

Staffordshire & Stoke-on-Trent Partnership NHS Trust

R1E

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)
R1EE4	Cheadle Community Hospital	Community end-of-life care	ST10 1NS
R1EE5	Bradwell Community Hospital	Community end-of-life care	ST5 7NJ
R1E56	Haywood Community Hospital	Community end-of-life care	ST6 7AG







This report describes our judgement of the quality of care provided within this core service by Staffordshire and Stoke on Trent Partnership NHS 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 Staffordshire and Stoke on Trent Partnership NHS Trust and these are brought together to inform our overall judgement of Staffordshire and Stoke on Trent Partnership NHS Trust

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Systems or processes were not sufficiently established or operated to effectively ensure the trust was able to assess, monitor and improve the quality and safety of End of Life Care services or to identify and manage risk. There was no overall vision, no executive board member providing leadership and no recognition of the trust-wide End of Life Care strategy group.

The service did not achieve many of its key performance targets in 2014/15, including fast tracking patients home in the last days of life and clinical quality indicators set by commissioners. The service carried out very few local clinical quality audits during 2014/15.

End of Life Care patient care plan records were not always fully completed and progress notes did not always match

the relevant goal on the plan. The 'do not attempt cardio pulmonary resuscitation' (DNACPR) Order recording systems were not operating effectively; practice varied across the trust and did not protect patients from the risk of avoidable harm. Systems in place to establish patients' capacity and to make decisions about their welfare and care were not always followed.

All staff caring for End of Life Care patients treated them and their relatives/carers with kindness, respect and compassion. Relatives caring for patients in their own homes were very positive about the support they received from community nurses supported by palliative care lead and specialist nurses.

Summary of findings

Background to the service

The trust provides end-of-life care community services across Staffordshire. Services were delivered in two divisions; North division and the South division, services were differently organised in the two areas. The trust had two palliative care consultant nurses in post, one in each area, who led the services. A nurse consultant is someone with highly specialised training who will practice autonomously at an advanced level.

In the North division, specialist nurses supported nursing staff in four community hospitals and community nurses providing care to patients in their own homes, care homes and nursing homes. The palliative care coordination service (PCCC) also operated in the North division and this sourced end-of-life care services for a patient from a range of available local providers.

There were no community hospitals in the South division area, but teams worked closely with local Hospices in the area. Specialist palliative care nurses supported community nurses who worked in integrated teams to provide end-of-life care services to patients in their own homes, care homes and nursing homes.

During 2015 there were over 2000 referrals to the end-of-life care community service. The number of patients seen in 2015 was 1424 in the North division and 1030 in the South division. During the 12 months before our inspection there had been 1180 deaths in the North division, data for the South division was not available.

Many staff across the trust were involved with delivering palliative and end-of-life care, supported by two teams of specialist nurses, one for each division. In the North division there were six palliative care nurse leads, in the South division there were four (3.8 WTE) Macmillan Nurses and 3.5 palliative specialist nurse practitioners. Almost 100 staff had roles dedicated to end-of-life care in hospital and community settings. Other staff groups based in the community delivered end-of-life care and palliative care as part of their normal service offer and it formed a small part of their role.

Our inspection team

Our inspection team was led by:

Chair: Professor Iqbal Singh OBE FRCP, consultant in medicine for the elderly, East Lancashire Hospitals NHS Trust.

Head of Hospital Inspections: Tim Cooper, Care Quality Commission

The team included CQC inspectors and a variety of specialists, including:

Head of quality; deputy director of nursing; consultant nurse; clinical quality manager, community matrons;

nurse team managers; senior community nurses; occupational therapists; physiotherapists; community children's nurses; school nurses; health visitors; palliative care consultant; palliative care nurse; sexual health nurses.

The team also included other experts called Experts by Experience as members of the inspection team. These were people who had experience as patients or users of some of the types of services provided by the trust.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

We inspected this service in November 2015 as part of the comprehensive inspection programme.

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

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

Before visiting, we reviewed a range of information we hold about the service provider and asked other organisations to share what they knew. We carried out an announced visit from 3 to 6 November 2015.

We did not hold a public listening event prior to this inspection as we were looking to assess changes and progress over a much defined period of time, however we

did contact Staffordshire Healthwatch and Stoke Healthwatch to seek the views that they had recently formed on the trust. Additionally, number of people contacted CQC directly to share their views and opinions of services.

We met with the trust executive team both collectively and on an individual basis, we also met with service managers and leaders and clinical staff of all grades.

Prior to the visit we held seven focus groups with a range of staff across Staffordshire who worked within the service. 120 staff attended those meetings and shared their views.

We visited the wards that provided End of Life Care services to inpatients in three community hospitals, accompanied nurses on visits to three patient's homes, spoke with ten patients and their relatives and 20 staff in various roles. We looked at records, including patient records, and observed care.

What people who use the provider say

A relative told us when we accompanied a district nurse on a home visit in the South division, "Absolutely marvellous, faultless, all of them are great". They told us they felt well supported and they got what they needed when they needed it, "all the nurses are brilliant".

