

# Staffordshire & Stoke-on-Trent Partnership NHS Trust

R1E

## Community end of life care

### Quality Report

Staffordshire & Stoke-on-Trent Partnership NHS Trust

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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)
R1EG3	Staffordshire and Stoke-on-Trent Partnership NHS Trust - HQ	End of Life Care Team	Various sites across Staffordshire

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

## Overall summary

When we last inspected in 2015 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 (EOLC) services or to identify and manage risk. There was no overall vision, with no board leadership. Records were not always fully completed 'do not attempt cardio pulmonary resuscitation' (DNACPR) Order recording systems were not operating effectively.

The previous CQC inspection of this core service, conducted in November 2015, was rated inadequate because:

Safe was rated as requires improvement, effective was rated as inadequate, caring was rated as good, responsive was rated as requires improvement and well-led was rated as inadequate. A warning notice was issued in November 2015.

Overall we saw the service had made significant progress and had addressed the majority of issues raised within the 2015 Warning Notice, however, there was still more to be done but we saw the service and the trust had sight of these and were working to improve them.

There is now an EOLC vision and the director of nursing was now the executive board member providing leadership and in line with the trust-wide End of Life Care strategy. The service fast tracked patient's home as per their wishes in the last days of life and followed clinical quality indicators set by commissioners.

As found at the last inspection, EOLC patient records were not always fully completed for example the spiritual needs and carer support section. However, we found that DNACPR order recording was much improved. Systems were in place to establish patients' mental capacity and to make decisions about their welfare and care were followed. We observed and heard that all staff caring for EOLC 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 leads and specialist nurses.

# Summary of findings

## Background to the service

The trust provided end-of-life care community services across Staffordshire. Services were delivered in two divisions; North division and the South division, which were managed very differently. The trust had two palliative care consultant nurses in post, one in each area.

In the North division, the integrated service manager oversaw the community service. Six end of life care lead nurses and a nurse consultant offered a seven day service and also supported nursing staff responsible for the five inpatient beds at Haywood community hospital. Community nurses providing care to patients in their own homes, care homes and nursing homes were supported by the lead nurses. The palliative care coordination centre (PCCC) operated in the North division and coordinated end-of-life care services for patients from a range of available local providers.

There were no community hospital beds in the South division area, but teams worked closely with local Hospices in the area. Four community nurse specialists (3.8 WTE posts) 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. One nurse was a medicine prescriber.

Specialist services were provided by the nurse consultants in Palliative Care, the Macmillan Clinical Nurse Specialist Team (South Division only - with palliative medical consultant sessional supports) and the Palliative Care Leads. These teams have defined service specifications, and work programmes which reflected local and national priorities, requirement, standards, as well as specific local population needs and priorities as defined by local commissioners.

The Nurse Consultants and Macmillan Clinical Nurse Specialist Team undertake specialist assessment,

complex / complicated case managements, complex or complicated Advance Care Planning (ACP), complex symptom management. They offer clinical support to GP's / medical staff / other specialist and non- specialist Multidisciplinary Team (MDT) members, undertake specialist MDT case reviews, participate in teaching and provide face to face and telephone clinical advice. In the North division the palliative care leads form a core part of the home first clinical assessment teams. They work very closely with all of the GP practices / medical colleagues in the area, commissioner, and have access to a broad range of extended team members including; therapists, social workers, mental health and learning disability services. They also work closely with all other Specialist Palliative Care Teams across the health economy e.g. acute trusts, and other specialist teams e.g. respiratory and heart failure.

The End of Life Care Team may provide some of these functions as above and the Nurse Consultants plan, devise, deliver and evaluate a range of education and training programmes, lead end of life related audits, and lead on the implementation of national and local quality initiatives and work programmes. They provide direct and indirect clinical support to clinical staff / teams engaged in the delivery of general level palliative care. The Nurse Consultant additionally provides senior clinical leadership, through expertise in clinical practice, research / evaluation, service development, management and education.

Between 1 March 2017 and 28 February 2018 there were over 4790 referrals to the end-of life care community service.

During the inspection we spoke with 18 nurses, five patients and their relatives. We looked at the records of seven patients.

## Our inspection team

Our inspection team was led by an inspection manager. The team included CQC inspectors and a variety of specialists in adult community and end of life / palliative care.

# Summary of findings

## Why we carried out this inspection

This inspection was carried out using CQC's focused inspection methodology. A focused is more targeted looking at specific concerns rather than gathering a holistic view across a service or provider.

