Care Quality Commission

Northern Lincolnshire and Goole NHS Foundation Trust

RJL

Community end of life care

Quality Report

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Summary of findings

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

Summary of findings

Ratings

Overall rating for the service	Good	🟢
Are services effective?	**Good**	🟢
Are services responsive?	**Good**	🟢
Are services well-led?	**Good**	🟢

Summary of findings

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Summary of findings

Overall summary

During our last inspection in October 2015 we rated end of life care as requires improvement for effective, responsive and well-led because:

- There was no internal end of care strategy for Northern Lincolnshire and Goole NHS trust.

- The trust had taken part in the 2014 National Care of the Dying Audit (NCDAH) and achieved three out of seven organisational key performance indicators (KPI's). In relation to clinical KPI's, the trust was better than the England average in only one out of ten areas. It was worse than average in eight out of ten areas, including communication regarding the patient's plan of care for the dying phase.

- We noted that national guidance was not followed in as much as the 'do not attempt cardiopulmonary resuscitation' forms (DNACPR) were not audited in the community. It was not known therefore whether decisions were made appropriately or if they were documented clearly.

- There had been a significant number of end of life patients (600) admitted to hospital who had died within 24 hours who could have died at home with responsive support.

- Staff told us the delivery of care in someone's preferred place was a priority, however there was no data to support this as no audits had taken place.

- Arrangements for monitoring quality of services could be improved; there were gaps in service performance measures. This meant it was harder for the trust to take action to improve performance and the delivery of the service.

- We found there was disconnection between the trust board and staff in the community.

At this inspection, we rated this service as good. This was because:

- The trust had been part of a multi-agency group that was set up to devise and implement an end of life care strategy that encompassed the whole of the local health economy. We looked at the document and found that the vision and purpose of the strategy was to ensure that appropriate care was provided in the appropriate setting at the right time, and to ensure that access to care was seamless and easy, and that the patient's needs and wishes were central.

- Following ratification of the end of life care strategy in June 2016, seven work streams had been developed by the trust, with a member of the senior team having overall responsibility for a sub-working group. These included working groups on; education, bereavement, palliative care, do not attempt resuscitation, long-term conditions, IT, and children and neonatal. Each group met separately and we saw action plans that had been developed, to meet the required outcomes of the strategy. This meant that arrangements for monitoring the quality of services was improving and the trust were taking action to address actions identified from the work streams' data collection and the National Care of the Dying Audit.

- We saw that since our last inspection the number of patients receiving care at the end of life who had died at home had increased whilst the number of patients who had died within the hospital setting had significantly reduced.

Summary of findings

Background to the service

End of life care is delivered by community staff throughout the Northern Lincolnshire area. There was a multi-disciplinary team approach to end of life care. Specialist palliative care nurses, community nurses, Macmillan healthcare support workers, therapists, social workers and doctors all worked together for the benefit of patients and their families. The specialist palliative care team (SPCT) provided support and advice for patients with complex needs and symptom management at the end of life. The SPCT also provided training to care home staff and home care agencies with a seven day remit.

A physiotherapist and an occupational therapist were in rotational posts within the specialist palliative care team and there was a team of community Macmillan healthcare support workers who delivered 'hands on' care to people in their own homes. There was a clinical psychologist who offered a range of therapies for end of life patients. There had been a rapid response equipment team put in place since our last inspection who could obtain equipment within a two hour timescale to minimise hospital admissions and improve discharge arrangements.

The SPCT were based in Scunthorpe; there were 5.2 whole time equivalent (WTE) nurses, plus administrative support. The SPCT were aligned to GP practices and had recently begun to deliver a seven-day service. The community nurses were based at three locations around the area (known locally as 'patches' or 'clusters') and were based with social workers as part of integrated teams. The community nurses were managed by a 'patch' team leader. The community Macmillan healthcare support team was based in Scunthorpe and covered the wider geographical area. There were 10 specialist nurses

and 32 healthcare support workers were also managed by a patch team leader. One palliative care consultant had recently been appointed and worked across both hospital and community services. There was an 'unscheduled care' team of nurses to support patients to remain in their own home or care home, if safe to do so, during an episode of acute illness.

