

Cornwall Partnership NHS Foundation Trust

Community end of life care

Quality Report

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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)
RJ866	Bodmin Hospital		
RJ842	Falmouth Hospital		
RJ807	Newquay Hospital		
RJ8A3	Liskeard Community Hospital		
RJ805	Helston Community Hospital		
RJ817	Camborne and Redruth Community Hospital	<Placeholder text>	<Placeholder text>







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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall, we found that end of life care required improvement because :

- Not all staff were up to date with the required mandatory training. The recording and monitoring of this training meant accurate up to date figures were not available.
- There were inconsistencies in the completion of the patient TEP forms (Treatment Escalation Plan) which could mean
- There was inconsistent understanding on the wards of the GSF (Gold Standards Framework) system being used to monitor and deliver end of life care. We found patients who were coded incorrectly and also staff who did not understand what the various codes related to, in terms of the stages of end of life.
- There was a lack of personalised information being recorded in the care plans for patients. There was little detail completed about any personal preferences or wishes, which may have been identified through discussion with a patient or their family.
- There were inconsistencies in the completion of specific end of life training, and also the levels of training undertaken. There was no record of the training provided by the specialist palliative care teams to other staff, nor any formal plan for what was provided. There was a lack of clarity around how this was organised, and what was available to ward and community staff.
- Staff working for the continuing care at home team were not provided with sufficient training in end of life care.
- There was a lack of clarity for some staff regarding the role of the specialist palliative care teams.
- There was inconsistency in the recording of capacity assessments on the TEP forms (Treatment Escalation Plan).
- There was variable provision for supporting patients in their own homes. The trust ran a continuing care at home team, that was very responsive and could be organised quickly, but this was only commissioned for one locality.
- There was no trust wide strategy group that focused on the implementing of trust policies and initiatives in relation to end of life care. There were no regular formal meetings which involved representatives from all staff involved in delivering end of life care.
- There was a fragmented approach to end of life care, due to a variation in service provision and the lack of visibility of the leadership for end of life care. There was lack of clarity about the future use of the GSF (Gold Standards Framework).
- There was only one end of life care facilitator and they were required to cover a wide geographical area, covering a range of staff teams and different hospitals.
- The trust did not have had an overarching vision for what it wished to achieve in relation to end of life care.
- There was not a bespoke risk register for end of life care. There was no assurance that any potential risks to the effective delivery of end of life care were being identified and recorded.

However:

- The service managed patient safety incidents well. Staff understood how to report incidents and felt confident about reporting them.
- Staff had training on how to recognise and report abuse, and knew how to apply it. Within the services we inspected in relation to end of life care, including the specialist palliative care team and the continuing care at home team, all were up to date with their mandatory safeguarding training.
- Patients receiving end of life care were prescribed anticipatory medicines, and these were well managed by staff. Appropriate and up to date guidance was in place.

Summary of findings

- Staff kept appropriate records of patients' care and treatment. Records were securely stored and patient confidentiality was protected.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse, and to provide the right care and treatment.
- Audits were completed to monitor the effectiveness of care and treatment, and the findings used to develop improvements.
- Staff spoke positively about the supervision and support they received from managers. All staff had an annual appraisal, and those requiring clinical supervision were having this completed.
- We observed compassionate care in the approach from all the staff working in the wards and in the community. Feedback from patients was very positive about the caring and professional approach of staff.
- Staff ensured that patients and families were involved in their care and understood their treatment and prognosis.
- Emotional support and information was provided to those close to people who use services, including carers and dependants.
- The trust worked with other stakeholders, commissioners and providers to promote end of life care across the county. There was a county wide strategy group for end of life care which was chaired by the Director of Primary Care.
- Relatives were supported to visit and stay in the community hospitals and most wards could provide side rooms for end of life care patients.
- Ward staff and community teams worked proactively to support patients to achieve their preferred place of care. Audits showed that improvements had been made over the previous 12 months.
- When care packages were available, the ward staff could organise a rapid discharge and could co-ordinate well with the community teams and local GPs.
- There was evidence of good local leadership, with staff speaking positively about their managers and the support and direction of the service.
- Staff were clear about the governance structure within their services, both in the hospitals and in the community teams. There were regular team meetings and opportunities for staff to talk to their managers.
- We found there was a positive culture across the services we visited. Staff were proud of their work and committed to providing high quality end of life care. Managers promoted a culture that supported and valued staff.
- The trust engaged effectively with staff to ensure they were kept informed of changes and developments, and also to provide opportunities to give feedback.

Summary of findings

Background to the service

Cornwall Partnership NHS Foundation Trust provides a range of mental health and physical health services to children and adults across Cornwall and the Isles of Scilly. It employs approximately 3700 staff across all its services. The services include community hospitals, adult community services, such as district nursing, and children community services.

End of life care was delivered when required in the wards of the community hospitals and in patients own homes. Care was provided by ward staff, including nurses, health care assistants and medical staff and by district nursing teams. In one locality there was a team of health care assistants, called Continuing Care at Home that worked with the district nursing team to provide care and support to patients in their own homes.

There were three specialist palliative care teams (SPCT) located across three localities. These staff worked from the community hospitals, or Truro Health Park, and linked with the other staff in their respective locality. The staffing compliment was 18.5 whole time equivalents. They provided specialist support and advice for those patients with complex needs, and/or complex symptom management relating to end of life care. The team also provided advice on all aspects of palliative care and palliative care education and training.

Working across the whole service was an end of life care facilitator. They liaised with, and supported, ward staff and district nursing teams with all aspects of the Gold Standards Framework. This was the framework for end of life care that was in place across the whole service. This is a national accredited system and programme for the provision of end of life care.

The total number of deaths recorded in the community hospital wards during the 12 month period from April 2016 – March 2017 was 411. Data shows that fewer people die in hospital in Cornwall than the national average. An audit from the trust showed that 23% of patients were supported to die at home. Data also showed that 87% patients had their preferred place of dying identified, and of these 84% achieved their preference.

As part of this inspection we visited six community hospitals. We also met with district nursing teams, the SPCT's, locality managers and health care assistants. We accompanied staff on home visits and attended multi-disciplinary meetings. We spoke with 8 patients, 6 relatives, and 35 staff in total. We looked at a sample of 22 patient records. We looked at audits undertaken by the trust and policies and minutes from meetings.

