Good	●
Are services safe?	Good	●
Are services effective?	Good	●
Are services caring?	Outstanding	☆
Are services responsive?	Good	●
Are services well-led?	Good	●

Summary of findings

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Summary of findings

Overall summary

Staffing levels were well managed by the team leader, with low levels of sickness and no current vacancies due to recent recruitment. However, trust managers had not taken a systematic approach to establishing the required staffing levels and acuity (level of patient need) of caseloads.

Appropriate equipment was available to patients. Medicines were managed appropriately. Information in relation to patient care and treatment was available to staff and records were adequately completed. There was a sufficient number of staff who had received appropriate high level training.

Patients received care and treatment according to national guidelines. Staff were patient focused on achieving the best outcomes possible for the people they cared for. Multi-disciplinary care was being provided and links were well established with good communication between disciplines.

Patient records were of a good standard and stored correctly in the patient's home. There were no serious incidents reported relating to end of life care in the community within the 12 months prior to the inspection. Patients told us they felt safe.

End of life services for adults were delivered by staff who were committed and enthusiastic about their roles. We saw evidence that staff took the time to familiarise themselves with patients and were welcoming and helpful. They were also very supportive to each other.

Staff showed an awareness of people in vulnerable circumstances and gave examples of how to make care more accessible to them. People had the opportunity to comment on the service they received. Complaints were dealt with primarily at local level.

The diverse needs of people were met and there were appropriate provisions of care for patients and their families in line with their personal or religious wishes.

There was no overarching performance quality dashboard for end of life care. Staff measured quality locally which helped staff steer the direction of the service. However, staff felt that some of the changes put in place across the trust had been rapid and on occasion had been difficult to deal with.

Audits results for 'do not attempt cardio-pulmonary resuscitation' forms go to the end of life steering group and then to the overarching safety and quality group. However, we found no evidence of action plans and learning as a result of these audits.

Whilst some staff had seen members of the board once or twice, some had never come into contact with any of them which supported the feeling that teams and services were locally driven.

Summary of findings

Background to the service

Cheshire and Wirral Partnership NHS Foundation Trust has a specialist palliative care team based in the community that provides specialist end of life services for adults in the West Cheshire area. The staff are split into two sub-teams, each covering a specific geographical area. Patients are allocated a specialist nurse and therapy services based on the area they live in and the GP they are registered with. All patients referred to the service have a life-limiting, advanced, progressive illness. Patients who require care at the end of their life from outside the West Cheshire area have their care coordinated by a local hospice.

The specialist palliative care team consists of specialist nurses and therapists. They provide advice and support; act as patient advocates and offer support with advanced care planning to patients in the community who have a life-limiting condition, with the focus on improving the quality of life. The team monitor individual patients in order to control symptoms effectively, be they physical, psychological or spiritual. The team also act as a link

between care agencies and the patient's home. Patients are occasionally supported by the team in a hospice if they are unable to remain in their own home. The team rely heavily on risk assessments being completed by community nursing teams, who provide hands-on nursing care to patients at the end of their life. Care is provided by multidisciplinary teams which include the patients GP, palliative care nurses, district nurses, therapists and a night sitting team. The team work closely with specialists such as Macmillan nurses and have close working links with a local hospice.

As part of this inspection, we spoke to three patients currently receiving support from the service and three relatives. We spoke to staff of different grades, including the service lead, team manager, three specialist nurses and one therapist. We reviewed records relating to the management of the service, four patient care plans and 11 comment cards that were completed by people using the service.

Our inspection team

Our inspection team was led by:

Chair: Bruce Calderwood, Director of Mental Health, Department of Health (retired)

Head of Inspection: Nicholas Smith, Care Quality Commission

Team Leaders: Sharon Marston, Inspection Manager (Mental Health), Care Quality Commission; Simon Regan, Inspection Manager (Community Physical Health), Care Quality Commission

The team that inspected this core service comprised: a CQC inspector and a palliative care nurse specialist advisor.