The health of people in both North and North East Lincolnshire is generally significantly worse than the England average. The areas are within the most deprived regions compared to other local authorities.

Within North Lincolnshire, there is a forecast that approximately 1,250 people per year will require end of life services. Around one in three deaths occurred amongst people aged over 80 years. A large majority of these deaths currently follow a period of chronic illness such as heart disease, diabetes, cancer, stroke, chronic respiratory disease, neurological disease or dementia. The number of deaths is predicted to rise by 17% by 2030. The average age at death is also predicted to increase and those dying will have increasingly complex co-morbidities. Services will need to adapt to be able to meet this increased need.

Before our inspection, we reviewed information from the trust about community end of life services. During our inspection, we visited a patient and their family in their own home and observed care being given by a community nurse. We looked at the records of four patients receiving end of life care. In total, we spoke with 17 staff including; community matrons, community nurses, specialist palliative care nurses, healthcare support workers, and senior managers.

Northern Lincolnshire and Goole NHS Foundation Trust

Community end of life care

Detailed findings from this inspection

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

Following our last inspection in October 2015, we rated effective as requires improvement because:

- There was no local end of life strategy or related performance indicators to measure the success of the service.

- We saw that staff used national guidelines, however the use of clinical audit could have been improved to determine the effectiveness of care. It was not possible to tell if patients' preferences at end of life were met, as preferred place of care was recorded, but not audited.

- Trust data indicated that a large number of end of life patients admitted to hospital in 2014 died within a short time of admission. A review of some of these patients indicated they may not have required a hospital admission if more end of life care services were in place. A number of these patients did not have advanced care plans in place; the implementation of such plans may have reduced unnecessary admissions for patients into hospital. The trust recognised this was a significant weakness and they were taking action to address this.

- The trust had taken part in the 2014 National Care of the Dying Audit (NCDAH) and achieved three out of seven organisational key performance indicators (KPI's). In relation to clinical KPI's, the trust was better than the England average in only one out of ten areas. It was worse than average in eight out of ten areas including, communication regarding the patient's plan of care for the dying phase. Action had been taken to address the audit findings; an individualised care plan and last days of life assessment and care plan were being piloted.

- We noted that national guidance was not followed in as much as the 'do not attempt cardio pulmonary resuscitation' (DNACPR) forms were not audited in the community. It was not known therefore whether decisions were made appropriately or if they were documented clearly.

Following this inspection we rated effective as good because:

- The trust had been part of a multi-agency group that was set up to devise and implement an end of life care strategy that encompassed the whole of the local health economy. We looked at the document and found that the vision and purpose of the strategy was to ensure that appropriate care was provided in the appropriate setting at the right time, and to ensure that access to care was seamless and easy, and that the patient's needs and wishes were central.

- Following ratification of the end of life care strategy in June 2016, seven work streams had been developed by the trust, with a member of the senior team having overall responsibility for a sub-working group. These included working groups on education, bereavement, palliative care, do not attempt resuscitation, long-term conditions, IT, and children and neonatal. Each group met separately and we saw action plans that had been developed, to meet the required outcomes of the strategy. This meant that arrangements for monitoring the quality of services was improving and the trust were taking action to address actions identified from the work streams' data collection and the National Care of the Dying Audit.

- We saw that since our last inspection the number of patients receiving care at the end of life who had died at home had increased whilst the number of patients who had died within the hospital setting had significantly reduced.

- The trust's care in the last days of life document was now embedded in practice in the community and this included the patient's preferred place of death.

- There had been an increase in the number of patients who died in their own home due to increased recognition of patients who were in their last days of life and seven day working practices in the specialist palliative care team, therapies and equipment provision. There had been a significant decrease in those patients who had died in hospital.

- Patients' care and treatment was in line with current legislation and best practice guidance.

Are services effective?

- There was a multi–disciplinary approach to care and treatment.

- There was proactive engagement with other health and social care providers. Referral, discharge and transfer was planned to ensure the patient had access to timely care.

- Staff received an induction and had access to a comprehensive training plan.

- Staff understood the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS).

Detailed findings

Evidence based care and treatment

- Patients received care according to National Institute of Clinical Excellence (NICE) guidance NG031 'Care of dying adults in the last days of life' published December 2015; Leadership Alliance for the Care of Dying People 'One Chance to Get it Right' published 2014, and 'Actions for End of Life Care 2014- 2016', fromNHS England.

