Stockport NHS Foundation Trust

RW6

Community end of life care

Quality Report

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Date of inspection visit: 19-22 January 2016
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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)
RWJ09	Stepping Hill Hospital		
RWJX6	Regent House		
RWJX9	Cheadle Hulme Clinic		
	Hazel Grove Health Centre		
	Crickets Lane Health Centre		

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

Summary of findings

Ratings

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

Summary of findings

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Overall summary

Overall rating for this core service GOOD ○

The specialist palliative care team worked as part of a multidisciplinary team covering the acute and community based services, with specific team members dedicated to providing the community element of specialist care. Their role was to assess, support, deliver, monitor and evaluate end of life and palliative care provided by the trust within Stockport, Tameside and Glossop.

The specialist palliative care team provided safe, co-ordinated care and had patients as the focus of their work. Patients were discharged quickly from hospital and equipment and services were put in place within the community to meet their needs.

There was excellent team working between the trust and other services to provide holistic patient care. General Practitioners, social services and community district nurse services all worked alongside the specialist team ensuring patients were a priority. The trust worked to national standards such as the Gold Standards Framework, and were working towards accreditation, and provided excellent educational programmes[DW1] for specialist staff and other clinical staff that may participate in end of life care as part of their role.

In twelve months between 31st March 2014 and 1st April 2015, 918 people had been referred to the community specialist palliative care team. This was less than the previous year. Of those patients 92% (844) had a cancer diagnosis.

Implementation of alternative documentation for the Liverpool Care Pathway[DW2] 2014 (LCP) had been slow. The service had used guidance and key action documents in the interim, to ensure individualised care planning had taken place and the introduction of the Individualised Plan of Care was still being rolled out at the time of inspection.

Patients and relatives we spoke with told us the care they received was delivered with an attentive and considerate manner. They felt involved in their treatment and felt their wishes were followed Patients were treated with dignity and respect.

There was good communication between the specialist palliative care management team and the executive team. Senior staff told us they felt supported and there was non-executive director representation on the trust board. Communication through the community teams, however, could be improved. Some staff told us they felt disconnected from the community and hospital senior leadership teams.

Plans were in place to merge services as part of the Healthier Together and Greater Manchester devolution programmes which would enhance service provision in the area.

Training took place at local level and the business group managed the outcomes from the two areas separately. Separate MDT meetings took place weekly in each area and although the trust had a specialist palliative care consultant in the community, they were only responsible for patients in the Stockport area. Patients in Tameside and Glossop were treated by their GP and any clinical advice was obtained from the local hospice.

Summary of findings

Background to the service

Information about the service

We inspected Stockport NHS Foundation Trust as an announced comprehensive inspection from the 19 to 22 January 2016. The specialist palliative care teams were based at Willow house in Stepping Hill Hospital, Stockport and Crickets Lane Clinic in Tameside. We visited Stepping Hill Hospital, Cheadle Health centre, Heald Green Health centre, Regent House and Crickets Lane health centre.

The trust had won the contract to deliver the community health services for Tameside and Glossop for the last four years but geographically and managerially the services had remained separate to meet the needs of their own demographics. The contract was due to end in March 2016 and Stockport NHS FT had not applied for renewal. Tameside and Glossop community health services were to become part of another trust from April 2016.

The trust provides care for patients in the Stockport area, which has an approximate population size of 290,000 and Tameside and Glossop with a population of approximately 260,000. Trust policies and procedures were shared across the two areas and they shared the same overarching management structure but many duplicated services were operationally different.

Our inspection team

Our inspection team was led by:

Chair: Gill Gaskin

Team Leader: Ann Ford, Head of Hospital Inspections, North West

The team that inspected this service were one CQC inspector, one specialist advisor with a background in specialist palliative care nursing in the community setting and an Expert by Experience

The team would like to thank all those who met and spoke to inspectors during the inspection

Why we carried out this inspection

This inspection was part of the full comprehensive inspection of Stockport NHS Foundation Trust

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew.

We carried out an announced visit on 19-22 January 2016.

During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors and therapists. As part of our investigation we examined data supplied by the trust, we inspected nine sets of patients records and spoke to ten patients/relatives. We observed interactions between staff and patients on the telephone. We spoke to 21 staff including, doctors, team leads, facilitators, co-ordinators and nurses. We attended the Stockport Multi-Disciplinary Team meeting.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the service SHOULD take to improve

1. The service should review the lack of medical cover for out of hours and annual leave for the specialist palliative care team.
2. Focus should be made on increasing the number of community staff that have attended the mandatory training programme in end of life care.
3. Fully implement and utilise the new IPOC documentand standardise this procedure for the end of life patient
4. Review the infection control risks to staff in respect of the procedure for the return and replacement of syringe drivers, with particular focus on the out of hours services
5. Specialist care team managers should be involved in engaging community staff in the trust and addressing the issues highlighted in the staff survey.

Stockport 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 found the end of life community services for the trust to be 'Good'.

Medicines were managed safely following prescribing protocols and availability of anticipatory medicines was established. Guidance for symptom control was readily available in notes and on the end of life microsite and specialist medical advice was on hand from either the trust or the local hospice.

The educational facilitator analysed all deaths of people referred to the palliative care team in order to assess the standard of care they received and if changes to practice could be made. This ensured any gaps in knowledge were highlighted and specific training delivered[AJ1].

The supply of equipment that may be needed by the patient in the last days of life was supplied by an external supplier. The contract held allowed patients to be discharged from hospital urgently and we were told that equipment had usually been delivered within four hours. Deliveries were also available at weekends.

The trust had implemented training programmes and included end of life as part of clinical staff induction.

Learning also took place and quality improved from the facilitator examining the notes of every palliative care death to look for inconsistencies in care and documentation.

There was acknowledgement that there were shortfalls in consultant specialist activity. There was one whole time equivalent whose workload included the hospital and community clinical work and non-clinical sessions. There was no overnight medical cover though an informal arrangement existed with the local hospice for advice.

