

Northamptonshire Healthcare NHS Foundation Trust

RP1

Community end of life care Quality Report

CQC Registered Location

Manfield Campus
Danetre Hospital
Trust Headquarters
Tel: 01536 410141
Website: www.nht.nhs.uk

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

Summary of findings

Ratings

Overall rating for End of Life Care		Requires Improvement	
Are End of Life Care safe?		Good	
Are End of Life Care effective?		Requires Improvement	
Are End of Life Care caring?		Good	
Are End of Life Care responsive?		Good	
Are End of Life Care well-led?		Requires Improvement	

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service Requires Improvement I

- We found that the trust was performing at a level which led to a rating of Requires Improvement.
 - A training system was in place to redress issues with training following a high turnover of staff. However this had not yet been achieved.
 - We attended multidisciplinary team meetings and saw evidence of wide communication throughout the services we visited, however supervision, appraisals and staff support was not always effective.
 - Staff told us that they did not always receive effective clinical supervision so people could not be sure that the service is providing an up to date and well-led service.
 - A specific end of life pathway care plan had been developed to replace the “Liverpool Care Pathway” which had been withdrawn, but it was not fully embedded in practice across the service.
 - Staff told us the care planning tool available at the time of inspection was not specific to end of life care, and difficult to edit to reflect the specific care pathway of the patients. The service had available a “care of the dying person” template care plan on the electronic patient record system that was specific to providing palliative care. Staff were unable to tell us about plans to improve the care plan system, and were resigned to accepting the system they were given to use.
 - At Cransley Hospice we saw evidence of clinical audits carried out by the Matron, however in we found no evidence of clinical audits at any level at Cynthia Spencer Hospice, other than infection control audits, or medical audits with national data sets at either hospice. This meant that there was not an effective system in place to ensure that clinical practices are in line with current research.
 - Clinical supervision was not consistent across the service and at Cynthia Spencer Hospice due to short staffing and unavailability of sisters due to sickness and other issues staff had not received effective clinical supervision for some time.
 - The trust did not carry out pain audits either in the community or in the hospices but we did see effective pain relief was offered to patients during the inspection.
 - In the community it was not clear how nutrition and hydration of patients was monitored. Staff recorded problems with nutrition and hydration on admission to the team and care planning, but this was not always updated during visits to people in their own homes.
 - At Cynthia Spencer Hospice and in the palliative care teams there was no evidence of audit systems in place to monitor the effectiveness to the care provided to patients.
 - The trust had not taken part in the National Care of the Dying Adult (NCDA) audit for some time, but the service manager told us that there were plans to contribute to this data this year.
 - Cynthia Spencer Hospice had difficulties providing blood transfusions for some patients due to staff not having completed training in haemovigilance (to minimize the potential risks associated with safety and quality in blood processing and transfusion for donors, patients and staff).
 - Staff were engaged in their roles but they told us that they did not feel they were consulted about previous changes, or would be involved in future plans of the trust despite information newsletters, emails and meetings that were in place.
 - The service did not have an effective system in place to continually monitor and improve the service.
 - The palliative care team at Kettering General Hospital did not have a clear management structure, and this meant that staff were not supported effectively in their roles.
 - There was variation in levels of support for different teams due to unclear and inconsistent management and leadership across the service.
- However;
- We saw evidence of comprehensive maintenance records for the environment and equipment, and saw

Summary of findings

that this was implemented in the areas we visited. We saw a system in place that ensured equipment was removed prior to servicing in order to ensure equipment was safe.

- All incidents, accidents, and near misses were logged onto a trust-wide computer reporting system.
- Staffing levels were adequate to provide the level of care people required on the day of our visit, and call bells were answered promptly. People told us that they did not have to wait long for assistance if they pressed their call bell.
- We looked at care planning documentation and saw that the needs of people were documented clearly with their plan of care to ensure that it was safe and effective for people using the service.
- We saw examples of do not attempt cardio pulmonary resuscitation (DNACPR) forms that were completed in accordance with trust policy.
- Staff understood the Mental Capacity Act and records showed that they had received training to ensure staff had a level of understanding about people's rights. We saw examples of mental capacity assessments to assess people's capacity to make decisions about their end of life care.
- The culture we saw within the service was open and kind. The interactions we saw between staff, families, and people using the service were kind, professional, and not rushed.
- Service user surveys were carried out and the feedback was generally very positive about the service.
- People we spoke to said positive things about the service they had received and the staff working in the service.
- People's dignity and privacy was respected.
- Family members and carers were kept involved and informed about the care and treatment of patients.
- All of the staff we spoke with were cheerful and enthusiastic about the service they provided. Staff worked flexibly to ensure that patients received a high standard of care.
- Patients told us that the staff in the hospices and in the community were kind and caring, and that they "could not fault" the service they had received.
- Spiritual and emotional support was provided to meet the needs of individual patients.
- We saw that changes had been made in the way the service was run in response to problems and changes in legislation that had been identified by management. This showed that the service was learning from challenges and improving the service they provided.
- Waiting times for responses to calls were within the trust's target of 24 hours, and visits or admissions were arranged within three days of referral in the main.
- We spoke to a number of staff working in different areas and they told us that they received information in newsletters and meetings from the trust.

Summary of findings

Background to the service

Background to the service

The palliative care and end of life services provided by Northamptonshire Healthcare NHS Foundation Trust are:

Chaplain's office, chapel, multi-faith rooms and ablution areas,

Mortuary viewing area and bereavement office.

Cynthia Spencer Hospice:

Hospice at Home,

McMillan Nursing,

Palliative Care Lymphedema clinic,

SPC Consultant Outpatients.

Danetre Hospital:

McMillan Nursing team.

Kettering General Hospital:

McMillan nursing team of two specialist palliative care nurses.

Cransley Hospice:

McMillan nursing beds and specialist palliative care nurses.

Our inspection team

Our inspection team was led by:

Chair: Peter Jarrett - Consultant Psychiatrist, Oxleas NHS Foundation Trust

Team Leader: James Mullins, Head of Inspection.

The team included a CQC inspector and a Specialist Consultant Physician in Palliative Care Medicine

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

organisations to share what they knew. We carried out an announced visit on 3rd, 4th and 5th of February 2015. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with 15 people who used services. We observed how people were being cared for and talked with 10 carers and/or family members and reviewed care or treatment records of 10 people who used services. We met with people who use services and their carers, who shared their views and experiences of the core service.

Summary of findings

What people who use the provider say

“It is very good here; they look after you; from the person that brings the water to the nurse that brings pain killers in the night”.

“As soon as you press the red light (on the nurse call bell system) someone is here straight away”.

“My only complaint is that you may just fall to sleep and they have to wake you to give you your painkillers”.

“I can’t think of anything that they could improve on”

“They have spent a lot of time sorting out my pain relief. I am able to go home now that I have tablets that will work and keep me pain free”.

“There is terrific support; they have a vast knowledge of each person’s situation. Any reviews happen fast and the doctors and nurses tell us what is happening”.

“Staff are very considerate and they really do care”.

“They bother to get to know you, call you by name, and are very kind”.

“The unit is very small but very intimate, I feel very safe here”.

“The care is so personalised it feels like a private hospital”.

“I am very confident in the ability of staff to answer questions. I don’t have to hang around- we get seen quickly by medical staff and support is made available for carers. They have organised community support as well”.