Cornwall Foundation Partnership Trust provides healthcare services to a population of approximately 536,000. The demographics of Cornwall and the Isles of Scilly are broadly similar to England, although there is a slightly larger elderly population in Cornwall compared with England (6% higher in proportion). Deprivation in Cornwall and the Isles of Scilly is lower than the England average, although about 18.1% of Cornish children live in poverty. Life expectancy in Cornwall and the Isles of Scilly is slightly higher than the national average, standing at 79.5 for males and 83.5 for females compared with 79.2 and 83.0 nationally.

Our inspection team

Our inspection team was led by: Karen Bennett- Wilson, Head of Hospital Inspections (mental health), Care Quality Commission

Team Leader: Michelle McLeavy inspection manager, Care Quality Commission and Amanda Williams inspection manager, Care Quality Commission

The team for end of life care included one CQC inspector, and two specialist advisors with palliative care nursing backgrounds.

Summary of findings

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 community health services

inspection programme. Cornwall Partnership Foundation Trust is an independent organisation providing NHS services and therefore we used our NHS methodology to undertake this inspection.

How we carried out this inspection

During our inspection we reviewed services provided by Cornwall Partnership Foundation Trust across Cornwall and the Isles of Scilly. We visited the community hospitals, the community nursing teams and the specialist palliative care teams. We accompanied staff on home visits to patients. We attended multi-disciplinary meetings and spoke with other professionals working in the community.

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

- Is it safe?
- Is it effective?

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 25 to 29 September 2017. During the visit we spoke with staff who worked within the service, such as nurses, healthcare assistants and managers. We talked with patients and their families. We looked at records and other documentation relating to this core service.

What people who use the provider say

Patients and relatives we spoke with during the inspection were very positive about the care, support and treatment they received from community teams and the ward staff in the hospitals. They were very complimentary about the approach of the staff, their caring attitude and their professionalism.

Quotes from patients we spoke with included;

- "They are all great, I usually see the same person but when someone else comes they are lovely as well."

- "The nurse is an absolute champion."
- "The staff are brilliant, I do not know what me and my wife would have done without her, we have struggled to cope at times".
- "The nurse from the palliative care team answers all the questions and always returns our calls, they are really professional and so helpful"

Areas for improvement

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

Action the service **SHOULD** take to improve

- Ensure that all staff are up to date with their mandatory training and that there is an effective system in place to monitor this.

- Ensure that staff are competent in the completion of TEP forms (Treatment Escalation Plans).
- Ensure that staff are competent in the use of the GSF (Gold Standards Framework) and the coding in relation to assessments of patients.

Summary of findings

- Ensure that individualised care plans contain sufficient detail to reflect the personal choices and preferences of patients.
- Ensure there is clarity around the training provided by the specialist palliative care teams and that records of the training completed are kept. Clarity should be provided around how this training is requested or organised. Greater clarity should be provided about
- Consider the need for a trust wide strategy group that focuses on the implementing of trust policies and initiatives in relation to end of life care. Consideration should also be given as to how such a group could involve representatives from services involved in end of life care.

- Provide a strategy and vision for end of life care across the service.
- Ensure that all risks to the provision of quality end of life care are identified and recorded on the risk register.
- Replace or repair the bed, and cover, used to transport the deceased patients to the mortuary at Camborne and Redruth hospital.

Action the service **MUST** take to improve

- Ensure that staff complete patient capacity assessments correctly and that consent to treatment is correctly recorded.

Ensure that risks associated with end of life care are identified and mitigating actions put into place

Cornwall 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

We rated the safety of end of life care as good because:

- The service managed patient safety incidents well. Staff understood how to report incidents and felt confident about reporting them.
- Staff had training on how to recognise and report abuse, and knew how to apply it. Within the services we inspected, in relation to end of life care, including the specialist palliative care team and the continuing care at home team, all were up to date with their mandatory safeguarding training.
- Patients receiving end of life care were prescribed anticipatory medicines, and these were well managed by staff. Appropriate and up to date guidance was in place.
- Staff kept appropriate records of patients' care and treatment. Records were securely stored and patient confidentiality was protected.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse, and to provide the right care and treatment.

However:

- Not all staff were up to date with the required mandatory training and the recording and monitoring of this training was in need of improvement. Accurate up to date figures were not available.
- There were inconsistencies in the completing of the patient TEP forms (Treatment Escalation Plan), which could mean
- There were inconsistencies in the completion of the forms, and the accompanying assessments, being used to implement the GSF.

Incident reporting, learning and improvement

- The service managed patient safety incidents well. Staff understood how to report incidents and shared lessons learned with the whole team and the wider service. Staff we spoke with explained how they reported and recorded incidents and gave examples of feedback that had been cascaded through staff meetings.
- All staff we spoke with said they felt confident about reporting an incident, and that they worked in a culture where learning was disseminated. For example, we were

Are services safe?

told of an incident relating to the prescribing of anticipatory medicines and the action that had been taken. Staff were kept informed of the issues, which ensured that a consistent approach was taken.

- There had been no never events report in relation to end of life care. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- In accordance with the NHS Serious Incident Framework 2015, the trust reported no serious incident (SIs) in end of life care service for the 12 months prior to the inspection.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person'.
- Staff had been provided with training from the trust governance team to assist with their understanding of the Duty of Candour regulation. Over the past 12 months, the trust had applied for Duty of Candour 234 times. None were within this core service. However staff we spoke with demonstrated their awareness of their responsibilities to use this process if required

Safeguarding

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Figures provided by the trust showed that overall completion rates for safeguarding training were low. For example training for Multi-Agency Public Protection Arrangements) within the services we inspected in relation to end of life care, including the specialist palliative care team and the continuing care at home team, all were up to date with their safeguarding training.

- Information about safeguarding procedures were displayed in ward and staff offices. Staff were aware of who to contact for information, guidance or support.
- We observed staff discussing a safeguarding referral. Information was passed onto the nurse, who was due to visit, and records were completed. Further information was communicated to other professionals, ensuring the situation was kept under review. The action taken respected the choice, and capacity, of the patient but also ensured their safety was fully monitored as far as they were able.

Medicines

- The trust prescribed, administered, recorded and stored medicines safely. Patients receiving end of life care were prescribed anticipatory medicines. These were prescribed in advance to promptly manage any change in the patient's pain or symptoms. There were satisfactory arrangements for the managing, prescribing, storage and security of dispensing of these medications. We looked at five patient records where anticipatory medicines had been prescribed. The recording was completed correctly, which ensured the safety of the patient.
- There was written guidance provided on the wards, that providing information on what medications could be prescribed, by whom, and the protocol to follow. Contact details for the palliative care team were provided, if further advice was needed. District nurses and specialist palliative care nurses were clear about the timescales for the prescribing of these medications.

