

Cumbria Partnership NHS Foundation Trust

RNN

# 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)
RNNDJ	Voreda	End of Life care	CA11 7BF
RNNY1	Workington Community Hospital	End of Life care	CA14 2UF
RNNX9	Wigton Community Hospital	End of Life care	CA7 9DD







This report describes our judgement of the quality of care provided within this core service by Cumbria Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Cumbria Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Cumbria Partnership NHS Foundation Trust

# Summary of findings

## Ratings

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

# Summary of findings

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# Summary of findings

## Overall summary

Overall we rated the end of life care services by Cumbria Partnership NHS Foundation Trust hospital as requires improvement. We rated safety, caring and responsive as good and effectiveness and being well-led as requires improvement. We identified areas where there was potential for improvement and these had been acknowledged by the trust. We saw evidence that work was in progress to address the shortfalls and improve the services. We have rated well-led as requiring improvement. This is due to the lack of monitoring of quality, lack of evidence of patient choice in treatment arrangements and the lack of measurement of the organisational performance against other similar services.

We saw good evidence that incidents were reported, investigated and outcomes were shared with staff and action taken to avoid it happening again.

Staff had a good understanding of the procedures for making safeguarding referrals. Patients and family members told us that they were satisfied that staff members respected their wishes and that they did not feel threatened or worried by them.

We observed staff adhering to the infection prevention and control policies when attending to patients. When visiting patients, staff carried with them hand gel and personal protective equipment and used them appropriately.

District nurses said that their jobs were challenging as they had high caseloads and also had to travel long distances when visiting patients in their homes. They said they prioritised and ensured patients with end of life care and palliative care needs were attended to. Community nurse specialists also got involved and worked alongside by delivering advice and treatment in the community.

Patients and families told us that staff continuously assessed the level of pain and administered appropriate pain relief. Although pain killers were in use, staff also introduced patients to other ways of relaxing and easing pain, such as aromatherapy and massage. Anticipatory medication prescriptions for pain relief were in use for people requiring end of life care and it was managed by district nurses or the community nurse specialists.

We attended two multidisciplinary meetings and found them patient focused, discussions were open, transparent and all attendees' views were considered when decisions were made about the management of patients. At each meeting in-patients and community patients were discussed.

We observed examples where staff sought valid consent from patients and gave patients time to understand what was discussed. Staff did not hesitate to revisit discussions when they found the patient was having difficulty concentrating.

Patients and their family members told us that staff were sensitive to their feelings and able to support when they were distressed. They said nothing was too small for staff and 'went that extra mile' to help them resolve problems.

Part of planning and offering care for palliative and end of life care patients meant that patients after treatment had to travel long distances between treatment centres and their homes/ community hospitals. Although this could not be helped, patients and carers said this was distressing for them. They said a lack of choice and the lack of treatment centres near them made it difficult for everybody.

People who used the services told us that they knew how to make a formal complaint and said that they were confident to speak up if they were unsatisfied.

We received positive comments from patients and relatives which confirmed that end of life and palliative care patients received a seamless service between the hospital and the community. We saw that the trust governance arrangements included the local GPs; where agreement had been reached to work to Gold standard frame work.

Medical, nursing staff and managers were fully aware of the required improvements in the service and also the need for up-skilling staff to sustain good quality care. Further work identified were: end of life care Pathway was not established and this remained on their risk register, Care of the Dying Patient programme had not been

# Summary of findings

implemented and a meeting with the acute trust was held to take this forward and there were plans to fund Care of the Dying facilitators and provide education for staff.

# Summary of findings

## Background to the service

End of Life and Palliative Care are new services provided by the Cumbria Partnership NHS Foundation Trust (the trust). Therefore there are few established EoLC clinics. The provision of this service is divided into the south and the north teams. The south team covers the south of the the trust division and Furness. The north team is also responsible for the east and west of the the trust areas.

We inspected the following locations:

- West Cumberland hospital, this is a district general hospital which provides generalist palliative and EoL care to patients on the wards.
- There was also a four bed suite known as the Loweswater suite on Copeland unit where in-patient care was provided by specialist palliative care nurses and doctors.
- Workington hospital, Eden Valley hospice and Weavers court locations were used for office space by the specialist palliative care teams. Some of the offices were also used for multidisciplinary team meetings and staff training. We visited the Penrith day hospice and met with the patients who were using the services.

The specialist palliative care teams were made up of community nurse specialists who carry out the same functions as McMillian nurses, palliative care consultants, district nurses and allied professionals such as physiotherapists and occupational therapists.

The teams outreach to their communities and also provide service to Westmorland General Hospital.

The main aim for these teams was to provide specialist palliative care to patients with life limiting disease in the community setting. Their role is to assess and manage complex symptoms, provide support or sign post patients and relatives so that they receive appropriate emotional, psychological, spiritual and financial support. community nurse specialists provide information regarding treatment plans and advance care planning. They work alongside the primary healthcare team and voluntary sector to improve quality of life for patients who are entering their last stages in life.

CNS teams are expected to provide informal and formal education on care at the end of life to all generalist staff to raise their level of knowledge and ensure all patients at the end of life receive good quality care.

There are plans to add a new clinic in the South Lakes to run in parallel with clinics run by specialist nurses, so that patients could be seen in clinics on an ad hoc basis and provide a flexible service.

A new consultant was due to take up post in April 2016 and this would ensure clinic facilities for people in Furness.

In the East there was a clinic on Thursday afternoon at Cumberland Infirmary Carlisle.

A joint clinic with the Head & Neck team on a Thursday morning helped minimise the need for the patient to come multiple times to see the team at different times and days.

At Penrith day hospice there is a weekly clinic on Thursdays.

## Our inspection team

Our Inspection Team was led by:

**Chair:** Paddy Cooney,

**Head of Inspection:** Jenny Wilkes, Care Quality Commission

**Team Leaders:** Brian Cranna, Inspection Manager (Mental Health) Care Quality Commission

Sarah Dronsfield, Inspection Manager (Acute) Care Quality Com

The team that inspected community end of life services included two CQC inspectors and two palliative care specialists.

# Summary of findings

## Why we carried out this inspection

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

## How we carried out this inspection

To 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 a range of information we hold about these services and asked other organisations to share what they knew.

During the inspection visit, the inspection team spoke with sixteen members of staff, fourteen patients and eight carers, reviewed nine sets of health care records and attended three meetings.

## What people who use the provider say

People who used the services included patients and their family members.

Patients and family members told us that they were satisfied that staff members respected their wishes and that they did not feel threatened or worried by them.

Patients told us that staff helped them manage their symptoms such as pain, sickness and anxiety well. They said staff continuously assessed the level of pain and administered appropriate pain relief.

Patients showed us equipment such as the hand rail, walking frame and hospital bed being made available to them and told us how helpful they were.

Patients and their relatives told us that they were included in the discussions about the way the risks were managed and in doing so their preferences were considered at all times by staff.

Patients and their family members confirmed that staff understood and respected their personal, cultural, social and religious beliefs and took them into consideration when planning care and treatment.