“I was so terrified when I came to the hospice as my hospital experience was so bad. I was so sore I was afraid to let anyone touch me. Now I am so much better and I can move now”.

“I don’t know my consultants’ name but the doctors are always here when I need them and they are always popping in. They give me all the information I need”.

“The food here is ok and my family can visit me at any time”.

“They helped me with my pain”.

Good practice

In all areas we visited people who used the service told us how happy they were with the care they had received. We heard stories where staff had taken steps above what would have been expected of them to ensure people had an individual service.

Areas for improvement

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

Action the provider **MUST** take to improve

- The trust must ensure that all staff in the service have effective managerial support and supervision.
- The trust should ensure all staff have the required training and competencies to provide appropriate end of life care and treatment in the service

Action the provider **SHOULD** take to improve

- arrangements to cover for planned and unexpected absence of staff and staff vacancies are established for all teams
- performance data is consistently collected and that outcomes are recorded and available
- The trust should implement clinical auditing systems to monitor the service and ensure that evidence based practice is implemented and monitored in the service.
- All patients should have their care and treatment needs for nutrition and hydration needs appropriately assessed and recorded.

Summary of findings

- The service should review how it monitors the effectiveness of pain relief provided for patients in the community.
- The service should review its care planning process specifically for end of life care patients

Northamptonshire Healthcare NHS Foundation Trust

Community end of life care

Detailed findings from this inspection

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

Good 

Are End of Life Care Services safe?

By safe, we mean that people are protected from abuse

Summary

Overall, we rated this domain as good because;

- We saw equipment maintenance records and servicing schedules in place in all areas we visited. We saw the system in place to ensure that equipment is taken out of use when it required servicing, and this meant that people using the service were kept safe from the risk of equipment malfunctions.
- We spoke to staff about accident and incident reporting and they told us how they escalated issues to their line managers and used the trust's electronic computer system to record these events. This meant that incidents were recorded in order for the trust to make changes and maintain the safety of people using the service.
- We saw the use of a dependency tool at Cransley Hospice which the Matron showed us reflected the number of staff required to provide safe care to patients. We were told that this tool was designed by a palliative care network and the Matron at Cransley Hospice demonstrated innovation in sharing information with a nearby trust in utilising and adapting dependency forms that had been developed. This meant that the service was able to risk assess the level of staff employed to care for people.
- We looked at medication storage areas and processes. We found that the medications were stored in accordance to the trust's medication policy, and we observed staff checking medication to ensure safe administration of medicines. This meant that people were protected from the risk of medication errors.
- The pharmacist at Cransley Hospice told us that the unit was working with patients to administer their own medication so that they were confident on managing this process once they had returned home on discharge. This meant that the service had systems in place to monitor and educate people on the safe administration of medicines.
- Records were held securely on a computer system which staff had log in details to access. Paper documentation was stored in accordance to the trust's policy in order to protect confidential information about staff and patients.

However,

- We did not see evidence of a monitoring or “early warning” system in place to highlight when a person who used the service may be deteriorating.
- Not all staff were confident in using the trust’s electronic patient record system and said it took time to input all care records and assessments completed on to it.
- There was no system in place to cover for the nurses when they were on holiday, sickness, or other leave in the palliative care teams.

Detailed findings

Incidents, reporting and learning

Staff told us about the trust’s electronic recording system which they use for reporting accidents and incidents. Staff in each area we visited told us about this process and that their line manager would follow up any incidents. Staff said that they did not always get feedback from incidents reported, but said that if they asked their line manager they would be updated about the outcome.

We spoke to staff about accident and incident reporting and they told us how they escalated issues to their line managers and used the trust’s electronic computer system to record these events. This meant that incidents were recorded in order for the trust to make changes and maintain the safety of people using the service. Different staff told us they would report issues differently. For example one person told us that they would report “any incident or near miss”, and another told us that they would report “low staffing levels and accidents and incidents”. Staff told us that they had received training when the system had first been implemented but this has not taken place for new staff.

We looked at four incident records that had been submitted at Cynthia Spencer Hospice and saw that appropriate staff were informed of the concerns and actions stated that a review of certain practices would be implemented. However we could not tell if this had taken place or not as staff were unable to give us examples.

We saw evidence that staff at Cynthia Spencer Hospice had been given a “falls prevention and management tool” leaflet, and signatures were collected to record who had

read and understood this document. This tool is used by the trust and is based on the trust’s “safer post falls protocol” which involved assessment, evidence and reassessment, as well as reporting the incidents.

We asked staff at Cynthia Spencer Hospice to describe where specific examples of actions taken as a result of incidents that had happened, but they were unable to describe any to us. This meant that we could not demonstrate where changes had been made as a result of learning from accidents or incidents.

At Cransley Hospice we were shown the results of a “releasing time to care” project where a system had been implemented to prevent nurses from being disturbed whilst drawing up medication. We were shown the communication book where messages were documented for the nurses and the time the message was taken. The care worker would then put a coloured card in a plastic wallet on the medication room door corresponding to the colour of the team that the nurse belonged to. This system meant that staff could leave messages for the nurses working on the unit in a timely manner, and ensured that messages did not get forgotten. The matron told us that a study had been carried out prior to the implementation of this system and will be completed again to measure the success. This process showed that the service was learning from challenges it has met and was taking steps to measure the results in order to improve the service provided to patients.

Safeguarding

We saw training records that demonstrated staff had had safeguarding training. Staff told us what the reporting system was for a safeguarding alert and told us about examples where this had been carried out in the past.

Staff training took place on a three yearly basis and staff told us that they had access to a trust safeguarding team although had not had the need to contact them. All staff had received safeguarding training, and new staff told us that this was part of their induction training.

We saw notices on display in both hospices advising staff, visitors, and patients of the telephone numbers they could contact if they were worried about a safeguarding issue.

Patients told us that they felt safe, and they felt able to report any concerns to staff and they were confident the

issue would we addressed promptly. Staff were able to explain the procedure for whistleblowing, and that they felt able to approach their line manager with any concerns they may have.

This meant that the service had taken steps to safeguard people from abuse.

Medicines management

In both hospices we saw that medicines were stored securely in locked cabinets in locked medication rooms, in accordance with trust policy. We saw staff administering medicines and checking medicines to ensure the patient was given the correct dose, at the correct time. We sampled some medicines and found all were within their expiry dates.

We spoke to the pharmacist at Cransley Hospice who told us about the system in place to help people practice taking their own medication before they are discharged home. This was to give people the information and practice under the risk assessment of nurses and increase their confidence for discharge.

Medicine storage in fridges was at the correct temperature and the staff checked this each day on a log sheet. Medicine fridges were clean and locked, and medications were stored in their original packaging with the opened date written on the packaging.

The pharmacist told us that they carry out regular stock checks and explained the system that was in place for staff to obtain medicines out of hours from the local pharmacy store. This meant that staff had access to medicines when a pharmacist was not on site.

Syringe drivers were used in both hospices and we saw policies and procedures were available for staff to follow when they are setting one up. We saw that anticipatory prescribing for syringe drivers was clear and stocks of these medicines were available should they be required on an evening or weekend.

All clinical supplies such as fluids, needles, and sterile equipment was stored in rooms which could only be accessed by a staff member with a swipe card to access them. Storage areas were organised and well stocked, and we saw evidence of stock rotation to ensure that supplies are used before their date of expiry.

We saw evidence at Cransley Hospice where the manager had investigated a medication error and this had been reported onto the trust system. This event had been followed up and discussed with staff at following meetings.