Environment and equipment

- We visited three mortuaries located at three community hospitals. Not all the hospitals had these facilities. Where this was the case, there were arrangements in place with local funeral directors. The mortuary at Newquay hospital was not in use, due to its poor state of repair. It was clearly signed as not in use. Staff working in the hospital however, were unaware if the repairs were to be carried out.
- We inspected the mortuary facilities at Liskeard and Bodmin hospitals. These were basic facilities with limited storage capacity, but were being correctly

Are services safe?

maintained. The freezer temperatures were being correctly recorded. Routine maintenance was being completed which ensured the safety and dignity of deceased patients.

- At Camborne and Redruth hospital the bed, and its cover, used to transport the deceased patients to the mortuary was in need of replacement or repair. The cover was badly worn and the bed was not deep enough to transport large patients without compromising their dignity.
- Syringe drivers were correctly stored and maintained. Community nurses checked this equipment was up to date with servicing before using. This equipment was supplied promptly when requested. We observed syringe driver training which included advising the nurse on checking the maintenance of the equipment.

Quality of records

- Staff kept appropriate records of patients' care and treatment. Records were generally clear and up-to-date and available to all staff providing care. Records were written and managed in a way that kept people safe and protected confidentiality.
- The trust used a computer system for patient records, and staff working in the community had access to this via mobile devices. We saw that the records in patient's homes were kept to a minimum. Staff were very positive about the system, though there were some occasional reported problems of connectivity.
- We looked at a sample of electronic records across a range of the teams. We found these records were up to date, detailed and provided staff with a wide range of information.
- In the offices and wards we visited we saw that patient records were securely and safely stored, which protected confidentiality.

Cleanliness, infection control and hygiene

- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean.
- We observed staff wearing the appropriate clothing and following infection control protocols, for example, when entering or leaving the wards and after visiting a patient

in their home. Community staff all carried protective clothing, for example, gloves and aprons. They also had hand-sanitising gel to prevent the risks of cross infection.

- In the areas we visited, such as the wards, offices and meeting rooms we saw that cleanliness was maintained. We observed staff following infection control guidance, and observing the trust policy of staff being bare below the elbow, to ensure handwashing techniques were thorough and to reduce the spread of infection.

Mandatory training

- The service provided mandatory training in key skills to all staff and there were systems in place to monitor completion. Within the services we visited all staff we spoke with told us they were up to date with their required mandatory training. However, in data provided by the trust, compliance for staff working within end of life care was recorded as being at only 36%, against a target of 85%. For the most recent time period data was provided for, (01/04/2017 – 31/05/2017) only three out of the 38 mandatory courses run by the trust had met their target compliance. The trust informed us that they had implemented a new system to record training compliance from 26/07/2017. This would capture information from the two existing systems that were in place from the two previous organisations prior to the formation of Cornwall Partnership Foundation Trust. Accurate up to date information about training compliance was therefore not available.
- There was a two month period when all staff were expected to complete a range of training, which included e-learning sessions. Some staff commented that this presented problems at times with access, due to the numbers of staff needing to undertake training at the same time.

Assessing and responding to patient risk

- Risks to patients were assessed, both on the wards and in their own homes. Patient safety was monitored and managed and they were supported to stay safe. However, there were some inconsistencies around the completing of some of the records.
- As part of the GSF (Gold Standards Framework) system that was in place, patients could be considered to be put onto this system of recording if they were thought to

Are services safe?

be within the last twelve months of their life. There were three stages, with appropriate colour coding, that a patient could be assessed as being at. We found that some patients on the wards had remained on their initial coding, when they should have been moving to the next stage. We also found patients who were not on any part of the framework, but who could have reasonably been considered for the initial stage of the framework. Whilst it was evident that staff were identifying patients who were approaching end of life in terms of weeks, days or hours, the paperwork, and the GSF framework and practice, were not always being used to establish or record this. This was partly due to the turnover of staff and the need for updated training, but there was a possibility that the changing needs of a patient would not be identified and correctly recorded.

- In the sample of patient records we looked at, all the appropriate risk assessments had been completed. These were in respect of nutrition and hydration, frailty and the risk of falls. Risks within the home environment were also assessed and recorded.
- We saw that on the ward boards, and on the printed handover sheets in use on the wards, details and concerns about deteriorating patients were identified and shared.

Staffing levels and caseload

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse, and to provide the right care and treatment. Managers and staff we spoke with in the specialist palliative care teams and the district nursing teams, said their caseloads were generally manageable. When district nurses had end of life care patients on their caseloads, they would ensure they had the time to complete visits. They were supported by their managers to prioritise these patients.

- The specialist palliative care teams were well established and provided a consistent and reliable service. The turnover rate for staff within the specialist palliative care teams was recorded as 6% during the period June 2016 to May 2017. This was lower than the trust overall rate of 12%. The team had a vacancy rate of 5% for this period. The sickness rate for the teams was recorded at 2.1%, against a trust average of 5%. Staff in the teams we spoke with said the consistency promoted teamwork, and the sharing of experience and knowledge.
- At the hospitals where there were mortuary facilities, there were no portering services available after 10 pm. This meant that nursing staff could be required to move a deceased patient. However sometimes, due to the busyness of staff, or for example it was a bariatric patient, this was not possible, and patients had to remain on the ward until the morning porters came on duty. When a patient was moved this posed potential safety risks, as two staff were required to transport a patient, leaving a ward temporarily short staffed. We were assured that the nurse in charge of the unit would make the clinical decision based upon the privacy and dignity of the deceased person and the needs of the other inpatients on the unit at the time.

Managing anticipated risks

- There was a lone working policy in place that staff were aware of. Staff explained the precautions and actions they took to ensure they remained safe. There were systems used to ensure staff knew of the whereabouts of colleagues who were working alone in the community. Additional measures were in place for evening and weekend working. Staff we spoke with told us their safety was promoted by the trust.
- In the event of poor weather community staff had contingency plans that were put in place to prioritise patient visits.