Why we carried out this inspection

We inspected the community end of life core service as part of our comprehensive inspection of Cheshire and Wirral Partnership NHS Foundation Trust.

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?

Summary of findings

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

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

Organisations to share what they knew.

We carried out an announced inspection between 23 June to 26 June 2015. During the visit we met with three patients currently receiving support from the service and three relatives. We spoke with the service lead, team manager, three specialist nurses and one therapist. We reviewed 11 comment cards that were completed by people using the service.

What people who use the provider say

All of the people we spoke with were very positive about the specialist palliative care and support provided by Cheshire and Wirral Partnership NHS Foundation Trust.

Feedback from people who use the service, their families and stakeholders was continually positive about the way staff treated people. Patients and families said that staff went the extra mile and that the care they received exceeded their expectations.

Patients told us, "I feel much happier now and I can face the future," and "The team who work with my partner are always warm and empathetic, giving us hope and comfort when we need it. I know we would have both been much more afraid of what's to come without them."

The service asked patients and their families or representatives to complete satisfaction surveys, if appropriate. However we noted that the bulk of feedback was received from close relatives after a person had passed away. All the feedback received from patients and their families expressed clear satisfaction with the service they had received. Comments included, "They have been our lifeline, without them I don't know how we could have carried on."

Good practice

- The team as a whole, worked to ensure that patients received all the emotional and practical advice and

support they needed. We saw good examples of team members going the extra mile to try and ensure that patients were able to end their days in the place they chose.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The provider should ensure that:

- There is an overarching strategy for the specialist palliative care team in relation to their role in end of life care, to ensure their role is well defined and clear.
- The strategic approach to end of life services is reviewed to ensure that there is a trust-wide approach to service development and a clear understanding of the impact of staff absence on patient care.

- There are sufficient numbers of suitably qualified skilled and experienced staff to meet the needs of the service during periods of planned sick and annual leave.
- The quality of end of life services is measured to ensure patients are receiving the appropriate care and treatment.
- Feedback is encouraged and shared among staff following incidents/complaints, to ensure that learning is shared across all teams in line with the principles of integrated working.

Summary of findings

- Where audits are undertaken, the outcomes are shared with staff to aid their learning and action plans (where potential improvements are identified) are developed, implemented and monitored.

Cheshire and Wirral Partnership 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

Staffing levels were well managed by the team leader, with low levels of sickness and no current vacancies due to recent recruitment. However, trust managers had not taken a systematic approach to establishing the required staffing levels and acuity (level of patient need) of caseloads.

Staff were familiar with incident reporting procedures and there was an open, honest culture of learning. All staff were aware of duty of candour regulation requirements. Staff we spoke to were able to give examples of how they demonstrated openness in their approach to incidents of harm or risk of harm affecting patients. Safeguarding policies were in place and staff understood what processes to follow if they had concerns. Staff had received mandatory training, which included fire safety, basic life support, moving and handling, and safeguarding adults and children. Learning from incidents was shared within the team; however, during our discussions we could not identify any formal mechanisms to share learning across the trust to other teams.

Patient records were of a good standard and were stored correctly in the patient's home. There were no serious incidents reported relating to end of life care in the community within the 12 months before the inspection.

Safety performance

- The specialist palliative care team did not routinely provide direct care to a patient, nor did they attend a patient's home as frequently as the community nursing team, and as a result they were less likely to note such things as pressure ulcers. It was more likely, therefore, that incidents would be reported by the community nursing team.
- Information in relation to patient care and treatment was available to staff, and records were completed adequately. Staff we spoke with were aware of how to report an incident or raise a concern. Nurses were able to describe safeguarding procedures and provided us with examples of how these would be used.

Incident reporting, learning and improvement

- There was one serious incident reported relating to end of life care in the community within the 12 months

Are services safe?

before the inspection. Staff we spoke with were aware of how to report an incident or raise a concern and gave us examples of how incidents would be investigated and learning shared.