Patients and their family members told us that staff were sensitive to their feelings and were able to support when they were distressed. They said nothing was too small for staff and 'went that extra mile' to help them resolve problems.

## Good practice

Patients and families told us that staff continuously assessed the level of pain and discomfort so that patients received appropriate and sufficient treatment to promote comfort. Treatment was not always medication as patients received alternative therapy such as massage to relieve anxiety and help with relaxing and easing pain.

Anticipatory medication prescriptions for pain relief were in use to avoid delays in treatment.

MDT meetings were patient focused, discussions were open, transparent and all attendees' views were considered when reaching decisions about the management of patients. At each meeting in-patients and community patients were discussed so that staff knew the latest conditions of patients nursed in their homes.

Patients were given information in a way it was easy to understand. Consent was sought only when patients were able to understand and discuss. In order to gain



# Summary of findings

valid consent staff revisited discussions when patients found difficulty to concentrate or wanted their family members to be present. Staff gave patients time to understand and did not rush them to make decisions.

## Areas for improvement

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

#### **Action the trust MUST take to improve**

- Systems and processes must be established by the trust and operated effectively to ensure good governance.
- The trust must ensure that all relevant staff are trained and the principles of the Mental Capacity Act (2005) including Deprivation of Liberty Safeguards are embedded within the trust.

- The trust must ensure proper and safe management of medicines is followed.

In addition the trust should:

- The trust should establish an EoLC Pathway to enable patients to move progressively through care based on evidence based practice.
- The trust should ensure that all staff receive appropriate training, support, development opportunities, supervision and appraisal.

# Cumbria Partnership NHS Foundation Trust

## Community end of life care

### Detailed findings from this inspection

Good 

## Are services safe?

By safe, we mean that people are protected from abuse

### Summary

We rated safety as good in the community end of life care services.

We saw good evidence that incidents were reported, investigated and outcomes were shared with staff and action taken to avoid it happening again.

Staff had a good understanding of the procedures for making safeguarding referrals. Patients and family members told us that they were satisfied that staff members respected their wishes and that they did not feel threatened or worried by them.

Good quality records ensured safe treatment of patients; therefore patients' records by staff had been audited and the outcome for 2014 was identified. There were increased number of patients notes had records of patients' NHS number, improvement in the general structure of the records were noted and condition of paper records kept by staff was judged to be of good standard. The findings also showed that fewer records contained illegible entries compared to the previous year.

We observed staff adhering to the infection prevention and control policies when attending to patients. When visiting patients staff carried with them hand gel and personal protective equipment (PPE) and used them appropriately.

Some locations were not storing medication in the appropriate way and the recording of drug fridge temperatures was not consistent across the service meaning that medication effectiveness could be affected.

District nurses said that their jobs were challenging as they were stretched with their caseloads and also having to travel long distances when visiting patients in their homes. They said they prioritised and ensured patients with EoLC needs and palliative care patients were attended to. CNS also got involved and worked alongside by delivering advice and treatment in the community.

Staff were well versed with lone working in the community and the winter weather contingency plans. We saw staff keeping each other informed of the weather conditions and family members of patients keeping staff informed of the weather conditions to maintain safety.

### Safety performance

- We spoke with three clinical nurse specialists, two district nurses and three ward staff who worked with

## Are services safe?

patients who received EoLC and palliative care. They told us that they used a range of safety indicators to monitor safety performance. These included monitoring of pressure ulcers, falls, occurrence of venous thromboembolism and urinary tract infections. The results were referred to as the safety thermometer readings and the data for these were collected each month.

- We observed the results of the safety thermometer readings displayed within the ward areas we visited.
- The community staff held the results of the safety thermometer readings in their offices and they were also accessible to community staff electronically in the form of dashboards. We found the dashboards had been recently introduced and as a result not all staff were familiar with them.
- The trust supplied us with information on reported pressure ulcers including root cause analysis investigations with action plans pertaining to end of life care for the six months between March and August 2015.
- We found the number of grade 3-4 pressure ulcers for patients managed by teams caring for end of life patients compared to the national statistics was low. In the six months between March and August 2015 there had been two patients with grade 3 pressure sores and one with grade 4 pressure sore. These had been identified as patients with a long term illness or people who had experienced a sudden acute episode of illness. Staff had been made aware of the findings by the investigating team managers and there were notes from the discussions to support this.
- We did not see any data on pressure sores or falls or occurrence of venous thromboembolism or urinary tract infections for patients cared in the community. Community staff informed us that some of the data was collected by district nurses and reported through a different care group management team. Staff told us the electronic system Ulysses was used to report incidents when they occurred.

### Incident reporting, learning and improvement

- The trust submitted details of incidents within end of life care services. A total of 20 incidents had been reported between 1 January and 31 October 2015. The incidents were categorised as clinical, equipment, falls,

medication, health and safety, information governance, safeguarding and violence/aggression. The majority (40%) of incidents reported were categorized as 'equipment' followed by 'clinical' (20%) and 'information governance' (20%).

- We saw incidents had been analysed and improvements had been made. For example a patient discharge was delayed due to the process which was in place for requesting equipment. A different process has been introduced and staff were monitoring to avoid recurrence.
- Due to problems with pharmacy arrangements staff informed us that several patients were delayed going home. This was identified as a clinical incident. We observed alternative arrangements coming into force during our inspection to remedy this.
- A medication incident was reported as staff identified a family member taking medication belonging to a patient. GP was involved and appropriate action was taken to minimize this happening again.
- In the trust's health, safety and security annual report for 2014-15 it demonstrated the trust had recognised and accepted its duty towards ensuring the health, safety and welfare of all its employees and any person who used its services. Following risk assessments all staff had been encouraged to take part in specific training to ensure health and safety legislative compliance had been met.
- During 2014-15 significant changes to the organisational structure took place including the transfer of health, safety, risk and security arrangements from the corporate governance to the Quality and Nursing Directorate. We were informed by the care group managers that they were responsible for taking action around reported incidents.
- During our conversations with district nurses and community nurse specialist this was confirmed. They told us action plans were discussed at staff meetings and during their clinical supervision meetings.

### Safeguarding

- We spoke with five patients and six family members who assured us that they were satisfied that staff members

## Are services safe?

they came into contact with were of good character, integrity and respected their wishes. They said they did not feel threatened or worried by staff and they were able to discuss matters in an open manner.

- Staff we spoke with had a good understanding of the procedures for making safeguarding referrals. They said the contact number to the safeguarding lead was accessible to all staff.
- They told us that they received safeguarding training during their induction and had updates during their mandatory training.
- During our inspection we observed two multidisciplinary staff meetings. Discussions took place and consideration was given by the team members on referring a family member to the local authority safeguarding team to ensure the safety of the patient.
- Trust information confirmed that there had not been any safeguarding incidents in the last 12 months involving the staff.
- Staff explanation of their compliance with safeguarding training did not reflect the figures provided by the trust. The records from October 2015 showed that safeguarding Adults - Level 1 training was attended by 75% doctors, 66% CNS in the East, 62% in the West and 87% in Kendal & Furness. The attendance records for district nurses were held by a different care group management team. However the district nurses we spoke with were familiar with the process for making safeguarding referrals.