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 the effectiveness of end of life care as requires improvement because:

- There was inconsistent understanding on the wards of the GSF (Gold Standards Framework) system being used to monitor and deliver end of life care. We found patients who were coded incorrectly and also staff who did not understand what the various codes related to in terms of the stages of end of life.
- There was a lack of personalised information being recorded in the care plans for patients. There was little detail completed about any personal preferences or wishes, that may have been identified through discussion with a patient or their family.
- There were inconsistencies in the completion of specific end of life training and the levels of training undertaken. There was no record of the training provided by the specialist palliative care teams to other staff, nor any formal plan for what was provided. There was a lack of clarity around how this was organised and what was available to ward and community staff.
- Some staff working for the continuing care at home team were not provided with sufficient training.
- There was a variable level of training completed by the end of life ward champions. We found this led to an inconsistent understanding of the GSF system, for example in the coding of patients, and when the framework was to be used.
- There was a lack of clarity for some staff regarding the role of the specialist palliative care teams.
- There was inconsistency in the recording of capacity assessments on the TEP form (Treatment Escalation Plan)

However:

- Anticipatory medicines were being effectively prescribed and administered and pain was being well managed for patients.

- Audits were completed to monitor the effectiveness of care and treatment, and the findings used to develop improvements.
- Spoke positively about the supervision and support they received from managers. All staff had an annual appraisal, and those requiring clinical supervision were having this completed.

Evidence based care and treatment

- The GSF (Gold Standards Framework) system was in place across the service. This is a nationally recognised training programme for end of life care. The wards within the community hospitals had received accreditation for this programme. However reaccreditation was due in 2018 and it was uncertain whether this would be re-applied for. The framework is underpinned by five key standards to ensure the right care is given to the "right person, in the right place, at the right time, every time." Early recognition of people approaching the end of life is an essential component, as is asking and recording an individual's preferences and wishes. There is colour coded system for recording for each patient. The initial question, termed "the surprise question", was "would you be surprised if this patient were to die in the next few months, weeks, day?". The guidance was that if the answer was "no", then a patient could be identified as being on the framework and recorded on the appropriate stage. There were three stages, which were also colour coded. This colour coding would also be identified on the ward whiteboard in the hospitals and on the handover sheets for the ward staff. Patients in the community would have similar recording completed to identify them as on the framework, and likely to be within the last twelve months of life.
- We found there were inconsistencies in the completing of this paperwork, and that some staff were unsure of the coding system. This was on the wards and also in the community. On some wards we found patients who could have been on the framework were not, and there was mixed understanding from ward staff as to who should be on the framework. For example, at Camborne

Are services effective?

and Redruth there were two wards. On one we found all the framework paperwork completed for the relevant patients, whilst on the other very little had been completed. Some ward staff explained how a multi-disciplinary meeting would lead to a patient being put on the framework, whilst others said that a nurse could start this process. At Newquay hospital we saw there were a number of elderly patients who had co-morbidities. However the staff did not feel these patients were suitable for putting onto the GSF framework recording, and coded accordingly. We saw some patients who were approaching the last few days of life whose GSF coding remained as green, when it could have been moved to red. Staff told us they thought they were good at identifying patients who were approaching end of life, as in the final stages, but there was inconsistency in the understanding of where patient should be coded within the framework. There was a possibility that patients would not be identified early enough for advanced care plans or personalised wishes to be identified and recorded. We saw the records from two patients who were approaching their final days, whose plans were still coded as yellow, when ideally they should have been red. We also the records from a recently deceased patient, whose coding had also not been changed to red.

- We spoke with six healthcare assistants during the inspection. Three had started work within the previous six months and were unaware of the GSF framework.
- On some of the wards we saw that the patient coding for the framework was recorded on the ward white board containing all the information about the patients. However, on other wards this was only recorded on the electronic handover sheet, used by the ward sister.
- Care plans contained assessments of patient's needs and the information needed by professionals to promote and ensure these were met. However, there was a lack of personalised care plans being completed, once it was identified that a patients was on an end of life pathway of care. There was generally very little detail completed about any personal preferences or wishes, which may have been identified through discussion with a patient or their family. Individualised care plans were also not in place for the patients we visited who were being supported and cared for in the community. However, an audit of community wards in September

2017 had shown that an improvement had been made. For 74% of patients whose death had been expected, a "priorities for care of the dying" care plan was in place. These care plans are developed when it is identified that a patient has only days or hours to live.

Pain relief

- Patients identified as requiring end of life care were prescribed anticipatory medicines. Records showed anticipatory medicines had been prescribed. Palliative medicines (which can alleviate pain and symptoms associated with end of life) were available at all times. Wards had an adequate supply of syringe drivers and staff told us these were provided promptly when requested. An audit of expected deaths on the community wards had reported that 88% of patients had anticipatory medicines prescribed.
- Community staff reported that syringe drivers were provided promptly, and that anticipatory medicines were correctly prescribed.
- Since our last inspection a change had been made to the recording of pain assessments. These were now recorded on the drug charts in the wards. In the records we looked at they had all been completed correctly and were up to date.

Nutrition and hydration

- On the wards we visited staff gave patients enough food and drink to meet their needs and improve their health. In the patient records we looked at, we saw nutritional assessments had been completed and were regularly updated. We saw that patients were assessed using the Malnutrition Universal Screening Tool (MUST), which is used to identify nutritional risks.

Patient outcomes

- The service monitored the effectiveness of care and treatment, and used the findings to improve them.
- Audits were completed on the wards, through the guidance of the end of life care facilitator and also in the community, by the specialist palliative care teams. These had been completed on the recording of a preferred place of care, and also whether this had been

Are services effective?

achieved. An After Death Analysis audit had been completed across all the community hospitals, which included reports on anticipatory medicines, TEP forms and the timely verification of death.

- The latest audits showed improved performance in a number of areas. For example, of the 26% of patients identified as being potentially in the last year of life 71% had a GSF plan in place, 54 % had been offered an advance care plan and 100% had a TEP form in place, with 100% having their preferred place of care identified and recorded.