The focused inspection was triggered by the merger of the trust with South Staffordshire and Shropshire HNS Foundation Trust to form Midlands Partnership NHS Foundation Trust on 1 June 2018.

## 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 gained through engagement with the trust. We carried out an announced visit on 18 and 19 April 2018. Prior to the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people who use services.

We observed how people were being cared for in the community and hospital and talked with carers and/or family members and reviewed patients care records. We met with people who use services and carers, who shared their views and experiences of the core service.

## What people who use the provider say

- We heard unanimous positive feedback from patients and relatives who we spoke with. They were 'full of praise and thanks' for the support they received from the palliative care and end of life teams.
- Patients valued the personal, one to one support either in through a visit or a chat over the telephone.

## Good practice

- The Home First Model ensured that a person would receive appropriate and timely assessment, to meet all palliative and end of life needs in a person centred manner; following the 'Home First' principle. A Standard Operating Procedure (SOP) described the processes within the Home First Service for Fast Track Assessments for palliative patients, to support patient care, safety and flow through Home First Pathway.

## Areas for improvement

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

**Action the service SHOULD take to improve**

- Formalise arrangements to evidence the competence of the palliative care nurse leads and consultants.

# Summary of findings

- Ensure all sections of patient care plan were completed including the recording of emotional, spiritual or carer needs.
- Report incidents to ensure lessons are learnt and risks are reduced.
- Clinical supervision should be formally documented in staff records.
- Fully embed the practice of revisiting 'preferred place of death' (PPD) conversations with patients and their carers.
- Services in the South division should consider extending their service in line with NICE guidelines by offering a seven day face to face service.



## Staffordshire & Stoke-on-Trent Partnership NHS 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

Last time inspected this service we rated it as requires improvement for safe because;

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

On this inspection we have rated this service as good for safe.

This is because:

- Staff knew how to report incidents. The Macmillan staff described events that should have been raised as incidents but had not been.
- Staff were knowledgeable about their role and responsibilities in safeguarding vulnerable adults.
- Records we looked at demonstrated regular assessments of patients' needs relating to risks.

- There was good practice around hygiene and control of infection.
- Patients were provided with the equipment and medical supplies they needed.

### Safety performance

- Outcomes from root cause analysis (RCA) were fed into local area working groups to consider emerging themes and actions to reduce occurrence. For example palliative care staff attended pressure ulcer risk group (PURG) meetings where RCA investigations were reviewed and quality visits and assurance audits were arranged.
- There had been no safety performance issues reported within the end of life teams we visited.
- The safety thermometer check was conducted one day per month by the community nursing teams and the ward staff at the community hospital. The safety thermometer is a measurement tool for improvement that focuses on the four most commonly occurring harms in healthcare: pressure ulcers, falls, UTI (in patients with a catheter) and VTEs. Data was collected

# Are services safe?

by district nurses and collated by administrative staff. Team leaders had monthly oversight. We saw that recent results in both areas were 'green' (met targets for harm free care) and 'amber' (mostly harm free care).

## Incident reporting, learning and improvement

- There had been no incidents reported by the end of life teams. Community nurses told us that they knew how to report incidents using the reporting system however incidents were reported by the nurses delivering the care. When incidents were reported they were involved in the review process and received feedback from their manager. We saw evidence of shared learning from incidents across the organisation led by clinical champions within the steering group meetings. General learning from incidents across the trust was shared at team meetings and via email. Any urgent messages following on from incidents were discussed at the first available opportunity such as the daily handover.
- Community nurses told us knew how to report incidents and always received feedback. For example a patient had a morphine drip sited wrongly by a different service; an incident form was completed and a safeguarding referral were raised. Nurses received further training as a result of this. The patient was not harmed by this event.
- The Macmillan team described a scenario where the district nurses had not attended a patient call as planned. The patient was found in distress by the Macmillan nurse, two days. They immediately attended to their needs. This event had not been reported as an incident or highlighted to the district nurse manager. When asked, why they said it just comes back to their manager. They said they realised they should report more incidents but did not always see the value as the report came back to their manager in their office.

## Duty of Candour

- Staff we spoke with was aware of duty of candour (DoC) and the need to be open and honest during practice. Staff told us should they need to raise a DoC they would meet with the patient and their family and send a letter of apology.

## Safeguarding

- Staff were knowledgeable about their role and responsibilities in safeguarding vulnerable adults from abuse and they understood what processes to follow when reporting a concern. Staff were aware of the trust's safeguarding policy available on the intranet.
- There had been no safeguard referrals by the community end of life team and two in-patient hospital referrals. Trust wide data demonstrated that the trust target of 90% had been achieved in all areas for adult safeguarding training up to level three.