At Cransley Hospice we saw medication audits took place and we saw in meeting minutes that feedback was delivered to staff in order to maintain and improve best practice in this area.

This meant that medications management systems were in place to maintain the safety of people using the service.

Maintenance of environment and equipment

At Cynthia Spencer Hospice we saw a clear system in place where all equipment was catalogued with a number on a spreadsheet. This is displayed on the wall in an office so that staff can look up equipment items and the date that it had been cleaned and serviced. The staff member in the unit overseeing estates showed us that servicing dates were also listed in the diary so that staff were reminded when equipment was due for servicing. We were shown the signs that were used to be placed on the end of equipment currently in use to remind staff to remove it from the clinical area for servicing once it had been finished with. This meant that equipment in use was taken out of use before the date for servicing had expired, and replaced with a serviced piece of equipment to ensure that care pathways were not delayed.

All equipment had portable electronic test (PAT) certificates in place and in date.

Oxygen cylinders were stored securely in accordance with the trust's policy. We saw that these were secured upright to prevent them from falling over and causing a hazard.

The décor of both hospices were tasteful and communal areas we kept tidy and free of obstacles or obstructions to fire exits.

At Cransley Hospice, we saw a comprehensive cleaning folder which contained rotas and responsibilities for the cleaning of the different areas of the premises. This included dressing storage areas, resuscitation equipment, blood pressure cuffs, and other checks of oxygen and suction systems. This meant that there were systems in place to ensure the environment and equipment was maintained.

Records systems and management

We saw that most patients' records were held on an electronic record system. This system was shared across the majority of the trust, but Specialist Palliative Care Nurses told us that some General Practices do not have this system and it could cause difficulties with information sharing. For example, the trust was using paper forms for "do not attempt cardiopulmonary resuscitation" (DNACPR) and some GP practices could not access these DNACPR forms on the computer system. The trust told us that they are aware of this issue with the computer system and were working on resolving it by meeting with General Practitioner's (GPs) and encouraging the use of one system across the board.

In both hospices we saw that white boards with bed allocations were of a folding design so information could not be seen unless they were opened. The white boards were positioned in offices or locked areas where members of the public do not have access. We saw no identifying information about patients stored near bedsides, on desks, or left unattended.

Paper records that were held in the hospices were kept securely to ensure people's personal details were kept safe. We saw that offices were kept locked when they were not occupied, and swipe card access for staff only was in place for some areas to ensure security.

A staff member told us that the electronic patient computer record system had been introduced last July, but staff were not given protected time to learn how to use it or get used to it. The system had become mandatory for staff to use, but not all staff were confident in its use and said it took time to input all care records and assessments completed on to it. This member of staff told us staff had brought this issue to management and it had not been addressed. The trust told us that specific training was provided to staff, together with on-going support and protected time to complete the training.

Cleanliness, infection control and hygiene

In all the areas visited we saw cleaning schedules in place to record that the environment and equipment had been cleaned. We saw "I am clean" labels on beds and appliances to indicate to staff and visitors that the item had been cleaned and when.

Each area had a dedicated member of staff in charge of the environment, and we saw that staff reported estates and equipment issues to this person. Staff told us that each

team has cleaning responsibilities and we saw schedules detailing when tasks were due to be completed, and who was responsible for carrying it out. We saw that tasks had been signed off by staff, and this meant that there was a system in place to ensure tasks were completed and addressed as appropriate.

We observed staff washing their hands between tasks, and saw that hand-washing technique posters were above all hand-wash basins to remind all staff, patients and visitors to wash their hands. We saw evidence of random hand-washing audits where staff were scored on their hygiene practices, nail condition, and "bare below the elbow" policy. The results of these were mainly fully compliant, and we saw that feedback was carried forward to staff meetings in agendas and minutes to ensure staff improve in this area.

Sluice areas, were visibly clean and bins were not full. Laundry and waste were stored appropriately and hygienically with no noticeable malodours. Sinks, toilets, showers and bathing facilities were in good order with no chips or damage which could harbour bacteria.

We saw that "cleaning sheets" were used at Cransley Hospice when cleaning a bed space for the admission of a patient. This form was detailed and included checking under the mattress cover to assess the cleanliness and condition of the mattress. This meant that there are systems in place to maintain a clean and hygienic environment.

We saw an infection control audit at Cransley Hospice dated 1st February 2014 with an outcome of 86% compliance. This audit was repeated on 19th of August 2014 and compliance was now 100%. This demonstrated that actions had been taken to improve the standards of cleanliness and documented.

At Cynthia Spencer Hospice, we were shown a recent infection control audit dated 10th December 2014 where the outcome was 73% and "not compliant" according to the trust's infection control policy. We were shown evidence about the steps the hospice had taken to improve this rating, and during our visit we saw a maintenance person changing taps to "elbow taps" as part of this process. This meant that the hospice was monitoring the environment and making improvements to ensure infection control guidelines were followed.

Mandatory training

Staff told us that newly qualified nurses complete induction training for a year. During this year nurses complete training in various competencies like administering intravenous medications, venepuncture, cannulation, syringe driver and catheterisation training. This meant that newly qualified nurses are supported in their new role.

Nurses on their preceptorship shadowed nurses in different parts of the service to get a full appreciation of the way the service worked.

We saw mandatory training records were up to date with the trusts expected subjects and timelines, where there was high sickness at Cynthia Spencer Hospice this had lapsed, but we were told plans were in place to improve this by staff attending paid training and supervision days to update skills.

In Cynthia Spencer Hospice we were told that newly qualified nurses did not have training in blood transfusion administration. This course was not part of the trusts' mandatory training to work in this area, and this meant that blood transfusions had to be planned around the staff on duty at the time.

Specialist palliative care nurses managing care in the community with little clinical support had no mandatory training in end of life care, pain management, or other areas relating to this type service. This meant that there was not a system in place to ensure that patients received treatment from staff with updated skill and knowledge. However the staff we spoke to that worked in the community had professional qualifications in end of life care, for example degrees or credit holding modules from the local University.

Lone and remote working

We spoke to the palliative specialist nurses based at Danetre Hospital about their lone working policy. They told us that they have a system to ensure each person "checks in" at the end of their shift so that all staff were accounted for. This policy had been developed in the main by staff working in the community as staff felt the trust policy was not so robust.

Each member of staff working in the community had access to a mobile telephone so that they could contact colleagues for safety reasons if required.

The nurses told us that they would occasionally plan visits in pairs or with other professionals if there was seen to be a risk where someone may have high levels of anxiety. This meant that systems were in place to protect staff when lone working.

Assessing and responding to patient risk

We saw risk assessments in place for patients around tissue viability, falls, mobility, and other risk assessments relating to their specific care needs, for example where a person is self-medicating.

We saw that observations were carried out and documented for patients at regular intervals throughout the day, four hourly for patients with a clinical indication for this. Care documentation described to staff how often risk assessments should be renewed, and how often various procedures and observations should take place.

Staff told us that patients were discussed at multidisciplinary meetings regarding the relevance of monitoring observations and the risks are measured against the individuals' wishes and care plan. This meant that some observations were not continued to allow the patient to be comfortable and not disturbed.

We did not see evidence of a monitoring or "early warning" system in place to highlight when a person who used the service may be deteriorating. This could mean that treatment is not given in a timely manner to people.