Competent staff

- End of life care was delivered by competent and qualified staff on the wards and by the district nursing teams in the community. On each ward there was an end of life champion, who met monthly with the facilitator. They had a role in cascading information and providing a lead for other staff. There were two link nurses for end of life care in each district nursing team. These staff were required to be up to date with the latest guidance, and also had a link with the end of life care facilitator. Apart from these meetings, there was no formal or mandatory training for staff to complete.
- The specialist palliative care teams could provide training to other staff, including district nursing teams and ward staff. However there was no formal programme for this, or audit undertaken, and we were unable to be shown any record of what had been provided. Some ward staff, and also health care assistants working in the continuing health care team, told us they had not received any training from the specialist palliative care team. This meant there was inconsistency in the levels of training undertaken. There was also a lack of clarity over who was responsible for organising these sessions.
- District nurses were required to complete syringe driver training and updates. The training involved theory and practical observations. All initial setting up of syringe drivers was completed by two nurses. This followed best practice guidance and help ensure patient safety. We saw training records for two community nurse teams that showed all staff were up to date. Also the most recently appointed nurse had the training booked to be completed shortly after their start date.
- The trust had trained nurses in every team to complete the Verification of Expected Death certified training, and there were plans for more to undertake this. This often helped families to deal with the process of the initial bereavement more easily, as they would not have to wait to be visited by a GP in order for death to be verified.
- The health care assistants in the CCaH (Continuing Care at Home) team were very motivated, and a largely experienced team, but had little or no formal training in end of life care. They often provided personal care to patients in the final weeks or days of life. Some staff had completed training several years before, when the team was first set up, but new staff had only a basic trust induction, and there was no formal programme of end of life training for this team. We were concerned that the staff were being asked to complete tasks for which they were not appropriately trained. This included completing certain checks on syringe drivers, escalating concerns to the district nursing teams and answering questions from relatives and patients. Whilst this was a motivated team, committed to providing quality compassionate care, this potentially placed the staff and patient at risk. We were concerned about their vulnerability and that of the patient and families they visited, due to a lack of training and oversight of their general competencies. Some staff we spoke to had not completed any training on end of life care, including basic awareness training and communication skills training.
- The CCaH service had not been audited, or reviewed for several years, but we were told by a manager this was planned to be done shortly. The nurses in charge of the team told us that all patients would have been visited and assessed by a district nurse, prior to the staff arriving to provide personal care and support. However, this was contradicted by members of the CCaH team, who said that very occasionally they had arrived to provide personal care prior to the patient having been visited by the nursing team, if this was an urgent fast track referral. This meant that a patient could be visited, in the first instance, by staff who were not sufficiently trained to answer questions, and respond to a patient and their families concerns.
- There was one end of life care facilitator employed to cover the whole service. This meant they had a very large portfolio of work, which covered a wide area. They

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had completed some excellent work in ensuring all the relevant and up to date paperwork and guidance was in place on all the wards. They also linked with district nursing teams and the specialist palliative care teams, as well as with the ward end of life link nurses. These were in place on every ward. However, due to the turnover of staff in some wards, there was a variable level of training completed by these ward champions. We found there was an inconsistent understanding of the GSF (Gold Standards Framework) system in place, for example in the coding of patients, and when the framework was to be used. Some health care assistants we spoke with were not aware of the framework, and one asked if it was going to be reintroduced onto the ward for end of life care patients.

- Staff across the services spoke positively about the supervision and support they received from their managers. All staff had an annual appraisal, and those requiring clinical supervision were having this completed. For the year to date the overall appraisal rate for this core service was 95%, against the trust target of 85%.

Multi-disciplinary working and coordinated care pathways

- Staff, teams and services within and across organisations worked well together to deliver effective care and treatment. However, some community staff felt the relationship with the specialist palliative care teams could be improved. Whilst some staff said the response was always good, others felt that at times it was difficult to arrange meetings, and that requests for patients to be seen were not met the specialist palliative care teams. We were told of two examples where patients were contacted by phone rather than visited, following a request for a visit, made by a community nursing team. Conversely some members of the specialist palliative care teams felt the communication with locality teams, and their managers, could also be improved with better communication, and more formal meetings between the two services.
- There were weekly multi-disciplinary meetings held in the community hospital wards. We observed two of these meetings. We saw there was a good attendance

with occupational therapy, physiotherapy, a GP, social work and ward staff all present. There was however no representatives from the specialist palliative care teams present.

- There was a lack of clarity for some staff and managers around defining the role of the specialist palliative care teams. Liaison and communication between community, hospital staff and specialist palliative care teams, both formal and informal varied between localities. There was clear professional respect between the various services, and excellent examples of joint working to meet patient and family needs. However, there were comments from staff across all the teams that improvements could be made in terms of arranging of joint visits, sharing of information, arranging training sessions, formal meetings and also communication with GPs. We saw the leaflet promoting the role of the team. Whilst this contained information about their roles, referral process and skills, it was on paperwork relating to the previous organisation and had last been reviewed in 2014. There was also limited references to recent guidance, with references from 1995, and the most recent being from 2004.
- GSF (Gold Standard Framework) meetings with local GPs were organised. However there was variable level of quality of these meetings across the service. At a meeting we attended the patients considered on the GSF list were part of a wider agenda. We were told however, that other GP surgeries had meetings solely to discuss patients on the GSF list, and would consider coding updates appropriately during these meetings. Staff felt this a more effective process to utilise the GSF in the community.

Referral, transfer, discharge and transition

- Staff worked together to assess and plan ongoing care and treatment in a timely way. We saw how the ward staff co-ordinated with district nursing staff and GPs when a patient was being discharged to their own home. Ward staff also explained how they worked with the two local hospices that patients were discharged to. Staff were clear about the referral process they followed. We were told the main obstacle to discharge was the accessing of care packages, as there was variable provision across the county.

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- There was a formal process for making a written referral to the palliative care teams. This paperwork was available on the wards and within the offices of the district nursing teams. However staff could also make an urgent telephone referral, or contact a member of the team for advice.

Access to information

- Staff had access to the information they required to provide good patient care. Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. Staff had access to an electronic records system that they could all update. Information about end of life care and the GSF (Gold Standards Framework), and anticipatory medicines, was available on the wards. Policies and protocols could be accessed through the trust's intranet.
- Patient information was transferred effectively between wards and community teams, including GPs, when patients were discharged. Information was also transferred to care homes if this was required.
- There were proposals in place for a countywide electronic care co-ordination system (EPaCCS) to be put into place, though there were not yet any definite timescale in place. The end of life annual report stated this would align well with the systems used on the ward to identify patients in the last year of life.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Consent to care and treatment was obtained in line with legislation and guidance. Patients were supported to make decisions and, where appropriate, their mental capacity to make decisions was assessed and recorded.