## Medicines

- The community staff did not handle medication in their advisory role. The prescription would be written by the nurse prescriber or GP. We did not see any prescriptions written whilst on inspection.
- The October 2017 pain assessment and medication authorisation in end of life audit identified four recommendations including a revised authorisation and administration record. Pain assessment tools were in place and ABBEY pain assessment scale was available for patients with cognitive impairment. The pain scale is an instrument designed to assist in the assessment of pain in patients who are unable to clearly articulate their needs.
- Syringe driver training was available and when completed logged on the electronic recording system. Whilst on a visit we saw a district nurse competently manage the review of a syringe driver in a patient's home and speak with the pharmacy regarding a delay in the delivery of some medication. Prescription charts were seen to be completed correctly, dated and signed and medicines were safely stored.
- We saw in the community hospital that anticipatory medicines were prescribed with relevant instructions.

## Environment and equipment

- The Macmillan team cleaned their equipment after each use and they signed a weekly cleaning rota when equipment was brought into the office to check and clean. Equipment such as thermometers were serviced as required.
- The ward environment at Haywood Hospital was found to be clean and tidy with no obvious trip hazards. Staff

# Are services safe?

told us they had the appropriate equipment to support the patients in the community hospital. Equipment at the hospital was part of the PAT testing and maintenance programme.

## Quality of records

- Patient records we saw during the inspection varied in their levels of completion. We looked at the records of seven patients. Not all care plans had the emotional and spiritual section of the care plan completed. We observed on one home visit that the main carer's needs and support was not documented in the individual patients care plan. Records audit results for 2017 showed results which ranged between 80% and 100%, with some areas rated between 55% and 70% for blank pages not scored through and signed.
- There was documented evidence of discussions with the patient and family/carers in regard to 'do not attempt resuscitation' order (DNACPR). The five orders we saw were completed appropriately however one had been completed by a nurse specialist and signed by the GP which is not in line with the trust policy.
- DNACPR forms seen in patient's notes were updated and reviewed. All the required information had been obtained including discussions with patients/family. Community nurses told us they always reviewed a patient's DNACPR if they were discharged from the hospital with one to ensure they contained all relevant information and were on the correct form. If the order was not on the correct form this was changed.
- The trust was compliant against this Quality Standard - the 'Last Days of Life Care Plan' was in place; participation by GP practices across the Local Health Economy (LHE) was poor and there was a resistance to introduce the plan and engage with the staff. This has been escalated to the Sustainability and Transformation Plans Board with CCGs devising a LHE-wide approach. The Quality Improvement Steering Group continues to monitor this on behalf of the organisation. The Last Days of Life Care Plan Audit (patients in their last days of life are appropriately supported) that was due to commence in January 2018 was to be replaced with a new audit that focused on the community elements of documentation from April 2018.

## Cleanliness, infection control and hygiene

- During patient visits in the community, staff were witnessed to follow good hand hygiene in patient's homes. Sufficient provision of personal protective equipment such as gloves, aprons and hand gel were available for staff and patients.
- The ward areas we visited were visibly clean. There were infection prevention and control systems in place to keep patients safe. Sufficient provision of personal protective equipment such as gloves, aprons and hand gel were available for staff and patients. Staff wearing uniform followed the arms bare below the elbow policy in the hospital and within patient's own homes.

## Mandatory training

- The trust provided records of mandatory training showing training compliance exceeded the trust target of 90% in most areas. Where training had not met the trust target records showed above 80% compliance; on line to meet or exceed the trust target by the end of April 2018. Basic life support and fire safety showed compliance above 80% in some areas.
- End of life staff we met told us they had received their mandatory training. Palliative care clinicians provided formal education for staff to increase individual's confidence and competence. For example, training to support verification of death.

## Assessing and responding to patient risk

- Records we looked at showed that assessments of patients' needs were recorded to minimise their risks and maximise symptom control. We saw that patients were regularly reviewed and risk assessments were effective.
- In the north team there was a 24-hour/seven day a week service for advice and visits for patients requiring assistance. Out of hours telephone advice was also available from specialist palliative care nurses or palliative care consultants based at the local hospice.
- In the south patients had 24-hour/five days a week telephone service for advice and face to face visits between 9 and 5pm. A telephone service for advice only was available at weekends, which did not meet the NICE guidelines. The telephone calls were triaged by a member of staff in the office and an answer phone was

## Are services safe?

available to ensure all calls were recorded and dealt with as soon as possible. If patients required assistance out of these times then they would be referred to their GP or local hospital.