### Medicines

- Anticipatory medicines were made available to patients in their homes so that patients were able to receive medication to control their symptoms without delay. This arrangement enabled nursing staff to respond and manage EoL patients' symptoms promptly. Although the medicines were kept in patients' homes, these were managed by district nurses and CNS only
- We viewed the management of medication on Loweswater unit. We observed two nurses checking controlled drugs before administering them to patients. We saw them checking the details of the patient, explaining to the patient and their relatives (who were present) the expected effects. We saw the medicine chart was signed when the patient had taken the medicine.

- We carried out a random check of two controlled drugs kept in the cupboard. We found the records were completed by two nurses and they were accurate.
- We checked the room where medicine was stored and the processes in place for staff to manage patients' drugs safely. Most medication unless specified otherwise, is required to be stored below 25 degrees centigrade as storage above this temperature could affect how effective the medication was. We did not see a thermometer in the room and two staff informed us that they did not have facilities to monitor the room temperature.
- We saw the drug fridge temperature was monitored daily and recorded. It was within the safe range of 2°C and 8°C. We saw medicines were stored appropriately and safely within the fridge.
- We asked to see the recent pharmacy audit by the supplying pharmacist. We were informed that changes to pharmacy supply had come into effect during our inspection week and they did not have any records of the previous medication audits to share with us.
- We discussed the management of medicines in patients' homes with the district nurses. They informed us that handling and managing medicines was up to individual circumstances and that they carried out risk assessments and decided on the best arrangement to ensure safety.
- During our visits to patients' homes, we observed patients and relatives getting involved in handling medicines. This was overseen by the district nurses and the community nurse specialists.
- Inpatients and patients we visited in their homes told us that staff helped them manage their symptoms such as pain, sickness and anxiety well.

### Environment and equipment

- Loweswater in-patient unit had been refurbished to provide four single occupancy rooms with en-suite. The unit was light, airy and welcoming.
- Staff and patients on the ward told us there was sufficient equipment to help deliver safe care.
- Community nurse specialists and district nurses informed us that as part of the initial assessment, they

## Are services safe?

carried out an environment risk assessment of the patient's home. This was to ensure they identified potential risks and took necessary action to minimise any harm.

- We saw two patients' environmental risk assessments where additional aids had been identified. During our visits we saw that these patients had received the aids.
- District nurses said they organised necessary equipment for patients when they required. Occupational therapy and physiotherapy staff confirmed they were involved in the discharge planning from the hospital or the hospice and they ensured patients were provided with appropriate equipment. They said on some occasions they visited the patient at their home to make sure they and their family knew how to use the equipment safely.
- Patients showed us equipment such as the hand rail, walking frame and hospital bed being made available to them.

### Quality of records

- Systems were in place to manage patients' individual care records and maintain people's safety. Patients' records were in electronic and paper format. The nurses used the electronic records which helped hospital staff and the community staff to access and share information and keep the records updated.
- Patients had paper records about their care and treatment in their homes. This was to make sure that patients and relatives were fully involved in their care and they were able to refer to it if they wanted to. We looked at four patients' records held in their homes. We saw staff recorded the care delivered to the patient, general wellbeing and comments by the patient.
- We received the results of the health record keeping standards audit report for December 2014, highlighted that there was a 23% increase in patient's NHS number recorded in patient's notes; improvement in the general structure and condition of paper records; less than 5% of records contained illegible entries compared to 9% last year.
- The audit also noted 60% of records had deletions or alterations countersigned compared to 23% last year. Areas of concern identified included the lack of information on patients' ethnic origin; this was particularly weak in patients receiving care in the community.

- We looked at eight patients' records with their permission. These included medical and nursing notes. Patients' needs were identified and plans for treatment had been discussed with the relevant people and these were recorded. This included three sets of patients who were nursed in the general wards.
- We were informed by the trust that 25% of staff had attended clinical records keeping training.

### Cleanliness, infection control and hygiene

- Loweswater unit was visibly clean and tidy. Staff worked bare below the elbow in accordance with infection prevention and control (IPC) policies.
- Other areas we visited were office space and patients did not have access to them.
- Community staff were seen adhering to the infection prevention and control policies when they attended to patients in their homes. They carried with them hand gel and personal protective equipment (PPE) and used them appropriately. Staff said they had plenty of PPE stock for them to use.
- < >  
During our inspection we visited patients on community hospital wards receiving EoLC. Staff told us that they had a link nurse for IPC who carried out audits and provided updates for staff. We saw minutes of the meetings and examples where information had been cascaded from the link nurse on to ward staff.
- The trust records showed in October 2015 staff compliance with infection prevention and control training ranged between 25% doctors and 62% to 88% other staff including CNS. We noted that 50% doctors and 75% to 100% non-medical staff had taken part in hand hygiene audit.

### Mandatory training

- We were informed by staff that, before commencing work at the trust, they completed the corporate induction followed by the local induction. They told us that they tried to attend mandatory training whenever possible.
- We received information on ongoing mandatory training for staff such as moving and handling, health and safety, fire safety, risk management and record keeping.

## Are services safe?

Mandatory training was an organisational requirement to limit risk and maintain safe working practice. Staff were expected to comply and complete the training at the required frequency.

- There were three consultants and one speciality doctor responsible for the EoLC at the trust. We noted that 50% of medical staff had followed the local induction and there was 100% attendance for corporate induction. Trust records showed 25% of medical staff had completed training on equality and diversity, informed consent to treatment, mental capacity act and deprivation of liberty safeguards. 50% of doctors had attended training in risk assessment and 75% had completed fire safety.
- Mandatory training uptake in non-medical staff varied. Records show that the south team attendance was better than the north. This was due to the spread of the service and staff having to travel long distances to attend training. Team leaders had already identified this and were exploring ways of helping staff access training.
- Examples of staff attendance at training included, fire safety training which ranged from 88 % in the south team and 100% in the north team. There was 100% compliance in the south team and 63% compliance in north team with moving and handling training. Attendance at basic life support in the north team was 50% and the south team was 88%.
- We had been informed that the Trust Information Governance team oversaw, monitored and promoted training. They refreshed the training content each year based on national guidance and internal information including incidents. They said that they monitored the Trust compliance based upon the date the new training was made available. This differed from the Trust central monitoring process which was an annual date based upon the date the training was last completed. They told us that the last year target of 95% compliance was achieved.
- We spoke with relatives who had been made aware of how to access help and support should a patient's condition deteriorate when they were being cared for at home.
- Patients and their relatives were included in the discussions about the way the risks were managed to ensure people's preferences were considered at all times. One patient wanted to spend time with their family during the morning and wanted to be free from pain but not be drowsy and unsteady on their feet this was facilitated by managing their medication.
- During the day, medical staff who covered EoLC and palliative care were available to respond to patients' needs. Out of hours care was provided by an out of hours specialist provider for patients with urgent medical problems. Staff and patients had the contact numbers if they needed their assistance.
- District nursing team provided out of hour cover and patients and relatives were aware of their contact details. Five district nurses whom we spoke with said that they all knew those patients receiving EoLC in their areas and made sure during each shift they updated their records with any changing conditions. They said at handover and also through electronic records they kept colleagues who were taking over the patient's care updated. Therefore when emergencies happened they knew about the patients.
- We attended two multi-disciplinary meetings and observed team members discussing risks to patients as part of a routine review and ongoing evaluation. Some of the risks discussed were poor nutritional intake of patients due to lethargy, patients experiencing depression due to the illness, isolation/loneliness due to not having relatives nearby, side effects of the medication and poor mobility therefore at risk of falls.
- We observed risks to patients were identified by the district nurses and the visiting professionals each time and records showed that risk assessments were carried out and appropriate actions were taken. For example one patient attended a support group once a week organised by a CNS which they said that they looked forward to every week. The CNS told us the patient was at risk of isolation and the weekly outing and meeting people of the similar condition had helped them.