A family caring for a patient at home in the South division told us when we accompanied a district nurse to their home, "we cannot recommend the teams [district/community nursing] and hospice teams highly enough. They are always on the end of a phone and visit quickly when asked".

Care workers caring for an EoL patient who lived in a local care home in the North division told us about palliative

care lead nurses, "we ring them and they come within 20 minutes. Waiting time to respond to pain is brilliant. The patient wants to die here and we will be able to achieve that for her".

We observed a china cup half full of cold tea sat on the tray and tea was spilled around the chair of an inpatient that was assessed as having dementia and needing encouragement to drink. When we asked them if they did not want the tea they told us, 'I don't drink cold tea'.

One inpatient with very complex needs including mental ill-health, told us they found the hospital environment unduly restrictive and wanted to return to their care home. They said they felt 'like they were in prison'.

Summary of findings

Good practice

The trust had recently set up a palliative care contact centre in the North division to better meet the needs of patients requiring palliative and End of Life Care by sourcing services from a range of local providers for individual patients as they needed them.

Areas for improvement

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

Action the provider **MUST** take to improve

- The trust must monitor response times for patients referred to the palliative care team to ensure patients receive care in a timely manner.
- The trust must ensure that DNACPR practice across the trust is consistent, the effectiveness of the DNACPR policy and procedures and regularly reviewed and audited.
- The trust must set clinical quality indicators for fast tracking patients who are in their last days of life, to their preferred place of death, which reflect nationally recognised good practice. Performance against the indicators should be routinely monitored to ensure patients are able to achieve their goals.
- The trust must review the nurse consultant prescribing procedures for pain management in end-of-life care services, ensuring that more effective systems of support and clinical supervision are put in place.
- The trust must develop a vision and strategy for end-of-life care services which sets out the objectives and plans for the service and reflects the local health

economy needs. The strategy should be embedded in the organisation and shared widely with staff so they understand it. Leadership of end-of-life care services should be clarified and clearly articulated to all staff.

- The trust must ensure that all staff have regular access to appraisals in order for them to develop their skills and competency.
- The trust must review arrangements for compliance with the MCA and improve staff competence to discharge their responsibilities under the Act.
- The trust must ensure care planning documentation is properly completed.
- The trust must set up a more effective system of audit to check the quality of End of Life Care services provided against national guidelines and local targets learn and improve from participation in audit.
- The trust must establish and keep under review the operation of systems and processes to more effectively monitor and improve the quality and safety of End of Life Care services.

Action the provider **MUST** take to improve

- The trust should include patient's emotional and spiritual needs in end-of-life care plans of care.
- The trust should improve arrangements for 24-hour medical cover for End of Life Care patients in community hospitals.

Staffordshire & Stoke-on-Trent Partnership NHS Trust

Community end of life care

Detailed findings from this inspection

Requires improvement



Are services safe?

By safe, we mean that people are protected from abuse

Summary

We have rated this service as requires improvement for safe. This is because:

- There were no formal arrangements in place to support and oversee the prescribing practice and competence of the palliative care nurse consultants.
- Patient care plan records were not always fully completed and progress notes did not always match the relevant goal on the plan.
- Community Hospital services did not have 24 hour medical cover for palliative and end-of-life care

However, we also found that:

- Staff knew how to report incidents. There were systems in place to investigate and learn from incidents.
- There was good practice around hygiene and control of infection.
- Patients were provided with the equipment and medical supplies they needed.

- We found staff in all roles delivering End of Life Care services we spoke with were aware of the incident reporting systems and told us they had access to them.
- There were 278 serious incidents reported across the trust, two of which related to End of Life Care. Both incidents occurred in the patients' home and were categorised as 'pressure ulcers meeting serious incident criteria'.
- The trust had systems in place to investigate and learn from incidents. For example there was a nutrition incident relating to the devices used to provide patients with nourishment and medication through a tube (PEG). Following the investigation, the trust instigated training to develop safer practice.
- We found some 'systemic incidents' such as delayed transfers for patients out of hospital to be cared for in their preferred place of care (PPC) were not routinely reported. For example a palliative care local leader told us that delays in fast tracking patients home [to their preferred place of care when very close to death] were "too high volume to keep reporting as an incident".

Incident reporting, learning and improvement

Safeguarding

Are services safe?

- Data sent to us by the trust before our visit showed End of Life Care services staff met the trust target of 90% compliance with level 1 adult safeguarding training; and exceeded the trust target of 90% for level 1 safeguarding children training which was 95% compliant.
- Staff we spoke with understood their role in reporting safeguarding issues, they were able to articulate the processes and show us how they accessed them.

