Northamptonshire Healthcare NHS Foundation Trust

RP1

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)
RP1A2	Manfield Campus	Cynthia Spencer Hospice	NN3 6NP
RP1A1	St Marys Hospital	Cransley Hospice	NN15 7PW
RP1Y8	Danetre Hospital	Palliative Care Inpatient beds	NN11 4DY

This report describes our judgement of the quality of care provided within this core service by Northamptonshire Healthcare 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 Healthcare 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 the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

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Summary of findings

Overall summary

We rated end of life care services at this trust as good overall because:

- Patients were protected from avoidable harm. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Arrangements to minimise risks to patients were in place.
- Patients were protected from abuse; staff had an understanding of how to protect patients from abuse and could describe what safeguarding was and the process to refer concerns.
- Patients received effective care and treatment that reflected current evidence-based guidance, standards and best practice.
- Patients had comprehensive assessments of their needs, which included nutrition and hydration and physical and emotional aspects of their care.
- Care from a range of different staff groups was coordinated effectively; there was effective multidisciplinary working, with staff, teams and services at this trust working in partnership to deliver effective care and treatment.
- Staff understood the consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005; this was reflected in the Do Not Attempt Cardio-Pulmonary Resuscitation orders reviewed during our inspection.
- The care provided to patients in the end of life care service was good. Patients were truly respected and valued as individuals and were empowered partners in their care.
- Feedback from patients, relatives and carers was consistently positive and there were many examples of staff being caring, compassionate and providing dignity in a respectful manner.
- Patients' needs were mostly met through the way end of life care was organised and delivered.
- The service was evolving, with a developing strategy. There were robust mechanisms in place to share learning across end of life services.

However,

- The trust did not collect data to establish how rapidly patients were discharged from inpatient services and how often delayed discharges occurred.

Summary of findings

Background to the service

The palliative care services provided by Northamptonshire Healthcare NHS Foundation Trust are located at:

- Cynthia Spencer Hospice, which included an inpatient hospice with 16 beds, a day hospice, palliative care lymphoedema clinic, palliative care clinical nurse specialist (PCCNS) service, hospice at home base and the end of life practice development team.
- Cransley Hospice, which was located at St Mary's Hospital, had nine inpatient beds, and was the base for the PCCNS service.
- Danetre Hospital, which had six palliative care beds on the community inpatient ward.
- A hospice at home service was also run by the trust. This was based at Cynthia Spencer Hospice.

A specialist consultant palliative care team supports Cynthia Spencer and Cransley hospices. The six palliative care beds at Danetre Hospital are GP led and supported by the specialist palliative care consultant from Cynthia Spencer Hospice.

Referrals for hospice admissions could be made by the local NHS trusts, GPs and community services.

There were 114 whole time equivalent staff employed across the service. Cynthia Spencer Hospice provided hospice and palliative care services for the population of south Northamptonshire, whilst Cransley Hospice provided care for the population of north Northamptonshire. Danetre Hospital provided care for patients in Daventry.

The service admitted 496 patients from January to December 2016.

We last inspected this core service in February 2015 and it was rated as requires improvement. Following this inspection we told the trust to take the following actions:

- 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.
- The trust should ensure arrangements to cover planned and unexpected absence of staff and staff vacancies are established for all teams.
- The trust should ensure 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.
- The service should ensure all patients have their care and treatment needs for nutrition and hydration appropriately assessed and recorded.

On examination of data provided by the trust and on evidence collected during the inspection we found that the trust has achieved all of these actions.

Our inspection team

Our inspection team was led by:

Chair: Mark Hindle, Chief Operating Officer, Mersey Care NHS Foundation Trust

Team Leader: Julie Meikle, Head of Hospital Inspection CQC

The team included one inspector, one specialist advisor who was a palliative care consultant and an expert by experience that had experience of using or caring for someone who uses the type of services we were inspecting.

Summary of findings

Why we carried out this inspection

We inspected this core service as a follow up comprehensive inspection.

How we carried out this inspection

To fully understand the experience of people who use services, 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 the inspection visit, we reviewed information that we held about these services. We carried out an announced inspection on the 24, 25 and 26 January 2017. During the inspection we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

What people who use the provider say

During the inspection, we talked to seven patients and nine relatives across the end of life service. We looked at the patient surveys from August to September 2016.

All of the responses we received were very positive about the services they had received with praise mainly relating to the level of care and compassion staff had shown them.

Examples of comments regarding both hospices, the palliative care service at Danetre Hospital and palliative care clinical nurse specialists:

- 'We could not have asked for anymore of the staff, the way my husband was looked after was second to none, thank you just doesn't seem enough'.
- 'Cransley hospice had a very calm and relaxing atmosphere, which put us at ease as soon as we arrived'.
- 'Nothing was too much bother'.
- 'My care could not have been better; I was treated with kindness, dignity and love throughout my stay. Staff were wonderful'.
- 'The whole family was treated with kindness and given support'.
- 'The garden and woodland area at Cynthia Spencer hospice was lovely to sit and walk around'.
- 'The care was provided by staff who really seem to care, rather than people just carrying out a job'.

Examples of comments regarding the hospice at home team:

- 'The hospice at home team were really supportive to me, I did not feel alone'.
- 'My husband was treated with great care and compassion for the few weeks he had left to live, the nurses were so kind, helpful and comforting'.
- 'The care was excellent, I could not think of anything else they could have done for their last few weeks'.
- 'All the nurses had a sense of calm and an understanding of all the emotions I was going through, I cannot praise them enough'.
- 'Staff made my husband's last few days bearable, they always talked to him whenever they carried out any aspect of care and explained what they were doing'.
- 'Every element of the hospice at home team was remarkable, they gave us comfort, support, knowledge and first class medical treatment'.

Summary of findings

Good practice

- The end of life care practice development team provided an outstanding training service to all staff across Northamptonshire Healthcare NHS Foundation Trust. Any member of staff could access their training services, not just the end of life care team. They had recently carried out training for one of the community psychiatric wards, to enable the patient to stay as an inpatient with them. This team was based at Cynthia Spencer hospice and had three teaching rooms available for the trust. The team had developed the trusts Advanced Care Planning document that had been published and awarded the Crystal Mark award. This was for clarity and approved by the Plain English Campaign. The document was available in other languages.
- The chaplaincy service, based at Cynthia Spencer hospice provided an outstanding service across both hospices. They were available 24 hours a day, seven days a week and could accommodate any faith or religion. They were seen to still see relatives or carers for bereavement support, even after a period of time had passed since their relative had died.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should ensure that data is collected to establish how rapidly patients were discharged from inpatient services and how often delays for discharge occurs, to ensure that they are evaluating the process and can make improvements as necessary.