- The service had developed a document called 'Care in the last days of life', which was based around the five key care components as defined by the Leadership Alliance. These were: recognise, communicate, involve, support, plan and do. The document included a variety of clear pathways and included guidance on symptom relief such as pain, vomiting and agitation.

- This document had been piloted in some areas and then ratified for use for all patients in April 2016. An audit of twenty standards had recently been completed; this included the discussion and documentation of patient's end of life care wishes. The results were not available at the time of our inspection.

- Staff had received training and had a good understanding of the documentation and used the document effectively in the community setting. We saw the document in use and completed appropriately.

- The SPCT delivered care in line with evidence-based guidance such as the North Lincolnshire End of Life Care Network and trust end of life care guidelines. The guidance was available on the hospital intranet with hard copies available in clinical areas.

- The SPCT participated in the Sub Regional Palliative & End of Life Care Group and the Yorkshire and Humber regional DNACPR strategic working group.

Pain relief

- Pain relief was available for patients, we found pain relief was prescribed correctly and reviewed for effectiveness. We observed that patients' pain levels were assessed and reviewed in the community and saw that they assessed the type and duration of pain as well as factors that made the pain worse.

- We saw that where appropriate, patients had syringe drivers which delivered measured doses of drugs at pre-set times. All qualified nursing staff were trained in the use of syringe drivers.

- We saw clear pathways in the care in the last days of life document regarding pain relief and this included prescribing of anticipatory drugs to ensure that there was no delay in pain relief. We observed that this was being practised. The 'Care of the last days of life' document also included guidance for staff to contact the Macmillan team if patients on morphine-based analgesia developed breakthrough pain.

- There had been an audit of anticipatory pain relief in October 2015 and May 2016. This showed an increase in the number of patients who had been prescribed anticipatory medications.

- We observed staff reviewing a patient who was no longer able to take medication by mouth. Staff completed an assessment of the patient's needs and this determined that a syringe driver was appropriate. A syringe driver was arranged and provided following the assessment. There was also a discussion with the patient's GP who had arranged a home visit to ensure pain relief was optimum.

- We saw that pain relief was an integral part of the last days of life document and that this was also discussed between professionals in multi-disciplinary team meetings.

- Staff told us they worked closely with local pharmacies to ensure there were adequate stocks of appropriate medicines for end of life care patients and that these were available as needed both during the day and out of hours.

- There was one incident during our inspection where a general practitioner had prescribed the correct dose but this was not clear on the prescription sheet. The community nurse had questioned this and the situation was immediately rectified with the general practitioner.

Are services effective?

Nutrition and Hydration

- Community nurses worked with families to understand the nutrition and hydration needs of their patients.

- Staff talked with carers about the changes in the patient's food and fluid intake when they were at the end of life. We observed a community nurse reassuring a relative, who was anxious, that a decrease in nutritional intake was a natural development in the last few days of life.

- We observed an assessment of a patient's nutrition and hydration during a home visit and this was documented in the care in the last days of dying document. Assessments incorporated patient choice, comfort and prompts for staff to make nutritional decisions in the best interests of patient without the mental capacity to make their own decisions. This took into account any known prior preferences and wishes and was in consultation with the person's family, carers and other members of the team.

- There was a strong culture of comfort requirements at the end of life and staff we spoke with were clear that nutrition and hydration needs were led by the patients.

- Specialist palliative care staff told us they provided advice about nutrition, hydration and regular mouth care to promote comfort at the end of life, to other staff on a regular basis.

- We saw guidelines for staff for clinically assisted nutrition and hydration (drips and artificial feeding), and how to seek advice from the SPCT in the event of this being discussed.

Patient outcomes

- Following our previous inspection, we were concerned that a significant number patients (600) who were at the end of their life were admitted to hospital and died within 24 hours of admission during 2014.

- The trust had identified that the recognition, by staff, that patients were approaching the end of their life was not robust. Recognition of end of life was now part of the work being completed by the strategy work stream groups. The service now collated this data and this showed that, since October 2015, of the 445 patients who were on the end of life pathway, only 60 patients had died in hospital.