Detailed findings

Safety performance

- We saw evidence in specialist palliative care governance minutes of meetings that harm free care/ NHS Safety Thermometer was a regular agenda item. The minutes we inspected showed nothing to report.
- Two district nurses (DN) separately stated that they would not hesitate to correct another member of staff if the patient was at risk, and would discuss after the visit if procedures were different.
- There were three incidents reported between 1 December 2014 and 30 November 2015, which were

listed as severe harm, all three were pressure ulcers. Actions taken were recorded and appropriate. In two cases, the patient had refused equipment and examination prior to the increased severity of the sore.

Incident reporting, learning and improvement

- The trust had an electronic system for recording incidents that was available to all staff via the intranet. Community staff told us they were familiar with the reporting system and gave us appropriate examples of when they had used it.
- There were 80 incidents recorded between 1 December 2014 and 30 November 2015 using the National Reporting and Learning System that affected End of Life / Palliative patients. Of these 77 were categorised as low or no harm.
- There were no reported Never events under Strategic executive information system (STEIS) criteria between October 2014 and November 2015. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- The community service also had no recorded incidents of Clostridium Difficile infection or other health care acquired infection.
- The community end of life care facilitator for Stockport analysed the records of all deaths of patients receiving end of life care in the community and nursing home environment. Every four months an audit report was circulated to the Lead Nurse for Palliative Care and Lead Nurse for District Nursing so that lessons were learned and improvements made. The facilitator provided a large amount of data and gave reflections on the information collated. This information was used to improve the service and examine shortfalls in education. A senior district nurse told us that sometimes the information was not passed on to the rest of their team, as it was ‘always negative and quite demotivating’.
- District nurse team leads and Macmillan nurses told us that incidents were discussed at daily team meetings. The meetings were used to inform staff of deteriorating patients and to analyse and discuss and learn lessons from incidents. Meetings were informal and no minutes were documented. Staff knew how to record incidents electronically and when to escalate serious events.
- Staff were aware of their responsibilities in relation to Duty of Candour (the regulation introduced for all NHS bodies in November 2014, meaning they should act in an open and transparent way in relation to care and treatment provided) and being open with patients when incidents occur.

Safeguarding

- Systems were in place to protect people in vulnerable circumstances from abuse. Staff were knowledgeable about their roles and responsibilities in relation to ensuring vulnerable adults and children were safeguarded. Staff understood what constituted a safeguarding concern and could demonstrate the processes to raise a safeguarding alert
- Staff participated in training for safeguarding adults and children to varying levels depending on role and clinical exposure. Safeguarding training was available from level one to level three for children and two levels for adults. The business group training report stated in August 2015, 93% of Tameside and Glossop staff and 95% of Stockport staff had received safeguarding adults level two training, and 90% Tameside and Glossop and 85% of Stockport staff were compliant to level two safeguarding children. We saw evidence of safeguarding training schedules in a health centre and staff confirmed they received regular training.
- An example of when the safeguarding procedure had been followed was given to us at inspection. The carer of a dying patient had learning difficulties and disclosed he was paying staff from the care agency cash on each visit and providing meals whilst caring for his relative. The respite team alerted the trust and the incident was escalated. This demonstrated the knowledge and care of the health care assistant.

Medicines

- Anticipatory medicines were prescribed for patients in the community, identified as requiring end of life care. These are medicines that may be required and can be prescribed in advance to ensure prompt responses to the management of symptoms that could occur in the last days or hours of life.
- Anticipatory medicines were usually prescribed by the patient’s general practitioner (GP) or via the hospital when the patient was discharged. Availability of supplies was good. District nurses knew which pharmacies in the

community kept stock of required medication. Local supermarkets, with pharmacies, were open out of hours. Other sources of supplies were the local hospices and some GP's kept a supply for emergencies.

- A symptom control in the last days of life guidance pack for healthcare professionals was available to assist prescribers and specialist nurses to assess and control the patient's symptoms. A symptom control algorithm provided a flow chart that staff used to assess the patient's symptoms at each visit. We saw evidence that medicine on the flow charts had been prescribed.
- A documentation review was conducted using deceased patients' records and recorded the number of patients that had been prescribed anticipatory medicines. Between April 2015 and September 2015, 93 health records were examined and 87% had all four medicines prescribed according to the national end of life care guidance ("One Chance to Get it Right" DOH 2014). The remaining patients had one of more medicines prescribed. This was an improvement on 77% from the previous audit. All medicines that were no longer required were disposed of in the sharps bin in the patient's home. If controlled drugs (CD's) remained, two members of staff had to be present to witness the destruction. We were told a CD denaturing kit was used. Occasionally if the police attended the deceased patient's home, the controlled drugs were removed by them and the badge number of the officer was recorded in the patient's notes. This was seen in one of the health records inspected.
- We inspected seven sets of care records of patients who were cared for at home and prescription charts, controlled drug logs and regular stock checks were evident in all cases. Prescriptions were completed clearly, including times of administration of medicines prescribed 'as required'.
- We assessed the accuracy of the syringe driver pumps by measuring the rates and remaining volumes at each visit and were satisfied with the results.