- Incidents or issues were discussed during routine staff meetings, which took place every week. The team maintained an updated list of issues and incidents, which we were told were monitored during weekly meetings that were minuted and actioned.
- Learning from incidents was shared within the team; however, during our discussions we could not identify any formal mechanisms to share learning across other teams such as community nursing, other than via training the team provided to colleagues.

Safeguarding

- Trust-wide safeguarding policies and procedures were in place. Staff demonstrated that they knew and understood how to identify potential abuse and would report any concerns to their manager.
- The specialist palliative care team were informed verbally about safeguarding alerts that had been generated by the community nursing team. Safeguarding concerns were also recorded on the electronic shared record-keeping system so as to alert staff.
- Staff were able to give examples of safeguarding concerns they had raised previously and staff told us they had always been supported by their line manager in raising concerns to the trust safeguarding lead.
- Data provided by the trust showed that all eligible staff in the service had received safeguarding training at level 2 or level 3, dependent on their role.

Medicines

- The specialist palliative care team were not responsible for the management and administration of medication. Patients who were approaching the end of life received their medication through a combination of GPs and the community district nursing team.
- The team lead was able to describe the process used in relation to the administration of controlled drugs to people who used the service. The community nurses administered controlled drugs through syringe drivers in line with the trust policy and National Institute for Health and Care Excellence (NICE) guidelines

- Controlled drugs were managed appropriately. We reviewed the policy for the management of controlled drugs and found this was current and reflected national guidance.

Quality of records

- We visited three patients in their own homes and noted that documentation relating to plans of care, risk assessment and the administration of medicines was up to date and legible. Community nurses maintained a full paper case file in patients' homes and also completed an electronic record using the online system. Staff said that they were due to change to full electronic systems using portable devices in the next few weeks.
- All the records we reviewed contained the necessary information, such as risk assessments, to allow staff to carry out their required clinical activities.
- We reviewed DNACPR forms recording decisions in relation to whether staff should attempt to revive patients with cardiopulmonary resuscitation (CPR). DNA stands for do not attempt. Where present, the forms were fully completed with details of who was consulted in the process of a decision being made. Forms were filed in patients' notes for easy access.

Cleanliness, infection control and hygiene

- There had been no cases of methicillin resistant staphylococcus aureus or clostridium difficile for patients using this service in the 12 months before our inspection.
- The trust had an infection control policy. Staff had an understanding of good practice to prevent and control the spread of infection.
- Staff were observed to be using personal hand sanitising equipment when caring for patients. Personal protective equipment was not available for the end of life care team; however, we were told that the team rarely provided direct care to patients.
- All clinical staff working within the team had completed infection control training. In addition, 100% of staff had completed training on preventing and responding to sepsis (a potentially life-threatening condition triggered by an infection).

Mandatory training

- Mandatory training provided by the trust included fire safety, basic life support, moving and handling, and safeguarding adults and children. Staff told us that the

Are services safe?

training they received was delivered in a variety of formats. Some training, for example safeguarding level one, was accessed electronically but safeguarding at level two or above was face-to-face learning.

- Training summary records were reviewed regularly by the team leader to monitor how many of the team had completed this training and when. We saw records that confirmed these audits and the information given to us by the individual members of the team.
- The trust set a target of 85% of staff having completed mandatory training, when required. We noted that 100% of the specialist palliative care team members had completed their mandatory training at the time of the inspection.

Assessing and responding to patient risk

- In patient records, there was evidence of risk assessments being completed, relating to issues of safety or the patient's general living environment. Risk assessments for venous thromboembolism (VTE), pressure ulcers, nutritional needs, falls and infection control risks were conducted by the community nursing team.
- The specialist palliative care team relied on community nursing to ensure appropriate risk assessments were completed. We saw notes in the paper documentation that alerted staff to risk assessments that had been recorded electronically.
- The team was not an emergency service. Patients and their families were advised if their condition suddenly deteriorated to contact their GP or to attend a hospital emergency services department. Staff were aware of the escalation processes for senior manager support and they could articulate what to do if a patient deteriorated.