- Information provided by the trust indicated, that in July 2016, 90% of patients had died in their preferred place of care.

- The service reviewed and audited the caseload for palliative care every two months and had agreed quality standards to identify gaps and to maintain standards.

- The audit also looked at completion of notes, including evidence of the information offered to patients and their families about end of life care services, and if letters had been sent to GPs. They had identified gaps in GP letters being sent and had introduced stickers to act as an aid for staff when completing the patient record.

- The trust had taken part in the 2015/16 National Care of the Dying Audit (NCDAH) and achieved seven out of eight organisational key performance indicators (KPI's). We saw that the one indicator not achieved was the provision of palliative care face to face as a minimum between 9am and 5pm Monday to Sunday. However, since the publication of the audit this was now being provided in the community.

- Since our last inspection the trust had started to collect data on indicators such as documenting communication with relatives and preferred place of dying.

- The care in the last days of life document was audited in 2016. There were key findings in the community which included a 50% improvement in the documentation of communication with patients to inform them of their last days of life, an increase of 33% in documentation showing communication with relatives, a 17% increase in anticipatory medicines being prescribed, a 75% increase in patients' spiritual needs being addressed. An action plan was due to be developed.

- We were told the Macmillan lead nurse had visited other trusts to see how an electronic palliative care template could be used to record and collate patient outcomes. We saw that this was part of the action plan for the IT strategy sub work stream however there was no completion date for this.

- We were told patients completed questionnaires at the beginning of their therapy with the clinical psychologist and again after therapy was completed. However, these were not collated to show patient outcomes.

- We saw that there was a flag on the electronic records system used in the community to identify patients who had a DNACPR order in place. This allowed for more effective communication across services.

- We saw that the end of life strategy included information which confirmed that the trust had considered initial work to implement the Electronic Palliative Care Coordination System. This is a national

Are services effective?

system which was recommended but not mandatory. Early work had identified problems of this being integrated with other electronic systems in the community, but would be pursued.

- The Gold Standards Framework (GSF) is a systematic, evidence-based approach to optimising care for all patients approaching the end of life. The trust did not participate in the gold standards framework or an end of life care patient register. However, we saw that this was an action for development in the multi-disciplinary end of life are strategy group.

Competent staff

- End of life and palliative care was provided by well-trained and competent staff. There were 5.2 whole time equivalent specialist palliative care nurses covering North Lincolnshire community and one palliative care consultant.
- We spoke with a new member of staff who told us they had completed an induction and had been supported by their manager. The induction included a competency framework for delivering end of life care. Staff completed the training to ensure they were able to provide high quality care to meet the needs of patients.
- Staff were provided training in end of life care in the acute and community services. There was a band 4 support worker who co-ordinated training.
- There was a training matrix for qualified and non-qualified staff. Qualified staff completed end of life care training, respiratory training, dilemmas in care at the end of life, DNACPR, the role of SPCT and communication skills training.
- There was a competency framework for all community nurses to ensure they were proficient in the use of syringe drivers.
- Non-qualified staff completed end of life care training, training to improve communication skills – (which they did with three patients), respiratory training, last days of life document and personal care after death training.
- The team provided training on the validation and verification of death. Staff had completed competency based training for verification of death which included a theoretical session and a simulated session.
- Palliative care community staff felt that the service had a learning culture. If staff attended a training event, it was expected that they would share the learning at the next team meeting.