Environment and equipment

- The community services had access to appropriate equipment to keep people reaching the end of their lives safe and comfortable.
- One brand of syringe driver was used across the hospital and community, which ensured a consistent approach to the care of patients requiring a subcutaneous infusion (a **subcutaneous infusion** is an injection of fluid under the skin). All clinical staff received training in the use of the driver as part of their End of Life care (EOL) mandatory training package.
- Staff in the community had access to a palliative care microsite on the trust intranet, which contained contact numbers for a 24-hour advice line available at hospices in both Stockport and Tameside and Glossop.
- Several syringe drivers were kept in each of the clinic bases, and in Stockport, district nurses were responsible for general record keeping such as batch numbers, battery changes and decontamination of the pumps.
- In Tameside and Glossop, syringe drivers were kept in district nurse bases. However, the specialist palliative care team at Crickets Lane clinic coordinated decontamination and held spare drivers. We inspected the process of recording, storage and decontamination at the clinic. Staff recorded the driver number, the service due date and to which clinic it had been issued. There were 34 syringe drivers available throughout the Tameside and Glossop community and the most remote clinic was approximately seven miles away from Crickets Lane in Ashton-under-Lyme. Out of hours, nurses from the area had access to spare syringe drivers and would enter the clinic and exchange a prepared driver for a used one.
- An external provider was used to supply patients with equipment in their home. District nurses told us that the provider had recently changed and the new company could deliver equipment within 4 hours, if required urgently. Patients at the end of life who were going home via the rapid discharge route had equipment delivered at weekends, where required. Carers we spoke with said they had had their needs met.
- District nurses or the palliative care team supplied and transported sharps bins to and from the patient's home. Sharps bins were used to dispose of syringes, needles and opened ampoules. Unused medicine was disposed of in the sharps bins.
- A risk assessment was carried out before the respite team entered a patient's property. The night sit team would assess the home situation of patients and if it was a safe environment to be alone. For example if the patient owned a dog.

Quality of records

- The Greater Manchester, Lancashire and South Cumbria Strategic Clinical Networks Palliative and End of Life

Are services safe?

Care Working Group had issued an Individual Plan of Care and Support for the Dying Person in the Last Days and Hours of Life (IPOC) document in October 2015. We received mixed messages regarding the document's use, some staff knew it existed but told not to use it until after training had taken place, other staff said it was in use and some didn't know of it at all. In Tameside and Glossop the IPOC document was present in one set of deceased health care records, though it had not been completed. Both community palliative care facilitators said that training was ongoing. In Tameside and Glossop 63% of active staff had received training.

- There was evidence that a North West End of Life Care Model was in use across the community. The model comprised of five phases of end of life and contained a good practice guide for staff, giving staff key prompts and practical information to documentation and decisions required. We saw the document in a set of current records and in an induction pack for new staff.
- Records seen contained evidence of personalised questions and answers and responses to patient/ carer requests. Daily documentation was detailed and clearly showed ongoing assessments and care given by all teams.
- The trust intranet had a microsite where information regarding palliative and end of life care could be accessed. This included links to the hospice, leaflets, care plans, standard operating procedures and policies and staff said they were aware of it.
- An electronic web based patient record system was partly in place and due to launch fully with Stockport patients at the time of our inspection. Stockport End of Life Care Portal for Anticipatory Care (Stockport EPAC) had been piloted and a team of four facilitators, including a GP, had been funded to support the system. The advanced care plan facilitator for the trust was delivering the training in health centres across the community area.

Cleanliness, infection control and hygiene

- Staff undertaking community visits had adequate supplies of hand sanitiser and personal protective equipment (PPE) such as disposable gloves and plastic aprons. We discussed cleanliness with three relatives of patients receiving care and they confirmed that staff wore PPE when necessary such as when changing dressings. One patient told us that the DN disposed of the PPE and any used dressings in her own household bin. We discussed this issue with two DN's and were told that this was common practice and trust policy.
- Infection control was considered and any potentially contaminated sharps bins were bagged and sealed in the patient's home before returning to the clinic. The trust's waste management department regularly collected clinical waste and stored it appropriately.
- We were told that syringe drivers were decontaminated between each use. There was a standard procedure for cleaning the equipment and each box was sealed and dated when ready for use. It was noted that used syringe drivers, in their plastic boxes, were left on the team co-ordinators desk overnight and at weekends by out of hours staff. This could pose an infection control risk to the office staff and it was agreed at the inspection that this process would be reviewed and changed.

Mandatory training

- In Stockport, a mandatory training programme had been developed for staff who had regular involvement in the care of the dying person. The training was a three-hour programme, which discussed communication, individual care plans, and patient's changing symptoms and needs. This programme was offered across the trust and between April and October 2015 only 21% (36) of community staff attended the course from a potential staff of 172, made up of district nurses, overnight, respite and palliative care staff. In Tameside and Glossop, all community staff were offered a one day training course facilitated by the Macmillan team. Since May 2014, only 32% (42) of a possible 133 staff had attended the course..
- During the inspection, we saw training schedules for district nurse staff based in a Stockport health centre. Mandatory training included basic life support, safeguarding level two for children and adults, safe use of insulin, manual handling, conflict resolution, mental capacity and deprivation of liberty safeguards, equality and diversity and end of life training. Information provided by the trust stated that one member of staff was overdue for mandatory training (by one month) all other staff that provided end of life care were compliant.
- A full time recurrent post was in place for a band 6 Advance Care Plan Facilitator, who had begun delivering EPAC training, furthermore an e-learning package had been developed.

Good ●

Are services safe?

Assessing and responding to patient risk

- Staff in the community used the guide in the North West End of Life Care model to assess the condition and deterioration of the patient and a copy was included in health care records. Documents including Priorities of Care for the Dying Person were followed and holistic assessment of risk, nutrition, pain and pressure ulcers was undertaken.
- Each district nursing team held daily team meetings to discuss individual cases and update staff regarding any deteriorating patient. We observed records of daily changes to patient's conditions within the records, along with frailty screening tools.
- Macmillan nurses in Tameside and Glossop met daily, triaged their caseload, and assessed any overnight calls. One hundred percent of patients between April 2014 and March 2015, who had been urgently referred to the service, were contacted and seen within 24 hours (164 patients). All non-urgent referrals were seen within five days (150).
- Relatives told us they knew how to access help and advice 24 hours. We saw advice leaflets with phone numbers both in and out of working hours and in Tameside and Glossop a 24 hour mobile phone was carried by the district nurse on duty overnight, and the number given to relatives of patients in their last hours of life.