Medicines

- The trust told us it followed the West Midlands palliative guidelines for the use of drugs in symptom control. We spoke with the chief pharmacist who confirmed that all palliative and End of Life Care prescribing within the trust should be in line with this guidance. We visited, with community nurses, three patients receiving care in their homes. We noted that the nurses had a clear grasp of medicines management including anticipatory medicines.
- The trust had two palliative care consultant nurses in post, both had authority to prescribe medication. There were no formal arrangements in place to oversee the prescribing practice and ongoing competence of these post holders.
- One of the nurse consultants told us the documentation for authorising prescribing of drugs was 'slightly different' in the North and South divisions of the trust. This was a record used to demonstrate the prescription and administration of pain relief and other medication for a patient. At the time of our visit, a unified palliative care authorisation form had been consulted on and agreed, the trust were waiting for funds to be confirmed before going into print.
- In the North division we found poor prescribing practices. Palliative care nurse consultant would prescribe medication for patients to be given at a dosage within a given range. The nurse administering the medication would select which dosage to give the patient. The charts we looked at showed nurse consultants were using very wide prescription ranges. Nurses with limited knowledge especially within community practice and at weekends in community hospitals were expected to pick from this range and no

advice was recorded on plans. This was illustrated by one patient who had a prescribed range of 5 to 50 mg of midazolam, a potent sedative agent that requires titration and slow administration.

- We found other examples of poor practice. For two inpatients, PRN (as and when required, not regularly prescribed) medication doses were wrongly selected by nursing staff. For one patient (too low) an opiate for the background dose. For another patient nurses were selecting PRN medication start doses of that were too high
- Another inpatient had an inappropriate use of Fentanyl patch for pain management prescribed by a doctor in September 2015. The opiate dose had not been stabilised prior to the patch being administered. There was no formal assessment of type of pain on record for the patient and no evidence of why opiates had not been considered.
- We reported our concerns to the trust during our inspection and they stated a review of prescribing practices across the trust would be commenced by 31 December 2015.

Environment and equipment

- We found patients both living in their own homes and on wards had the appropriate equipment in place to support their care plans.
- Local leaders in the North division told us they maintain a small stock of equipment including continence products so it can be sent out to patients at short notice and over weekends and bank holidays.
- Relatives we spoke with in the South division told us equipment was delivered quickly when it was needed but the service was slow to pick it up again when no longer needed. One relative in the South division told us "there is a lot of onus on you to chase things."

Quality of records

- We noted within the 15 sets of records we looked at that End of Life Care patient care plans were not always fully completed and progress notes did not always match the relevant goal on the plan. For example emotional and spiritual needs were not recorded. In some cases,

Are services safe?

reviews were marked as 'on-going', which was not informative as it showed no evaluation of the effectiveness of, for example pain management or nutritional plans.

- We noted when we accompanied district or community nurses to visit palliative or End of Life Care patients they documented the visit appropriately on patient's records.

Cleanliness, infection control and hygiene

- We saw staff had good hand hygiene and aseptic technique and made appropriate use of personal protective equipment such as gloves and aprons with patients in community hospitals and patients in their own homes.

Mandatory training

- The trust told us it had ten mandatory training courses. The trust target completion rate for each course was 90%. According to trust data (no timescale provided) End of Life Care services met their target for all courses apart from 'conflict resolution' which had an overall completion rate of 83%. Basic life support, fire safety and safeguarding adults level 1 met the target at 90% compliance. The other topics exceeded the trust target at between 92% to 97% compliance.

Assessing and responding to patient risk

- There was no formal arrangement for specialist medical input to End of Life Care services. Community hospitals did not have 24-hour medical cover for palliative and End of Life Care patients. Doctors who were not specialist in palliative medicine worked on the wards and staff told us the out of hours (OOH) on call service could be accessed but response times were variable and inconsistent. For example, at Cheadle Community Hospital, staff told us out of hours GP services did not respond in a timely way for patients with pain or requiring medication; there could be a delay of up to

three hours. Hospital managers told us the trust was working with the out of hours service to improve performance. A re-tendering process for the out of hours service contract was also underway with the outcome to be confirmed by the end of November.

Staffing levels and caseload

- In the North division, staff were supported and trained by six palliative care nurse leads. In the South division, integrated health and social care community teams were supported by a team of four (3.8 WTE) Macmillan Nurses and 3.5 palliative specialist nurse practitioners. A palliative care nurse consultant clinically led palliative and End of Life Care services in each division.
- Leaders told us where possible community nurses would arrange for night visits in advance or as urgent priority from the third sector. In the South division and east of the county the night sitting service was staffed by auxiliary nurse assistants as part of the integrated health and social care team.

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. We saw that the community hospital management team attended monthly management meetings where they reviewed all potential risks, lessons learnt, and outstanding action plans. These meetings would include End of Life Care issues.

Major incident awareness and training

- The trust told us arrangements for emergency and major incident planning arrangements for End of Life Care services were part of the trust wide arrangements which were at stage one of planning at the time of our inspection. A table top exercise was completed in September 2015.