- Documentation of requirements under the Mental Health Act 1993 and the Mental capacity act 2005 was not always consistent. The trust had introduced the new TEP (Treatment Escalation Plans) form which had replaced the document used previously. This form contained the DNACPR (Do Not attempt Coronary Resuscitation) decision, and also information about whether a patient had capacity or not. Whilst we saw all patients had a TEP in place, there was some inconsistency in the detail that was recorded. Not all forms we looked at had the detail recorded of whether a patient had capacity or not, or how a decision had been reached.
- An audit by the specialist palliative care teams showed that of the patients on their caseload, 76% had treatment escalation plans (TEP) forms in place and 81% had anticipatory medicines prescribed. This related to patients receiving a service in their own homes. Audits conducted with the community hospitals showed that 100% of patients had TEPs in place. However we found there was some inconsistency in the full completing of these forms in some of the patient records we looked at. This included details about who had been involved in the multi-disciplinary decisions, details about any personal preferences of the patients and the extent of family or relative involvement in decision making. This had also been identified in the audits undertaken by the trust. Feedback had been provided to the ward staff. The Do Not Attempt Coronary Pulmonary Resuscitation forms (DNACPR) were part of the TEP form. The inconsistent completion of parts of these forms could mean there was a risk that patients' choices and preferences for care may not be met.
- Mental Capacity Act training was encompassed within the trust statutory learning packages. As at 31 May 2017, the overall compliance rate for this was recorded at 95%.

Are services caring?

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

Summary

We have rated caring for end of life care as good because:

- We observed compassionate care in the approach from all the staff working in the wards and in the community. Feedback from patients was very positive about the caring and professional approach of staff.
- Staff ensured that patients and families were involved in their care and understood their treatment and prognosis.
- Emotional support and information was provided to those close to people who use services, including carers and dependants.

Compassionate care

- We observed compassionate care in the approach from all the staff we saw on the wards. This included consultants, nurses, care assistants and cleaning staff. In two hospitals we spoke with the domestic staff working on the ward. They explained how they always knew if a person was receiving end of life care, and tried to do what they could to be considerate. One staff member told us they always tried to ensure that families were offered drinks and also “knew where everything was”. We were also told how they would check with staff before cleaning the single rooms to ensure it was appropriate to do so at that time.
- District nurses were described to us by families as “magnificent” and “fantastic”. One patient told us “they are all great, I usually see the same person but when someone else comes they are lovely as well.” Another patient and their family told us the specialist palliative care nurse who visited them was, “an absolute champion”. Another relative of a patient told us the nurse was “brilliant, I do not know what me and my wife would have done without her, we have struggled to cope at times”.

Understanding and involvement of patients and those close to them

- All the relatives and patients we spoke with were positive about their involvement and understanding about their care, and the decisions that needed to be made.
- Patients and relatives we spoke with said they had been provided with sufficient information and that all their questions had been answered appropriately. We were told that staff had communicated sensitively and honestly.
- We observed five home visits, undertaken by specialist palliative nurses and district nurses. We saw how staff spoke clearly and responded to any questions from patients or their families.

Emotional support

- Emotional support and information was provided to those close to people who use services, including carers and dependants. Besides talking to patients and relatives, information leaflets were given to relatives. These provided practical advice and also information about the bereavement process. Information also signposted people to other services. An audit of expected deaths in September 2017 had shown that 95% of families had been offered bereavement support and information.
- There was a formal process for the specialist palliative care team to follow. This involved making a phone call to relatives after a bereavement and then, if required, undertaking a follow up visit. The team also sent a follow up letter six weeks after a bereavement.
- We observed district nurses and specialist palliative care nurse undertaking home visits. Staff provided emotional support to patients to minimise their distress. Staff demonstrated they understood the impact a patient’s care and condition had on their wellbeing and their relatives. Staff asked questions with a sensitive and professional approach, and responded to queries with reassurance and honesty. We saw a selection of cards from relatives written to staff across all the services, thanking them for their care and support.

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 the responsiveness of end of life care as good because:

- The trust worked with other stakeholders, commissioners and providers to promote end of life care across the county. There was a county wide strategy group for end of life care which was chaired by the Director of Primary Care .
- Relatives were supported to visit and stay in the community hospitals and most wards could provide side rooms for end of life care patients.
- Ward staff and community teams worked proactively to support patients to achieve their preferred place of care. Audits showed that improvements had been made over the previous 12 months.
- When care packages were available the ward staff could organise a rapid discharge, co-ordinating well with the community teams and local GPs.

However:

- There was variable provision for supporting patients in their own homes. The trust ran a continuing care at home team, that was very responsive and could be organised quickly, but this was only commissioned for one locality.

Planning and delivering services which meet people's needs

- The trust worked with other stakeholders, commissioners and other providers to promote end of life care across the county. There was a county wide strategy group for end of life care.
- However, the services provided across the whole county did not always meet the local needs. This was due to the difficulty in some areas of accessing care packages, to support patients to receive end of life care at home. We saw that the hospital and community staff were able to support rapid discharge, organise transport and provide support for patients being discharged. However, if there was no availability of a care package to provide the safe amount of personal care that a patient required to return to their home, this would not be an option. There

was no local definition of what constituted a rapid discharge. The term 'rapid discharge' was applied to any discharge that could be facilitated speedily and was not defined by a time frame.

- Within the community hospitals staff did their best to accommodate end of life patients in appropriate accommodation, and support relatives to visit and stay. Where possible, patients were provided with a side room to receive end of life care. For example at Bodmin hospital they had opened a newly furnished room for end of life patients, which had been funded with the help of local volunteers. Both wards at Bodmin hospital now had designated end of life patient rooms. This was a very comfortable environment for patients and families. These rooms helped provide privacy, and promoted dignity for patients who were receiving end of life care. Pets were allowed to visit patients, which was an excellent example of promoting spiritual care and respecting patients' final wishes.
- Relatives told us they were able to get drinks and food. On the majority of wards there were small side rooms where relatives could talk privately to staff. Parking was also free at the community hospitals, which helped with the process of visiting.
- The latest data available showed that of the total deaths in Cornwall and the Isles of Scilly during a twelve month period 43% died in hospital and 27% died in their own homes, with 30% dying in care homes or hospices. This was 2% higher than the previous years figures for patients dying at home. This represents a lower than average hospital death rate and a higher than average rate of patients dying in their own homes, compared to national figures.