### Assessing and responding to patient risk

- We saw in three patients' records comprehensive risk assessments been completed. These had been reviewed and amended regularly as the patient's needs changed by the staff.

### Staffing levels and caseload



## Are services safe?

- Community specialist end of life service included CNS and district nurses. They provided care in the south and the north (included east and west) regions within the trust. The trust did not provide us the data on the number of district nurses employed for each region to care for patients with EoLC. However the CNS shared their staffing data. In the east there were six community nurse specialists, six in the west and eight in the south. They informed us that they did not have any vacancies.
- CNS took on an advisory role for EoLC patients and their relatives in the hospitals and in the community. They also supported and gave guidance to district nurses.
- Staff working in the community hospital wards informed us that there was one CNS allocated by the trust to support staff on the wards and this was viewed by ward staff as insufficient support and they said they had suggested having link nurses to improve this provision.
- An acuity tool was not used to decide on the levels on the Loweswater unit. However nurses on duty told us that they had sufficient staff during the 24hour period.
- On the day of our inspection on Loweswater unit there were four nurses to three patients during the day. The staffing levels were integrated with Copland ward. The duty rota showed that during the day there were three to four nurses and on nights there were two nurses or a nurse and a health care assistant. There was evidence on the duty rota that the staff numbers were viewed by the ward manager to reflect the number of patients and amendments had been made. The manager confirmed this.
- We visited three community hospital wards where patients requiring EoLC were nursed. They were two wards in West Cumberland Hospital and the Wigston community hospital.
- We received some concerning information during our inspection about Wigston community hospital that patients requiring EoLC were put at risk due to lack of staff during night time. We visited the hospital ward early one morning and met the night staff. There were three patients who needed EoLC and the other patients had varying degrees of dependencies such as a person requiring mental health support, patients with dementia and patients with chronic illnesses. During our visit there was a member of staff short on duty according to the staff rota. We were informed that this was due to the shortage of staff. Staff informed us that this was an ongoing issue and their managers expected them to stay on after shifts and work over and help each other..
- Staffing shortage was a standing item on the risk register. This confirmed staff concerns. The shortage of nursing staff affected the wards and the community.
- The trust was unable to give us sufficient information on the Bank and agency staff required and used during each month in the north and south regions. The information supplied for September 2015 stated that Loweswater unit needed 2.1 WTE and in west team 0.6 WTE staff. There was no further information if the shortage was filled.
- Staff told us that staffing levels were not changed to reflect the dependency of patients on the community hospital wards such as Wigston hospital. They said an acuity tool was in use but often the care demands were greater and they felt rushed when attending to patients.
- We found out from staff that it was difficult to fill staff vacancies due to staff having to travel long distances in rural settings and the public transport was poor. Staff fully appreciated the difficulty recruiting and replacing staff who left.
- District nurses told us that they prioritised patients with palliative and EoLC needs. They all had different caseloads and they managed their work load through good team work.
- We were told by one of the Palliative care consultants that they had appointed a consultant who would take their post later this year which would bring them up to full complement.
- The Trust provided information on the overall sickness between 1 July 2014 and 30 October 2015 as being 4.8%. The EoLC team sickness rate between the same periods was reported as 4.2%. This included two staff on long term sickness.
- The Trust reported in the preceding 12 months to 30 October 2015 the percentage of staff turnover for the trust was 14.1%. The CNS team informed us that they did not have any turnover of staff. However they had recruited a new nurse into a long standing vacancy in the north team and a new doctor and two secretaries to meet with their needs.

## Are services safe?

### Managing anticipated risks

- Staff working in the community were acquainted with the trust lone working policy. CNS told us that they always let the secretarial staff know their whereabouts and also wrote on the white board in their office letting others know who they were visiting. We saw staff writing on the board as they left for visits.
- District nurses had their schedules and let their colleagues and secretarial staff know of their whereabouts.
- Staff were well versed with the winter weather contingency plans due to the wide areas they covered.

We saw staff kept each other informed of the weather conditions they were encountering during our inspection. Family members of patients also kept staff informed of the dangerous weather conditions.

### Major incident awareness and training

- There was a major incident policy in the staff office with contact numbers and staff were aware of this.
- Staff working within the community wards told us if there were to be a major incident they would contact the senior nurse manager in charge and follow their instructions.



# Are services effective?

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

## Summary

We rated effective as requires improvement in the community end of life care services.

Staff informed us that they did not have regular supervisions but they were able to regularly discuss issues relating to work with their colleagues and managers. Annual appraisals attendance figures for staff varied and the average was 22% which is below the expected percentage by the trust.

Each week multidisciplinary staff meetings were held at local level within the north and south teams and practice issues were discussed within the team.

We found across the services there was not a consistent approach to monitoring outcomes for patients and the trust was unable to make comparisons with other similar services or benchmark their services.

We observed examples where valid consent from patients was sought by staff and patients were given time to understand what was discussed. Staff did not hesitate to revisit discussions when they found the patient having difficulty concentrating. We observed several examples where patients' were given choices and their consent was sought before staff took action. We did not see any written evidence that medical staff had completed mental capacity assessments on patients as part of discussions about patient's cardiopulmonary resuscitation decisions. But patients and relatives told us that they had discussions about the chance of survival following cardiopulmonary resuscitation (CPR) and the quality of life when decisions were made with their doctors.

We observed multidisciplinary staff teams demonstrating a good understanding of the use of the five Priorities for Care. Staff told us that through emails and staff meetings they received information on updates or changes in practice within end of life care. Managers had identified the need for staff to receive training on specific end of life care plans so that staff were able to demonstrate the embedding of the five priorities of care.

Patients and families told us that staff continuously assessed the level of pain and administered appropriate pain relief. Although pain killers were in use staff also introduced patients to other ways of relaxing and easing pain, such as aromatherapy and massage. Anticipatory medication prescriptions for pain relief were in use for people requiring end of life care and it was managed by district nurses or the community nurse specialists.