Staffing levels and caseload

- The specialist palliative care team consisted of two band 7 nurses, five band 6 nurses, one full-time band 7 therapist, who was also the team leader, and one part-time band 3 therapy assistant. Each member of the nursing team had an average caseload of between 30 and 35 patients at any one time. Due to the nature of the service, this fluctuated day by day.
- Direct patient care for patients approaching the end of life was predominantly provided by community district nursing teams and therapists. Senior managers said

further work was needed to make the caseload tool for daily patient visits robust and to ensure that patient acuity (their level of need) was fully taken into account. The trust reported that each of the clinical leads reported the acuity of patients to the team managers, which was then escalated to the locality senior leadership team, but not all staff we spoke with were aware of the process and did not fully understand the system.

- We asked for feedback from the trust regarding the nursing caseload tool and prioritisation. We found that there were criteria for prioritising patients but no formal metrics for assessing the level of risk relating to staffing teams – for example as red, amber or green. A red rating would mean a high level of risk relating to the staffing of teams, a rating such as this would also highlight potential high level risk to the quality of support patients who access the service receive.
- Staff told us that they were generally able to manage their workload and ensure that patients received the appropriate care and support. However, we found that the trust had no plans to ensure that staff were available to cover planned absences such as annual and maternity leave.
- We reviewed records which showed that, at times caseloads among the specialist palliative care team were as high as 70 to 75 patients because of staff sickness and annual leave. Discussions we had with management at trust level confirmed that there were no contingency plans to cover planned or unplanned (long-term) absence.
- The team were available 9am to 5pm Monday to Friday, excluding bank holidays. Staff told us that they did not have enough staff to provide a seven-day service but were hoping to introduce this in the future.

Managing anticipated risks

- There was routine engagement with the district nurses, GPs, hospice staff and social workers so that staff were kept informed of a patient's condition and could make arrangements for patients who were awaiting referral for end of life care services. The end of life care team were well placed geographically within the localities they served.
- We saw evidence of weather warnings distributed to individual teams for action and escalation in line with trust policies.

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

Patients received care and treatment according to national guidelines. Staff were patient focused on achieving the best outcomes possible for the people they cared for. Multi-disciplinary care was being provided and links were well established with good communication between disciplines. Roles and responsibilities were clear and management structures were in place and clearly understood. We observed excellent working practice by the team.

Staff were suitably qualified to perform their roles and had the opportunity to gain experience through extra high level training which was offered to enhance skills. Within the team, staff members had the opportunity to lead on specific areas such as dementia and safeguarding. All staff received timely appraisals with the team manager.

Evidence based care and treatment

- Patients received care according to national guidelines such as National Institute for Health and Care Excellence and guidance from other organisations, such as the Macmillan Cancer Support and Marie Curie Cancer Care. Clinical audits included monitoring of NICE and other professional guidance.
- Staff within the specialist palliative care team were highly trained and had a good understanding of existing end of life care guidance and implemented these effectively.
- The trust's end of life care plan had previously been based on the Liverpool Care Pathway for the Dying Patient. The end of life team were in the process of piloting a new personalised care plan at the time of our inspection.

Pain relief

- Pain relief was reviewed regularly for efficacy and changes were made as appropriate to meet the needs of individual patients.
- Staff confirmed that syringe drivers were accessible for patients who required subcutaneous medication for pain relief. This was available seven days a week and out of hours, via the community nursing teams.

- Staff were able to access clear guidance on the prescription of medications to be given 'as required' for symptoms that may occur at end of life, such as pain, anxiety, nausea, vomiting and breathlessness. This meant that patients had access to the most appropriate pain and symptom relief. Medications were ordered and delivered as part of multi-disciplinary working by the patients GP with support from the community nurses and local pharmacy teams

Nutrition and hydration

- The specialist palliative care team worked with professionals in other disciplines (district nursing, continence, dietetics) to assess patients for possible malnutrition. The trust used the malnutrition universal screening tool (MUST) to ensure that patient's requirements in relation to nutrition and hydration was assessed and effectively managed.