Staffing levels and caseload

- The specialist palliative care (SPC) consultant for the trust had 22 hours of protected time for community end of life work throughout Stockport. Two hours each week were used for the multi-disciplinary team meeting held at Stepping Hill hospital. The consultant held a palliative care outpatient clinic and participated in domiciliary visits as well as telephone advice for patients, carers and colleagues.
- There was no medical cover out of hours for EOLC. The associate specialist at the hospice attended the weekly SPC MDT and provided cover "where possible" but it was acknowledged by the service there were gaps in specialist medical provision.
- All patients were given a named contact and Macmillan teams had approximately 30 patients known to them on a caseload, which was considered manageable by the staff we asked.
- GP cover was used within the Tameside and Glossop area. The on-call GP service was used out of hours and the local hospice provided any clinical advice required by staff seven days a week from a clinical nurse specialist.
- Stockport community palliative care team was divided into Stockport and Tameside and Glossop teams. There was a discrepancy in the service provision of the two locations by the trust. Stockport community teams had access to a dedicated palliative care consultant (22 hours) and a team made up of a dietician, pharmacist and a social worker, whereas Tameside & Glossop did not. There was also no dedicated administration staff in Tameside and Glossop.
- The district nurses managed end of life patients as part of their general caseload. A band seven district nurse told us her team was currently 18% under staffed due to sickness and vacancies, however the trust reported a 12.5% overall across the community service. There were high sickness absence levels in the Community Healthcare Service. In 2015, 812 FTE days were lost to stress-related absences across Bands 2-6 with the highest number recorded in band five Staff Nurses. Staff turnover was running at 15.86% in September 2015 against a trust target of less than 10%.
- We were told there were only three district nurses on the bank agency for Stockport. All district nurses we spoke to during the inspection told us that end of life patients took priority and workload would be reorganised to accommodate EOLC patients. However, there were two incidents reported relating to staffing issues and end of life patients between 1 October 2014 and 30 September 2015
- District nurse teams were managed by locality, with several teams working from the same location. Staff daily schedules were available on the trust intranet for each clinic to view and workload was allocated in units. Any shortfalls in staffing could then be backfilled with teams that had capacity. This system had the potential to optimise both nursing time and the number of daily visits achieved.

Managing anticipated risks

- Staff in the community told us that major incidents and winter management plans were coordinated from each health centre by the band seven district nurse team leader. Caseloads could be triaged and shared with other nurse teams as necessary.

- The trust major incident policy was available on the hospitals intranet and staff knew how to access the policy.

Good ●

Are services effective?

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

Summary

We rated the community services as good for effective.

The palliative care team followed national guidance and delivered care in line with One Chance to get it Right and Priorities for Care of the Dying Person. The services were checked annually to ensure compliance.

Staff explained the methods for assessing a patient's pain levels and their response. Evidence of pain audit tools were seen in care records and prescriptions recorded when medication had been given.

An excellent induction programme existed for nursing staff new to the end of life service. A series of training sessions and accompanied visits took place over a six month period. Training included advanced communication skills where staff learned how to manage difficult conversations.

There was evidence of excellent multi-disciplinary working across the community. Teams from the trust, general practice and social care ensured a holistic approach was made to the patient wishing to die at home. Work was also being undertaken at the time of inspection to merge some of the teams to provide greater resources and avoid duplication of work.

The trust was in the process of implementing a comprehensive care plan. In a partnership Greater Manchester, Lancashire and South Cumbria had devised a document to replace the Liverpool care Pathway which we saw at inspection. The document is currently not widely used but we saw that a training programme had been implemented and spoke to staff that had attended. The document would ensure that a plan of care and the patients' needs and wishes would be known to all staff caring for them in the last days of their life.

Detailed findings

Evidence based care and treatment

- The palliative care team had developed an 'individual plan of care and support for the dying person in the last days and hours of life' (IPOC) document. The team were in the process of introducing the document to staff across the trust and the planned implementation date was March 2016. Facilitators were training groups of staff individually and as part staff induction for new staff caring for EOL patients. This introduction was as a response to the withdrawal of the Liverpool Care Pathway (LCP) in July 2014. The trust had followed the guidance of the North West end of life model after the Liverpool Care Pathway was discontinued and recorded patient's wishes in their records based on key actions[DW1].
- As part of our inspection, we examined nine sets of records for patients referred to the palliative care teams that had since died at home. We found that there was disparity between notes completed in Tameside and Glossop compared to Stockport. In Stockport, none of the four sets of records examined contained the new individualised plan of care documentation. There was a palliative community core care plan in place which provided a list of issues that should be included in a plan, and other documents such as pain assessments, but there was no single detailed plan in any of the records reviewed. In Tameside and Glossop, however, there was evidence of individualised plans.
- There was an audit programme in place for EOL care, which included an audit on the recognition and communication of the Gold Standards Framework Prognostic Indicators. A subsequent action plan had been developed. The Gold Standards Framework (GSF) is a programme that supports the development of good quality care for people nearing EOL by planning care in line with their needs and preferences. We observed the Gold Standards Framework (GSF) in use in the community[AJ2]. The trust were working towards GSF accreditation. Twenty GP's in the Tameside and Glossop area were registered on the Going for Gold GSF programme.
- A documentation review had been undertaken to provide an insight into care delivered to dying patients and their families and establish whether national EOL care guidance, One Chance to Get it Right (Leadership Alliance for the Care of Dying People) was followed. Between 1 April and 30 June 2015, 65 sets of records were reviewed. There were some positive findings,

including that 94% of patients were identified as their condition was declining and the dying phase was recognised. Ninety eight percent of patients had anticipatory medicines in place, and in 74% of records, dying was recognised and discussion with the patient and family had taken place. Reflections meetings were held to communicate the results to staff which resulted in cohesive learning.

The place of death of patients on the Stockport palliative caseload was recorded. At home, deaths were compared with deaths in hospital and hospices. Between October 2014 and September 2015, 75% of palliative patients died in their home.