## Evidence based care and treatment

- The multidisciplinary staff team demonstrated a good understanding of the use of the five priorities of care. Staff told us about the most recent guidance from the Department of Health, 'One Chance to get it Right, June 2014'. This document looked at improving people's experience of care in the last few days and hours of life.
- Staff told us that through emails and staff meetings that they received information on updates or changes in practice.
- Staff also knew the recommendation made by the independent Neuberger review of the Liverpool Care Pathway (LCP) and the phasing out of it in July 2014. They said the alliance's five Priorities for Care had replaced LCP. Staff told us that within the hospice and in the community patients receiving EoLC had individualised care plans based on the five priorities. We saw evidence of this during our visits to people's homes.
- We looked at five care plans and found them to be holistic care plans which identified individualised needs. We noted from the minutes of a recent clinical governance meeting that managers had identified the need for staff to receive training on specific EoL care plans. A suggestion was considered that the training should be delivered by the CNS in their capacity of support and advice to other staff. This training has not commenced.
- We were informed by a palliative care consultant that it was vital that patients who required EoLC and palliative care treatment were referred to them without delay from the acute trust. They said the referral process within the acute trust were not robust which delayed their input. The consultant said the time lapse in referral was not audited.

## Are services effective?

- The consultant in palliative medicine explained that they were currently doing an audit with the acute trusts around care of the dying patient, where a patient died in hospital – which was working across boundaries and involving staff working in the Acute Hospitals.
- There was no data on the National Care of the Dying audit as the trust had collated the information and submitted them but no results were available at the time of inspection.
- We were informed by the managers and saw minutes of governance meetings that they have plans to prioritise the community audits for next year.

### **Pain relief - EoLC and inpatients, include for others**

- Five patients and five family members told us staff continuously assessed the level of pain and administered appropriate pain relief in a timely manner.
- We observed staff asking patients whether they were comfortable or in pain and finding out the nature of pain patients experienced. Some pain killers can contribute to constipation and this discomfort causes abdominal pain therefore we saw nurses talking to patients and finding out the cause of pain before administering any treatment.
- Although pain killers were in use, staff also introduced patients to other ways of relaxing and easing pain, such as aromatherapy and massage. One of the patients told us how much they enjoyed attending massage therapy and during treatment they often forgot about the pain.
- Patients in their homes told us nurses helped to control their pain most of the time. Two family members said sometimes district nurses contacted the community nurse specialists to help them decide on the best ways to control pain. CNSs were nurse prescribers and were able to prescribe painkilling medicines. In the absence of the CNS the GPs were contacted by the nurse.
- We observed patients on the wards being offered pain killers at regular intervals by staff.
- We spent time with a patient who had been admitted to a ward for symptom control following a clinic appointment. The palliative care specialist assessed the patient and prescribed medicine to help better control the symptoms. . The patient wanted to return home without being admitted on to the ward. We observed staff explaining to the patient that they had 24 hour

medical support and able to monitor and offer them the correct dose of medication to control their pain so that when they return home they would be comfortable. Patient agreed to stay overnight.

- Anticipatory medication prescriptions for pain relief were in use and this was in line with the appropriate guidance. This was only used for people requiring EoLC.
- Relatives and patients informed us that symptoms such as nausea and vomiting increased the pain and this was carefully managed by the nurses and GPs in the community.
- At the MDT meetings we noticed patients' symptom management was discussed and plans were agreed to ensure patients received effective treatment.
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### **Nutrition and hydration**

- We saw two inpatient records where nutritional needs were assessed and dietetic advice had been sought to ensure patients were in receipt of adequate nutrition.
- Patient hydration was also monitored and patients were given advice on the choices of drinks to help them have sufficient fluid intake. We spoke with a patient about their food and drinks.
- Staff involved with EoLC were aware of the complication when patients did not receive appropriate nutrition and hydration. They told us the likelihood of patients developing urinary tract infections, pressure sores, mouth ulcers and lethargy increased with poor nutrition and hydration.
- In the community, staff gave advice to relatives and patients on how they could keep hydrated and the different products were available for them to try out.
- We saw staff encouraging and helping patients maintain good mouth hygiene to minimise sore-mouths so that they were able to eat and drink well.
- Medical staff were fully aware of the updated 'good medical practice guidance' (2013), which included specific guidance regarding nutrition and hydration for end of life care.

### **Patient outcomes**

- The trust was under the Cumbria, Northumberland and Tyne and Wear NHS area team therefore the results for the 2012/2013 National Bereavement survey were not specific to the trust. The area team results

## Are services effective?

demonstrated that quality of care and support for carers was excellent; most of the time patients were free of pain and felt that staff treated them with dignity and respect in their homes.

- The service informed us of their present arrangements and the future changes to monitor the outcome for patients. For example in the South Lakes area the team did not collate patient outcomes on the EMIS electronic patient record system but they discussed patients' outcome at Gold standard framework (GSF) meetings with the GPs every month and records were maintained of these sessions. In the Furness area the team attended GSF meetings with the GPs and they documented their key performance targets on EMIS system. The West and East Teams had no GSF meetings; however they had palliative care meetings that involved their GPs.

We found across the services there was not a consistent approach to monitoring outcomes for patients and the trust was unable to make comparisons with other similar services or benchmark their services.

### Competent staff

- A rigorous recruitment process was in place to ensure that staff with the correct knowledge, experience and suitable character were employed. This was monitored at supervision sessions. We spoke with seven staff about their recruitment and induction process. They told us that they received induction and were given opportunities to shadow staff before they were allowed to work alone.
- We observed staff to be competent when involved in the care and treatment of patients. This was confirmed by the patients and relatives who spoke with us. Two patients praised the competence of the specialist palliative care team and told us how they all worked together to keep them in their homes and controlled the pain and other unpleasant ailments. Relatives said staff were attentive to the welfare of the patients and them.
- We attended two MDT meetings and observed the discussions amongst staff. It was evident that staff needed to be competent and confident when contributing to the care and treatment plans of patients.
- Staff were registered with their individual professional bodies and their registrations status was checked by the person appointed by the trust for each profession. This included checking to see if their qualifications had been revalidated as part of their renewal of registration.

- Staff were proud to explain that they had specific EoLC related training delivered by one of the team managers, which included basic care of the dying, communication skills, "sage and thyme" (this is a prompt which acts as an aid memoire for all levels of staff giving them the confidence to hold difficult conversations with patients and or their families/carers, which allowed them the opportunity to address issues which may be adding to the persons distress).
- The trust was unable to supply us with the specific EoLC and/or palliative care training figures. We were informed these were collated by the different care management group. CNS told us that they all had specific training and yearly updates and the compliance was 100%; but we have no information on district nurses or the community ward nurses on their training.
- We were told by staff that they did not have regular supervisions but they said that they regularly discussed issues with their colleagues and managers. Four staff members said that they could request formal supervision if they felt appropriate.
- Staff who spoke with us said that they had completed the yearly appraisal. The percentage of non-medical staff that had had an appraisal in the last 12 months was 22%. This did not include district nurses.
- Community hospital ward staff informed us that patients were not allocated to nurses with specialist EoLC training and/or experience. This was due to staff not being able to access the training. To help with this situation staff told us that they had suggested having an EoLC link nurse to cascade training.
- District nurses told us that staff who were not experienced in caring for people with EoL or palliative care needs were supported by the district nurses with experience and CNS. They said in some circumstances inexperienced staff needed support and this was not possible to give due to the shortage of experienced staff.