- All staff told us they would call 999 for critical emergencies. If patients required urgent but not critical treatment, staff accessed the GP who was responsible for caring for the patient at home.

### Staffing levels and caseload

- End of life care was provided by community nurses, physiotherapists and occupational therapists across the county. The district nursing service delivering the care worked between 8 am to 6 pm, seven days a week. An out of hour's team worked between 6.30pm to 8.15 am enabling time for handover between themselves and day staff.
- The community specialist nurses were linked to GP practices and had a caseload of approximately 30 patients each. We were told that this was currently manageable but was assessed on a weekly basis to ensure visits and demand could be met.

- Haywood hospital provided five beds for palliative care patients and the staffing was arranged by the ward manager using the safer staffing tool.
- Staff worked in line with the 'Protection of Lone Workers Policy' (dated June 2017 for review 2020). This policy sets out the responsibilities, actions and procedures to be followed by all employees to ensure their safety when required to work alone either routinely or on an ad-hoc basis.
- The Macmillan team described a process to raise concern whilst on home visits and a text system to ensure their working day had been completed when working out of the office.

### Managing anticipated risks

- The winter management plan ensured that end of life care patients received a safe and appropriate level of service in adverse weather conditions. During poor weather conditions the team leaders prioritised the patient need with the skills available to manage palliative care patients.

# 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

Last time inspected we rated this service as inadequate for effective because;

- Documentation was poorly completed with no pain assessments evident.
- Care plans were seen to be out of date.
- Arrangements for the clinical supervision of the two palliative care nurse consultants were unclear and not carried out.
- The trust did not have any quality indicators for fast tracking patients who chose to die at home.

On this inspection we have rated this service as good for effective.

This is because:

- The 'do not attempt cardio pulmonary resuscitation' (DNACPR) Order recording systems were operating effectively.
- In all but one case DNACPR documentation was completed appropriately within community practice and the inpatient ward. One order was seen to be completed by a nurse and countersigned by a GP which is against trust policy.
- Completion of patient care plan records had improved since the last inspection.
- Systems were in place to establish a patients' mental capacity and decision making about their welfare and care were documented.
- The trust care plans for the replacement of the Liverpool Care Pathway were in place.
- Individual care plans were up to date with pain assessments completed and updated.
- The service carried out very local clinical quality audits led within the strategy group.
- EOLC staff had received an appraisal during 2017/2018.

However

- Clinical supervision was carried out but not formally documented in the Macmillan team.
- There were no formal arrangements in place to evidence the competence of the palliative care nurse leads and consultants.
- The trust recognised that there was still work to do to fully embed the practice of revisiting 'preferred place of death' (PPD) conversations with patients and their carers.
- Although the trust had initiated their own care plans since the removal of the Liverpool Care Pathway these had not been adopted by the GP's causing a delay in their full implementation.

## Detailed findings

### Evidence based care and treatment

- NICE quality standards for end of life care for adults Oct 2013 statement 3; modified from 2001 guidance was followed to ensure people identified as having palliative / end of life needs are offered a comprehensive assessment in response to their changing needs and preferences, with the opportunity to discuss, develop, and review a personalised care plan for current and future support and treatment.
- NICE guidance care of the dying adults in the last days of life 1.5.13; and 1.6. were adhered. The principles of pain management were followed using the dying person's preferences for how it is given. The use of an individualised approach to prescribing anticipatory medicines was followed for people who are likely to need symptom control in the last days of life specifying the indications for use and the dosage of any medicines prescribed.
- The strategic vision demonstrated that the trust were committed to providing high quality, well-coordinated person centred Palliative and End of Life Care, accessible 24 hours a day. It stated that services provided would be in line with best clinical practice and national standards (NICE, 2015; NICE 2011 /13 /17; National Palliative and End of Life Care Partnership, 2015) as well as service user feedback. Services would

## Are services effective?

be delivered by educated, supported and appropriately skilled professionals who promoted continuity of care, dignity and privacy and those close to the individual would be supported in their caring role and in their bereavement.

- The Board recognised that palliative and end of life care was a core function and a high priority / key strategic priority of the trust, as it cut across and was the end point for all clinical and care pathways. Outcomes achieved in palliative and end of life care were considered a mark of the quality and effectiveness of clinical practice and care delivery.
- The trust supported and endorsed the World Health Organisation 2002 Definition of Palliative Care: An approach that improves the quality of life of patients and their families facing the problems associated with life threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychological and spiritual care.