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 have rated this service as inadequate for effective. This is because:

- The 'do not attempt cardio pulmonary resuscitation' (DNACPR) Order recording systems was not operating effectively; practice varied across the trust and was unsafe.
- DNACPR documentation was poorly completed, varied in its completeness within inpatient wards and within community practice.
- Systems in place to establish patients' capacity and to make decisions about their welfare and care were not always consistently followed.
- The trust care plans for the replacement of the Liverpool Care Pathway were still in draft format and there were no timescales for implementation.
- Individual care plans were not always up to date.
- There were poor pain assessment systems in place.
- The service carried out very few local clinical quality audits during 2014/15.
- Data provided showed that 56% of staff had an up to date appraisal.
- Arrangements for the clinical supervision of the two palliative care nurse consultants were unclear
- The trust did not have any quality indicators for fast tracking patients who chose to die at home.

Evidence based care and treatment

- Before our visit we asked the trust to tell us arrangements in place to manage End of Life Care services in accordance with NICE guidelines, in particular NICE QS13 End of Life Care for Adults and NICE CG140 Opioids in palliative care. The trust told us the management and implementation of NICE guidance is the responsibility of the trusts NICE Guidance Group.

The group meet monthly to assess guidance for its initial relevance and then it is allocated to a lead within the organisation to complete a baseline assessment and provide a decision of compliance.

- The trust said NICE guidance QS13 End of Life Care for Adults was published prior to SSOTP forming as an organisation and was being monitored via a legacy project to provide assurance of compliance. As part of this project the guidance was allocated to palliative care leads in both North and South divisions. Both divisions had identified that there were gaps in the service delivery in relation to this guidance; therefore a status of partial compliance was recorded by the trust. We noted that the Quality Standard Response Forms completed by the trust showed a deadline for completion of all actions to achieve compliance for North and South divisions as 1 March 2016.
- The trust gave us a contradictory account of its monitoring of guidance. It told us it wasn't included within its monitoring process but it intended to do this and then it then it told us that all relevant NICE guidance was reviewed monthly by the NICE guidance group.
- In response to the 2013 review of the Liverpool Care Pathway (LCP) the trust had withdrawn the LCP document from practice and guidance had been issued to staff on the need to generate an individualised personalised care plan reflective of patient needs.
- We asked the trust to tell us arrangements in place for End of Life Care services to achieve the Priorities for Care of the Dying Person set out by the Leadership Alliance for the Care of Dying People. They told us that a care plan is in draft and being consulted upon which is built on the priorities. Timescales for implementation of the care plan were not provided.
- We looked at care plans in place for inpatients and patients living in their own homes. We saw the plans included evidence based tools for assessments such as pain, skin integrity and nutrition and hydration. Plans were tailored to the individual needs of patients through identification of a range of relevant goals that achieved

Are services effective?

the care outcome a patient needed and desired. Not all plans were completely or properly up dated and advanced care planning was not effective in place for some patient's notes. For example, the care plan for one inpatient with very complex needs had all the review dates marked as 'on-going'. Progress notes did not relate directly to some goals and there were no assessments of the patient's mental capacity against any of the planned goals.

Pain relief

- During normal working hours, advanced nurse practitioners (ANP) and medical staff on community wards sought advice from the palliative care nurse consultants for the management of complex pain and other symptoms.
- We noted the trust maintained a list of palliative care commissioned pharmacies around the county that kept stocks of medicines, with their contact and access details so community teams could access pain management drugs quickly for their patients.
- Some prescribing practices in the North division resulted in poor pain management. This included the palliative care nurse consultant providing a wide prescription range for drugs given via continuous sub-cutaneous infusion (i.e. syringe pump) in community hospitals and for patients at home.
- We found for one patient at Cheadle Community Hospital an inappropriate use of Fentanyl patch for pain management prescribed by a doctor on 17 September 2015. The opiate dose had not been stabilised prior to the patch being administered and neither had it been established that the patient's pain was opiate sensitive. The application of a Fentanyl patch and subsequent rapid increase in patch strength resulted in the patient developing symptoms of opiate toxicity that they found distressing. There was no formal assessment of type of pain on record for the patient and no evidence of why either other, shorter acting opiates and/or other categories of analgesic agents had not been considered.
- The trust had guidelines dated 2012, in place for the use of drugs in symptom control.

- Care workers from a local care home in the North division told us about palliative care lead nurses, "we ring them and they come within 20 minutes. Waiting time to respond to pain is brilliant. The patient wants to die here and we will be able to achieve that for her".

Nutrition and hydration

- All patients and relatives we spoke with in community hospitals told us the food patients received was good.
- Inpatient care records we looked at included fluid balance charts and food diaries. However for one inpatient where their care plan said they required 'encouragement' with eating and drinking because they were identified as being at risk of dehydration, we observed a half cup of cold tea sat on their tray and tea was spilled around their chair. We raised this with a health care assistant (HCA) who confirmed the patient required a beaker with handles and put right the situation.