Staffing levels and caseload

Cransley Hospice was a nine bedded unit staffed with two specialist consultant doctors, 16 registered nurses (12 whole time equivalent staff), and 11 health care assistants (7.9 whole time equivalent staff).

Cynthia Spencer Hospice was a 20 bedded unit staffed with eight whole time equivalent registered nurses, carer workers, four junior doctors, two registrars, and one consultant. The hospice had three volunteer workers each day that work in the coffee shop and carry out administrative and other tasks.

We were told that agency staff were used regularly at Cynthia Spencer Hospice, but staff were unable to give us figures relating to the number of shifts that required covering by agency staff. During our inspection we did not see evidence that the service was short staffed.

A total of 13 specialist palliative care nurses covered the trusts area; nine whole time equivalent specialist palliative care nurses were based in three different locations in the community. Three were based at Kettering General Hospital, with some based at Danetre Hospital.

Staff told us that there has been a high turnover of staff recently, and in all areas the case load has been recognised to be high by managers and the trust.

The trust told us that recruiting registered nurses across the board was a problem, and they were working on a system improving the streamlining of the recruitment procedure in order to interview and start people in their roles quicker.

Cynthia Spencer Hospice had recently employed three new registered nurses and as a result some aspects of the service were reduced during and following their recruitment. For example the hospice had stopped accepting student nurses who would require coaching support from nurses who were stretched and mentoring new staff, also the hospice had reduced their out of hours telephone service so that patients calling would not speak to a nurse but have a call back from a nurse the following day.

Both MacMillan nursing teams at Danetre and Kettering Hospitals told us that the staffing levels had been low. We were told that each hospice had vacancies for registered nurses of just over one full time equivalent member of staff.

At Cynthia Spencer Hospice we spoke to medical staff who explained to us that an on call system is in place to cover two sites at night. This could mean that the one member of staff was required at both sites at the same time. Staff were unable to tell us if this had been risk assessed.

Managing anticipated risks

There was no system in place to cover for the nurses when they are on holiday, sickness, or other leave in the palliative care teams. The nurses told us that they had to arrange holidays around their colleagues, and cover each other's sick leave to ensure that the service continued to be provided. Staff told us that they had not yet been unable to cover their colleague, but they feared this could happen in the future.

At Cransley Hospice we saw a dependency tool that evaluated the needs of the patients. This was in order that the unit manager could ensure that the appropriate level of staffing was in place to provide safe care for people using the service. The Matron told us that this tool had been from a palliative care network, and demonstrated that the hospice has used external sources to compare and contrast the service provided.

Major incident awareness and training

None of the staff we spoke to told us that they had attended major incident awareness training. This subject was not part of the trust's mandatory training. Staff were not aware of the trust's major incident policy,

At Cransley Hospice we were shown an investigation that the manager had conducted into the risks staff were exposed as a result of a person visiting a patient that became aggressive. The manager employed security for the hospice at this time in order to prevent the occurrence of incidents. There was no plan in place by the trust for occurrences such as these, and the manager told us it was left to their responsibility to foresee and manage any event occurrence.

Are End of Life Care Services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

Overall, we rated this domain as requires improvement because:

- A specific end of life pathway care plan had been developed to replace the "Liverpool Care Pathway" which had been withdrawn, but it was not fully embedded in practice across the service."
- The care planning tool available at the time of inspection was not specific to end of life care, and difficult to edit to reflect the specific care pathway of the patients. Staff were unable to tell us about plans to improve the care plan system, and were resigned to accepting the system they were given to use.
- At Cransley Hospice we saw evidence of clinical audits carried out by the Matron, however in we found no evidence of clinical audits at any level at Cynthia Spencer Hospice, other than infection control audits, or medical audits with national data sets at either hospice. This meant that there was not an effective system in place to ensure that clinical practices are in line with current research.
- Clinical supervision was not consistent across the service and at Cynthia Spencer Hospice due to short staffing and unavailability of sisters due to sickness and other issues staff had not received effective clinical supervision for some time.
- The trust did not carry out pain audits either in the community or in the hospices but we did see effective pain relief was offered to patients during the inspection.
- In the community it was not clear how nutrition and hydration of patients was monitored. Staff recorded problems with nutrition and hydration on admission to the team and care planning, but this was not always updated during visits to people in their own homes.
- At Cynthia Spencer Hospice and in the palliative care teams there was no evidence of audit systems in place to monitor the effectiveness to the care provided to patients.

- The trust had not taken part in the National Care of the Dying Adult (NCDA) audit for some time, but the service manager told us that there were plans to contribute to this data this year.
- Cynthia Spencer Hospice had difficulties providing blood transfusions for some patients due to staff not having completed training in haemovigilance (to minimize the potential risks associated with safety and quality in blood processing and transfusion for donors, patients and staff).

However,

- We saw outcome boards on display in both hospices detailing areas of achievement and for improvement including details such as accidents causing harm, incidents, and staffing levels.
- The care plans that were in place met the needs of individual patients.
- Individual patients had their pain relief needs assessed regularly.
- Multidisciplinary team working being was effective and we saw evidence of team collaboration in use to form holistic plans of care for patients
- We saw six examples of do not attempt cardio pulmonary resuscitation (DNACPR) forms that were completed in accordance with trust policy.

Detailed findings

Evidence based care and treatment

At Cransley Hospice the Matron told us that she had contacted other palliative care teams for advice and sharing of good practice, for example, the dependency tool for predicting staffing levels was sourced from a palliative care network.

The MacMillan nursing teams told us that they did not take part in external meetings or forums relating to palliative care and current research in treatment, and the team at Kettering Hospital explained that they would research

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areas where they feel their knowledge is lacking when they come across them. For example, if a person had symptoms that they were unable to manage they would speak to colleagues and doctors for advice.

Although there was some sharing of knowledge within the trust teams, there was a lack of wider clinical research, for example participation in national data sets, which means that changes in evidenced based treatment, may not have been implemented in a timely manner.

The trust had not taken part in the National Care of the Dying Adult (NCDA) audit for some time, but the service manager told us that there were plans to contribute to this data this year.

We saw that staff used the latest “British Lymphology Society Guidelines” when providing care to people who used the service. This meant that evidence based care was researched and provided in the development of this care pathway.

Pain relief

Patients in the hospices were admitted with documentation which recorded the pain level of people. These records were reviewed regularly by nursing staff, and patients told us that nurses came back to ask them if medication they had been given for pain was working. If the medication did not have the desired affect patients told us that the nurses would try other prescribed medications or speak with doctors so that they could be comfortable.

One person told us that they had been admitted to Cynthia Spencer Hospice for pain management as they were unable to manage at home. They told us that they suffered from disturbed sleep initially due to the schedule of medications given to them, but that within a couple of days the staff had found a medication and dose which allowed them to be pain free. This meant that there were systems in place to monitor and solve pain symptoms for patients.

The trust did not carry out pain audits either in the community or in the hospices. This meant that practice in relation to pain control was not reviewed, improved upon, or shared among the trust to allow all patients to benefit from prompt treatment.

Nutrition and hydration

People we spoke to in Cransley and Cynthia Spencer hospice told us that the food was nice. There was a menu system in place for patients to choose meals, and there was a wide variety available to suit the tastes of people from different religious backgrounds and cultures.

We saw people being served their meals at lunch time in a prompt manner and they were covered and hot when delivered to the bedside of the patients.

We were told that nutrition and hydration was only monitored in patients where it was clinically required. We saw that food likes and dislikes were recorded in care plan documentation, along with food allergies.