### Multi-disciplinary working

- Care and treatment of patients involved a multidisciplinary (MDT) approach. Each week multidisciplinary staff meetings were held at local level within the north and south teams where every patient receiving EoLC were discussed. At these MDT meetings in-patients and community patients were discussed. We

## Are services effective?

attended two MDT meetings and found them patient focused. Discussions were open, transparent and all attendees' views were considered when decisions were made about the management of patients.

- Monthly GP meetings were also held to involve and share the care of the EoLC and palliative care patients in the individual practices. Discussions were shared with the professionals who were not present through electronic records and patients and families were kept informed during the visits to the homes.
- We were informed by a Palliative care consultant that there was further work to be done to improve the working relationship between different specialists so that patients benefit by a seamless service. This was in reference to specialist consultants working as a team when treating patients with palliative care needs and those requiring EoLC.
- District nurses told us that they were well supported by the GPs and CNS. They could attend MDT meetings and share their comments. However due to the work schedules they found difficulty attending local MDT meetings.
- CNS worked Monday to Friday and supported district nurses and patients and their families.
- Out of hours medical support for Patients was provided by Cumbria Health on Call (CHOC)

### Referral, transfer, discharge and transition

- Patients were referred to the palliative or EoLC consultants by their GP or other health care organisations. There was no clear pathway for referral to specialist palliative care services within the trust. This has been identified by the consultants as a concern and that patient were not always referred to them promptly.
- All referrals were assessed and as far as possible managed in the patient's own home with appropriate care packages.
- Patients were admitted to hospitals/ hospices for symptom control if it was difficult to be achieved in their homes.
- Patient discharges were organised by staff at the hospitals with the help of family members if appropriate. Staff contacted the district nurses, CNS and the patient's GP before organising transport for discharge.

- Family members told us that before discharge staff at the hospital informed them of the support their family member was going to have at home.
- We saw that patients were given summary documentation about their condition to take home so that visiting professionals would be able to have access to information without delay.
- We requested data on the rapid discharge of patients to their preferred place of care by the hospitals. The trust responded that the acute hospital teams dealt with rapid discharges and that they did not have any data on it. However the north team at a recent MDT meeting had looked into collecting data on rapid discharge.

### Access to information

- District nurses and CNS told us that the electronic information sharing system they used enabled them access patient's risk assessments, care plans, case notes and test results so that they were able to deliver care effectively. Staff told us they also used paper information as a backup.
- Patients had paper records of their care and treatment plans to refer to and these were updated when electronic records were updated by staff.
- We were informed by district nurses that GPs were also able to access the information about their patients from the electronic information system.
- When people moved between teams and services, during treatment, including referral, discharge and transfer information was shared appropriately and in a timely way by the staff involved. We observed staff transferring a patient's medical and nursing notes to the treatment centre the patient was being transferred to. This was carried out in line with the trust protocol. The protocol included confidentiality and data protection.
- Four nurses we spoke with were fully aware of the data protection act and their responsibility to protect patients' information.

### Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We observed examples where consent from patients was sought by staff. During our visit to a patient's home they told staff they had received a letter which they thought was from the hospital and was unable to

## Are services effective?

remember what was in the correspondence. We observed the nurse seeking permission from the patient to read the letter and reminded the patient of the content.

- In two further instances staff asked patients' approval to read the discharge notes from the hospital. On one occasion they asked the patient's permission to discuss the content of the letter with the CNS and their GP and they explained the reason for it.
- We saw patients were given time to understand what was discussed. Staff did not hesitate to revisit discussions when they found the patient was having difficulty concentrating.
- We observed several examples where patients' were given choices and their consent was sought before staff took action. Before we visited patients' homes we asked staff to get patients' agreement. We were informed that two patients did not feel like having visitors so the staff visited them without us. Another patient told us that they did not wish to take part in a patient satisfaction survey which they had received and that was respected by staff who told them that it was optional.
- We spoke with eight staff members from different professional backgrounds and seniority. They were consultants, senior nurses, CNS and district nurses. They verbalised their understanding of the Mental Capacity Act 2005 and decision making requirements.
- We were informed that most mental capacity assessments were carried out by the patient's own GP and sometimes the doctors at the hospitals. We looked at six medical records of patients receiving EoLC. The doctors had marked that two patients did not have the capacity when completing the DNACPR forms. But we

did not see any written evidence that medical staff had completed the patient's mental capacity assessments. However for those who had capacity the discussions with the patients with regard to DNACPR had been recorded by the doctors.

- We were informed by a senior doctor that they were involved in a regional initiative 'Deciding right' and its authority comes from the Mental Capacity Act and its national guidelines for health and social care professionals. Deciding right meant that people could make their wishes known in advance about any part of their future care in case they lose the capacity to make those decisions.
- Two medical staff informed us that they were aware of the current DNACPR guidance regarding anticipatory decisions about whether or not to attempt resuscitation. The new edition took into account developments in clinical practice and developments in the law regarding anticipatory decisions about cardiopulmonary resuscitation (CPR). Although the fundamental ethical principles were unchanged the medical staff informed us they had taken action to update their forms. These had been submitted to the governance committee for agreement before it becomes the standard form used across the trust and in the community by the GPs.
- Records submitted by the trust on staff attendance of MCA and DoLS training rated 65% compliance across the EoLC teams. We looked at each area team and found that none of the Palliative Care Consultants and staff working in day care centre had received training. The attendance of CNS from the east and west team were 17% to 50% respectively and the south team was 100%.



# Are services caring?

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

## Summary

We rated caring as good in the community end of life care services.

Comments from patients and their family members confirmed that staff understood and respected patients' personal, cultural, social and religious beliefs and took them into consideration when planning care and treatment.

Patients and their family members told us that staff were sensitive to their feelings and able to support when they were distressed. They said nothing was too small for staff and 'went that extra mile' to help them resolve problems.

MDT meetings addressed each patient's holistic wellbeing by discussing physical, psychological, social and spiritual needs so that they were able to understand the needs of the individuals and involve them and their family members in the care.

Views of Informal Carers – Evaluation of Services (VOICES) data was collected each year through the National Bereavement Survey to assess the variation of the quality of care delivered in the last three months of life for adults who died in England. This helped benchmark the quality of care. Data for this had not been collected by the trust since 2013 and this had been identified as a matter to be addressed and in October 2015 staff had been employed to collate the data.

## Compassionate care

- Staff understood and respected people's personal, cultural, social and religious beliefs and took them into consideration when they planned patients' care and treatments. This was confirmed by the comments made by patients and their family members. They talked about how staff maintained their dignity and privacy, how they felt listened to and consulted about their feelings.
- Patients liked being visited by the same CNS and on most occasions by the same district nurses. They commented that they were able to get to know staff, develop trust and understanding between them which made it easy for them to discuss personal issues.

- Patients and their family members told us that staff were very sensitive and always able to support when they were upset. They said nothing was too small for staff and help them resolve problems. One patient told us that they would not be alive if not for a CNS going that extra mile and organising prompt treatment.