Patient outcomes

- The trust were not able to participate in the National Care of the Dying Audit (NCDA) and they undertook few local clinical quality audits. They told us that the recommendations from the NCDA report (13 August 2015) were to be discussed at the mortality review group on the 4 November 2015.
- The trust told us that it had undertaken no audits of End of Life Care services within national frameworks beyond NICE QS13 End of Life Care for Adults Guidance compliance assessment.
- The trust had not contributed to the National Minimum Data Set but told us it intended to do so in January 2016.
- The trust told us in the 12 months preceding our visit there had been a total of 1180 patient deaths across the North division area (240 were in community hospitals, of which 76 had also been cared for by the community End of Life Care team). In the South division area, there had been a total 401 deaths. The trust told us that all palliative care deaths were reviewed at the Mortality Review Group (MRG). We noted the annual MRG report showed only 195 deaths, including in the community, were reviewed in 2014/15.

Are services effective?

- The trust achieved two out of four KPI targets for End of Life Care. Compliance with CQUINs showed: the safety thermometer was not achieved; raising concerns was partially achieved for Q1 and Q4; partnership for patients was partially achieved for Q1; seven day services was not achieved for Q3 and Q4.
- Priority two was 'experience – customer satisfaction'. Data collected in the North division. It showed that the percentage of patients who have a preferred place of care recorded met the trust target of 100%; the percentage of patients offered a support care plan (SCP) met the trust target of 100%; the percentage of patients who achieved their preferred place of death was 50.5 % against the trust target of 75% and the percentage of patients with DNAR status who were informed of GPOOHs/24/7 (GP out of hours service) specialist palliative care provider by The palliative care coordination service (PCCC) met the trust target of 100%.
- The trust told us the Improving Patient Safety and Ensuring Appropriate Outcomes for Palliative Care South Staffordshire safety/quality rating was green.
- We asked the trust if the service was working towards an independent accreditation standard such as the Gold Standards Framework Accreditation (GSF). The GSF provides a framework for a planned system of care in consultation with the patient and family. It promotes better coordination and collaboration between healthcare professionals. It is a model that enables good practice to be available to all people nearing the end of their lives, irrespective of diagnosis.
- The trust has implemented a "Purple Bow" scheme in the community hospitals. Using sensitive, purple bow signage on side room doors and bay curtains all hospital staff are discreetly made aware that a person is nearing the end of life and that their family or friends may be present. The scheme is also a means of opening up conversations with patients, relatives or carers about the end of life nearing and to ensure that all that can be done in terms of special requests can be accommodated.
- We received conflicting information about formal clinical supervision arrangements for the two palliative care nurse consultants. The trust told us there were arrangements in place but the consultant nurses' view was they had nothing beyond 'good will' relationships with the acute trust oncology consultants. Also, there was no formal arrangement for specialist clinical supervision in End of Life Care services.
- District nurses in the South division and care home workers in the North division we spoke with, were very positive about the level of skill and knowledge demonstrated by palliative care leads in their areas.
- Local nurse leaders told us there was a programme of End of Life Care competencies for health care workers being rolled out across the North division at the time of our inspection. This was confirmed by district and community nurses we spoke with. Data provided showed 285 staff had completed syringe driver training and 49 staff trust-wide had been trained on advanced care planning.
- For health care assistants in the South division, there was no specific training on End of Life Care. However the trust told us, as part of QCF/NVQ health & social care level 2&3 training, staff would cover End of Life Care as one of the modules. Forty-six staff undertook this training in 2014 and the trust had eight staff on programmes at the time of our inspection.
- The trust also told us the need for bespoke education and training may also be identified via incidents and concerns being raised, as part of an action plan or following the identification of a risk. For instance; it provided verification of death training to support implementation of the updated verification of death policy. We were not given figures as to how many staff had completed this training.
- The trust told us communication skills training had been offered and provided, as required by NICE guidance 2011/13, (also NICE 2004) and reflected recommendations in the 'one chance to get it right' national reviewwork2014. However we were not given data as to how many staff had completed this training.

Competent staff

- Data sent to us by the trust showed End of Life Care services staff had an appraisal rate of only 56% as at July 2015.

Multi-disciplinary working and coordinated care pathways

Are services effective?

- The PCCC coordinated planned and unplanned supportive services for patients requiring palliative and end-of-life care in the North division. There was no equivalent service in the South division but an integration project had recently been initiated and this involved a multidisciplinary approach to combining health and social care service for End of Life Care.
- End of Life Care services worked closely with District nurse/community nurse teams and local GP's

Referral, transfer, discharge and transition

- The PCCC facilitated the approval of funding and sourcing of a care package within 48 hours of referral for patients identified as being in the last three months of life and eligible for fast-track NHS fully funded Continuing Health Care. Data provided by the trust showed that this was achieved in 92% of cases.
- The trust recorded the preferred place of care for all (100%) end of life care patients. Data provided by the trust showed that 50.5% of patients achieved their preferred place of death, against a target of 75%.
- The trust did not have any quality indicators for fast tracking patients in the last days of their lives who chose to die at home. A nursing leader told us it was common for patients to be discharged within 48-hours but this could be subject to delays. Local leaders told us this was due to community care packages not being available in a timely manner, the trust told us they were engaging with local commissioners to address this. A palliative care nurse consultant told us there were too many delays in fast tracking patients home to keep reporting as an incident.
- Local leaders told us the North division had been running an admission avoidance project with care homes in the three months prior to our visit. Trust staff contacted care and nursing homes daily to offer advice and support for caring for residents receiving palliative and End of Life Care. Staff in one care home we visited with a palliative care lead nurse were clear that this intervention allowed their resident to remain in the care home. Early indications showed the scheme had a continued positive impact with a year to date reduction in activity from the previous year equivalent to 11 acute

beds. Overall admissions were down by 5% for the target homes versus an increase of 8% for all other homes not in the pilot. This information was in draft form at the time of our inspection.