- We saw evidence from the Quality and Patient Experience Committee (February 2015) that showed that funding from NHS England was used to deliver additional end of life care training throughout the trust.
- Specialist palliative care nurses we spoke with told us they had the opportunity to attend relevant training, conferences and were able to participate in projects that developed their roles.
- We saw that 75% of the SPCT had received an appraisal between October 2015 and September 2016. There were seven months when this had been 100%. Appraisals were recorded electronically and staff received an alert when theirs was due to take place. 94% of the Macmillan healthcare team had an annual appraisal in the last year. The appraisal rate for community nurses varied from 61% to 100%, the average was 85%.
- Supervision was in place for SPCT nurses by psychology staff. This offered staff the opportunity to reflect on their practice and discuss their own welfare needs.
- SPCT nurses delivered advanced communication skills training to community nurses, and a wide range of end of life care training including advanced care planning to groups of staff including care home staff and home care agencies. This training included priorities of care and recognising dying. Training was also provided to care home staff about the use of individualised care plans.
- Community nurses told us they had had access to opportunities to develop their end of life care skills and knowledge. This included attending out of area professional networks.
- Senior nurses had been trained to complete DNACPR forms. This formed part of the care at the end of life documentation.
- We saw that there was further training in place for Macmillan healthcare support workers which included level 2 in health and social care. Band 3 staff were completing level 3 health and social care qualifications, and were given the opportunity to attend a ten week palliative care course.
- The healthcare support workers were appraised by one of the patch team leaders and one of the band 4 support workers.
- Support workers had the opportunity to reflect on their practice and case management with a Macmillan nurse on a monthly basis.

Are services effective?

Multi-disciplinary working and coordinated care pathways

- Clinical review meetings were held each week at the local hospice between the palliative care consultant and the palliative care team to discuss all referrals made to the hospital and community specialist palliative care teams. Staff told us they found the meetings were well attended and ensured they were informed about the needs of patients.
- The palliative care team met with general practitioners (GPs) on a monthly basis to discuss patients who were identified as being at the end of their life. We were told that there were closer links with the district nursing service since the development of the seven day service as they worked from the same base.
- Staff told us that the unscheduled care services which included the rapid assessment time limited service (RATL) and the frail, elderly assessment team (FEAST) were beneficial to ensure patients were not admitted to hospital unnecessarily.
- We saw joint working between social care and health staff sharing face to face information to mitigate two different electronic systems in place.
- A report from the British Psychological Society (2013) deemed the inclusion of a clinical psychologist in the end of life care to be best practice. This was in place for patients in the community.

Referral, transfer, discharge and transition

- There was a clear pathway for referral to specialist palliative care services so staff knew when and who to contact.
- The service had a single referral point for the community palliative care team. Staff felt this worked well and allowed them to contact patients and their relatives promptly.
- Community patients were contacted within three working days to arrange a mutually convenient time for a face-to-face assessment to identify their support needs.
- The community teams were able to access a fast track service for equipment to allow a patient to be transferred home the same day. The fast track response team could provide equipment within two hours.
- There were systems in place for the timely discharge of patients from hospital to home with the support of a palliative care consultant.

- We were told that there were timely processes to admit patients to the planned investigation unit at Scunthorpe Hospital for procedures such as blood transfusion. Community nurses and community matrons told us they worked together with hospitals when patients were transitioned between services. We saw information about an 'unscheduled care' team who helped to keep patients in their own home, if it was safe to do so, during an episode of acute illness. Although we did not get the opportunity to speak with anyone from this team during our inspection to find out how they are involved with end of life care patients, community nurses confirmed their involvement with patients receiving end of life care.

Access to information

- Information about palliative and end of life care was available on the trust intranet for staff to access.
- We viewed electronic and paper records that included detailed information about the management of symptoms, discussions and interventions. We also saw that when patients were seen by the SPCT, information and advice continued to be clearly recorded so that other staff could easily access the guidance given.
- Community nurses and community matrons told us there continued to be some issues with patients being discharged from the acute hospital in terms of access to information. They said they sometimes found out patients had been discharged when family members or carers contacted them. We could not corroborate this however, we observed one community nurse contact hospital staff to obtain information about patients who had been discharged and we saw one incomplete discharge summary.
- Staff were supported to deliver effective care and treatment by the use of electronic care records which included case notes, risk assessments and care plans. All community staff including GPs had access to this information.
- Paper records were kept in care homes; community nurses told us end of life patients in care homes also had electronic care records for health staff to access. Hospice staff could also access electronic records.

Are services effective?