Staff told us that the manager overseeing the coffee shop had implemented a system to show the ingredients of food sold to comply with recent changes in legislation around allergen information being available.

Drinks were available at drinks rounds in the hospices, although drinks were available at any time for patients or visitors to help themselves to, or ask for.

In the community it was not clear how nutrition and hydration of patients was monitored. Staff recorded problems with nutrition and hydration on admission to the team and care planning, but this was not always updated during visits to people in their own homes.

Approach to monitoring quality and people's outcomes

In all areas of end of life care services that we inspected we saw clear signs for visitors and service users to complete a questionnaire providing feedback about the service. This was called “I want great care”.

We saw information displayed on the walls in both hospices detailing comments that have been received and the changes that have been implemented following these. For example, at Cransley Hospice we were told that a person had commented about the lack of a shower facility for the bay areas which have no access to unsuited facilities. As a result of this, the Hospice changed one of the two bathrooms into a wet room to meet this request.

At Cynthia Spencer Hospice we saw that the feedback forms were collated by an external company and the results were sent back to the trust. This meant that

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feedback was collated independently. This meant that the service was seeking feedback from people who used the service and using comments to monitor the quality of service provided to people.

At Cynthia Spencer Hospice and in the palliative care teams there was no evidence of audit systems in place to monitor the effectiveness to the care provided to patients. Although feedback was gained through questionnaires; care pathways, waiting times and other key evidence was not used to measure the quality and performance of the trust. This meant that the trust did not have a robust system in place to improve the service it provided to patients.

Patient outcomes performance

We saw an example of an “Advance care planning” document which was designed to document the choice of the user of the service in their choices of care and decisions around resuscitation. This document was clearly laid out, and included contact telephone numbers for people to contact various services for advice.

We asked in all the locations we visited what care planning tool the trust were using in replacement of the “Liverpool Care Pathway” which had been withdrawn from use in line with national guidance. At Kettering General Hospital we were told by the palliative care team that a new care planning document was being developed and was at the piloting stage; however this was not part of Northamptonshire Healthcare NHS Foundation Trust they told us.

We saw care plans that had been developed for people using the service and staff told us that an end of life pathway care plan had not yet been developed to replace the “Liverpool Care Pathway” which had been withdrawn. We were told that the trust are working on the development of a replacement.

Within the “Strategy for End of Life Care for Northamptonshire 2014-2019” that we were given, we saw a document named “Considerations for care of a person who is dying and likely to be in the last days or hours of life”. This made reference to the replacement of the “Liverpool Care Pathway” with the “Five Priorities of Care”; however it is not clear how staff were implementing the holistic plan of care which was described, or if this had an impact on the care provided to patients.

The trust had recently developed a multi-agency strategy for end of life care, but as this had been recently signed off before our inspection only staff working on the project were knowledgeable about its aims and objectives to improve the end of life care provided to people living in Northamptonshire.

The trust subsequently told us that following the national withdrawal of the Liverpool Care Pathway, the Leadership Alliance for the Care of Dying People ‘One Chance to Get it Right’ document specifically advised against a care pathway as this had an inevitable end point but recommended individualised care plans. The trust therefore developed an end of life care plan in collaboration with local hospitals, which was implemented in November 2014. The plan was used in the last hours or days of life and has a component which supports the carer during their initial bereavement. This care plan was in line with national practice and is specific to palliative patients.

We saw outcome boards on display in both hospices detailing areas of achievement and for improvement. These boards were large and clear for patients and visitors to see, and details such as accidents causing harm, incidents, staffing levels, and actions taken on comments from people were highlighted so that staff, patients and visitors could see the performance of the units and track the level of compliance against the trust’s goals.

Competent staff

Some teams have recently recruited new staff to fill existing vacancies as the end of life care services have recently suffered from vacant posts and recently recruited into them. Staff told us that the newly recruited staff have ensured that services were continued to be provided safely, but that some of these new staff had not yet completed their induction training and competencies.

New staff told us that their induction lasted over four weeks where they were able to visit other services and departments to understand the services provided by the trust. The induction covered training, working supernumerary with experienced members of staff, and attending meetings with the multidisciplinary teams.

We spoke to a new member of staff about their induction training at Cynthia Spencer Hospice and we were told that the induction lasted for four days and included “moving

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and handling” training. The staff member told us that they felt supported in their role and that they had many opportunities at hand overs or on a one-to-one with a nurse to ask questions where they were unsure.

We saw that Cynthia Spencer Hospice had difficulties providing blood transfusions for people due to staff not having completed training in haemovigilance so that they were able to administer and monitor blood transfusions. This training was to minimize the potential risks associated with safety and quality in blood processing and transfusion for donors, patients and staff. This meant that the service could not effectively provide this service at all times as admissions had to be planned around staff working schedules.

At Cynthia Spencer Hospice we saw that new staff were given protected supervision days where updates, clinical supervision, and training took place. This was predominantly on a face-to-face basis in the training rooms in the hospice, but also with electronic learning courses staff are able to access online at home.

A staff member at Cransley Hospice told us that they were studying for a specialist care degree and had the support of their managers to conduct it. We were told about study modules that were funded for staff to study at university, and we saw the leaflets advertising this opportunity on notice boards in the hospice.

Neither hospice carried out one-to-one supervisions with staff but yearly appraisals for staff were evidenced. Staff were not able to explain the trust’s policy for clinical supervision, but that they understood the monthly meetings and teaching sessions with the consultants to be clinical supervision.

Staff in all areas of the end of life services told us that they felt had effective informal support from their line managers to discuss issues, concerns, or training requirements.

We looked at performance appraisal reports for five staff at Cynthia Spencer Hospice, including non-clinical roles. These were based on “SMART” objectives (specific, measurable, attainable, relevant and timely) and we saw that they documented achievements, progress against objectives, skills and challenges, along with mandatory and developmental training needs.

This meant that there was a system in place to monitor and maintain the competencies of staff, although this system was not found to be robust specifically in clinical support for specialist palliative care nurses as the lack of support had not been identified prior to our inspection.

Use of equipment and facilities

In all the areas we visited we saw that equipment was cleaned, maintained and serviced in accordance with the schedules in those areas.

We found that premises were clean, there were cleaning schedules in all areas, and staff responsible for each task was clearly documented.

Patient bed spaces were uncluttered and call bell systems were available and in working order.

Beds and equipment

At Cransley Hospice we saw that covered wheeled containers were in use to house linen for space and convenience. This meant that linen was hygienically stored before it was required.

Multi-disciplinary working and coordination of care pathways

In both Cransley Hospice and Cynthia Spencer Hospice we saw evidence of multidisciplinary team working. We saw doctors, pharmacists, nurses, care assistants, estates teams, and therapists working together to plan care for people staying in the hospices.

This team working meant that health professionals could recommend specific treatment for patient symptoms, for example physiotherapy or pain management utilising the knowledge and experience of the team.

We saw minutes of regular multidisciplinary team meetings, and each service we visited showed us scheduled meeting planners with other members of the multidisciplinary team. Staff told us that as their work bridged the transition between community and hospital care for people, that communication with all other health professionals was important. This meant effective multidisciplinary team working was in place.