Patient outcomes

- We were told that the trust does not collect information to contribute to the national care of the dying audit as there was no national requirement to do so.

Competent staff

- Appraisals were being undertaken and staff spoke positively about the process. The trust provided appraisal data for May 2015 which showed that 85 % of the staff team had undergone their yearly appraisal.
- Staff within the specialist palliative care team had regular one to one meetings. Staff told us they received annual appraisal, clinical supervision (every six weeks) and were meeting their mandatory training requirements. This was supported by information we had received from the trust.

Multi-disciplinary working and coordinated care pathways

- Patients received effective support from a multidisciplinary end of life care team, which included

Are services effective?

specialist palliative nurses, consultant and therapists. Multidisciplinary staff meetings took place on a weekly basis to ensure any changes to patients needs could be addressed promptly.

- The specialist palliative care team also engaged with GP's, acute trust staff, a local hospice and social workers to ensure care was coordinated across other organisations within their localities.
- The team leader told us that the team tried to attend as many multidisciplinary team meetings as possible to share the work of the team, and help identify and coordinate care for an individual approaching the end of life or requiring supportive care.

Referral, transfer, discharge and transition

- Community services staff were able to refer directly to the community specialist palliative care team, as were GP's. Referrals were also made by palliative care colleagues working within local hospitals and patients could self-refer also. This service operated between 9am and 5pm, five days a week, staff we spoke with reported that the process worked quickly and effectively.
- Referrals to the team from GP's and colleagues in the community were made via fax but staff reported that were not always sure of when referrals had come in. Staff we spoke with told us that they were confident that they triaged all referrals appropriately, with life expectancy being used to assess patient priority. However, staff reported that they often had incomplete fax transcripts. This made them feel anxious about whether referrals were always received.

Access to information

- We saw examples of where people moved between services and teams for example, from hospice care to their own home. We reviewed paper and electronic records which confirmed information to support their care was available to staff in a timely way across community services.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We reviewed eight electronic patient records and noted that consent had been obtained and was recorded appropriately.
- Staff received mandatory training in safeguarding children and vulnerable adults, which included aspects of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberties Safeguards (DOLS).
- Staff understood the legal requirements of the MCA. Records we received from the trust during our inspection confirmed levels of staff training which were in line with the information we received from the trust prior to our inspection.
- Do not attempt cardio-pulmonary resuscitation (DNA CPR) forms were in place for patients if indicated. We spoke with one nurse who was able to fully outline to us, that although all active care was being given, the patient had been given the choice regarding DNA CPR. We were told the trust carried out an annual audit of DNA CPR.



Are services caring?

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

Summary

End of life services were delivered by highly trained, hardworking, caring and compassionate staff. We observed that staff treated patients with dignity and respect and planned and delivered care in a way that took into account the wishes of the patients.

Staff provided a caring service and people told us that they felt safe and happy with the care and support both they and their families received from the End of Life team. Interactions between staff and patients demonstrated a respectful, kind and compassionate approach.

The experiences of patients impacted on staff in a positive way. They took time to interact with the people using their service and knew where to find additional support for people if required.

Staff were highly sensitive to the needs of patients who were seriously ill and recognised the impact this had on the individual patient and those close to them.

Compassionate care

- Patients were treated with compassion and empathy. Staff provided care and support in a kind, calm, friendly and patient manner.
- Patients and relatives were complementary about staff attitude and engagement. We observed patients that had difficulty with their speech were listened to patiently and staff responded to their queries appropriately.
- The comments received from patients demonstrated that staff cared about meeting patients' individual needs. For example one person, whose relative received care from the specialist palliative care team commented; "They have been extremely caring and attentive to our needs as a family. The way they have encouraged and challenged [relative] in this incredibly difficult journey has made everything easier to face. They've been spot on in their attitude and have supported [relative] wonderfully."

- Another person who was receiving care and support from the team said; "I would just be so lost without them, they are always here when I need them. It makes everything easier to bear."
- Nursing staff told us it was a privilege to provide care and support to people at the end of their life and saw their role as vocational.