Access to information

- Staff and local leaders told us IT systems were a problem as they did not 'talk to each other'. For example the PCCC in the North division told us it had good links with GP's and out of hours services on a shared IT system but information was not visible to the NHS ambulance or acute trusts.
- We observed two examples, one in the North and one in the South division where local leaders had difficulty accessing the trust information we asked of them on their computer terminals. In one case the intranet web page immediately timed out and we were told this was usual, in the other case the leader had not yet been transferred to a new system as a user.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We found there were systems in place to establish patients' capacity and to make decisions about their welfare and care. However these were not always consistently followed and there was confusion among staff around obtaining valid consent from patients who did not have the capacity to give it.
- We were told by nursing staff, an inpatient had a diagnosis of dementia. However we found there was no documentation of an assessment of mental capacity at the time of admission and the formal dementia screening tool had not been completed on admission.
- For another inpatient whose records showed non-compliance with their medication and blood tests on occasion, there was no best interest discussion on record. We observed further examples where a patient had no notes about an MCA assessment although it was recorded that one had been undertaken.
- Local leaders told us it was 'unlikely' teams would feel confident or competent in the MCA after only basic training.
- We found the 'do not attempt cardio pulmonary resuscitation' (DNACPR) Order recording systems were not operating effectively; practice varied across the trust

Are services effective?

and was unsafe. This meant a patient may be resuscitated when they had expressed a wish not to be. It also meant a patient may not be resuscitated when they wished to be because the documentation available to a clinician at the point of care was not complete and up to date.

- DNACPR documentation was poorly completed, varied in its completeness within inpatient wards and within community practice. We looked at the care records of six inpatients (one very recently deceased) at two community hospitals. We found for one patient who was assessed as 'able to express their wishes effectively and can communicate clearly', the DNACPR Order on file was appropriately signed and dated but 'not discussed with the patient'. Another patient had no DNACPR Order on file and there was no record that a discussion had taken place.
- Many patients' care files contained no DNACPR Order although they had DNACPR review sheets being actively used by clinicians. Three of the six records we looked at had a review sheet but no Order on file. This meant clinicians did not know what they are signing to review.
- For a patient living in their (care) home we found no Order on their file but there was a review sheet. This indicated the DNACPR decision had been made in 2013. We noted the GP was signing it off annually from June to June without reference to a proper review as the decisions and reasons for it were not available at the point of care.
- A palliative care local leader in the North division of the trust told us they had never seen the DNACPR Order on the file of a patient being cared for at home, only the review sheet. This meant GP's may not know what they are signing to review.
- This meant that staff could not be assured that patients with a DNACPR continued to agree to the order being in place or they continued to have the capacity to agree to such an order.
- We raised our concerns about this with the trust during our visit and they undertook to review this.

Are services caring?

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

Summary

We have rated this service as Good for caring. This is because:

- We observed nursing, medical and support staff caring for patients requiring palliative care or at the end of their lives in community hospitals and their own homes.
- All those staff treated patients and their relatives/carers with kindness, respect and compassion.
- Nurses treated patients gently and checked their comfort at various stages of care and treatment.
- There were dignified arrangements for deceased patients in community hospitals.

Compassionate care

- We observed nursing, medical and ancillary staff caring for patients requiring palliative care or at the end of their lives in community hospitals and their own homes. All staff treated patients and their relatives/carers with kindness, respect and compassion. We noted that staff supported patients' dignity and right to appropriate privacy.
- We observed when we accompanied a palliative care lead to a patient's care home that the patient was treated gently and their comfort checked at various stages during a dressing change.

- We spoke with two funeral directors contacted by the trust. They told us deceased patients were presented in a dignified way for removal from the community hospital wards and their belongings were treated with respect.

Understanding and involvement of patients and those close to them

- A relative told us when we accompanied a district nurse on a home visit in the South division, "Absolutely marvellous, faultless, all of them are great". They told us they felt well supported and they got what they needed when they needed it, "all the nurses are brilliant".
- We observed appropriate involvement of the patient and their family in assessing the patient's condition when we accompanied a district nurse to a patient's home in the South division. For example the nurse asked the family what behaviours the patient exhibited when in pain and how they distinguish pain from agitation. We heard the nurse explain the need for changes in equipment and drug regime to the family using language appropriate to their knowledge of clinical terms.

Emotional support

- We noted that patient records we looked at did not include any psychological or spiritual goals in their care plans.
- Relatives we spoke with in community hospitals and patient's own homes told us nursing staff helped and supported them in their caring role.