Equality and diversity

- Services were planned to take account of the needs of different people, for example on the grounds of age, disability or gender. The trust had an Equality, Diversity and Human Rights Steering Group. This group had the role of providing the board with assurance that they were compliant with all the relevant legislation.



Are services responsive to people's needs?

- Arrangements were in place to access translation services. Hospital and community staff had access to a telephone based translation service. Staff were aware of how to access this.

Meeting the needs of people in vulnerable circumstances

- When a patient was admitted onto a ward the initial assessment included information about any disability, or if they were living with dementia. Ward staff were able to undertake dementia awareness training but there was inconsistency in the completion rates for this. Dementia awareness training had been introduced as part of the organisational safeguarding action plan. We were not provided with the data confirming the exact compliance, but most staff we spoke with told us they had completed the training. The trust had appointed a dementia nurse consultant to work alongside the trust wide dementia liaison service. This was part of a safeguarding action plan that had been put into place across the trust.
- Nurses on the wards explained how they approached pain assessment in patients who had dementia. We saw records where this had been recorded.

Access to the right care at the right time

- Generally people could access the service when they needed it.
- In the one locality where the service was commissioned, Continuing Care at Home provided a very responsive service, that could be put into place at short notice, within a few hours if required. The service employed healthcare assistants, who worked in conjunction with the district nursing team. Care packages for personal care for patients for the last few weeks of their life were organised. The service criteria was for care provision for a maximum of three months. The team could provide care for a just few days, at short notice, and we saw, how in conjunction with the district nursing team, this was put into place.
- Staff across all the teams worked together to help patients achieve their preferred place of care. The trust achieved positive results that had improved yearly, and were well above the national average. An after death audit analysis completed on the community ward showed that all patients whose death had been

expected, had their preferred place of care identified and recorded. We were told by ward staff, that for patients for whom a care package was available, or the family were able to provide care and support, the majority of these patients would be discharged.

- Data provided by the trust showed that the specialist palliative care team received 1618 new patient referrals between April 2016 and March 2017. The teams undertook 1631 assessments visits and 4786 follow up visits. The teams audited the outcomes for patients preferred place of care. This was the identifying of the preference, and also if this was achieved. The latest figures for 2017 recorded that the preferred place of care was identified for 84% of patients, with 87% of these achieving their preferred place of care. This represented an increase of 10% on the previous year.
- The specialist palliative care teams provided a 9 to 5 seven day service, with one person available in each locality at weekends.
- Where possible, community staff and hospital staff worked together to support patients whose preferred place of care was at home, to achieve this. We saw the patient records for two occasions where this fast-track discharge had been organised. The recording showed communication between the specialist palliative care nurse, the district nurse and the GP. This showed that the preparation included ensuring assessing the risks, putting the right equipment in place, organising the visiting times from nurses and also ensuring the staff could safely meet the needs.
- Patients were supported to have their spiritual needs met. On the wards, patients were supported to access chaplaincy services from the local community if this was requested. The trust chaplaincy services were only commissioned to provide a service to mental health patients. Ward staff had contact details for various local religious leaders that they could arrange to visit at short notice if requested.

Learning from complaints and concerns

- Information was displayed in the community hospitals giving information about how patients could make complaints or raise concerns.

Are services responsive to people's needs?

- There had been no formal complaints made in relation to end of life care for the period June 2016 to May 2017. The trust had documented there had been 32 compliments for this core service during the previous 12 months.

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 for end of life care as requires improvement because:

- There was no trust wide strategy group that focused on the implementing of trust policies and initiatives in relation to end of life care. There were no regular formal meetings which involved representatives from all the staff involved in delivering end of life care.
- There was a fragmented approach to end of life care due to a variation in service provision and the lack of visibility of the leadership for end of life care. There was lack of clarity about the future use of the GSF (Gold Standards Framework).
- There was only one end of life care facilitator and they were required to cover a wide geographical area, covering a range of staff teams and different hospitals.
- The trust did not have had an overarching vision for what it wished to achieve in relation to end of life care.
- There was no assurance that any potential risks to the effective delivery of end of life care were being identified and recorded.

However:

- There was evidence of good local leadership, with staff speaking positively about their managers and the support and direction of the service.
- Staff were clear about the governance structure within their services, both in the hospitals and in the community teams. There were regular team meetings and opportunities for staff to talk to their managers.
- We found there was a positive culture across the services we visited. Staff were proud of their work and committed to providing high quality end of life care. Managers promoted a culture that supported and valued staff.
- The trust engaged effectively with staff to ensure they were kept informed of changes and developments and also to provide opportunities to give feedback.

Service vision and strategy

- In Cornwall the work on an end of life strategy was being implemented as part of a whole system approach, of which the trust was a part. However the trust did not have had an overarching vision for what it wished to achieve in relation to its own provision of end of life care. The end of life facilitator had a clear set of objectives, and agreed plan of work for their role, but outside of this there were limited objectives and action plans for other parts of the service in respect of end of life care.
- There was not a designated strategy and action plan, to achieve any identified objectives. There was also a lack of clarity for staff around the service strategy and future plans. This could make it harder for staff to work collectively across team towards shared objectives.
- The trust policy on end of life care was based primarily around the Gold Standard Framework, for which the community hospitals were accredited for. However, a decision had yet to be made by the trust whether to apply for reaccreditation, when this was required in 2018. Changing from this framework would represent a significant change for staff in various areas. The lack of clarity did not support the developing and promoting of consistent and best practice.
- There were however objectives identified in the trust operational improvement plan around improving advanced care planning and enabling more patients to achieve their preferred place of care.
- The annual report on end of life care, produced by the end of life care facilitator, had made some recommendations. These included the development of learning pathways, linked into national training pathways for staff, including the end of life care for all e-learning programme (e-ELCA). The end of life facilitator had a comprehensive work plan and said they were well supported in their role. However, the role was expected to cover all the community hospitals and all the

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community teams. With one person covering such a wide area, and with staff turnover, it was difficult for all staff to have the contact and input that ensured the strategy had the profile required.

- The trust had a vision for their overall provision of care which was “Delivering high quality care”. This was underpinned by five strategic objectives; safe and accessible services, maximising the potential of the workforce, achieving best value and financially sustainable, to diversify and develop services and to work in partnership to create life opportunities for patients. The objectives were supported by the trust core values of compassionate care, achieving high standards, respecting individuals and empowering people. However we found that whilst the vision of “delivering high quality care” was understood by most staff we talked with, the strategic objectives and core values generally were not.