### Pain relief

- Pain relief and anticipatory medicines were prescribed by the nurse prescribers or the patient's own GP. The end of life staff were able to suggest advisory medicines which were written in the care plan to be considered should the symptoms develop.
- Patients we spoke with told us when they did have pain it was well managed.
- Community nurses now had a greater understanding of pain control due to the palliative care lead inputting a wealth of training for them. Specialist palliative care advice was available 24/7 via the telephone services.

### Nutrition and hydration

- Although not responsible for the management of patient's nutrition and hydration the specialist palliative care nurses would alert community nurses if they felt referral to the dietician was required.

### Patient outcomes

- All community nurses had a good understanding end of life care, how to keep patients comfortable and how to meet their needs in respect of physical comfort, pain relief and emotional care. One community sister had a very good understanding of patients with palliative care needs and had previously worked in oncology.

- The trust had 22 Commissioning for Quality and Innovation (CQUIN) National Goals for the north team. Of these goals 13 had been completed; five were behind schedule and four on schedule to be completed. The palliative care centre dashboard (North/Stoke) identified that 100% of patients had their preferred place of death recorded in an individualised care plan with a DNACPR order in place. Of those patients 75% achieved their preferred place of death.
- In the South a CQUIN aimed to explore the issues and factors that affect the achievement of the preferred place of death (PPD) for patients receiving end of life care who have a Staffordshire or Stoke on Trent GP. 42% of the overall data was collected for patients who did achieve their PPD.
- There was evidence that re-visiting the patients PPD when there are significant changes in their health and/ care aids the effective reporting of achievement of PPD. Where a person's needs and preferences change during their last days of life it is important that the PPD is revisited to ensure that services are able to demonstrate accurately the responsiveness to this. Otherwise there is a danger that in some cases failure to achieve PPD is reported as a 'false positive'.
- During 2017 a re-audit was launched to measure the compliance of the DNACPR orders on all wards against the trust's DNACPR Policy from documented evidence within the patient's records. This was undertaken to ensure all active DNACPR orders in place were fully completed to monitor quality improvement by comparing previous quarter results with the previous quarter results, and to ascertain whether changes to practice that were made have had the desired effect. Eight out of the 11 questions met 100% compliance where the DNACPR order was completed correctly. The three areas which required improvement in Q3 had improved in Q4 related to completion of the form, welfare attorney being informed and communication with relatives.
- The trust recognised that there was still work to do to fully embed the practice of revisiting PPD conversations with patients and their carers. They recognised that the promotion of the last days of life care plan was one way of addressing this issue in practice and strengthened by the communication training programme for staff supporting difficult conversations.



## Are services effective?

- We observed care being delivered and saw that staff made every effort to ensure people's needs were met. Staff told us the importance of ensuring that support for relatives was recognised, medicines were delivered and the necessary equipment was provided.

### Competent staff

- Each team had access to a reference folder in their office where they could find up to date information on the appropriate assessment material. Access to specialist advice and support was available such as dietetics and physiotherapy.
- Training for end of life nurses included fast track and early recognition, advanced care planning and communication and last few days of life and symptom management. Clinical supervision was completed in group sessions and some 1:1 sessions but the MacMillan manager told us they did not formally document it. Staff attended palliative care update days and their individual palliative care competencies were checked.
- The staff appraisal process encouraged staff to pick a priority from the strategy. They then added personal objectives to promote theirs and a team objective. All staff we spoke with had received an appraisal for 2017/2018.
- Staff adhered to Gold Standard Framework for palliative care patients which were displayed on the office wall. One of the band 5 nurses based at Meir had recently completed a palliative care master's degree. Nurses were offered syringe driver training, three day course which is required to be updated every two years. We saw this was on track.

### Multi-disciplinary working and coordinated care pathways

- Patients confirmed and records demonstrated that there had been effective multidisciplinary team working between specialist nurses, district nurses, occupational therapists, physiotherapists and GPs.
- Access to the five inpatient beds at Haywood hospital was managed by a single point of access. The community hospital received referrals from GPs or the community.
- We were told that delays in hospital discharge were mainly due to lack of care packages available for patients in the own homes. The trust did not monitor the timeliness of rapid discharges.

- The Home First Model commenced in the North during September 2017. The outcome of the process was that a person will receive appropriate and timely assessment, ensuring all palliative and end of life needs are met in a person centred manner; following the 'Home First' principle.
- This step up / step down model used a track and triage process in a control room set up at UHNM. Complex discharges were identified on admission and patients were discharged home with a Home First package and received an assessment from the Home First Team within 24 hours. Any equipment required was ordered by the hospital. A Standard Operating Procedure (SOP) describes the processes within the Home First Service for Fast Track Assessments for palliative patients, to support patient care, safety and flow through Home First Pathway. Many of the processes currently only apply from a neighbouring trust and in the Northern Division.