Are services responsive to people's needs?

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

Summary

We have rated this service as requires improvement for responsive. This is because:

- The trust did not have any quality indicators for monitoring the response times when patients are referred to the palliative care team
- Services in the South division did not fully reflect the needs of the local population and the commissioning intentions of the local CCG.
- Not all care plans were holistic and many did not include spiritual and emotional needs and focussed only on physical aspects of care and support.

However we also found that:

- Ninety-seven per cent of End of Life Care staff had completed Equality, Diversity and Human Rights training.

Planning and delivering services which meet people's needs

- End of life services including palliative care were delivered across the trust through two geographical divisions, North and South. Each division was clinically led by a palliative care nurse consultant and support to district nurses/community nurses by palliative care specialist practitioner nurses or 'leads'. The configuration of services was different in each division.
- In the North division there were three community hospitals offering palliative care services. Palliative care nurse leads supported community and district nurses to care for patients at home. There was one independently provided Hospice. The North division also provided a palliative care coordination centre (PCCC) that had been developed specifically to respond to local need. The PCCC worked with the third sector as one point of contact to coordinate the service a patient needed.
- Local leaders in the North division told us there were typically delays in obtaining care packages for patients

at home. They developed 'informal workarounds' to ensure the system worked best for patients, for example the care delivered to people was the same regardless of where they lived despite which CCG was funding it.

- In the South division there were no community hospital palliative care services. Local leaders told us they worked well clinically and strategically with a number of Hospices. The trust provided a Macmillan nurse team based at Stone. Palliative care practitioner nurses supported the integrated health and social care community nurse/care teams in the east to provide care for people in their own homes. The service provided support to care and nursing homes, prisons and independent mental health hospitals. Local leaders in the South division told us they felt the service being delivered to the local community did not fully reflect the commissioning intentions of the local CCG and they were concerned about the impact on the service if commissioners opted to enforce the terms of the contract.

Equality and diversity

- In the community hospitals, where it was identified that patients required support we saw that this was pre-arranged. Disability access was appropriate in all areas and support was available should the need arise. A 'butterfly scheme' ensure support for patients living with dementia.
- Data provided by the trust showed that 97% of End of Life Care staff had completed Equality, Diversity and Human Rights training.
- We noted the inpatient service did not proactively recognise the additional needs that lesbian or gay patients and their partners may have, particularly those who, habitually, may not feel safe disclosing a significant relationship; 'we treat everyone the same' staff told us.

Meeting the needs of people in vulnerable circumstances

Are services responsive to people's needs?

- The trust told us manual processes were in place to inform teams of newly admitted to hospital people with End of Life Care needs, there were no automatic flags on patient record systems.
- The palliative care nurse consultant in the South division provided support to specifically vulnerable patients in mental health care hospitals and prisons including patients with learning disability.
- Care plans we looked at for inpatients and patients being cared for in their own homes did not include emotional and spiritual goals. They were not holistic in their approach and they focussed only on physical needs.

Access to the right care at the right time

- The trust did not have any quality indicators for monitoring the response times when patients are referred to the palliative care team. Data collected locally showed that in the South division, 67% of patients were seen by the palliative care team within 24-hours of referral. In the North division, response times were not monitored.

- Care workers looking after an End of Life patient who lived in a local care home in the North division told us the service was responsive. They said, “we ring them and they come within 20 minutes”.

Learning from complaints and concerns

- The trust received one complaint in 2014/2015 relating to End of Life Care services. We tracked it through the trust's electronic records system. We saw that a rigorous procedure of investigation, writing to the complainant and informing them of the outcome had taken place. The complaint was partially upheld. There was an action plan and a process review to ensure the correct information was shared with practitioners for learning. This complaint had triggered the duty of candour. We noted a letter from the trust to the patient's family that included the lessons learned. The action plan did not address any organisational actions at a higher leadership level in the trust although the circumstances of this complaint would have warranted this.
- We noted information on how to raise a concern or make a complaint available around the community hospital wards we visited.

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 have rated this service as inadequate for well-led. This is because:

- There was no overall vision for End of Life Care services.
- There was no Executive Board representation and no recognition of the trust-wide End of Life Care strategy group.
- Systems or processes were not sufficiently established or operated to effectively ensure the trust was able to assess, monitor and improve the quality and safety of end-of-life care services.
- Nurse consultants, on who the delivery of End of Life Care depended, had no direct influence on strategic or operational risk management and commissioning arrangements. They felt their voice was not heard by senior leaders in the trust.

Service vision and strategy

- Staff at different levels, in different roles and in different parts of the organisation told us there was no overall on-going vision or strategic overview of the End of Life Care service.
- An integration project had recently been initiated in the South division and this involved a multidisciplinary approach to combining health and social care service for End of Life Care. Staff at different levels and roles told us that End of Life Care services were a priority for the trust until the project started but were no longer a focus for the executive senior operational leaders. Clinical leaders told us there had been 'multiple' changes to senior management since the integration project started.