Governance, risk management and quality measurement

- The trust did not have a systematic approach to continually improving end of life services, but there were clear processes in place for the reporting of information. The locality manager, with the responsibility for leading on end of life care, provided a report to the trust performance group on a monthly basis. There was a trust wide quality assurance group, that met quarterly, and the end of life care facilitator had presented their most recent annual report to this group.
- Staff were clear about the governance structure within their services, both in the hospitals and in the community teams. There were regular team meetings and opportunities for staff to talk to their managers. Staff received relevant and appropriate information in relation to the trust and their area of the service. We were told they could raise concerns and ideas and these would be listened to.
- Managers told us they felt the governance arrangements were more robust since the merger of the two organisations. There were more formalised feedback from meetings, and an increased amount of briefing papers circulated about trust issues and developments. This related to end of life care and the wider trust business.
- There was not a bespoke risk register for end of life care, but there was one identified risk on the trust wide register. This was in relation to the maintenance and use of one office located on the site of St Michaels Hospital. Action was being taken to manage this risk. There was no trust wide end of life strategy group, and no trust wide meeting of the different teams delivering end of life care. End of life care was provided by wards, community teams and the specialist palliative care teams. This meant there was potential for risks not to be fully identified and shared. For example, the shortfall in training on the wards for the end of life champions due to the turnover of staff and also the uncertainty of the future use of the GSF.

Leadership of this service

- Staff were proud of the quality of the professional care provided, and clear about the objectives of the particular service they worked in. However, some staff commented that a more collective approach to end of life care could be of benefit. The board lead for end of life care was the medical director. The end of life care facilitator reported to a locality manager, who had a lead role of end of life care. The specialist palliative care teams worked to their individual locality managers. Several staff we spoke with were not aware of who the board lead was, and were also unclear about the role of the county wide strategy group. The county wide end of life strategy group had representatives from a range of services and stakeholders. The trust had representatives on this group, and the minutes were disseminated through the service. There was, however, no trust wide strategy group that focused on the implementing of trust policies and initiatives. There were no regular formal meetings which involved representatives from all the staff involved in delivering end of life care.
- The leadership for end of life care lacked visibility, and for some staff the priorities lacked clarity. This could lead to an inconsistent approach and variation in the quality of service. To some extent end of life care was slightly fragmented, with three separate specialist palliative care teams, each with their own manager, and with different working arrangements in different localities for the various district nursing teams. For example, the continuing care at home service was only provided in one area, and there were also different on call and evening working arrangement in different areas

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for the district nursing teams. The end of life care facilitator worked across the whole service, but this was a very large area and their focus was mainly the hospital wards. Some staff commented they felt outside of the end of life care “bubble”, and that they would benefit from increased contact, closer working and communication with all staff involved in delivering end of life care. There was also some criticism from community based staff that the communication from senior managers around end of life issues and initiatives could be improved. Some staff felt they were not kept as informed as they could be, and that senior managers responded too slowly to requests for information.

- Community staff told us that whilst the move to the new organisation had gone smoothly, and they were kept well informed, they felt that the main focus and emphasis of the trust board was their mental health services. Managers and senior staff we spoke with told us that some new management arrangements had been challenging, and that progress was needed to promote a more joined up service between the two organisations. There was a perception of a lack of visibility of board members. Only two staff we spoke with had met or seen board members, in relation to their area of work since the merger of the two organisations.

Culture within this service

- We found there was a positive culture across the services we visited. Staff were proud of their work and committed to providing high quality end of life care. Managers promoted a culture that supported and valued staff.
- Staff were aware of the trust lone working policy and felt their health and safety was promoted and valued by the organisation.
- Ward staff we spoke with told us they were proud of the care and support provided to patients and their families in respect of end of life care. At all the community hospitals we visited, we were told that as a team they wanted to ensure that end of life care was provided that met individual needs.

- Staff within the community teams spoke positively about their managers and colleagues. We were told how they supported one another, and were able to access professional and emotional support from within the team and from managers.

Public engagement

- The service gathered the views and experiences from patients using their services. The organisation used the friends and family test to gather feedback about the service. The friends and family test enabled patients and those close to them rate whether they would recommend the service or not. There was not specific data in relation to end of life care, but the trust scored better than the England average for all six months between January and June 2017 for recommending the trust as a place to receive care. For example, in August it was recorded that

the percentage of staff who would recommend the trust as a place to receive care was 82% compared to the England average of 79%. The percentage of staff who would not recommend the trust as a place to receive care was also better than the England average, at 5% compared to the England average of 7%.

Staff engagement

- The trust engaged effectively with staff to ensure they were kept informed of changes and developments and also to provide opportunities to give feedback.
- A monthly newsletter, Cascade, was sent to all staff. This contained learning from incidents, information about performance and training, and development opportunities for staff across the organisation.
- There were quarterly engagement meetings which could be attended by all staff. These forums were run by the chief executive, the director of nursing and the medical director. Two managers we spoke with had attended these meetings and were positive about the experience. However, frontline staff we spoke with, were either not aware of them, or told us they did not have the time to attend.
- The trust had an organisational development programme in place. Part of the programme involved the forming of a Staff Experience Group. This met monthly and was chaired by a board member and attended by a Non-Executive Director. Meetings had

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been scheduled across the county to ensure accessibility for all staff. The aim of the group was; listening to staff, understanding the issues and concerns staff and teams encounter at work; hearing staff views and ideas, for service improvement; and developing high quality care and taking action to help by supporting and enabling next steps, change and innovation. The agenda was based on issues raised by staff throughout the trust. Staff who had attended said the meetings were informative, but could describe any specific changes that had been made as a result.

Innovation, improvement and sustainability

- It was planned that members of the specialist palliative care team to work in conjunction with the local hospice movement to promote a “Compassionate Communities” initiative. These initiatives promote community engagement, encouraging people to adopt an understanding that ‘health’ is everyone’s responsibility. One aim is to involve the wider community more in end of life care, engaging with the public, and also different sectors such as local schools and businesses.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

11.—(1) Care and treatment of service users must only be provided with the consent of the

relevant person.

The provider must ensure that staff are fully aware of the requirements of the Mental Capacity Act and that patients with mental capacity are involved in decisions about their care and treatment

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

17.—(1) Systems or processes must be established and operated effectively to ensure

compliance with the requirements in this Part.

(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service

users and others who may be at risk which arise from the carrying on of the regulated

activity;