## Understanding and involvement of patients and those close to them

- At MDT meetings staff addressed each patient's holistic wellbeing by discussing physical, psychological, social and spiritual needs so that they were able to understand the needs of the individuals and involve them and their family members in the care.
- We looked at the records which showed that most people's preferred place of death (PPPoD) was in their own home. This was fully supported by the trust. Patients were given information on what help they could have and families were offered support.
- District nurses and CNS told us information of the patient's wishes was shared between professionals involved so that sensitive communication was able to take place between staff, dying person, and those identified as important to them.
- Views of informal carers – evaluation of services (VOICES) data was collected each year through the national bereavement survey to assess the variation of the quality of care delivered in the last three months of life for adults who died in England.

## Emotional support

- Three patients and their relatives told us that all the professional staff they had come into contact with were very aware of the emotional impact on them. They offered their help or signposted them where they were able to get support.
- One patient said their district nurses were always willing to go that extra mile in providing them emotional support. They gave an example where a district nurse sat listening to them without rushing off and giving them practical suggestions with comforting words.

## Are services caring?

Another relative said that a CNS organised for them to attend a support group where they are able to talk to others in the similar position and find ideas to help them cope.

- The Specialist Palliative Care teams did not have any specialist palliative care Chaplaincy service. Staff referred patients to their local chaplain/vicar as appropriate.
- Chaplaincy or religious support for inpatients was managed through the individual wards / units.

# Are services responsive to people's needs?

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

## Summary

We rated responsive as good in the community end of life care services.

Staff told us that the services provided reflected the needs of the local population and they made sure they worked flexibly to help the patients and relatives. Part of planning and offering care for palliative and EoLC patients meant on occasions patients had to travel long distances between treatment centres and their homes/ community hospitals. Although this could not be helped patients and carers said this was distressing for them. They said a lack of choice and the lack of treatment centres near them made it difficult for everybody.

Staff had a good understanding of dealing with inequalities and how they met the diverse needs of local people. They said that the trust provided alternative formats such as easy read and alternative languages on request.

Patients in vulnerable circumstances such as those with dementia and learning disabilities were referred through their GPs to the palliative or EoLC consultants and jointly cared for in the community.

We were informed by the managers and staff that there had not been any formal complaints in the last twelve months. People who used the services told us that they knew how to make a formal complaint and said that they were confident to speak up if they were unsatisfied.

## Planning and delivering services which meet people's needs

- Information about the needs of the local population was used to inform the North and South team's when planning and delivering the service. We saw minutes of meetings involving the service commissioners and relevant stakeholders regarding planning of services.
- The trust covered a large geographical area when providing palliative and EoLC to people in the community hospitals and in their own homes. Staff told us the services provided reflected the needs of the local

population and ensured services were flexible. But due to the distances between treatment centres patients did not always get their choice and this had a negative impact on the continuity of care.

- Managers talked about the challenges they faced when providing services for such a large area and maintaining consistency. When patients needed chemotherapy, radiotherapy they travelled from their homes or from a community hospital to the treatment centre which was often several miles away and situated in an acute hospital. We were informed that although patients may not feel well enough to travel following treatment, due to the lack of available beds patients were transferred on the same day back.
- Two relatives told us that due to the lack of facilities near them their relatives had to travel long distances in a state of ill health. Loweswater ward staff confirmed that this did happen and we saw a patient returning following treatment due to the lack of provision at the place they received treatment. The trust management were aware of this and told us looking into this.
- We found at a local level in the community hospitals there was poor consistency in care planning. We saw two examples where a palliative care consultant's advice was over ruled by other consultants. For example advice was given to treat a dying patient with comforting care only and this was ignored and the patient was having a scan, physiotherapy and speech and language therapy (SALT) input. Patient's relatives were confused over the treatment.

## Equality and diversity

- Five members of staff we spoke with had a good understanding of dealing with inequalities and how they met the diverse needs of local people. At an MDT meeting we observed staff discussing a serious diversity issue of a patient and how they made plans for dealing with the issues.
- Staff told us that the trust provided alternative formats such as easy read and alternative languages on request. They had access to interpreters.



# Are services responsive to people's needs?

- On the community hospital wards there was provision for patients to have privacy and relatives were able to stay with them.
- Staff had a good understanding of religious and cultural requirements of patients and relatives, although all the people we met were White British.
- The North and South Palliative Care Teams referred to the palliative care, end of life care and bereavement (Change Cancer Series) and easy read format if needed by patients with a learning disability. They said they had access to the easy read version of the Preferred Priorities for Care () document.
- We were informed by the trust that there was also a CQUIN measure in place for learning disability (LD) this year. The Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and achieve transparency and overall improvement. This means better experience, involvement and outcomes for patients.
- There were resources for LD patients on the trust intranet site. Information about the referral system and that anyone can refer into the service including people with learning disabilities and family or carers. How the service can be contacted, through their GP or by contacting the team. It also provides easy read material to help people.

## Meeting the needs of people in vulnerable circumstances

- We observed that end of life services were accessible to all members of the community including people with conditions such as dementia.
- Patients in vulnerable circumstances such as those with dementia and learning disabilities were referred through their GPs to the palliative or EoLC consultants and there were several examples where patients were jointly cared for in the community.
- Staff on the wards told us that work had commenced to make the environment dementia friendly and staff to be trained on care of the patients with LD and dementia. They said little progress has been made. Four staff members said that when they had attended training on LD they were more designed to fit the needs of the mental health workers than them. They said they had informed their managers of this and had requested training to suit their category of patients.

## Access to the right care at the right time

- We requested information on how many people were able to end their lives in their preferred place. We were informed that South Lakes team collected data on patients' preferred place of care (PPC) in 2012/13 however this was not collated for last year due to work demand, and a lack of administrative support. They said that they had recommenced the data collection as of August 2015.
- We were informed that the Furness team collected PPC activities for all their patients though clerical support and the north team informed us they could access the information from EMIS an electronic patient record system. We asked for the information and have not received the data to make a comparison with the national index. This means the trust is unable to demonstrate its performance relating to ensuring patients were looked after in their preferred place.
- We asked for information on patients being rapidly discharged home so that they could end their lives where they chose to. We were informed that such information was not collated by the south team and that the north team had recently started to collect this data.
- Three patients and their families told us that they were able to access care packages without delay. This was helped by staff working well with tertiary providers.

## Learning from complaints and concerns

- Three people who used the services told us that they knew how to make a formal complaint and said that they were confident to speak up if they were unsatisfied.
- A patient and spouse told us that when they were not happy with the treatment plan they were able to raise their concern with a CNS who gave them help and support to resolve their complaint.
- People said when they had raised a concern, staff listened and took action which they were satisfied with.
- We were informed by the managers and staff that there had not been any formal complaints in the last twelve months. This was confirmed by the information provided by the trust.

## 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.

We rated well-led as requires improvement in the community end of life care services.

The trust informed us that the provision of specialist palliative care and end of life care services was a recent development and that they had identified areas for development, improvement and the need for monitoring and benchmarking the services they provided against similar services. There was further work needed to ensure patients were in receipt of choice, reliable treatment arrangements and were able to follow appropriate care pathways.