Northamptonshire Healthcare 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 end of life services as good for safe because:

- Openness and transparency about safety was encouraged.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses and where incidents had been raised actions were taken to improve processes.
- Safeguarding was given sufficient priority. Staff had an understanding of how to protect patients from abuse, could describe what safeguarding was and the process to refer concerns.
- Arrangements to minimise risks to patients were in place with measures to prevent falls, malnutrition and pressure ulcers and good infection control practices.
- Staff recognised and responded to the changing needs of patients with anticipatory medications readily available and care needs assessed and reviewed appropriately.
- There were appropriate arrangements for out of hours cover with close partnership working between the trust and external providers.
- Specialist equipment needed to provide care and treatment to patients in their home was appropriate and fit for purpose so that patients were safe. Syringe drivers were maintained and used in accordance with professional recommendations.

Safety performance

- Safety information, such as incidents relating to end of life care, were recorded and investigated by the matron for each service, with support from the service manager.
- The safety thermometer indicators also monitored the services safety performance. This was developed by the NHS as a point of care survey tool. It allows teams to measure harm and the proportion of patients that are harm free, in relation to pressure ulcers, falls, urinary tract infections (UTIs) and venous thromboembolism (VTE). Data was collected on a certain day each month. From December 2015 to December 2016, the service reported on average, 21 new UTIs and 21 new VTEs. This was similar to other end of life care services.

Good

Are services safe?

- The NHS Safety Thermometer results were discussed at the monthly team and clinical governance meetings.

Incident reporting, learning and improvement

- The staff we spoke with were aware of the process for reporting incidents using the trust wide electronic system. All incidents, accidents and complaints were recorded using this system.
- Individual staff told us that they were empowered to raise incidents and concerns to their managers.
- Staff told us they received feedback from incidents that had been investigated and made changes where possible to prevent similar incidents from happening again.
- We saw evidence of learning from incidents discussed at the monthly team meeting, shared through emails, in the monthly newsletter and individual feedback to staff.
- Following our inspection, we manually reviewed all incidents, reported by the end of life care service, from October 2015 to September 2016. We found 412 incidents raised through the electronic reporting system. Of these, 35 were attributable to other organisations. This showed that the organisation was highlighting areas of concern, even if it was not the services fault. The majority of the incidents reported, 157, were related to pressure ulcers.
- From October 2015 to September 2016, one serious incident was reported to the Strategic Executive Information System (STEIS). This was a confidential information leak incident. This had been formally investigated and we saw the serious incident report. It showed that the staff member had not followed the trusts information governance policy or the health records policy. The recommendations were for all staff to be up to date with the policies, further training to be given, to review the process of 'signing in' and 'signing out' patients care records and review who had overall responsibility of tracking the records and to investigate the need for paper records. The family was informed of the incident, but declined to be involved in the investigation, they were reportedly happy with the trusts investigation.
- We looked at one near miss incident, where a wrong dose of a specialist antibiotic was going to be prescribed. The pharmacist intervened early and the correct dose was prescribed and given to the patient. This incident was discussed at the clinical governance meeting and investigated. This showed that the dose had been misinterpreted from the nurse taking the call from the local NHS hospital and then relaying the dose regime to the doctors at the hospice. The service had changed their practice and had a clear guideline, which all calls relating to doses of specialist antibiotics from microbiologists at the local NHS trusts, had to be from doctor to doctor. This reduced the risk of doses being misinterpreted. Shared learning was seen from meeting minutes, all doctors across both hospices were aware of the incident, and the changes made. It was on the agenda for the next team meeting also.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations is the regulation that introduced the statutory duty of candour. For NHS bodies the duty came into force on the 27 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.
- We spoke with staff from all teams across each service and they were able to describe the actions and responsibilities required by the duty of candour. We saw evidence of this through the root cause analysis of the serious incident. The family were formally communicated with and told about the incident straight away.

Safeguarding

- Staff we spoke with demonstrated a thorough awareness of safeguarding procedures and understood how to escalate a concern to the local authority.
- Staff had received training in safeguarding vulnerable adults and children and understood what constituted a safeguarding concern to a person at the end of life. If there were safeguarding concerns, this would be discussed at the multidisciplinary meetings.

Good

Are services safe?

- Staff told us that any safeguarding concerns would be raised as an incident on the electronic reporting system as part of the escalation process. There was a prompting if the incident should be considered as a safeguarding concern.
- Safeguarding training was part of the trust mandatory training. They received level 1 and 2 training, in both adults and children safeguarding, 96% of all staff across the service had completed level 1 and 88% had completed level 2, against a target of 90%. Some staff had completed level 3 training in adult and children's safeguarding, although this was not a requirement and compliance for this was 100%.

Medicines

- In all locations we inspected, we saw that medicines were stored securely in locked cabinets in locked medication rooms; this was in accordance to the trust policy.
- We saw that staff checked and administered medicines to ensure the patient was given the correct dose, at the correct time. Medications we looked at were all within their expiry dates.
- Medicines were stored and managed appropriately, including controlled drugs (CDs) and medical gases. We saw that trust guidance on the administration, as well as the destruction of unused CDs was followed.
- Medicine storage fridges were at the correct temperature and this was checked and recorded each day.
- All staff had access to procedures and guidelines for the prescribing of palliative medicine and for the use of anticipatory medication at the end of life and this was in line with national guidance. Anticipatory medicine refers to medication prescribed in anticipation of managing symptoms, such as, pain, agitation and nausea. These symptoms are common at the end of a patient's life, so these medications need to be prescribed so can be given without unnecessary delay.
- The trust had a pre-printed palliative care medicines administration chart. This contained the prescription and administration record by prescribers. As part of our record check we looked at 15 medication records and found them all to be completed correctly. We noted that there was clear recording of the prescribed medicines, which also included additional instructions for safe administration. Medication charts had been written up with clear indications of 'when required' medication.
- The consultants and doctors carried out medicine reconciliation at the admission process and this was recorded on the electronic care records.
- Medicines were available and supplied by the trust. Nursing staff had access to local community pharmacies for out of hour's medicine requirements. Medicines, required on discharge were organised in advance to ensure sufficient medication was available.
- The hospice pharmacist completed clinical checks of the medicine charts, attended the multi-disciplinary meetings and provided pharmacy support to the prescribing team.
- Medicine incidents were reported using a specific medicine incident form with arrangements in place to ensure they were investigated. They were discussed at clinical governance meetings, which the hospice pharmacist attended.
- There was a pharmacist and a technician that worked across both hospices, Monday to Friday, 9am to 3pm. The pharmacist told us that they carried out regular stock checks and explained the system that was in place to obtain medicines out of hours. This meant the staff had access to medicines when a pharmacist was not on site.

Environment and equipment

- The design, maintenance and the use of facilities kept patients safe. We saw that each location had clear systems in place where all equipment was catalogued with a number on a spread sheet. We could see the equipment items and the dates they had been cleaned and serviced.
- The trust used syringe driver pumps for end of life patients who required a continuous infusion of medicines to control their symptoms, such as pain and nausea. A continuous infusion is a controlled method of administering intravenous medicines without interruption. Syringe driver equipment met the requirements of the Medicines and Healthcare Regulatory Agency. Patients were protected from

Good

Are services safe?

avoidable harm when a syringe driver was used, as they were tamperproof and had the recommended alarm features. All staff were up to date with the syringe driver training.