Governance, risk management and quality measurement

- We found no executive trust board member was committed to taking strategic responsibility for End of Life Care services and there was no recognition of the trust-wide End of Life Care strategy group. As a

consequence, End of Life Care services did not have an identity or profile at a senior level within the organisation; Nurse consultants told us they had no influence on strategic or operational risk management.

- We noted there were few items on the corporate risk register relating to End of Life Care services. The trust informed us there was no separate risk register for End of Life Care services.
- The trust were not able to participate in the National Care of the Dying Audit (NCDA) and they undertook few local clinical quality audits. Some audits of compliance with NICE guidelines were undertaken. An audit undertaken by the trust in the South division in the spring of 2015 had found under dosing. However NICE CG140 Opioids in palliative care guidance was not being monitored by the trust. We noted that where audits had been completed there was no evidence that any actions required were followed up and monitored.
- The Liverpool Care Pathway (LCP) was withdrawn by the trust in 2013 in response to national guidance. The Priorities for Care of the Dying Person set out by the Leadership Alliance for the Care of Dying People were published in 2014. The trust told us that a plan to replace the LCP was in draft and being consulted upon. Timescales for implementation of the care plan were not provided. There had been no strategic oversight or monitoring of the implementation of the plan.
- DNACPR Order recording systems were not operating effectively; practice varied across the trust and was unsafe. These risks had not been identified by the trust because there was little or ineffective quality measurement of services.

Leadership of this service

- We found service delivery depended on two palliative care nurse consultants. These nurse consultants had to relate to a number of different area operational managers and had limited support further up the organisation. This limited their capacity to lead the service whilst developing and influencing how End of Life Care is managed within multi-disciplinary teams.

Are services well-led?

- We found there was no formal clinical supervision arrangement for the palliative care nurse consultants in the North and South divisions.

Culture within this service

- We noted specialist nurse practitioners strove to build good professional relationships and team working arrangement with other stakeholders and were committed to providing the best outcomes for their patients.
- Many staff we spoke with in different roles, although committed to their patients felt disconnected and undervalued by the trust.
- Some told us they felt isolated in their role in the trust. Palliative and End of Life Care specialist practitioners in the South division told us they believed the trust leadership had a poor understanding of what End of Life Care is and what their role was.
- The Macmillan nurse team in the South division told us three out of the four experienced Macmillan nurses were working their notice at the time of our visit. They said they “were drowning” in the service changes made in 2015 and they reported they experienced a diminished ability to influence good outcomes for their patients.
- All staff we spoke with said they felt confident about speaking up and raising concerns with their line managers. However local clinical leaders told us their voice was not heard by senior leaders in the trust.

Public engagement

- We saw no evidence of public engagement specific to End of Life Care services. The trust told us Friends & Family Test results from the six months prior to our inspection had been consistently high, but this was a trust wide assessment.

Staff engagement

- The trust reported it had held “1Vision” staff briefing events each quarter since March 2014. These were designed to improve senior manager visibility and communication across the organisation. End of Life Care staff in a variety of roles we spoke with were aware of these events and said they had attended at least one event.
- The trust had schemes in place to motivate and reward staff. We noted for example, the palliative care co-ordination centre (PCCC) in the North division received the trust’s outstanding team of the year award winners 2015 corporate/support services.
- We saw an example of staff engagement at a local level with material on display on the office wall demonstrating how the team were engaged and motivated through a recent team away day.

Innovation, improvement and sustainability

- The trust set up the palliative care coordination service (PCCC) in the North division in 2009. The service provided a focal point around which NHS and third sector services can cluster and deliver effective care to patients.
- The trust was responding to new contractual arrangements in the South division for End of Life Care services. Staff told us this had been ‘put on hold’ for six months, a period that had just ended at the time of our visit, but they had no information about how it was going to proceed or what the future services would look like.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

You are failing to comply with Regulation 11 (1), which states:

Care and treatment of service users must only be provided with the consent of the relevant person.

Staff were not acting in accordance with the Mental Capacity Act 2005 and there was poor understanding of its application amongst staff.

The DNACPR documentation was poorly completed, varied in its completeness within inpatient wards and within community practice. Many care files contained no DNACPR Order although they had DNACPR review sheets being actively used.

This meant that staff could not be assured that patients with a DNACPR continued to agree to the order being in place and they continued to have the capacity to agree to such an order. Staff could not be assured that patients living with dementia were consenting to care and treatment or that these decisions were being formally made in their best interest.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA 2008 (Regulated Activities)
Regulations 2010 Respecting and involving people who use services

You are failing to comply with Regulation 17 (1) (2) (a) (b) (c) which states:

(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.

This section is primarily information for the provider

Requirement notices

(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to —

(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity

(including the quality of the experience of service users in receiving those services);

(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at

risk which arise from the carrying on of the regulated activity;

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided

There was no overall on-going vision or strategic overview of the service. No Board member was committed to taking strategic responsibility for end-of-life care services.

Systems or processes were not sufficiently established and operated to effectively ensure the trust was assessing, monitoring and mitigating the risks which arise from providing of end-of-life care services.