We saw a multidisciplinary team meeting being conducted at Cynthia Spencer Hospice and saw evidence of team collaboration in use to form a holistic plan of care for patients. However we were told by staff that the care

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planning tool available was not specific to end of life care, and difficult to edit to reflect the care pathway of the patients they looked after. Staff were unable to tell us about plans to improve the care plan system, and were resigned to accepting the system they were given to use.

Referral, transfer, discharge and transition

We saw that referrals were made to care services by a wide range of health professionals, and a system was in place to ensure that the referrals were appropriate for admission to the unit. Clinicians took a telephone handover and completed pre-admission documentation to ensure that patients' needs were assessed at an early stage.

People who used the service told us that support was provided for them in the community once they were discharged from a hospice, and that staff understood their needs to be able to provide a responsive service.

Staff could not give us figures on readmission to the service, as some patients have acute problems which mean they require a short admission to manage their symptoms, for example pain management; and then return home.

A patient told us that they were apprehensive about going home, but that staff had referred them to community services and they knew that if they needed a readmission that the option was available to them. Patients were referred to community services and sometimes these professionals visited them whilst they were in the hospice so that the handover of care was comprehensive and the patient could be introduced to them before their discharge.

Availability of information

We saw notice boards in both hospices which displayed information to patients, visitors and staff relating to the performance of the unit in areas such as slips, trips and falls, infection control audits, and feedback from patient surveys. This board also included where actions had been taken to meet requests so people could monitor progress of their suggestion.

We saw that staff used a computer system for care planning, and we were told that not all GP surgeries and community services have access to this information. This meant that telephone calls and paper print outs had to be forwarded to these services to ensure patient information was transferred effectively.

Patients in the hospice were not able to review their care plans as they were in a digital format, this meant that patients did not have access to their documentation and there was no evidence that these had been written with their agreement.

We saw leaflets and information for people on display around the hospices. Community nurses handed out information leaflets during their visits and gave telephone numbers out so that people in the community had access to information if they requested it.

Consent

Staff understood the Mental Capacity Act and records showed that they had received training to ensure staff had a level of understanding about people's rights. We saw examples of mental capacity assessments to assess people's capacity to make decisions about their end of life care.

Three patients we spoke to told us that they felt staff gained their consent for each action they were assisted with. We saw consent forms signed for procedures, however we were unable to see written evidence of consent when care planning, although people we spoke with stated that they understood their plan of care and were happy with it.

We saw care assistants asking for permission to enter their rooms, and to assist them with care. Nurses that introduced us to patients checked that they were happy to speak with us beforehand.

All staff we spoke to had a clear understanding of consent and how to obtain it. One member of staff told us that if they were not sure if a person was able to give consent they would contact a senior nurse and that further multidisciplinary discussions or "best interests meetings" would be required if consent was required for a procedure or important decision. This meant that the trust had a system in place to ensure that consent was gained from people to receive care and met the requirements of the Mental Capacity Act (2005).

We looked at "do not resuscitate" (DNACPR) forms in use in the trust. We saw that the trust was proactive in arranging these forms to be completed early in a patients' care. We reviewed six "do not resuscitate" (DNA CPR) forms. All of these forms were signed by senior clinicians, and four documented that they had been completed in discussion

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with the patient and family or carer involved. Where the forms were not discussed with the patient this was clearly documented in both cases; in one case because a patient

did not have capacity to make this decision, and further mental capacity act documentation was completed; and in the second case where a patient did not want to be involved in the decision.

Are End of Life Care Services caring?

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

Summary

Overall, we rated this domain as good because;

- The culture we saw within the service was open and kind. The interactions we saw between staff, families, and people using the service were kind, professional, and not rushed.
- Service user surveys were carried out and the feedback was generally very positive about the service.
- People we spoke to said positive things about the service they had received and the staff working in the service.
- People's dignity and privacy was respected.
- Family members and carers were kept involved and informed about the care and treatment of patients.
- All of the staff we spoke with were cheerful and enthusiastic about the service they provided. Staff worked flexibly to ensure that patients received a high standard of care.
- Patients told us that the staff in the hospices and in the community were kind and caring, and that they "could not fault" the service they had received.
- Spiritual and emotional support was provided to meet the needs of individual patients.

Detailed findings

Compassionate care

The culture we saw within the service was open and kind. The interactions we saw between staff, families, and people using the service were kind, professional, and not rushed.

We spoke to all levels of staff in the hospices and palliative care teams we visited, and all of them told us that the service users' experience was important. One staff member told us "we listen to people's wishes, and we've got to make it happen for them".

We saw that families and friends were involved in the care of people where the individual wanted them to, and we were shown "memory boxes" at Cynthia Spencer Hospice which were made with children in order to forge memories with their ill friend or relative.

Staff at Cransley Hospice told us; "my job is to make sure the patients feel safe and relaxed and to comfort the families".

We saw interactions between patients and staff and noticed that staff took time to listen to people and communicate on their level. Staff were observant of patients' situations and offered assistance where they saw people were struggling. Staff told us that their goal was to help people stay independent, but that they would offer assistance if it was needed.

One comment in the feedback of people who used the services read: "I cannot think of a single area in which this wonderful hospice could be improved". We did not see any negative comments on the feedback forms and saw that between October 2014 and December 2014 there were 21 positive responses. 19 were in relation to customer service, 19 were with gifts to staff, 15 related to the quality of care, and 15 mentioned professionalism of the staff.

We saw results of a service user survey called "I want great care" from Cynthia Spencer Hospice which showed 21 positive comments had been received between October 2014 and December 2014. The results from this survey in the period October 2014 to May 2015 showed that 99% of 136 responses would recommend the service.

People we spoke to said positive things about the service they had received. One patient at Cynthia Spencer Hospice said: "I don't see the doctors very often but if I ask a nurse to see a Doctor one will come along". "The food is nice and I can stay in bed if I am not feeling so good".

One member of staff told us that they would "give them a hug to help them feel better" when talking about providing care to their patients. They were clear that they would ensure that it was appropriate to do so.

Dignity and respect

Are End of Life Care Services caring?

In both hospices we saw staff speaking with people using the services in a respectful manner. We saw staff knocking on doors before they entered them, and consent or choice was asked for where necessary.

Staff explained to us how care plans and advanced care decisions are discussed with people who used the service. Staff spoke about the communication training they had had in order to approach sensitive subjects with people and assist them in judging when it is appropriate to ask personal or sensitive questions about their care and wishes.

A staff member at Cransley Hospice said to us; “I listen to patients. I always try to keep a patients’ dignity, for example, I put the curtains up around a bed, explain all procedures to patients, and provide reassurance. I talk to patients, and their families to get information on the persons likes and dislikes so that care can be personalised. I try to give them choice, for example with clothes, meals and drinks. We constantly hand over any care provided to the trained nurse so that the persons care record is kept up to date. Everywhere should have the same quality of care as we give here”.

We saw evidence in the care plans at Cynthia Spencer Hospice of a patient requesting that a family member carries out their personal care for them, and this was documented in their care plan and communicated to staff.

We were told about how people were facilitated to carry out their wishes while they were staying in the hospices. Relatives told us in both hospices that they had been given every opportunity to visit their family member and we were shown the facilities where people visiting can stay, wash, and cook meals for themselves.

Staff told us about weddings that have been arranged, and where taxis were organised in one instance so that a person could visit a sick relative at Cransley Hospice. Also a service user had wanted to go to France and had not had the opportunity to go. Staff told us that a “French Night” was held where they decorated the dining room and served French food to give that person a flavour of France. We were told that the individual and their family appreciated the effort the staff made.