- Equipment was available to meet the patients' needs, for example, syringe drivers and pressure relieving equipment. Whilst the hospice at home team told us they did not stock equipment for patient use, they could arrange for equipment to be loaned and delivered to people in their homes. No delays were reported in obtaining equipment.
- Medical gases, such as oxygen and nitrous oxide, were stored securely in accordance with the trust's policy. We saw that they were secured upright to prevent them from falling over and causing a hazard.
- The end of life services carried out monthly health and safety audits, which looked at items, such as, furniture and fittings, fire exits and windows and floors. These were not scored as a percentage, but ticked if compliant and comments made on any issues. For example, in September 2016 it was noted that an automatic fire door was faulty, it was documented that it had been reported and the date this action was complete.

Quality of records

- We saw evidence of patient's individual care records were written and managed in a manner that kept them safe.
- We saw the medical records were held on an electronic record system. This system was shared across the trust and GPs had access. These were updated contemporaneously.
- We reviewed 10 sets of medical records. The records were accurate, complete, legible and up to date.
- Care records were audited as part of the end of life quarterly audit to provide assurance that individual person-centred care plans were planned and delivered in line with The Leadership Alliance for the Care of Dying People (LACDP) 'Five Priorities of Care' and patient risk assessments, such as falls and manual handling. The data for September 2016 showed they were compliant.

Cleanliness, infection control and hygiene

- We saw systems in place to prevent and protect people form a healthcare associated infection.
- Both hospices and the six bedded palliative care beds at Danetre hospital were visibly clean and hygienic for patients receiving end of life care.
- Throughout the end of life care services, we observed staff to be complying with best practice with regard to infection prevention and control policies. Staff were observed to wash their hands and use hand sanitising gel between each patient.
- Staff we saw followed the 'arms bare below the elbow' policy. Hand washing facilities and hand sanitiser gel were available in all of the areas we inspected.
- There was access to personal protective equipment (PPE) in each area we inspected, which included gloves and aprons. The staff in the hospice at home team had access to PPE and took fresh stock with them to each patient.
- Patients admitted with infections would be nursed in a single room with the necessary equipment. Relatives and carers were shown how to wash their hands effectively and put on aprons and gloves.
- The personal protective equipment was for staff to use when in contact with a deceased person, to protect their health and safety.
- The service carried out local audits, such as infection control and cleaning audits.

Mandatory training

- Systems were in place to ensure that staff were trained in safety systems, processes and practices.
- Mandatory training covered a range of topics which included fire safety, health and safety, basic life support, manual handling and information governance.
- Staff in the palliative care teams were up to date with their mandatory training. Compliance for Cynthia Spencer hospice, including the day hospice was, nursing at 98% and administrative and clerical staff at 97%. Hospice at home was 92% for nursing and for Cransley hospice compliance was 97% for nursing and 96% for administrative and clerical staff, against a trust target of 90%. These figures included the palliative care clinical nurse specialists.

Good

Are services safe?

- Danetre hospital staff compliance rate for mandatory training is discussed in the community inpatients report, this is due to the staff that worked on the six bedded palliative ward being employed by that hospital and not the hospices.
- Mandatory training was available as face-to-face sessions and online. Staff said they were given time to complete these sessions.
- Basic life support was mandatory. The trust had decided that nursing staff would complete immediate life support as part of their mandatory training, this had not commenced at the point of our inspection.

Assessing and responding to patient risk

- Comprehensive risk assessments were carried out for patients and risk management plans were developed in line with national guidance.
- We reviewed the medical records for 10 patients identified as being end of life. Risks to patients such as dehydration, falls, malnutrition and pressure damage, were assessed, monitored and managed on a daily basis using nationally recognised risk assessment tools.
- Risk assessments were completed appropriately on admission and reviewed at the required frequency to minimise risk.
- We saw that clinical observations were carried out appropriately, using the National Early Warning Score (NEWS) system. This system would alert clinicians if a patient was deteriorating depending on their score. These observations were carried out four hourly, unless it had been discussed at the multidisciplinary team meeting to withhold these observations. For example, if the patient was end of life, then the relevance and risk of not carrying out these observations was discussed, along with the patient's wishes and individualised care plan. Staff completed NEWS audits and we saw that charts were completed appropriately and staff escalated deteriorating patients when appropriate.
- Staff ensured that patients increased needs were identified as early as possible so they could respond in a timely manner. We saw that medications would be identified and ordered in advance when needed, especially before a weekend.
- End of life care advice and support was provided by the palliative care clinical nurse specialists (PCCNSs) and the palliative care consultants. They were available out of hours and had a rota showing which doctor was on call and phone numbers.
- Staff at Danetre hospital had the phone number of the palliative care consultant if there were any queries or changes needed to be made to medication prescriptions. Out of hours, they would call the on call GP. The service had a formal document for recording these telephone calls and included action required and taken, the reason for the call. This form was then forwarded to correct team.
- Staff in the hospice at home team and the PCCNSs telephoned the team base if they were delayed in a patient's home due to crisis or a rapid deterioration. This allowed other visits they had scheduled to be re-allocated to other staff, to give them the time to spend with that patient and family.

Staffing levels and caseload

- Staffing levels, skill mix and caseloads were planned and reviewed by the matron for each hospice and inpatient ward at Danetre Hospital.
- The whole service used an electronic rota system. This took into account the registered nurses and healthcare assistants and would allocate the planned number for each shift. The matrons took into account the acuity of the caseloads and how many admissions and discharges were planned.
- At Cransley hospice we saw a dependency tool used that evaluated the needs for the patients, this ensured an appropriate level of nursing was in place to provide safe care.
- Caseload management for the end of life service was undertaken by the matron for each hospice and at Danetre Hospital. The average caseload for a member of staff was 37 patients each month.
- We reviewed the data for the staff fill rates to compare the proportion of planned hours worked by registered nurses and healthcare assistants to the actual hours worked these staff. Staffing fill rates for registered nurses and healthcare assistants at both hospices was from 91% to 120%.

Good

Are services safe?

- To always meet their planned staffing hours, some of the staff worked bank hours to cover shifts that were empty due to sickness or vacancies. All agency staff had a full formal induction and this was repeated if they had not worked in the department for a certain length of time.
- The services average vacancy rate from October 2015 to September 2016 was 10%. Which was 10 whole time equivalents (WTE), however, we did not have the formal data for this. The matron told us that this number had reduced in January 2017 due to recruitment taken place. Cynthia Spencer had two healthcare assistants leaving, so the matron had recruited and interviewed for these two posts before they had left. This meant they would not have to use bank or agency staff to cover until they were in post.
- The rate of sickness for all end of life services was 4% from October 2015 to September 2016. This was the same as the trust average of 4%.
- Medical staffing for the six palliative care beds at Danetre Hospital was provided by a duty GP service which ran from Monday to Friday. Every Wednesday the palliative care consultant from Cynthia Spencer hospice would carry out a ward round on all the patients and would be on hand for any advice. Nursing data for Danetre Hospital can be found in the community inpatient report.
- There were two palliative care consultants at each hospice. Cynthia Spencer had two specialist registrars and three junior doctors, whilst, Cransley hospice had three junior doctors and one GP trainee. Each hospice also employed allied healthcare professionals, such as physiotherapists and occupational therapists, this equated to two WTEs. There were 12 WTE PCCNSs across both hospices and nine WTE nurses on the hospice at home team, these figures were correct for September 2016.