Understanding and involvement of patients and those close to them

- Patients and relatives explained how staff had worked to establish a good rapport with patients, their relatives and close friends.
- Patients and their relatives were overwhelmingly positive about their care and the way staff communicated with them and they told us they felt involved in decision making.
- Staff were aware of a patient's beliefs and were respectful of their wishes.
- We observed how staff adapted their approach by communicating with patients and relatives using terminology and language relevant to the situation.

Emotional support

- We witnessed therapy staff providing emotional support during a visit to a patient's home. Relatives also confirmed that staff provided them with emotional support.
- Although specific information leaflets or booklets were provided, people told us that staff informed them about local services such as counselling services and services providing assistance with anxiety and depression.
- Staff felt well supported by the team lead and their colleagues and could describe examples of when they had received emotional support following the death of a patient.
- During home visits we made with members of the team, we saw that staff promoted self-care wherever possible. This was confirmed during our discussions with staff, patients and relatives.

Are services responsive to people's needs?

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

Summary

Staff showed an awareness of people in vulnerable circumstances and gave examples of how to make care more accessible to them.

People had the opportunity to comment on the service they received. Complaints were dealt with primarily at local level.

We found people's diverse needs were met and that there were appropriate provisions of care for patients and their families in line with their personal or religious wishes.

Planning and delivering services which meet people's needs

- Staff had a good understanding of the needs of the local population. Staff worked as part of multidisciplinary teams and routinely engaged with local hospices, GP's, adult social care providers and other professionals involved in the care of patients.
- The team delivered comprehensive training to nursing staff to ensure that care was responsive to people's needs in such areas as, preferred priorities for care and communication skills for palliative care.
- Staff were responsive to patients' needs and provided the right level of care and support. Staff monitored patients and delivered person centred care in line with national guidance. Staff communicated on a daily basis with community nurses and we observed staff regularly checking patients' electronic records.
- Staff were confident patients could access the end of life care services when needed. The team routinely engaged with community nursing staff, GP's, local hospices and adult social care providers so patients could be referred promptly and to provide advice, where necessary and patients could self-refer to the team.

Equality and diversity

- Patients who used the service were asked about their spiritual, ethnic and cultural needs as well as their medical and nursing needs. Staff were respectful and took the needs and wishes of the patients into account when caring for them.

- Staff could access an interpreter for patients whose first language was not English if needed and we were told of situations when an interpreter was able to accompany staff on home visits.

Meeting the needs of people in vulnerable circumstances

- Patient needs were assessed and care and treatment was planned and delivered in line with their individual care plan. We saw that risk assessments were completed by staff and updated as the patient's condition changed.
- Patients living with complex needs such as learning disabilities, dementia or cognitive impairment were supported and staff could contact specialist nurses within the trust for advice and support.
- We visited patients in their own homes and noted that there were leaflets available for people to read in their own time. We saw that these provided information about common side effects of medications, organisations that could offer support and details about how to make a complaint. However the only information we saw was provided in English, which was the first language of the patients we met at home.
- Staff told us that information in other languages and formats was easily accessible if their individual patients required it.

Access to the right care at the right time

- Staff were confident patients could access the end of life care services when needed. Care was provided in conjunction with colleagues in community nursing who could liaise with the team directly for advice. The team routinely engaged with GP's, local hospices and adult social care providers so patients could be referred promptly.
- Patients were referred to the end of life care services through a number of routes including via GP or consultant referral, or they could visit local hospices or access the service via outpatient appointments.

Are services responsive to people's needs?

- There were no waiting times for patients awaiting specialist end of life care services and patients would be seen promptly upon referral. Decisions on the priority given to any referral was undertaken based on the prognosis for the individual concerned.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. 'Quality of service' leaflets were available for patients/relatives to raise a concern/make a formal complaint or pass on a compliment.
- There had been no complaints relating to the specialist palliative care service during the past 12 months. Records we reviewed confirmed that all complaints would be recorded on a centralised trust-wide system. The clinical leads would investigate formal complaints relating to specific teams.
- Relatives and patients we spoke with confirmed that information regarding how to make a complaint was given to patients when they entered the service.