### Access to information

- Community staff had access to each patient's care plans and risk assessments as they were retained in their home.
- Hospital staff had access to both nursing and medical records within the community hospital. GP's were informed when their patients were admitted or discharged from the inpatient beds.

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

- On this inspection nursing staff were knowledgeable about the trust policy and processes to follow when a patient's ability to give informed consent to care and treatment was in question.
- Staff were able to share their understanding about consent in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- We observed community staff gaining informed consent appropriately prior to carrying out a home visit.
- We reviewed five do not attempt cardio pulmonary resuscitation forms (DNACPR) and found they were completed accurately. One form had been completed by the nurse specialist and signed by the GP which is against the trust policy. We escalated this to the senior management team.

## Are services effective?

- A DNACPR audit dated 2017/2018 showed evidence of some discussion with the patient and their family in relation to the DNACPR order and exceeding the trust target of those audited above 90% clearly identified that the form was in the front of the patient records.



# Are services caring?

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

## Summary

Last time we inspected we rated this service as good for caring.

On this inspection have rated this service as good for caring. This is because:

- We observed nursing staff respectfully supporting palliative care patients in their own homes and within Haywood hospital.
- The nurses offered support and advice in a compassionate manner, giving patients and carers' time to ask questions.
- Hospital staff were aware of their role in supporting palliative and end of life patients. The end of life tracker held at trust level identified that some nurses were not competent to undertake difficult conversations with patients. Most staff had now attended training to overcome their fears.

However

- Not all patient records that we looked at were seen to include a record of carers' needs or the patients' psychological or spiritual goals.

## Detailed findings

### Compassionate care

- When we accompanied palliative care lead nurses visiting patient's in their own home, we observed them to be polite, respectful and compassionate on all occasions. They gave introductions and checked that the patients could hear them and was comfortable. We observed staff promoting privacy and dignity in the patient's home.
- Nurses showed compassionate and emotional care and looked after the family as a whole. We observed an open rapport conversation with good eye contact which was engaging.

- We saw that there were some gaps in the care records where the recording of emotional, spiritual and carer need was to be noted.
- Families and patients unanimously told us that the staff were all amazing, caring and thoughtful.
- Patients told us they were given the opportunity to express their feelings and describe their symptoms without feeling rushed. On one visit the patients' wife and friend were also engaged in the conversation.
- The lead nurses offered advice only but they left support plans for the district nurses to observe should further intervention be required. Community nurses were seen to be very caring showing a great understanding of patients' end of life needs. A nurse said, "Ensuring a patient has a good and dignified death is part of my job".
- Staff were given time to visit bereaved relatives whom they had built a relationship with.

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

- Patients told us that they were fully informed about their care plan and felt supported by the palliative care nurses.
- Relatives we spoke with also felt supported and able to contact the nurses as required.

### Emotional support

- As during the previous inspection we found that not all patient records that we looked at were seen to include a record of carers' needs or the patients' psychological or spiritual goals.
- Relatives we spoke with in the patient's own home told us that the team were supportive and listened to their concerns. They were assured that their risks had been appropriately assessed and monitored. We were told that contact numbers had been given to patients should they need some advice in between calls.
- Patients told us that the nurses worked closely with the GP's and referrals to the social services could be arranged if further support and assistance was required.

# Are services responsive to people's needs?

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

## Summary

Last time inspected we rated this service as requires improvement for responsive because;

- The trust did not have any quality indicators for monitoring the response times when patients were referred to the palliative care team
- Not all care plans were holistic and individualised to meet the patient's unique needs.

On this inspection we have rated this service as good for responsive

This is because:

- The trust followed quality indicators for monitoring the response times when patients were referred to the palliative care team.
- Nurses told us pain management, communication; care planning and preferred place of death had all improved since the last inspection due to good palliative care leadership and training.
- Data provided by the trust showed that 100% of End of Life Care staff had completed Equality, Diversity and Human Rights training.
- Patients admitted into one of the five community hospital beds were specifically under the care of the end of life care team

However we also found that:

- We observed that the telephone triage process in the MacMillan office went to answerphone whilst we were in the office and the calls were not returned until some hours later that afternoon.
- Services in the South division were not in line with NICE guidelines of a seven day service as they offered only a five day 'face to face' service with weekend telephone advice only.