We were told that a male volunteer member had been trained to provide personal care to people who request to have a male person provide that care for them due to the mix of male/female staff at the hospice, although staff were unable to tell us if this was in line with the trust’s policies.

This meant that staff were providing care to people with dignity and respect.

Patient understanding and involvement

We saw that both hospices displayed information on notice boards to assist people using the service and their friends or relatives in understanding various services which are available in Northamptonshire. Staff told us that they regularly care for people using the service where English is not their first language.

We asked patients if they were involved in their care and they said that they thought they were. As most of the records held for patients was on a computer system it was not possible to see care plans signed in agreement with patients.

Both the hospices told us they held regular events and meetings with patients and their families and carers. This meant that they were involved in the social aspects of the hospice, and also in the care that was being provided.

Staff gave us examples of situations where they were able to use interpreters in person and over the telephone in order to ensure that patients understood aspects of their care planning and provide consent to them.

Emotional support

We saw that Cynthia Spencer Hospice had a purpose-built chapel for staff, visitors, and patients to use if they so wished. We saw that the room was laid out in a multi-faith manner, with a display of religious books from many religions and beliefs.

We were shown a room which can be used by family and friends of people who used the service in order to stay the night close by when required, however if more than one set of relatives required accommodation there were no further facilities available.

The Chaplain we spoke to told us how they can arrange for priests to attend the hospice when a person who used the service had a preference, and that staff endeavoured to

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meet the wishes of people who use the service in any way they can. For example, staff told us that they have been able to conduct weddings, arrange specific meals, and allow people to have time with close friends and family.

Cransley Hospice had a “quiet room” which can be used for these functions, and staff there also told us about weddings that have been conducted in the past, and how the facilities can be used for family or friends to stay the night and prepare meals if they wish.

This showed that the service provides emotional support to people who used the service and their families and friends.

Promotion of self-care

At Cransley Hospice we were told by the pharmacist of the system in place to assist people with taking their own medication in the run up to their discharge.

Care workers told us that they aimed to support people to be independent so that they felt confident when they returned to their own home. We saw this reflected in care plans in relation to assisting with self-medicating before a patient was discharged home.

We spoke to a person at Cynthia Spencer Hospice who was due to be going home the following day. They told us that they had the preconception that “if you go in a hospice you don’t come out”, and as such they were anxious on their admission to the hospice for symptom management. The person told us that the staff had been very kind during their stay and they feel confident in going home. They told us they would not be so worried about returning if they became ill again, now they know what to expect.

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

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

Summary

Overall, we rated this domain as good.

We found that staff responded to the requirements and wishes of patients.

We heard from people who used the service that they were listened to, and saw evidence that individualised care planning was documented and handed over to staff in the multidisciplinary team.

People told us that they did not have to wait long to be admitted to a hospice, and this was evidenced by the trusts records on admission an access to service times.

We saw that feedback was gathered from patients, and changes had been made to the environment and care provision following suggestions from members of the public.

Detailed findings

Service planning and delivery to meet the needs of different people

The electronic computer system had template care plans in place which were generic, and not specific to end of life care. Staff told us that this system could be personalised, however we were told that the training provided "did not give a lot of information on how to personalise the pathways".

We saw that the trust had recently developed a five year plan which had been agreed the month prior to our inspection. This documented statistics on people receiving care at home and in hospital, and detailed the aim to put systems in place to allow more people to stay at home.

Staff told us that there were plans for funding for the hospices to be reduced. Currently the clinical commissioning group funds 70% with charities funding the remaining 30%. They said plans were to switch this to 70% charity funding and 30% from the trust, but at present the charities are not able to manage such a significant increase in funding. We did not see any written plans or research from the trust around this.

Equality and diversity

We saw that leaflets were widely available in care areas on wall racks, and staff told us that they are able to request these leaflets in different languages if they are required.

Menus offered to patients in the hospices gave patients the options to choose meals which may be specific to their religious or cultural beliefs.

Multi faith rooms or quiet rooms were available at both hospices. These were decorated in a neutral way and contained a variety of religious books so that people from different religions and cultures would feel comfortable using the room.

Meeting the needs of people in vulnerable circumstances

We asked staff if they had care plans in place for people with dementia to make end of life choices early on in their illness. We were told that this did not exist in the trust; neither were care pathways in place for people with learning disabilities or other diagnosis which may require different services and support.

There was no evidence of research into specific care groups in the trust's locality, and as a result specific care planning processes had not been put into place.

This meant that the trust did not have systems in place to meet the needs of people in vulnerable circumstances.

We were told by a palliative care team that they collect data around the choices people take about where they would like to be at the last stages of their life, and they showed us figures which showed that the trust was currently meeting their target of 95% of people spending their last days where they wished to.

Access to the right care at the right time

We were told that initial assessments of patients were carried out jointly by nursing and medical staff simultaneously with relatives present where possible and if requested by the individual patient.

Staff told us that the patients and their family or friends were asked of their expectations from admission, so that

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these could be discussed at an early stage. Staff told us that they explained the purpose of the hospice and that the nature of the stay is short term; for example for symptom control.

We saw figures of admission to Cynthia Spencer Hospice that showed that generally there was no waiting list for care services. At the most people waited one to four days to be admitted to the hospice, which was within the trusts' target although staff were not able to specific as to what this target was.

Staff and patients told us that there was not a long wait to be admitted to the hospices, or seen by a palliative care nurse. We saw data from one hospice which showed waiting times for admission averaged one to two days. We were told that the trust aims to respond to calls for admissions within 48 hours and that this target was met, although we did not see figures to support this as the manager did not monitor the calls.

Complaints handling (for this service) and learning from feedback

We were shown information from feedback forms for "I want great care" which showed only positive comments. We asked staff about complaints received at the service and no-one was able to describe any to us. We did not see a complaints log in any of the areas we visited.

We saw at Cransley Hospice that feedback from the service users' questionnaires had been displayed on a board along with the actions taken to resolve those issues. This showed that the service had a system in place to learn from feedback.

A palliative care specialist nurse told us that not every negative comment was recorded in a log, but could not explain why. This means that complaints may not be addressed, and learning may not take place from feedback which has not been recorded.

No areas we inspected held complaints logs. We were told by staff that all complaints were submitted onto the electronic reporting system, or if they were in writing they would be passed to their line manager.

We found that staff had varying understanding of what a complaint is, and at which level incidents should be reported on the computer system.

Are End of Life Care Services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

Overall, we rated this domain as requires improvement because:

- We found that the trust had developed their own plan for the future of end of life care called “A strategy for End of Life Care across Northamptonshire 2014-2019, and aim to be using more resources in this area although some staff we spoke to were not fully aware of these plans.
- There was lack of consistency across the service in terms of monitoring outcomes and carrying out regular audits: Cransley Hospice had defined systems but this was not the case at Cynthia Spencer hospice.
- The service did not have an effective system in place to continually monitor and improve the service.
- The palliative care team at Kettering General Hospital did not have a clear management structure, and this meant that staff were not supported effectively in their roles.
- Staff told us that there was a lack of clinical support and supervision.
- There was variation in levels of support for different teams due to unclear and inconsistent management and leadership across the service.
- We found that systems had not yet been implemented to ensure that evidence-based care was provided to people who used the service, although we saw that a five year plan was being developed but not yet in place. This meant that there was a lack of clinical leadership in the end of life care services.