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We found 92.2% and 86.4% of relevant staff had completed training on MCA and DoLSas part of their mandatory training, against a trust target 95%. Staff we spoke with had an understanding of MCA and best interest meetings.
- We saw staff seeking patients' consent and explaining what they were doing before providing care and treatment. Patients were given the opportunity to ask questions when staff were providing care.
- We looked at three DNACPR forms during our inspection. The forms were kept at the patient's home. These had been completed appropriately and in line with national guidance. We saw records of a mental capacity assessment carried out and appropriate best interest decisions being made for an end of life patient who lacked capacity.
- The service completed an audit of DNACPR forms completed between September 2015 to December 2015. Fifty-four deceased patient notes were reviewed and all patients had a DNACPR form completed before they died. Of the 54 completed, 20 (37%) of the forms were completed by the SPCT. The audit showed that discussions with patients and their families were documented in the patient record.
- We also found patients and their carers had been involved in making the decision and discussions were recorded in the patient's notes.
- All specialist staff we spoke with, understood the mental capacity act and issues around deprivation of liberty safeguards.
- We viewed prompts on the last days of life document for patients at the end of life relating to best interest decisions for patients who did not have capacity to make decisions about care and treatment.
- We saw that the DNACPR form in use was in line with national guidance and included in the Care in the End of Life Document. We saw four of these completed appropriately.
- The non-medical verification of death policy included reference to deprivation of liberty safeguards (DoLS) and guidance on procedures if patients died with a DoLS in place.

Are services responsive to people's needs?

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

Summary

Following our previous inspection in October 2015, we rated responsive as requires improvement because:

- We were shown information which indicated that 600 end of life patients were admitted from home or care homes and died within 24 hours of admission to hospital, in 2014. We were not assured that this had been their preferred place of death.

- Staff told us the delivery of care in someone's preferred place was a priority. There was no data to support this as no audits had taken place.

Following this inspection we rated responsive as good because:

- We found that the number of patients who had died at home with a care in the last days of life document in place had increased and the number of patients dying within 24 hours of admission to hospital had significantly reduced to 60.

- The trust had implemented a care in the last days of life document which included the identification of patients' preferred place of care. This data was being audited by the trust.

- We found that services were planned and delivered to meet people's needs, including those people in vulnerable circumstances.

- We found that the community teams were quick to respond to patient need and that referrals were prioritised based on need.

- There was now a rapid response equipment team in place seven days a week, which meant that equipment could be obtained within two hours and this reduced delayed discharges from hospital.

- All community nurses were trained in non-medical verification of an expected death; which meant bereaved families did not have to wait for a doctor to attend.

- There had been no complaints about the SPCT in the twelve months prior to our inspection.

Detailed findings

Planning and delivering services which meet people's needs

- We saw that services were planned to meet people's needs. The SPCT were available seven days per week and provided support to the other community based services and the GP out of hours service. District nursing teams told us that this had been a positive step and they felt well supported in the management of those patients who were on end of life pathways of care.

- We saw that there was an unscheduled care team, which included a rapid assessment time limited service (RATL) which aimed to prevent hospital admissions where appropriate and supported rapid discharge from hospital. This included the rapid response equipment service and social work team who gave advice and supported families.

- We saw that there was now an overarching End of Life Northern Lincolnshire and Goole Strategy Group in place. We saw two sets of minutes which clearly defined seven work streams aimed at planning patient and relatives' needs. These were bereavement, information technology, DNACPR and resuscitation, specialist palliative care, long-term conditions and children/neonatal.

- The service had a checklist of information available for patients and their relatives. Information was also available in other languages. There was information and booklets for children whose relatives were ill.

- Information on dementia, heart disease and lung disease was also available.

- The service completed an annual clinical audit of case notes. In 2015, 97% of patients had been offered information and this had been documented in the patient's notes.

Equality and diversity

- We saw individualised patient care of end of life care patients in the community and we saw staff using assessment tools in the cre in the end of life document.

- Equality and diversity training was delivered to all staff as part of their induction to the trust and thereafter every five years. In August 2016, this was 93.9% against a trust target of 95%.

Are services responsive to people's needs?

- We saw end of life policies which all contained reference to equality and diversity. The equality and diversity policy included reference to the protected characteristics of the Equality Act (2010).
- The care after death policy included guidance for staff in relation to people's cultural and religious preferences.
- Translation services were provided as a full 'one stop shop' service for all interpretation and British Sgn Language requirements. Both telephone and face-to-face translation services were available for staff to utilise.
- Patients in their own home accessed their own spiritual advice from their own religious leader. Part of the last days of life document allowed staff to document what the patient identified as important to them. This included specific spiritual, religious or cultural needs.
- We saw that the chaplaincy service was part of the end of life strategy group.
- There were male healthcare support workers, so if patients preferred care delivered by a male member of staff, this was accommodated as far as possible.