The trust, the clinical commissioners and their partners were working to develop the palliative care strategy for Cumbria and meet national framework and pathway requirements. This was currently in progress.

We looked at the care pathways of patients between the community and the hospitals. We received positive comments from patients and relatives which confirmed that EoL and Palliative care patients received a seamless service between the hospital and the community. We saw that the trust governance arrangements included the local GPs; where agreement had been reached to work to Gold standard frame work. We saw regular meetings had taken place and we viewed minutes of meetings to confirm this.

EoL and Palliative care services had a executive lead representative at board level. Comments from medical and nursing staff highlighted that each team (south and north teams) and specialist areas were working in isolation and tried to manage their challenges in their individual service areas.

Staff told us there was a culture of helping staff rather than blaming staff. The Team managers for EoLC had reviewed their services and they have viewed the feedback from people. They informed us that work was in progress to present the information and share the feedback with staff.

Staff said that they had been involved in meetings with the senior managers of the trust and found them to be open and shared with them the vision for the future and the challenges they faced.

### Service vision and strategy

- We were informed by the service that the specialist palliative care services were fairly recent and that they were working on building a county wide model to reflect the different hospitals, hospice and hospice at home provision.
- The trust, commissioners and their partners were working to develop the palliative care strategy for Cumbria and meet national framework and pathway requirements. This was currently a work in progress and there were no end date. Therefore we did receive any information on this.
- The previous EoLC strategy expired in 2013 and we were informed that the EoL and Palliative care team had developed a strategy to replace it and that it was currently under review and due to be ratified in October 2015 by Cumbria CCG.
- Recruitment of specialist palliative care staff had been achieved during this year to comply with the service level agreement.

### Governance, risk management and quality measurement

- We looked at the care pathways of patients between the community and the hospitals. We received positive comments from patients and relatives which confirmed that EoL and Palliative care patients received a seamless service between the hospital and the community. We saw governance arrangements included the local GPs; where agreement had been reached to work to the Gold standard frame work. We saw regular governance meetings had taken place and we viewed minutes of meetings to confirm this.
- SPC staff told us that quality and risk information about the EOLC services, including feedback from people who use services were regularly reviewed at local levels such as the South and North teams. However this was not formalised and therefore they were unable to provide us with information on quality measurements.

## Are services well-led?

- EoLC Pathway was not established and this remained on their risk register.
- The trust risk register on 5 November 2015 had nine risks listed which were associated with Palliatives Care and EoLC services.
- The risks listed included lone working of staff in the community, staff having to travel long distances to see patients, staff reporting increased levels of stress as a result of low staffing levels, care being compromised due to delayed discharges and not being able to discharge patients to place of their choice, asking relatives or staff members to collect medication from community pharmacies, problems with communication such as breach of confidentiality and data protection issues when records be accessed by unauthorised persons. delayed treatment as a result of waiting for records to be found and delivered from non-central source and staff subjected to violence & aggression due to the nature of the work in regard to working with very vulnerable individuals with palliative care needs and those who are dying, staff are at risk of verbal abuse from both patients and their relatives.
- The action plan showed that the hazards from the risks had been analysed and controls had been put in place to minimise or avoid the harm to patients and staff. We saw some controls had been achieved during our inspection such as the issue relating to patients not being able to receive their medication on time for discharge.

### Leadership of this service

- EoL and Palliative care services had a executive lead representative at board level.
- EoL and Palliative care services came under a care group management. The services were led by two consultants, the local GPs and two CNS team managers. District nurse, ward nurses and CNSs told us that their line managers were knowledgeable, experienced, visible and approachable.
- Managers understood the challenges to delivering good quality care and the need for specific specialist training for staff. One of the team managers delivered bespoke training to staff on caring for patients reaching end of their lives. This was to be rolled out to all staff in the next year.

- Comments from medical and nursing staff highlighted that each team and specialist areas were working in isolation and there was a need to work across boundaries with other teams and establish joint working and develop and learn from each other. This has been identified at the governance minutes for action to be taken.
- Health record keeping standards audit report highlighted that many services within the trust were not clear as to which Care Group they belonged to and the reason for being in the specific care group. Staff spoke to us about this.

### Culture within this service

- Ten staff from different professions and grades told us that they felt respected and valued by their line managers.
- Managers gave us examples of how they helped staff address behaviour and performance that was inconsistent regardless of seniority. Staff told us there was a culture of helping staff rather than blaming staff.
- Staff organised their work schedules centred on the needs of people who used the services.
- We were informed by two relatives of how they found staff including the clinicians being open and honest with them about the treatment.
- The spread of community services and homes visited by staff was large. Managers and staff told us that there was a strong emphasis on promoting the safety and wellbeing of staff.

### Public engagement

- We saw Family and friends surveys were available to patients and relatives. The Team managers for EoLC informed us that they had reviewed their services and viewed the feedback from people. They informed us that the feedback was positive and that work was in progress to present the information and share the feedback with staff. We did not have access to this information during our inspection.
- Staff told us that they had often discussed when it would be appropriate to involve patients and families

## Are services well-led?

through surveys. They said they found informal discussions about the care and treatment was more productive. Therefore they did not keep a record of the discussions.

- On 6th August 2015 at the Project Group Meeting they were to discuss how best to involve patients, the outcome of the meeting was not known to the managers when we spoke.
- The trust was part of the Cumbria, Northumberland and Tyne & Wear NHS area Team. The last combined result was published in 2013. We were informed by the managers due to the lack of secretarial support there had not been any further data collected. But in October 2015 they had employed two secretarial staff who would be given this task.

### Staff engagement

- Staff told us that they had completed a staff satisfaction survey this year. They also told us that when action was taken as a result of the survey they were informed of them by their managers and had opportunities to discuss at staff meetings.

- Five staff said that they had been involved in meetings with the senior managers of the trust and found them to be open and shared with them the vision for the future and the challenges they faced.

### Innovation, improvement and sustainability

- The trust started delivering EoLC and palliative care services in the last three years. Medical, nursing staff and the managers were fully aware of the required improvements in the service and also the need for training staff to sustain good quality care.
- Community staff told us that there was a limited number of staff who had experience of looking after people with palliative or EoLC needs. This often caused problems and that this has been reported to their manager in the community.
- The Care of the Dying Patient programme had not been implemented and a meeting with the Acute Trust was held to take this forward. There were plans to fund Care of the Dying facilitators and provide education for staff.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 (2)(g) Safe care and treatment

The trust must ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines.

The trust should establish an EoLC Pathway to enable patients to move progressively through care based on evidence based practice.

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17(1), (2) (a, b)

The trust must ensure that systems and processes are established and operated effectively to ensure compliance with the requirements of the quality and safety of the services provided.

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing  
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18 Staffing (1) (2 a)

The trust must ensure that staff are trained and the principles and requirement of the Mental Capacity Act (2005) including the Deprivation of Liberty Safeguards is implemented.

This section is primarily information for the provider

## Requirement notices

The trust should ensure that all staff receive appropriate training, support, development opportunities, supervision and appraisal.