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

The specialist palliative care team had an awareness of the trust's vision and values. The trust had a focus on the 'six' Cs; which were centred on staff providing services that offered care; compassion; competence; communication; courage and commitment. We saw several examples of this in action during our visit.

There were effective systems and processes in place to ensure staff were trained, supported and appraised and were able to give feedback to their team leaders and line managers. The service had a lead for end of life care. The specialist palliative care nurses were line managed through the team leader and clinical service manager. Professional development was supported by the professional development lead for nursing.

Staff we spoke with across the trust were extremely positive about the specialist palliative care team and felt that they were both responsive and supportive to community nursing staff managing patients at the end of life. However, we were unable to confirm that there was an overarching quality monitoring process specifically for patients receiving end of life care. Staff measured quality locally which helped staff steer the direction of the service. However, in discussion with us it was clear that staff felt that some of the changes put in place across the trust had been rapid and on occasion had been difficult to deal with. The reports from staff suggested that end of life services were seen as addition to the main trust focal point of mental health. As a result, they did not always feel as valued as mental health colleagues. There wasn't a clear overriding strategy for the end of life service and the service may be under utilised as a result. The trust should raise the profile of the service within the trust to develop it further.

Whilst some staff had seen members of the board once or twice, some of the staff we spoke with had never come into contact with any of them. This supported the feeling that teams and services were locally driven.

Service vision and strategy

- All staff were able to tell us about the 6 C's (a framework for care and support for patients and staff) and gave us examples of where it was being used to support trust services.
- Staff had awareness about the trusts visions and strategies. However, there was a disconnect between the team and trust. For example, no one within the specialist palliative care team was able to tell us about the audit schedule of key processes, or if one was in place.
- There wasn't a clear overriding strategy for the end of life service and the service may be under utilised as a result. The trust should raise the profile of the service within the trust to develop it further.
- Staff felt that changes put in place across the trust had been rapid and on occasion had been difficult to deal with.

Governance, risk management and quality measurement

- There was no overarching performance quality dashboard for end of life care. The service was monitoring its own performance with monthly updates. This consisted of reviewing patient feedback, waiting times from referral to first appointment and patients care files, both paper and digital. In discussions with the team, no one could give us a clear overview of how the quality of service delivery was reviewed. We observed many excellent examples of caring, and high quality care and support offered to patients and their families. However, we felt that the trust could work to develop a culture of more open conversations around sharing the expertise of the team as part of the patient's journey.
- Audit results for 'do not attempt cardio-pulmonary resuscitation' forms go to the end of life steering group and then to the overarching safety and quality group. However, we found no evidence of action plans and learning as a result of these audits.

Are services well-led?

Leadership of this service

- The service had a lead for end of life care. The specialist palliative care nurses were line managed through the team leader and clinical service manager. Professional development was supported by the professional development lead for nursing.
- We did not see evidence of visible discussion at board level regarding end of life care provision.

Culture within this service

- Staff we spoke with across the trust were extremely positive about the specialist palliative care team and felt that they were both responsive and supportive to community nursing staff managing patients at the end of their lives.
- Staff within the service were clearly highly motivated and positive about their work. The staff we spoke with told us they received support from their line manager.

Staff engagement

- Many of the staff we spoke to felt that the intranet was a useful form of engagement. For example there were regular podcasts and published messages from board members.
- Whilst some staff had seen members of the board once or twice, some had never come into contact with any of them which supported the feeling that teams and services were locally driven.
- Staff told us that working within the team was an extremely positive experience and that their major source of support was the other members of the team and the team manager.
- Staff reported that despite completing a staff survey, they did not know if any actions had been taken or if there were actions to be taken.
- The reports from staff suggested that end of life services were seen as addition to the main trust focal point of mental health. As a result, they did not always feel as valued as mental health colleagues.