Pain relief

- There were tools in place to assess and monitor a patient's pain, and pain control was a priority for staff involved in patient care. A district nurse explained how she would assess a patient's pain level using verbal and non-verbal expressions of pain.
- The trust had guidance on EOL medication and pain relief, which was adapted from a local hospice's algorithms. This was available on the trust microsite and included advice, key messages and numbers to call for further information and guidance
- We spoke to eight relatives of dying patients and all said that pain was discussed and managed well by the staff that attended. We found that there had been no issues with availability of pain medication.
- We reviewed nine sets of records of deceased patients and symptom control prescription sheets were seen in all cases. The documentation was used to check accuracy of the syringe drivers delivering medication, thus ensuring effective pain relief was given.
- At the Multi-Disciplinary Team (MDT) meeting we attended during the inspection, there was evidence of good symptom control by the community nurse specialist. A discussion took place regarding a patient with compromised renal function and an understanding of which opioid to use following National Institute of Health and Social Care Excellence (NICE) guidance. There was also discussion at the meeting about mode of administration of medicines (oral, sub-cutaneous or patch).

Nutrition and hydration

- The guidance of the North West End of Life model prompts the nursing team to discuss eating and drinking with the patient, if appropriate, as it was not always a benefit to the patient to be offered food. As part of the trust's health care record review (1st April and 30th June 2015), in the 65 community notes examined only 54% had evidence that the benefits and burdens of food and fluids were discussed. This was shown to be an improvement on the previous review. A subsequent action plan was in place to improve compliance, which included the new EPOC documentation including an entire section for discussing nutrition and hydration with the patient and therefore all considerations could be recorded.
- There was a strong culture to provide comfort to patients at the end of their life and staff explained that nutrition and hydration needs were patient-led.
- The palliative care facilitators had developed an educational information resource named 'Bitesize a palliative care message', which gave staff a useful source of information about mouth care.

Technology and telemedicine

- At the time of the inspection, the Stockport End of Life Care Portal for Anticipatory Care (Stockport EPAC) system had not been rolled out to all users and was expected to be operational by March 2016. The system will allow all healthcare professionals to access patient details by all healthcare professionals involved in the patient's care.

Patient outcomes

- As a result of bimonthly case note audits, reflections were shared with staff in order to improve the care the patient received. An example shared with us was a mental capacity/consent issue.
- Both Stockport and Tameside and Glossop provided a respite service for relatives and carers of palliative patients. Relatives could request additional help if they needed support. Both teams did not meet the needs of the community and the team co-ordinator in Stockport had conducted an audit to examine the unmet need for respite in the Stockport area. At the time of the inspection, 70 patients on the caseload met the criteria to request respite care. The respite team could provide 22 day sits (between 3-4 hours) and 13 overnight sits 10pm –7am seven nights a week. The trust also had an intermediate care team that provided domiciliary care

and were able to provide some additional staff to the palliative team and therefore reduce the pressure on the service. Bank staff could also be used but funding was limited. An average of 32 day sits and nine night sits per month were refused between July and October 2015.

- The Macmillan palliative care lead nurse had undertaken a review of services in line with the Stockport Together integration work to determine how the respite services should function. The REaCH (Reablement and Community Home Support Service) team was part of adult social carers in house domiciliary care team. A proposal to merge the services was planned to enhance the patient outcome. The advantages would be reduction in duplication, reduce number of different professional arriving at a person's home, better use of the available resource with a single point of access. It will be one service with one point of access providing a 24 hour service.
- A rapid discharge process had been operating within Stockport since 2012. This was reviewed regularly to ensure patients were discharged, where appropriate, within 24 hours. In Stockport there was an enhanced rapid response support team employed by the trust along with the district nurse to provide the first 72 hours of care when the patient was discharged, though not necessarily end of life patients. Subsequently, care was transferred to district nurses in the community.
- Fifty-one GP practices in the Stockport area participated in the Gold Standard Framework (GSF) model of quality care. Monthly meetings held included the team involved in end of life care. Twenty GP practices in the Tameside and Glossop area had registered for the going for gold GSF programmes.

Competent staff

- End of life palliative care education was provided by well -trained and competent staff. There were full time facilitators for the hospital, care homes and community for Stockport and Tameside and Glossop. Staff had a variety of postgraduate qualifications, advanced communication skills, train the trainer and clinical qualifications such as advanced pain and symptom control.
- There was a comprehensive induction programme available to new staff working in the end of life component of the community. The package gave clear educational steps to competency. Trust facilitators trained staff on a 1:1 basis as well as group session training. The programme included five steps of learning that took place within the first six months of employment. This included an 'Introduction to End of Life care', 'Care of the dying person,' 'Care after death' and 'Supportive palliative care'. Levels of competency were checked at monthly intervals and visits to patients were accompanied.
- The trust provided figures for staff appraisal rates of 100% for specialist palliative care and Macmillan teams. Staff we asked confirmed that they had had a personal development review within the last 12 months.
- District nurses also completed a series of additional clinical skills training included dementia training, catheterisation and competency monitoring for syringe drivers and insulin administration. Staff attendance was recorded and up to date, in the training file, at the time of the inspection.
- The specialist palliative care team had a GP EOLC Facilitator who was involved in providing education and training. At the time of the inspection, 150 GP's had received education from this service.
- Staff caring for end of life patients were also given advanced communication training using the Sage and Thyme model in Tameside and Glossop. The Sage and Thyme model foundation level workshop was developed by members of staff at University Hospital of South Manchester NHS Foundation Trust (UHSM) and a patient in 2006, to teach the core skills of dealing with people in distress. Since 2013, 56 staff from Tameside and Glossop community services had attended the workshop. In Stockport a one day course discussing 'Handling difficult conversations' was available to staff and all specialist palliative care clinical team members had attended. A two day enhanced communication training was also available and between April 2014 and March 2015, 16 staff attended.
- The business group had supported some staff to undertake a Masters degree in Dementia over several years.

Multi-disciplinary working and coordinated care pathways

- Members of the palliative care team participated in multidisciplinary meetings (MDT) in both Stockport and Tameside and Glossop, working with other specialities to provide a holistic approach to care. During our inspection, we were able to observe a Stockport MDT meeting. A variety of specialists attended the meetings, including the SPC consultant, nurses from community and hospital, the SPC dietician, pharmacist and social worker. The hospice, chaplaincy and mental health liaison and the respite coordinator also participated.