Managing anticipated risks

- Potential risks were taken into account when planning services, for example seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing. Business continuity plans were in place and available to staff should there be any disruption to the day-to-day running of the service.
- The matrons would increase staffing if the demand needed it. However, we were told this rarely needed to happen due to the nature of their work.

Good

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 end of life care service for effective as good for effective because:

- Patients' care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- Care records were personalised and aligned to the Leadership Alliance for the Care of Dying People 'Five Priorities for Care' and included a comprehensive plan of care that reflected both patient and carer/relative involvement and continuous monitoring of patient need to ensure changes in condition or symptoms were dealt with in a timely manner.
- We saw where patients' symptoms of pain were suitably managed and staff were proactive in assessing the patient's nutrition and hydration needs. Patient outcomes were routinely monitored and we saw where comprehensive plans had been put in place to improve outcomes for patients.
- Care and treatment was planned and delivered by health care professionals appropriately trained in end of life care.
- The practice development team had produced a published Advanced Care Planning document.
- Clinical supervision was formally recorded and each member of staff had a clinical supervisor allocated to them.
- We saw evidence of effective multidisciplinary working, with staff, teams and services at this trust and external organisations working in partnership to deliver effective care and treatment.
- Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- Do Not Attempt Cardio Pulmonary Resuscitation forms had been fully completed in accordance to with the trust policy.
- End of life care was managed in accordance with the National Institute for Health and Care Excellence (NICE) guidelines. For example, the review of the medication prescription charts showed symptom control for end of life patients had been managed in accordance with the relevant NICE quality standard. This defines clinical best practice for the safe and effective prescribing of strong opioids for pain in palliative care.
- In response to the 2013 review of the Liverpool Care Pathway, patient care records included personalised care plans aligned to the Leadership Alliance for the Care of the Dying People 'Five Priorities of Care'. In all the medical records we reviewed, we saw a robust 'care of the dying person' assessment; this was a plan of care that reflected both patient and carer/relative involvement and continuous monitoring of the patients' needs. This ensured changes in condition or symptoms were dealt with in a timely manner. All staff had training on the Five Priorities of Care, these were to recognise, communicate, involve, support, plan and do.
- The care of the dying person care plan showed that the principles of the MCA should be applied throughout and had an internet link to the trusts Mental Capacity policy.
- A holistic needs assessment was in place which meant discrimination, including on grounds of age or disability, gender, race, religion or belief and sexual orientation was avoided when making care and treatment decisions.
- The palliative care inpatient ward at Danetre Hospital took part in the Gold Standards Framework (GSF) and achieved this award for 2015/16. They were currently in the process of applying for this again for 2017. The GSF was a national accreditation scheme and provided training to in relation to end of life care for trusts that met the national guidance.
- Patients approaching the end of life were identified appropriately. A senior doctor who assessed the patient

Evidence based care and treatment

completed a 'recognising the dying' form. This was a collaborative decision made in discussion with the patent and/or family and the relevant healthcare professionals.

Pain relief

- The pain of an individual was assessed and managed appropriately. Pain scores were included in the patient's initial assessment both as an inpatient and in if treated in their homes.
- Pain was regularly assessed by staff in all interactions with the patients. We saw that appropriate pain relief was administered in a timely manner.
- Patients who had been identified for end of life care were prescribed anticipatory medicines. These 'as required' medicines were prescribed in advance to properly manage any changes in patient's pain or symptoms, such as, nausea and vomiting. We saw that these medicines were had been prescribed and administered appropriately.
- Patients were given pre-emptive pain relief before they were due to be mobilised or repositioned in bed.
- The service carried out an audit in July 2016 to assess the use of strong opioids at Cynthia Spencer hospice. The audit showed compliance with NICE guidance around titration (the mixing of medicines together) of opioids, prescribing laxatives, but it showed non-compliance around providing patients with written information. The service was now developing an information sheet for all patients and carers.
- Specialist palliative care advice, in relation to symptom control, was available 24 hours a day, seven days a week. This was provided by the staff at both hospices. The staff who worked at Danetre Hospital would call Cynthia Spencer hospice.

Nutrition and hydration

- Patient's nutrition and hydration needs were assessed and met. We saw robust assessments of each patient's nutrition and hydration needs in the 10 medical records we reviewed.
- The service used the Malnutrition Universal Screening Tool to identify patients at risk of malnutrition. It included management guidelines to be used to develop a care plan if required.
- We saw evidence of fluid balance and nutritional intake charts completed. This was important if the patient could no longer take oral fluids.
- Where interventions were required, such as, prescribing oral supplements, or a referral for swallowing difficulties, we saw these were documented in the patients individualised care plan.
- Medical staff were aware of the General Medical Council guidance for doctors, in supporting nutrition and hydration in end of life care.

Patient outcomes

- Information about the outcomes of patient's care and treatment was routinely collected and monitored. This was achieved by monitoring, auditing and benchmarking the services.
- The service was looking to commence the Integrated Palliative Outcome Scale. This scale used a variety of tools used to measure patients' physical symptoms, psychological, emotional and spiritual, as well as their information and support needs. This is a validated instrument that is used in clinical care, audit, research and training. The end of life service manager and the professional development team were due to meet with a local NHS trust to discuss how they can start to implement it at Northamptonshire Healthcare NHS Foundation Trust (NHFT).
- The service had conducted local clinical audits such as, medicines management, blood sugars and nutrition. The service had developed recommendations in response to these audits. For example, an audit comparing assessment and management of constipation in the hospice to NICE guidance showed the service was not achieving al standards around constipation. The audit was presented at the departmental teaching session and the importance of reviewing bowel charts and prescribing appropriate interventions were discussed. Bowel charts were now reviewed during the consultant ward rounds.
- The service was committed to delivering a programme of comprehensive end of life training in support of a local Commissioning for Quality and Innovation (CQUIN). The lead for professional development for end

of life care lead on this. The CQUINs framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare.