## Detailed findings

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

- The Macmillan teams operational policy stated that all patients referred to the team would be contacted within five working days (routine) and one working day (urgent). Between March 2017 and March 2018 the team

achieved this target (97.5%) for all but seven patients referred (2.5%). The review identified the delays were due to a large increase in referrals at the time of staff sickness, annual leave or bank holidays. All response time deficits were recorded, reviewed and discussed at the weekly meeting as per the Standard Operating Procedure (dated 2017 for review 2019).

- The community hospital provided a step down function; with on average 70% of referrals coming from acute hospitals, 3% of referrals from A&E and 13% from GPs. 11% of referrals come from other referral sources, which could include self-referrals.
- The average waiting time from referral to commencement of service was 2.0 days. Bed occupancy rates remain high at 91%, consistent with reporting from previous years. The average length of stay remained just under one month at a duration of 27 days. 61% of service users were discharged home, with 14% being discharged to an acute hospital.
- The 'Purple Bow' scheme was launched by staff in the community hospital to focus on ensuring the highest level of dignity for patients during their 'end of life' care. We saw that the purple bow initiative was promoted on the inpatient ward to ensure patient dignity, privacy, independence or individuality was not compromised by healthcare interventions. The uses of sensitive, purple bow signage on side room doors, bay curtains etc., discreetly highlights to all hospital staff that a person is nearing the end of life and that their family or friends may be present. Part of the scheme's success has been the improvement in communication between staff and relatives. The programme helps staff provide extra support when required, such as offering refreshments, keeping noise to minimum and checking if relatives or carers may need any additional support.
- The trusts 'customer service and experience' team have worked in partnership with the north community hospital ward and palliative care lead actioning improvements in the 'supporting bereavement project'. Within quarter three they have reviewed the following

# Are services responsive to people's needs?

areas i) end of life purple bow scheme, ii) the process of issuing of death certificates, iii) dealing with personal belongings, iv) pets at end of life and introduction of a Chaplaincy directory.

## Equality and diversity

- Data provided by the trust showed that 100% of End of Life Care staff had completed Equality, Diversity and Human Rights training.

## Meeting the needs of people in vulnerable circumstances

- Nurses told us pain management, communication; care planning and preferred place of death had all improved since the last inspection due to good palliative care leadership and training. Patients with dementia, learning disabilities and other health issues were supported by specialist nurses and link nurses.

## Access to the right care at the right time

- Between April 2017 and March 2018 there were 156 deaths on the Macmillan CNS caseloads and of these 100 patients had requested home care and 89 achieved this, eight patients had requested hospice care and 33 patients died in Katharine House Hospice, zero patients had requested hospital care however, 34 patients died in local hospitals.
- Between April 2017 and March 2018 the Macmillan team achieved 100% response rate for eight of the twelve months. The four existing months results were 92 - 95%.

## Learning from complaints and concerns

- Community and inpatient staff told us they had not received any complaints in relation to end of life care.
- Patients in the community hospital had access to the Patient Advice and Liaison Service (PALS) who provide advice and support to NHS patients and their relatives and carers. We noted information on how to raise a concern or make a complaint available in the hospital.

# 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

Last time we inspected we rated this service as inadequate for well-led because;

- There was no overall vision for End of Life Care services.
- No Board representation and no recognition of the trust-wide End of Life Care strategy group.
- Systems and processes were not sufficiently established to effectively improve the quality.
- Safety of end-of-life care services and senior staff felt their voice was not heard by leaders in the trust.

This time we have rated this service as good for well-led.

This is because:

- There was a clear vision for End of Life Care services, executive board representation and a trust-wide End of Life Care strategy which front line staff were aware of and bought into.
- We heard that since the last inspection the strategy was 'everyone's business' and the vision had improved team working.
- A quality improvement and assurance plan 2017-2018 was developed to take the trust beyond those actions developed in the response to the CQC inspection in November 2015. Nine of the eleven actions had been achieved.
- Processes were established to effectively assess, monitor and improve the quality and safety of end-of-life care services.
- Since the last inspection the team approach was positively welcomed. The new programme stimulated and supported changes in practice. There is evidence of improvements in establishing and maintaining standard of good practice e.g. pain assessment, medication authorisation and administration, and verification of death.
- Nurse consultants and clinical leads influenced the strategic and operational management arrangements. They felt their voice was now heard and their service was fit for purpose.