- At the MDT, we saw discussions about patients who had died since the last meeting and follow up of patients previously discussed. There was evidence of good holistic care where patients' physical, psychological and social needs were considered by all teams.
- Learning was shared across the teams in a variety of ways. Each DN team met daily to discuss details of their end of life care patients and update other care providers such as the Macmillan nurses, REaCH team and GP's.
- Within each of the sets of records inspected, we saw evidence of multi-disciplinary working across teams. There was evidence of co-ordination of visits with local authority teams and multiple agency involvement.
- Both Stockport and Tameside and Glossop worked closely with their local hospices. Advice could be sought from the nurse specialists and clinicians at the hospice and staff attended meetings to share information.
- A multidisciplinary approach was taken to place a person on an end of life pathway' however a patient was also assessed by a doctor who was competent to make the decision. MDT meetings were held weekly in both Stockport and Tameside and Glossop.
- Stockport palliative care team were part of the strategic network for Greater Manchester, Lancashire and South Cumbria. The network was responsible for developing and improving end of life services across the North West.

Referral, transfer, discharge and transition

- A co-ordinated approach to transfer and discharge patients was in evidence at the MDT meeting and discussed with the Macmillan team in Tameside. The process included the input of the hospital involved with the patient, and the community teams including support agencies and equipment providers.
- We saw evidence of a rapid discharge process checklist that had been updated in July 2015. The checklist included the patient's preferred place of care, medication, Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) details signed by medical staff and useful information such as Macmillan team phone numbers and ambulance contact numbers. The document was thorough and facilitated a fast track discharge.
- An audit of the number of patients discharged in less than 48 hours of the decision to die at home was undertaken. The Stockport Clinical Commissioning Group (CCG) had a key performance indicator that 85% of patients should be home within 48 hours. From January-December 2015 90% of patients discharged from Stepping Hill Hospital were home within 48 hours. Of these, 45% were home within 24 hours.
- The End of Life Care Home Project Facilitator had supported care homes to facilitate preferred place of care and avoid unnecessary hospital admissions by providing a programme of education and support to implement changes in practice. Since the start of the project, a 36% reduction in deaths in hospital had been achieved by care homes that had taken part.

Access to information

- Patients could be referred to the palliative care team from many sources. Patients, relatives or carers, hospital doctors and GP's, district nurses or clinical nurse specialists and hospices all had a route to refer a patient for care. Information regarding referral criteria was accessible on the trust's end of life microsite, which was available to district nurses in the community, and phone numbers were available on the trust's internet page . [AJ3]
- We saw that information needed to plan and deliver care and treatment was shared appropriately in patient's records and available to relevant staff.
- Once a patient was identified as in the last days of life documentation containing all relevant information was attached to the notes including symptom control and good practice guidance.
- The electronic EPAC system would be available to the service later in the year. Patients' details were accessed via paper records in the patients home or on the trust database at the time of the inspection.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Specialist palliative care staff received training around consent and staff we asked understood the Mental Capacity Act and issues around Deprivation of Liberty Safeguards. Staff were trained to follow guidance of the Priorities of Care for the Dying Person which sets out how to manage a dying person who lacks capacity.

Good ●

Are services effective?

- The records we reviewed that had a DNACPR in place had been completed by the patient’s GP. Out of the nine sets of records that we inspected, we found one of the forms, was incomplete with patient’s details missing from the form.
- At the MDT meeting, the mental health team raised a discussion about mental capacity and incidences where the palliative care team became advocates for patients. The discussion was appropriate and demonstrated thorough knowledge from the teams involved.
- District nurses undertook training to care for patients living with dementia as part of their clinical skills training. The records we inspected stated that staff were compliant with training. Advice could be sought from the Palliative Care Dementia Liaison Nurse who was part of the palliative care team.

Good ●

Are services caring?

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

Summary

We rated the community end of life service as good for caring.

We were told that staff were sensitive, kind and compassionate. We spoke to nine patients and relatives and all said they were treated with dignity and respect and their wishes were acknowledged. Staff were sensitive to the emotional needs of patients and those close to them and mindful to respect their wishes.

Patient satisfaction surveys carried out in Stockport and Tameside and Glossop stated that all patients knew the name of their nurse, felt the nurse had improved their symptoms or problems and the nurse had listened to their wishes.

The service considered bereavement support as an important part of the end of life care process and kept in contact with the families after their relative had died.

Detailed findings

Compassionate care

- Patients were treated with dignity, kindness and compassion. Relatives we spoke with told us that staff were professional, supportive and kind. We were told that patients were treated with respect.
- A wife of a person at the end of life spoke at length of the care they had received. She said she felt supported and grateful that, because of the team, her husband's wishes were met. She said staff were exceptional, both her and her husband had been involved in decisions made and she felt informed of what to expect
- A Macmillan nurse explained the sensitivity required to gain the confidence of patients who had not come to terms with their condition. She gave an example of a patient that refused to allow a Macmillan nurse into his property and she respected his wishes and only returned when his condition had deteriorated and he had asked for help.
- Patient experience surveys had been carried out by both Stockport and Tameside and Glossop palliative care teams. In August 2015, 31 patients responded to Tameside and Glossop's survey. One hundred percent of patients knew the name of their Macmillan nurse, felt the nurse had improved their symptoms or problems and all patients felt listened to and treated with dignity and respect. One patient said, "I don't feel alone anymore, I can talk about my innermost feelings without upsetting my family". Ninety three percent of patients would not make any changes to the service, one patient wanted more frequent visits.
- The Stockport SPC survey was conducted in March and April 2015. Twenty-nine patients returned surveys which were posted back to ensure confidentiality. Sixty nine percent of the patients, who replied, were cared for in the community. All patients knew the name of the carer, thought the staff were polite and considerate and treated them with dignity and respect.