- We were shown evidence of one CQUIN the service had carried out lead by the professional development team, had been published in The National Council for Palliative Care journal in October 2016. This was, Transforming Care: a collaborative end of life care CQUIN. The staff told us that this had resulted in changes in their day-today practice. For example, the standardisation of community specialist nurses' mobile phone voicemail messages, to give patients/relatives and other staff alternate contact details if they were unavailable, additional training around having discussions with patients and their preferred place to die and advanced care planning.
- The lead for the professional development team told us that having a CQUIN encouraged them to challenge systems and processes in order to improve the experiences of patients and those important to them.
- The staff at Danetre Hospital were working towards their second independent accreditation standard for the GSF Quality Hallmark in End of Life Care.
- The service had not taken part in the National Care of the Dying Audit for the last two years. However, staff told us that they may be contributing to the local acute trust's audit, as they were the lead for contributing the data for this audit. A medical service level agreement and the NHFT palliative care consultants support the specialist palliative care nurses employed by the local acute trust.

Competent staff

- Staff were qualified and had skills, knowledge and experience to do their job. Staff told us they felt competent to provide end of life care for their patients.
- Arrangements were in place for supporting and managing staff. Staff told us and we saw evidence of nursing and medical staff receiving clinical supervision and an annual appraisal.
- Appraisal compliance for all staff across the end of life service for October 2015 to September 2016 was 95%, against a trust target of 90%. We reviewed an annual appraisal report and this showed us that there was a system in place to monitor and maintain the competencies of staff.
- Staff each had a clinical supervisor assigned to them. They would book formal sessions in advance, also clinical supervision was recorded if staff had an unplanned session. Clinical supervision should be made available to all staff in end of life care, as stated in the NICE guidance. Clinical supervision is an activity that brings skilled supervisors and healthcare staff together in order to reflect upon their practice.
- The trusts clinical supervision policy stated that from April 2016, two sessions needed to be carried out quarterly. Before April 2016, they were carried out monthly. The appraisal rate for the specialist palliative care doctors for November 2015 to October 2016 was 89%; we saw evidence of 70 sessions recorded for this period. The appraisal rate for all nursing, healthcare assistants, therapy services and allied healthcare professionals across the service was 90%, with 749 sessions recorded for this period. The trust target was 90%. This was an improvement from the February 2015 inspection, where no formal clinical supervision was recorded.
- The medical staff received onsite training twice a month.
- Staff said they had received appropriate training to meet their learning needs and were encouraged and given opportunities to develop within end of life care. Staff said there were excellent training opportunities that they could access through their professional development team. For example, there was a recognised course for all members of staff giving training on communication and how to listen to patients in emotional distress or are concerned. This course had received positive feedback from all staff, from consultants to the administrative staff.
- The professional development team carried out the training for syringe drivers. If a member of staff needed an update or a refresher, they would accommodate this. We saw the nurse's competencies and training dates that showed completion and newly recruited staff were booked in for this training.
- Staff across the service had received training in the Advanced Care Planning (ACP) document. This was

provided by the practice development team. The training included education including the principles and legalities of ACP and the associated communication skills. The practice development staff had developed and produced the document and it was available across Northamptonshire Healthcare NHS Trust.

- We saw through training records that nurses had completed their training in blood transfusion in each department. This had improved at the Cynthia Spencer hospice since the February 2015 inspection.

Multi-disciplinary working and coordinated care pathways

- All staff, including those in different teams and services were involved in assessing, planning and delivering patients care and treatment.
- During our inspection, we attended two multidisciplinary meetings. These were attended by the palliative care consultant, specialist registrars, junior doctors, the pharmacist, ward sister, staff nurses, family support worker, hospice at home staff, physiotherapists and an occupational therapist.
- These meetings included detailed discussions about the patient's physical health, their psychological wellbeing and how this affected those close to them.
- We saw evidence of family support input, discussion of care at home when at end of life and working with other agencies to support patients and those important to them. They showed a holistic approach to the patient's plan of care. Advanced care plans were discussed and a review of recent deaths, to discuss support for the bereaved family and carers and if any lessons could be learned.
- GPs were informed that a patient of theirs had been identified as requiring end of life care, through the electronic coordination system or by telephone.

Referral, transfer, discharge and transition

- Staff worked together to assess and plan on-going care and treatment in a timely way when patients were due to be referred, discharged or transferred between services.
- There was a clear pathway for referral into the hospices or to the palliative care beds at Danetre Hospital. Referrals could be made by the acute NHS hospitals, GPs and community services. Through discussion by the referring team and the hospice, it was identified if the patient required end of life care. An end of life care plan (EoLCP), either paper or electronic would be commenced and this would be sent with the patient and continued. This care plan encompasses the five priorities of care.
- If the patient's preferred place of death was to be at home but had been referred to a hospice, the team would liaise with the hospice at home staff and other end of life care providers to see if their care could be met at home.
- If the patient was assessed at being at the terminal stage of their illness at time of admission, the EoLCP would be initiated after discussion with the palliative care consultant and the members of the multidisciplinary team.
- If the patient was being cared for at home by the hospice at home team and their condition deteriorated and needed admission to the hospice, then the EoLCP would continue upon admission and be updated onto the electronic care record.
- Discharges were managed effectively and mostly were timely to allow the patient to be cared for in their preferred place. The trust would record data relating to delayed transfers of care and use this information with their strategic partners to develop this service. There was a 'fast track' discharge service for patients who could go to their own home or nursing homes. This was discussed at the multidisciplinary team meetings. They would have input from the occupational therapists to ensure the right equipment was ordered and delivered in a timely manner.
- Each hospice had a family liaison support worker, who would speak with families, advise and give information regarding the discharge process. They would navigate families through the whole process and assist with the practical elements of discharge.

Access to information

- Information needed to deliver effective care and treatment was available to all staff in a timely and accessible way. Patients care plans and risk assessments were stored electronically and GPs and

other teams had access to these. If a patient was transferred to a nursing home or the acute NHS trust, then these records would be printed off and go with the patient.

- The service used an electronic palliative care coordination system. This enabled the recording and sharing of patients care preferences and key details about their care at the end of life.
- All teams, for example, hospice at home, all used the same electronic system.
- Staff had access to electronic information, such as policies, national guidance and newsletters via the hospitals intranet.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff understood the relevant consent and decision making requirements of legislation and guidance, including the MCA and Deprivation of Liberty Safeguards.
- There was clear information on the hospitals intranet about the MCA guidance, which included the policy.
- Staff received three yearly training sessions on the MCA and Deprivation of Liberty Safeguards as part of their mandatory training.
- We reviewed 10 sets of care records. We saw that consent to care and treatment was obtained in line with legislation and guidance, including the MCA. Patients we spoke with told us that they were supported to make decisions.
- Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) forms were completed accurately. We looked at seven DNACPR forms, all were in date and completed in accordance to the trust policy. There was evidence that either the patient had consented or mental capacity assessments had been completed in the decision making process. Relatives had been informed and were part of the decision making process.
- GPs, the ambulance service and the out of hour's service, would be sent copies of the DNACPR forms.

Outstanding ☆

Are services caring?