However,

- Staff in all teams worked hard to support each other and told us of a positive work culture.
- Feedback was regularly sought from patients and their relatives.

Detailed findings

Vision and strategy for this service

We were shown a recently approved document called “A strategy for End of Life Care across Northamptonshire 2014-2019” which set out information about the growing population of Northamptonshire, and the plan for development of end of life care service in order to meet the needs of the local community. A variety of aims were listed in the document, including the provision of “holistic care” and to reduce the incidence of people passing away in hospitals. The document contained research into the percentages of people passing away at home or in hospital, however figures around the choice of these people was not included.

Staff involved in the development of this document were able to describe the aims and practical implications of this document; however nurses working in the hospices were not able to explain this to us.

Governance, risk management and quality measurement

We saw that the trust has taken some steps to manage risk and measure quality in some areas of the end of life care services, however there were differences in the quality assurance audits carried out at the two Hospices. Cynthia Spencer Hospice staff were unable to show us evidence of clinical audits that had taken place to ensure practices are in place, whereas evidence of these audits were in place by nursing staff at Cransley Hospice.

We saw that the trust was involved with end of life forum groups and outside agencies to improve and share practice with other areas. We asked managers and clinical staff about this and they told us that the hospices had submitted figures to national data sets for end of life care in previous years but that this had stopped. The service manager told us that there were plans to reinstate this.

There was also no evidence of clinical audits or research held by physicians to monitor and continually improve practices in end of life care. We spoke to doctors and clinical staff about clinical audits that were carried out and they could not describe any to us.

We spoke to a palliative care specialist nurse who told us “we record every good thing that is said about our service

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in a log". When we asked if every negative thing was logged we were told it is not. The nurse could not explain why these things were not recorded as she did not recognise that this feedback contributed towards quality measurement.

This meant that the service did not have an effective system in place to continually monitor and improve the service, and therefore some concerns were not effectively addressed.

Leadership of this service

We spoke to the service manager who had been in post for eight months. They told us that they were working with the Hospice Matrons in order to provide support to the staff working there. This included introducing a "protected supervision" day for staff at Cynthia Spencer Hospice as it has been working well Cransley Hospice, and the service manager recognised the opportunity to share this development.

We saw that the leadership of Cynthia Spencer Hospice had changed recently and there were a number of new staff on induction training. Staff told us that things have been stressful with low staff levels, but with the recent staff recruitment this had been improving.

At Cransley Hospice the leadership has been stable for some time and we saw documented evidence that cleaning schedules, clinical governance meetings, and other procedures have been implemented and sustained over time. Staff told us that they felt they were well supported, and we saw minutes of meetings where issues and lessons learnt were shared.

We saw evidence showing support from a line manager to a member of staff assisting them in working through a role-specific issue at work. This showed support was offered, along with guidance and a specific plan of action to address the problem to support that individual in their work.

In all areas staff told us that they were made aware of trust plans through their line manager, but staff were unable to identify key trust members in their service line. One manager was unable to identify the lead in the trust for end of life care services when we asked them.

Staff told us that there was a lack of clinical support and supervision, and the trust were open with us that there have been staffing issues which has had an impact on the

training and development of staff in end of life services. During our inspection the service manager confirmed that there were areas where the palliative care team based at Kettering General Hospital "fell through the cracks" and that they would be working on this. We did not see evidence that this had been identified prior to our inspection or what actions would be taken to resolve this.

Both the palliative care nursing teams we spoke to told us that they regularly attended meetings and their appraisals were conducted. However they were unable to describe clear clinical supervision with their line management, and told us that the majority of their clinical supervision came from physicians they worked with. This was described to be informal clinical supervision, not specific supervision relating to the staff members' professional development.

The MacMillan nurse team based at Kettering Hospital told us that although they are based at the hospital they are funded by Northamptonshire Healthcare NHS Foundation Trust. This caused some confusion as to line management and responsibility for training and supervision. As a result, the clinical supervision and guidance for this team was not clearly evident and meant that the staff were not supported effectively to carry out their role.

The palliative care team at Kettering General Hospital did not have a clear management structure, and this meant that staff were not supported effectively in their roles. The service manager recognised during our inspection that there were gaps in responsibility for the mandatory training and clinical supervision of these staff. This issue had not been identified by the trust prior to our inspection, and therefore no action plan was in place to manage this.

Culture within this service

We saw that each team of MacMillan nurses or hospice staff worked closely together and we were given examples where staff cover shifts for each other, and ask each other for advice and support when they feel they need it.

At Cransley Hospice the management were clearly forward thinking and striving to improve the service at each opportunity. The systems that were in place were supported by the staff team and meant that new changes were carried through. For example; we saw that the cleaning rota had been completed almost without any missing signatures for the previous three months which was as far back as the records went. The matron sought

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innovative ideas from other services, and we were told the “protected study days” had been such a success at Cransley Hospice that the same system has been adopted by Cynthia Spencer Hospice.

We found a lack of clarity in managerial support for some staff working in hospices and palliative care teams. For example, the matron at Cransley Hospice had been managing the unit for some time and maintained clear documentation and audit systems. At Cynthia Spencer hospice the matron was new in post and not fully conversant with the policies and procedures of the trust. The palliative team staff spoke about varied levels of support, one team felt very close and supported, while the other team told us that they were not clearly supported by management and that training and clinical supervision were not overseen effectively.

Public and staff engagement

The trust had engaged both staff and public in questionnaires to seek feedback on the services provided.

The information from public was positive; however the trust did not seek feedback from the public in other formats. For example by way of patient or relative group meetings, involving patients in service improvement or recruitment.

Feedback from the questionnaires, audits, and other information was displayed on the walls in both hospices we visited so that people who used the service and their visitors could review these results and see what actions had been taken as a result of comments.

The trust showed us that they asked staff to complete a questionnaire about their satisfaction in their role and the

support that the trust provides. All of the staff we spoke to told us that they felt comfortable approaching their line management if they felt they had an issue, however none had felt the need to raise a concern that that they could describe to us.

The MacMillan nurses pointed out to us that each service has a different questionnaire, and people receiving end of life care can come into contact with many people in a short space of time and be “bombarded” with questionnaires about the various services. This may lead to confusion so that the results do not reflect the service it was meant for, and may also cause distress to a person who may be dealing with bad news. However the nurses had not escalated this point to their line managers.

Innovation, improvement and sustainability

At Cransley Hospice we saw that the matron had encouraged staff to problem solve under the “releasing time to care” initiative and empowered staff to think about ways to improve the service.

We saw the trust’s “Strategy for End of Life Care in Northampton 2012-2019” which shows research into end of life services in Northampton and how they plan improve services based on research carried out. This document was not widely known about by staff working in the hospices or community, but the management team explained to us that it had recently been approved and had not yet been implemented.

We asked staff to show us evidence of clinical audits or innovative projects that the trust was involved in but they were unable to describe any to us.

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff</p> <p>Regulation 23 (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010 Supporting workers (now Regulation 18(2) Staffing of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014).</p> <p>The registered person must have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to delivered care and treatment to service users safety and to an appropriate standard, including by –</p> <p>(a) Receiving appropriate training, professional development, supervision and appraisal.</p> <p>Northamptonshire Healthcare NHS Foundation Trust:</p> <p>Suitable arrangements were not in place to ensure staff received appropriate training, supervision and appraisal to enable them to deliver care and treatment to people who use the services. Regulation 23 (1) (a).</p>