Understanding and involvement of patients and those close to them

- Patients and family members told us they had been involved in the decisions of care and asked about personal preferences. A wife told us that the Macmillan nurse had discussed the end of her husband's life with great sensitivity and knowledge. We saw documentation regarding patient's wishes written in the records we inspected.
- During the inspection we were able to witness interactions between patients and Macmillan staff. Staff were caring, practical and confident but supportive.
- Advice lines and contact details were given to patients when identified as requiring palliative care. Each patient was told the name of their Macmillan nurse. Leaflets and booklets were available to patients and carers giving advice. Contact details were also available on the trust website and a patient information leaflet with details of how to help a dementia patient eat well to download if needed.
- The respite teams were available to allow the relative's time to sleep or time in the day to leave the house and be assured the patient would be cared for. A service user told us how invaluable it was just to walk to the pharmacy herself and get some fresh air and exercise.

Emotional support

Good ●

Are services caring?

- Staff who cared for patients at the end of life told us that they were proud to allow people to die at home peacefully. Some district nurses wished they had more time to give and sometimes stayed with patients in their own time.
- We saw evidence of specialist nurses assessing patient’s emotional needs in their records. Staff had advanced communication training to help them have the difficult conversations with patients and family.
- Bereavement support was available for families offering practical guidance and support in the weeks following the death, and visits and support was offered to all families after their relative had died.

Good ●

Are services responsive to people's needs?

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

Summary

We rated the community end of life service as 'Good' for responsive

Services were planned and delivered to meet people's needs. There was an open referral system to the service and any member of the public could contact the team for advice or information.

The team had provided education for care home staff to allow more people to remain in the home instead of hospital transfer in their last hours.

If an urgent referral was made to the specialist palliative care team, the patient was seen within 24 hours and a plan put in place to ensure their needs were met. Patients[DW1] were given a named member of staff to contact, though some service users told us that it was difficult to reach individuals when not planned.

A rapid discharge service allowed seriously ill patients to be transferred from hospital quickly and equipment supplied as needed, usually within 24 hours.

There was a respite service available in both Stockport and Tameside and Glossop, that allowed the relatives time to sleep or time in the day to leave the house and be assured the patient would be cared for.

Regular surveys were performed and staff responded to negative comments with action plans and made changes, where possible. Three quarters of patients surveyed knew how to make a complaint.

Detailed findings

Planning and delivering services which meet people's needs

- The specialist palliative care consultant had three days protected time to visit patients in the community. He was able to hold outpatient clinics and provide domiciliary care.
- The specialist palliative care team assessed the needs of the population by monitoring patients referred to the team. By monitoring the time it took to see a patient after referral and the number of people who died in their preferred place meant that services could be planned to meet shortfalls.
- There were plans in place to merge the respite services provided by the trust with the carers provided by the local authority, this would streamline the service and hopefully fill the unmet needs of the community.
- The service recognised that number of care home patients that were transferred to hospital at the end of life could be improved and more people would prefer to die in the home. A care home facilitator was employed by the trust to provide education and support for care home staff. Care home forums had also been developed.
- Patient's experiences were surveyed every twelve months to monitor the service delivery and respond to feedback. In Tameside and Glossop a patient's husband was involved in a project to improve the service following feedback of his own experiences.
- A dementia liaison nurse was an extended member of the specialist palliative care Multidisciplinary Team (MDT) and was available to offer staff help and advice for patients living with dementia[DW2].
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Equality and diversity[DW3]

- All patients receiving end of life care were treated as individuals. This was evident from conversations with patients and reading health care record entries.
- Equality and diversity training formed part of all staff training and the IPOC forms contained a section regarding the individual's faith and beliefs.
- Patient information leaflets had details of how to get the leaflet in other formats such as large print, audiotape or translated into another language. There were also details of how to access the trust's interpreter service,

Meeting the Needs of people in vulnerable circumstances

- We spoke to relatives of end of life patients who told us that the team had provided all information they required. Leaflets were available entitled 'care and support in the last days of life' which provided relatives with invaluable information about what to expect. Staff also showed us bereaved carer support leaflets that district nurses and Macmillan nurses could share.

- A carer we spoke with wished to highlight some areas of exceptional care. A nurse had noticed an area of skin that was beginning to break down and had left the home and returned within the hour with cream to treat the area. Another staff member had arrived with an inflatable bowl and offered to wash her husband's hair. This was not necessary but added to the comfort of the patient.

Access to the right care at the right time

- Regular triage meetings were held within the Macmillan team to respond to phone calls and requests, as needed. Patients whose needs were urgent were prioritised and seen within 24 hours and patients with less urgent needs were seen within 10 days.
- The respite service had an open referral policy and anyone wishing to access the services was able to do so. However, at the time of inspection, services could not meet the demand and plans were in place to join with other service providers to improve the access.
- Contact numbers were given to palliative patients to discuss issues or request a visit. Families of people at the end of life were given a 24-hour number in order to reach help quickly. However, feedback from patient surveys in Stockport, and feedback from patients spoken with during the inspection identified that patients usually reached an answerphone and replies were not always received. The survey results were discussed at the team governance meeting and action plans to improve the telephone contact was included.

Learning from complaints and concerns

- The trust did not provide us with data as to how many complaints had been made against the end of life service; however, the business group gave details as to the percentage of complaints that had been dealt with satisfactorily (100%). Patients who participated in the survey said they would not need to know how to complain and only two issues were raised to us when asked. These issues were resolved and did not become formal complaints.
- Tameside and Glossop Macmillan team had received a complaint/ negative comment around two years ago regarding being able to reach a professional in an emergency. A working group was formed which included the relative, the Macmillan lead, a district nurse, a hospice nurse and a trust business manager. The result was the purchase of a mobile phone, which was carried 24 hours a day, and the number was only shared when a patient was within hours of dying.
- The Stockport respite team co-ordinator gave an example where there was a complaint against one of the team. The complaints process was followed and the problem resolved.
- The specialist palliative care nurse lead met monthly with the Deputy Director of Nursing to review any complaints or issues that involved the end of life service.
- As part of the patient's survey, people were asked if they knew how to raise a complaint. 71% from Tameside and Glossop and 76% from Stockport said they did. However, 93% of patients said they would recommend the service to others and one thought that the need to complain would never arise.
- When asked if improvements to the service could be made, many comments were “nothing” however communication with staff for example telephoning and leaving an answerphone message, was a problem. Patients said that you have no idea when your call will be returned.