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

Summary

We rated the end of life care service as outstanding for caring because:

- We observed a strong, person-centred culture. Staff treated people with compassion, kindness, dignity and respect.
- Feedback from patients and their families were consistently positive and included many examples of where staff provided kind and compassionate care.
- We saw where patients' emotional, social and religious needs had been taken into account and were reflected in how their care was delivered.
- All staff were committed to providing compassionate care not only to patients but also to their families and post bereavement.
- Patients and their families were truly respected and valued as individuals and were empowered as partners in their care.
- Nursing staff were excellent at providing emotional support to relatives and signposted them to external sources of support when required.
- Staff provided a caring service and people told us that they felt safe and happy with the care and support both they and their families received.
- Interactions between staff and patients demonstrated a respectful, kind and compassionate approach.
- The experiences of patients were important to staff. They took time to interact with the people using their service and knew where to find additional support for people if required.

Compassionate care

- Throughout our inspection, we observed patients being treated with compassion, dignity and respect. Staff we spoke with showed an awareness of the importance of treating patients and their families in a sensitive manner.
- On observing a nurse with a patient, we saw excellent holistic care undertaken. The patient had difficulty communicating; the nurse demonstrated good awareness of the patient's needs. They provided support, showing kindness and gave the patient the time they needed.
- We spoke with seven patients and nine relatives during our inspection. Patients and relatives were consistently complementary about staff attitude and engagement. The comments received from patients and relatives demonstrated that staff cared about meeting patients' individual needs. An example of a patient's description of the care provided was, 'all staff are very caring and make me feel comfortable and that nothing is too much trouble'.
- Relatives told us that staff had been extremely caring and attentive to their needs. For example, a relative told us, 'the staff have shown kindness and care, not only to my mum but the whole family' and 'the staff took the chaos away, enabling us to grieve'.
- We saw one of the doctors speaking with a relative who was worried about filling in certain forms, the doctor told the relative to bring them in to the hospice, where they would help and advise them with these forms.
- The friends and family test results for September 2016 for the end of life service showed positive feedback, with 99% to 100% of responders extremely likely to recommend the service.

Understanding and involvement of patients and those close to them

- Patients and relatives were very positive about their care and the way that the staff communicated with them. They told us that they felt involved in the decision making process.
- Relatives told us that staff communicated in a sensitive and unhurried way to ensure they could understand the information being given to them.
- Patients and family members told us that they were involved in the patients care plan and treatment. A family told us that they found the discussion about the

advance care plan (ACP) very helpful. This was a document enabling people to consider their wishes and preferences and plan for a time when they may longer speak for themselves.

- The needs of family members who were caring for a dying person were always considered. This included assessment of carer stress by the family liaison support workers. Relatives highlighted how important this aspect of end of life care was to them.
- One patient told us that they were kept fully informed by the medical team about all their medical problems and clear explanations of their treatments.
- Patients records showed detailed discussions had been held with patients and their families and that they had understood what had been discussed.

Emotional support

- Emotional support was provided to patients and their families through a variety of services, including the voluntary sector.
- The family liaison support workers provided emotional and psychological support for families, carers and friends. They would refer patients for further support if needed, for example, if there were bereaved children following a death of a parent, they would be referred to the child and adolescent bereavement service.
- We saw evidence that patients' records included spiritual and psychological goals in their care plans.
- During the inspection, we saw a relative come back to the hospice to speak to the chaplain, even though their relative had died a few months previously. Staff told us, they continue the emotional support for families as long as they need it.
- Patients were able to keep close links with their families and friends through the internet and social media. We spoke with one patient whose relative lived in abroad and they were able to talk to them every day using an internet video call.
- A bereavement support group was also held every third Monday of each month at Cynthia Spencer hospice.
- Emotional support was also offered to the staff by the chaplain if needed and they would have debriefs to discuss individual patient deaths that may have affected the team.

Good

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 end of life care service as good for responsive because:

- Services were planned and delivered in a way that met the current and changing needs of the local population.
- End of life services provided services for people in vulnerable circumstances and the differing needs of individual patients.
- Care plans were holistic and included an assessment of the patients' spiritual and emotional needs.
- The needs and preferences of patients and their relatives were central to the planning and delivery of care with most people achieving their preferred place of care.
- Leaflets were available in other languages, Braille or audio tapes and disc.
- Complaints were managed effectively.

However:

- The trust did not collect data to establish how rapidly patients were discharged from inpatient services and how often delayed discharges occurred.

Planning and delivering services which meet people's needs

- The end of life services had monthly team meetings and 'away days' for the senior nursing staff at both hospices. Caseloads would be discussed and the service as a whole, so that services could be planned.
- We saw minutes from the end of life steering group meetings, which was attended by the service manager for specialist palliative care at Northamptonshire Healthcare NHS Foundation Trust, Clinical Commissioning Group (CCG) and staff from the local acute NHS hospital. They discussed the implementation of the electronic care record being implemented in primary care services and starting the palliative outcome scale, which had a lead for driving this forward since the meeting.
- The service manager for the specialist palliative care service told us that the NHS CCG take the lead for commissioning services with a 70% majority and the charities fund the remaining 30%.
- The hospices provided appropriate facilities for the delivery of end of life care. Cynthia Spencer had 16 beds, with eight being single rooms with an en-suite and four bays with three beds. Cransley hospice had nine beds, four being single rooms with an en-suite and two bays with three beds in. The six palliative care beds at Danetre hospital were all single rooms with an en-suite. At each location, there was a bedroom specifically for relatives to stay over. There were beds provided for relatives at each department if they chose to stay in the patient's room.
- Patients, who were nearing the end of their life, could choose if they wanted to be in a single room, or in a bay. Patients we spoke to in the bays, preferred it, as they could chat to other patients and relatives and did not feel lonely. They commented that it was not noisy or busy due to only one or two other patients in the whole bay.
- When a patient died in the hospices, they would be taken for their families to spend as much time as possible with them to a designated room. These rooms, were quiet, tastefully decorated and had the provision to play music if the families wished.
- Cynthia Spencer and Cransley hospices did not have onsite mortuaries. Patients would be taken into the viewing room for the family to spend time with their loved one and the funeral directors would collect from the hospice. The hospices had a contract with a local funeral director if the family had not chosen one. There had been no incidents relating to the transferring of a deceased patient. Danetre Hospital had an onsite small mortuary.
- The lymphoedema service was based at Cynthia Spencer hospice and was an outpatient clinic. The service was for the whole county and served the cancer patients, 50% of these would be palliative.

Equality and diversity

Good

Are services responsive to people's needs?