## Detailed findings

## Leadership of this service

- The end of life steering group was chaired by the Director of Nursing and Quality who is the executive lead for end of life who reports directly to the board. The Director of Nursing and Quality made recommendations to the SSOTP Quality & Safety Committee and Trust Board through the End of Life annual report.
- Members promoted and led the development of high quality co-ordinated palliative and end of life care across the organisation and other stakeholders. They monitored and assured the group that incidents, themes and achievement of national standards, measures and markers for end of life and palliative care were achieved. The work of this group linked in with other work programmes within and outside the organisation e.g. long term conditions management.
- Since the last inspection end of life care has been included in the board meetings. The director of nursing now the lead and they promote the service by being a voice promoting strong leadership to take the strategy forward.
- Community nurses in the North and South told us they felt very well supported by palliative care lead; they offered lots of advice and were always available.

## Service vision and strategy

- The trust followed a 'Palliative and End of Life Care Strategy 2017' to promote the best possible quality of life for each individual (and those important to them) that has a life limiting and progressive condition from which they are not expected to recover. We heard that the since the last inspection the strategy was 'everyone's business' and the vision had improved team working.
- The Palliative and End of Life Service aimed to keep patients in their preferred place of care and strive to achieve the highest quality outcomes for patients and their families. The service includes streamlined and accessible end of life services, respite in community hospital for symptom management, a central, first point

## Are services well-led?

of contact for community services for health and social care professionals, expert support in palliative care clinical decision making and a Macmillan clinical nurse specialist team (Stafford).

- The Operational Group acted as a conduit for staff from across the trust to influence areas relating to palliative and EOL care that have operational significance within the divisions. It was a forum to develop, revise, update and implement the Palliative and EOL Care Strategy, and documents arising from it in line with the Project Plan. It supported learning from incidents and complaints and shared good practice across the organisation and feed into service development.

### Governance, risk management and quality measurement

- A quality improvement and assurance plan 2017-2018 was developed to take the trust beyond those actions developed in the response to the CQC inspection in November 2015. Eleven assurance actions were developed to capture key issues. At the time of the inspection nine actions were completed, one required further evidence and one was partially completed. The partially completed action referred to the GP's support in taking forward EOLC documentation.
- There were two risks recorded on the risk register during 2017/2018 which were now both closed; their outcomes monitored to ensure lessons had been learnt. These two risks related to the prescribing of anticipatory medicines and the recording on standardised prescription charts which we saw were now in place.
- Gold Standard Framework meetings took place with GPs, where sharing of palliative care information took place.
- Since the last inspection the team approach was positively welcomed. The new programme stimulated and supported changes in practice. There is evidence of improvements in establishing and maintaining standard of good practice e.g. pain assessment, medication authorisation and administration, and verification of death.
- Staff told us that decision making had become a valued team discussion linked to confidence building within the teams. The combined team showed evidence of

integration and improved performance through case management, utilising resources more appropriately and the use of the communication board where patients were seen at a glance.

### Culture within this service

- We were told that since the last inspection there had been a great improvement in the culture of the organisation. The staff were encouraged to work collaboratively and the voice on the board had promoted their service.
- Team meetings were formal and minuted and available on the intranet. Staff were encouraged to be link nurses and work with other specialities to bring back fresh ideas, learn from previous experiences and share up to date knowledge. There were now clear lines of accountability for sharing information to the senior management through the steering groups.

### Public engagement

- We saw that GP's were contacted about the reconfiguration of the community teams to ensure they were engaged with the process.
- Patients and their families were informed about the reconfiguration of the community teams during their home visits to ensure they were familiar with the process.
- The trust sent us data to show they regularly sought and acted upon patient feedback. Each team had to send out a set number of feedback forms per month and the results of these were then analysed. Any negative feedback was acted upon where possible.
- We saw that local partners were consulted with when service redesign was indicated. This ensured feedback from these partners was obtained and considered before making decisions about the future of services.

### Staff engagement

- Staff had access to briefing, board papers and updates via the intranet.
- Staff engagement events were held to ensure staff had the opportunity to engage with the process of the planned merger by another local trust. Staff told us they were asked for their input regarding the new name for the combined trust.

## Are services well-led?

### **Innovation, improvement and sustainability**

- As part of their development course a Band 5 nurse created a spreadsheet to monitor patient journeys for patients with palliative care needs.
- To support the younger, more mobile patient's lifestyle a drop in clinic had been introduced by the Macmillan team based at Katharine House Hospice. This was a nurse led clinic, held once a week. The nurse had access to on site consultant advice should the need arise.
- The palliative care leads have been working with 28 care homes to avoid hospital admissions where possible by training the care home staff to be confident in 'next steps' and health competencies. The team won a Nursing Times Award 2016 for their work in this area.