Good 🟢

Are services well-led?

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

Summary

We rated the end of life care service for well led as Good.

The palliative care service had executive and non-executive representation on the trust board and senior managers told us they felt supported and had good communication with the executive team.

There were plans to merge services in line with Healthier Together and Greater Manchester devolution, which would positively impact on the service with the merger of teams and streamline the service provision.

Although staff engagement was poor, the management were aware and improvement plans were in place.

Staff were incredibly proud of the work they did and the culture was one of commitment for providing high quality end of life care that was patient focused.

Detailed findings

Service vision and strategy

- End of life care had representation on the trust board with the medical director representing end of life and a non-executive director, who was passionate about the service and the future plans to integrate the community and hospital services.
- The senior managers spoke of plans to merge the services of the palliative care team and create seamless care for patients. The Tameside and Glossop services were due to become part of a neighbouring trust in April 2016.
- Staff in Tameside and Glossop were unsure of the effects of the transfer to an alternative employer on their day-to-day work. Both specialist palliative care staff and community nursing staff told us there had been little communication with individuals from either Stockport Trust, as the outgoing employer or their incoming employer. The trust told us the staff terms and conditions would be the same under the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) directions.
- There were plans in place to re-model the provision of EOLC and the SPC team described themselves[AJ1] as being in a period of transition until the end of March 2016. At the time of our inspection the team had re-located to be hospital based, but despite some overlap was still primarily split into designated areas of either hospital or community. Future plans were to integrate into one team across the hospital and community services, with the named nurse following the patient between home and hospital, rather than handing over to the team.

Governance, risk management and quality measurement

- Specialist palliative care (SPC) in the community was managed within the structure of the business group. Performance figures and targets were an agenda item on the group meetings and issues were raised with the quality board.
- The trust had a governance framework in place that focused on the future changes within the region resulting from the Healthier Together and Greater Manchester devolution programmes The business group ran leadership forums, every two months, for staff that were band seven and above to promote trust strategy, network and generate ideas[DW2].
- There were no risks recorded on either the business services risk register or the trust wide risk register for the end of life community services but risks affecting the end of life service were recorded on alternative registers. However, some risks identified during the inspection, such as funding to support the essential training programmes and lack of supported medical cover were not on a risk register. Similarly, staff shortages in the district nursing teams was not recognised centrally and the impact of this on end of life care specifically, was not recorded.
- There was evidence that quality audits took place on a regular basis, though some were specific to hospital care, for example, Naloxone use in patients on long term opioids Subsequent action plans and quality improvements had been implemented.
- There were effective arrangements in place to monitor and manage quality and performance. An example of

Good ●

Are services well-led?

this was the implementation of the Individual Plan of Care and Support for the Dying Person in the Last Days and Hours of Life (IPOC) forms, following structured training across the trust.

Leadership of this service

- A palliative care consultant and lead nurse managed the SPC. Both told us they were well supported by their line managers and the consultant was in regular contact with the Medical Director to ensure there was an awareness of end of life issues at board level.
- We observed clear leadership for end of life care within the specialist community services. All staff we spoke with in leadership roles had a good understanding of the importance of high quality end of life care and we consistently heard from staff that end of life care was prioritised based on patient need.
- Staff in the community knew who the Chief Executive and some of the trust board were but said they felt remote from the day-to-day activities of the trust. Team brief was available via the trust intranet and the band six district nurse told us she regularly printed copies for staff to access.
- When asked if staff felt supported there were mixed responses. There had recently been changes to the middle management structure within the wider EOLC Stockport team and staff felt that they would benefit from better communication. Macmillan nurses in Tameside and Glossop told us that the support network within their team was excellent.
- Community staff were familiar with the Chief Executive ‘Choc and Chat’ meetings but stated that the pressures of their workload meant it had not been possible for them to attend.

Culture within this service

- Staff we spoke with were incredibly proud of the work they achieved. To allow someone to die with dignity and peacefully in their own home was their main objective. When asked what they would change, most staff told us that more time and more district nurses would be their goal.
- Good team working was evident in records and during the MDT meeting and minutes of meetings, we inspected. The priority across the team was to ensure the best possible care for the dying patient.
- Staff said they all felt valued by the patients and considered care of the dying person as their priority.
- Macmillan nurses told us they had excellent support from their manager and their peers. They felt they could share emotional, distressing situations with colleagues.

Public engagement

- Surveys from service users were undertaken and the feedback given was used to implement change where possible. For example, an action plan was to be developed to review arrangements when named patient contacts were absent.
- We were told that patients were invited to the monthly Quality Board to tell their story and share experiences of care.

Staff engagement

- Communication within the specialist palliative care team was good, with particular regard to sharing knowledge. The recently created training packages were excellent and sharing of information via meetings and the end of life microsite on the trust intranet was good.
- Community staff generally felt detached from the trust and some were unaware of the annual Pride of Trust award.
- The manager of the Macmillan team told us she had a good connection with her team and with senior management and the executive team. Staff confirmed the excellent management support they received.

Innovation, improvement and sustainability

- Plans to implement a joint respite service to provide additional support to patients were good. Multi-disciplinary working with other service providers was a good use of resources.
- The specialist care team facilitators within the GP, care home, and hospital and community services were providing Stockport with cohesive education that would ultimately lead to improved patient care.
- The trust was in the process of implementing the Stockport EPAC system. It was envisaged that, once fully implemented, this would improve the communication and access to records within the community.