- Services provided met the needs of the local population. We observed services that had been planned to take into account the needs of patients and their family, for example on the grounds of age, disability, gender, religion or belief. Staff told us that they would take into account patients who had children, or patients that were identified as homeless. Each department had its own kitchen for relatives, where they could bring in food from home for the patients; this met the needs of patients who had specific dietary requirements related to religion or culture.
- Staff had access to interpreter and translation services through an external company. Staff demonstrated a good awareness of the language needs of the local community and told us the process they would follow should they require an interpreter.
- There was a separate chapel at Cynthia Spencer hospice. The chapel was called the Chapel of Peace; it was open 24 hours a day and was available for all staff, patients and relatives. There was an ablution room at the entrance to the chapel; this was a designated room for the use of washing hands and feet. The chapel entrance could accommodate a bed, so that patients who were unable to mobilise could still attend for prayers or services.
- The chaplaincy service worked across both hospices. The lead chaplain for the service could access all religious and cultural requirements if needed. With the patient's permission, their local minister or religious leader would be contacted, to continue the patient's religious service to them and their families. The chapel was also used for pastoral care and counselling, patients or relatives could use the chapel to talk about any issues or concerns in a confidential safe and secure place. They had an on call service 24 hours a day seven days a week.
- Danetre Hospital had a trust chaplain who visited the ward, they supported the staff as well as the patients, and the hospital had links with the local clergy if needed.
- There were adjustments made so that patients or relatives with a physical disability could access and use the services, such as, ramps, lifts and larger rooms. All bathrooms had access for wheelchairs if needed.

Meeting the needs of people in vulnerable circumstances

- Services were planned, delivered and coordinated to take into account patients with complex needs, for example those living with dementia or those with a learning disability.
- Care plans identified patients with a learning disability and living with dementia. The matrons could access the trusts learning disability team for advice and support if they had an end of life patient who had a learning disability.
- We saw the 'This is me' document used on the older people care wards to assist with patients living with dementia. 'This is me', is for people with dementia receiving professional care in any setting. It is a practical tool that people with dementia can use to tell staff about their needs, preferences, likes, dislikes and interests. It encourages health care professionals to see the person as an individual and deliver person-centred care that is tailored specifically to the person's needs.
- We saw that staff gave patients and those close to them information leaflets. We saw a joint trust and hospice produced leaflet called 'What to Expect when Someone is Dying'. This leaflet contained information about what to expect when someone is dying such as physical and mental changes. There was also a leaflet called 'When Someone Dies', this contained initial practical advice and support. Both these leaflets were available in other languages and could be ordered in Braille or audio tapes and discs.
- The palliative care bedrooms and relatives room at Danetre Hospital had been decorated to be dementia friendly. They used the correct colours on the walls and floors.
- In each of the three departments we inspected, we saw that 'pet therapy' was used. A local charity would bring in dogs to sit with patients. Patients could also have their own pet's visit them, staff told us that a patient's horse had been brought to the hospice garden, so that they could spend some time with them before the patient died. Staff told us of the joy and happiness it brings to the patients whilst they are being cared for at the hospices. We were told that animal-assisted therapy could significantly reduce pain, anxiety, depression and fatigue for patients with a range of health problems.

Good

Are services responsive to people's needs?

- There was a 'hearing loop' facility available at each department to enable people with hearing aids communicate and understand what staff were saying.
- There was an open visiting policy for patients receiving end of life care at both hospices and at Danetre Hospital. Cynthia Spencer hospice had a designated 'quiet' time for patients from 1pm and 2pm. However, this would be overruled if the patient was in the last hours of life.
- Staff told us they tried to allocate side rooms to patients who were receiving end of life care in order to offer quiet and private surroundings for the patient and their families. They also said that often patients at the end of life had to be cared for on open wards, as the use of single rooms were prioritised for patients who required isolation.
- For patients who wished to take communion the chaplain or an authorised member of the team brought communion to their bedside.
- We saw that a memorial evening was held. This provided an opportunity for relatives, friends and hospice staff to share a time to remember those that had died. It included music, readings lighting of candles and a chance to reflect and talk to other families and staff.
- Staff told us that if a patient died when the family were not present; the staff ensured that they offered the family the opportunity to come to the ward before the deceased person was transferred to the funeral directors.
- Memory boxes could be made up for relatives to take home with them. Parents who were at the end stages of life, would be given a blanket to 'cuddle', so that their children could take this home with them to still smell their mother or father. This helped children through the bereavement process.

Access to the right care at the right time

- Patients had timely access to initial assessment and diagnosis. At Cransley and Cynthia Spencer hospices, 100% of patients admitted, were seen and assessed at point of admission, both in and out of hours. Patients admitted to Danetre palliative care beds, were seen on the same day of admission by the ward doctor, unless this was after the ward round time and the patient had already been seen by the referring GP and sent in with a medication chart and management plan. If there was then a clinical need to be seen before the next day's ward round the duty doctor within hours would be contacted or the out of hours service. If the admission plan and medication chart were not sent with the patient, the duty doctor was contacted to admit the patient on the same day.
- Nursing and medical staff carried out initial patient assessments jointly. Relatives would be present where possible and where patients had given consent.
- Staff told us that the patients and their families would be asked of their expectations from admission, so that any worries, concerns and expectations could be discussed at an early stage.
- The trust provided data for the number of patients who died in their preferred place of care. From January to December 2016, the percentage of patients across the NHFT end of life service who died in their preferred place of care was 91%. The national average was around 80%. We saw evidence from patients care plans that this was discussed and recorded.
- From October 2015 to September 2016, the palliative care consultants met the national target of 18 weeks from referral to initial assessment for outpatient referrals, reporting an average of two days. Palliative care lymphoedema had the highest average days from referral to initial assessment reporting an average of eight days.
- We saw evidence that there was generally no waiting lists for either hospice or the six palliative care beds. If there was, it was generally no longer than two days. If a patient was waiting at home to be admitted they would implement the hospice at home team and the palliative care clinical nurse specialist would visit.
- Bed occupancy rates (including leave days) from October 2015 to September 2016 were:
  - Cransley Hospice 83%
  - Cynthia Spencer Hospice 86%
  - Danetre Hospital 111%. This rate was due to patients being on leave, and their bed being filled whilst they were away.

Good

Are services responsive to people's needs?

- Overall, the trust had an average of 17 days length of stay across all wards for discharged patients from October 2015 to September 2016. Cransley Hospice had the shortest length of stay at 13 days and Danetre Hospital had the longest at 19 days.
- There was access to specialist palliative care advice at any time of day or night. This was given by nursing and medical staff at both hospices.
- The service had provisions for out of house care and treatment, such as at weekends. For example, doctors carried out ward rounds, there was chaplaincy cover and the health care assistants were trained in enablement, to continue the patients rehabilitation if the occupational therapists and physiotherapists were unavailable.
- If patients wished to be cared for at home the discharge process could occur in 24 hours. Staff told us that sometimes there were delays, for reasons such as not acquiring the right equipment in a timely manner. However, the trust did not collect data with regards to delayed discharges and we did not see any incidents relating to delayed discharges. Therefore, we could not evaluate how often delays occurred.
- The service had introduced a seven-day working for the palliative care clinical nurse specialists and the service managers were planning a transformation plan for a community palliative care multidisciplinary team, which would link in with the hospices.

Learning from complaints and concerns

- Staff were able to describe the complaints procedure. Relatives of patients we spoke with felt confident to raise issues with the staff. Staff told us they would deal with issues and concerns raised promptly; this eliminated the need for a formal complaint to be raised. Staff told us this happened rarely.
- The service had received three complaints from October 2015 to September 2016. The trust categorised the themes, two of these complaints were not upheld after investigation and one partially upheld. In all cases three cases responses had been sent in a timely manner and where appropriate, the changes that had been made to procedures or where further training had been given to staff.
- Information on how patients or relatives could make a complaint was displayed in each area we inspected.
- Community end of life care services received 331 compliments from 1 October 2015 to 30 September 2016.
- Cransley Hospice received the greatest number of compliments at 102, followed by Cynthia Spencer Hospice with 99 and the hospice as home team had 83.

Good

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 end of life care service as good for well-led because:

- Staff were engaged and demonstrated commitment to delivering high quality end of life care for the trust.
- End of life care services had been considered at board level. This was evident in the end of life care strategy 2014/2019.
- Leadership was strong with good public engagement.
- There were robust mechanisms in place to share learning across end of life care services.

Leadership of this service

- The end of life service at Northamptonshire Healthcare NHS Foundation Trust (NHFT) was managed and lead by a service manager. They reported to the head of service for unplanned care, who represented the service at board level.
- Each hospice and the palliative care beds at Danetre hospital were managed by a matron, who reported to the service manager.
- These leaders had the skills, knowledge and experience to manage this service.
- Staff told us they were supported in their roles by the service manager. Staff were positive about the leadership and the support and encouragement the service manager and the consultants provided.
- Staff felt they were able to approach their managers for advice and staff commented on the open culture where issues and concerns could be discussed.
- Staff told us the service manager and matrons were visible and approachable. The matrons of the two hospices would work closely together and visit each other's hospice so staff knew who they were.
- Staff had confidence in the service manager and matrons to provide expertise and training to improve the care of end of life patients.
- The nursing staff at the hospices told us that they had met the trusts director of nursing. They had visited the hospices and taken part in training.

Service vision and strategy

- The service had an end of life strategy for the service. The strategy delivery plan outlined the development of the end of life service across Northamptonshire for 2014/2019. It showed seven key principles to be delivered, including, improved coordination of care, introduction of the electronic palliative care coordinated system and having sufficient specialist palliative care capacity in the right location to support patient choice at end of life and working towards meeting demand. These were reviewed at the clinical governance and departmental meetings.
- Staff we spoke with could tell us of this strategy. The service manager had been involved in the development of this strategy and could describe the aims and practical implications of this document.
- The staff in each area knew the trust vision, which was to be leading provider of outstanding, compassionate care and the objectives that underpinned this statement.

Governance, risk management and quality measurement

- There was an effective governance framework that supported the delivery of the strategy and good quality care. The service would have monthly clinical governance meetings discussing the strategy and other agenda items, such as, incidents, audits, guidance and policies and patient/carer information.
- We saw that the service took part in clinical audits, medical staff we spoke with could tell us about these. This was an improvement from the inspection in February 2015. We saw that there was now a systematic programme of clinical and internal audit.
- We were assured that staff were aware of how to identify risks and ensure that controls were in place and reviewed to reduce the impact of risk. We saw evidence

of a trust wide risk register, however, the end of life care service had two risks allocated, one related to a faulty electrical generator at one of the hospices. The action plan was up to date which showed mitigating actions. The second related to staffing, this added to the register in August 2016 stating that patients would receive a reduced service as staffing levels were not adequate to meet demand. The action was to complete the recruitment process, which had been completed. This risk was reviewed in November 2016 and the risk level had reduced.

- Lessons were learned from patient death reviews and minuted. These were used to improve the end of life care service.
- During our inspection, we reviewed incident data. Data was easily identifiable and related directly to end of life services. The service manager told us that incidents and any complaints were discussed at the clinical governance meeting, where the senior responsible clinician would be present. Nursing staff told us that any incidents; risks or complaints would be communicated through their immediate line manager, also through department meetings and a newsletter.
- Staff told us they would visit patients in pairs if there was a potential risk identified.

Culture within this service

- Staff were clearly committed to providing good end of life care. Each individual member of staff we spoke with saw end of life care as their responsibility. Comments form staff, included; 'I love my job, I know where to go if I need support' and 'supporting the patients and families is something we excel at'. They also told us, they felt respected and valued by all senior managers and their peers.
- Staff could tell us of times they had been supported, both emotionally and in other areas, such as training and education. One nurse said that they had been a student at the hospice and had wanted to return as a registered nurse and the culture was supportive and caring, which would enable them to provide the best care for their patients.
- Measures were taken to protect the safety of staff who worked alone, such as the hospice at home team and the palliative care clinical nurse specialists. They had all read the lone worker policy and carried out risk assessments. The staff could show me on the intranet where to access the policy.
- Staff told us they worked together to resolve conflict quickly if it occurred. They received training in conflict resolution as part of their mandatory training.
- There was a lone worker policy available to those staff working in the hospice at home team and the PCCNSs. Staff we spoke to were aware of this policy. To minimise risks to the staff, they would fill in a lone worker risk assessment and an assessment of the patient's home. They would have a calendar showing where every member of staff was and when. They each carried a mobile phone with the team base phone number on speed dial and call base to say of any delays or concerns.

Public and staff engagement

- People's views and experience about the service was gathered and the service used the information to identify improvements that could be made.
- Feedback from patients, relatives, friends and carers was positive. This information was displayed in all areas of each department we inspected. The visitors could see these results and what improvements had been made. A comment made by a relative on a feedback form was that, maybe the patient could be asked if they did not want to be in a bay with another patient that was actively dying. This was now always asked.
- Families were invited to meetings with staff to discuss their relatives care and on-going treatment plan.
- Staff felt actively engaged and that their views were listened to and shared. As well as raising concerns. In the department meetings staff could raise issues and concerns formally or talk to their line manager on a one-to-one basis.
- There was an end of life care link group for staff to become members of; the next meeting was 16 March 2017.

Good

Are services well-led?

- The trust carried out staff surveys on staff satisfaction, the surveys were trust wide and did not specifically identify end of life care results. However, staff told us they were satisfied and felt proud to work for the service.
- To raise money for the charities, staff have taken part in sponsored skydives and treks abroad.

Innovation, improvement and sustainability

- Leaders and the staff were focused on continually improving the quality of care across the service. The service had made many change in the last two years, including, one of the matrons overseeing the end of life team, introduced structured team away days, the implementation of formal clinical supervision, introduction of the National Early Warning Score system and all new staff had a one-to-one session with the service manager.
- The practice development team had implemented the hospice at home team to be part of the multidisciplinary team meetings, this had improved the care for patients at home. For example, patients waiting to be admitted would be identified and the hospice at home team could be involved straight away, instead of receiving this data at a later date.
- The service was planning a two-year project to increase services at the day hospice, by summer 2017, it was planned to be a five-day service instead of two.
- The service had received a number of awards, including, the skills for health mark award for the practice development team, they were the first end of life development team to receive this award, and they were also runner up in the NHFT team of the year award. In May 2016, the palliative neurology team were the runners up in the British Medical Journals award for the best palliative team category.