Meeting the needs of people in vulnerable circumstances

- The trust had a dementia strategy in place. This included training to increase the awareness of dementia and increasing the number of dementia champions.
- Staff we spoke with knew how to access services for patients with additional needs such as hearing difficulties.
- We found the Macmillan healthcare team had taken action to remove barriers to care for some people who find it hard to use services. For example, packages of care for the travelling community included the acknowledgement that families may move and return to the area. Patients received between one and four visits a day from the Macmillan healthcare team, and in addition, they could receive day or night 'sits' to allow family / carers some time for themselves.

Access to the right care at the right time

- The palliative care team now offered a seven-day service in the community. Staff told us that this worked well and prevented delays in pain reviews and care management over the weekend.

- New referrals over the weekend were accepted if patients met the criteria as defined in the end of life standard operating procedure which defined four levels of intervention. These ranged from advice from other professionals as level one, to levels three and four which set out further assessment and care.
- Therapy staff were now included in seven-day service provision to complete pathways of care.
- Staff explained that they were able to arrange for patients to visit the local hospice, or for the hospice staff to visit them in hospital, if they were approaching the end of their life and their preferred place of care was the hospice.
- We saw that the provision of equipment at home could now be fast tracked and requests responded to by the fast track equipment team within two hours.
- We saw that the unscheduled care team provided care for end of life care patients to help them stay in their own home and prevent unnecessary hospital admissions. This included the rapid access, time limited service which co-ordinated services to prevent admissions and provide services. We saw that the co-ordinator of the unscheduled care service reviewed unscheduled hospital admissions over the previous 24 hours to liaise with community services in order facilitate rapid discharge.
- There was no formal agreement with the trust's current patient transport provider. However, staff could access an alternative provider to be discharged rapidly and sensitively.

Learning from complaints and concerns

- There had been no complaints about the SPCT in the twelve months prior to our inspection.
- Patients we spoke with were aware of how to raise a complaint, but did not feel the need to complain about the service. Staff in both the community units and community nursing teams felt that they had a low number of complaints. We looked at community nursing minutes which discussed any complaints. We saw complaints discussed in end of life meeting groups, but these did not relate to patients receiving end of life care in the community.
- Information was displayed on the community units about how to raise concerns.

Are services well-led?

Good ●

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

Following our inspection in October 2015, we rated well-led as requires improvement because:

- There was no internal end of life care strategy for Northern Lincolnshire and Goole NHS trust. We found the absence of a strategy had resulted in staff not knowing the vision for end of life care.

- We found arrangements for monitoring quality of services could be improved; there were gaps in service performance measures. This meant it was harder for the trust to take action to improve performance and the delivery of the service. We found there was disconnection between the trust board and staff in the community.

At this inspection we rated end of life care for well-led as good because:

- The trust had been involved in the development of a multi-agency end of life strategy that encompassed the whole of the local health economy.

- The trust was collating and monitoring quality measures such as patient outcomes through seven strategy sub-working groups. A quarterly update on the progress of each working group was reported to the board.

- There was a non-executive director, at board level, who challenged and supported the leadership team.

- The service was monitoring and auditing the use of the end of life care document.

- End of life care risks were now included in the end of life community risk register.

- The services had regular team meetings which looked at performance, referrals, incidents, complaints, compliments and audits.

- Staff felt part of the trust and information was shared through the internet, by email and newsletter.

- Patients were asked for their views and feedback about the service. We observed positive leadership at a local level in the community. The specialist palliative care team, patch team leaders and Macmillan lead nurse were visible and approachable.

- Staff we spoke with demonstrated a commitment to the delivery of good quality end of life care. There was evidence that staff felt proud of the care they were able to give and there was positive feedback from nursing and care staff as to the level of support they received from the SPCT.

Detailed findings

Leadership of this service

- The palliative care service was part of the community health directorate. There was a manager who had day to day management of the service. The leadership team was clearly defined and all staff told us managers were supportive and visible.
- Managers told us that they felt supported at a senior level but sometimes there was not a good understanding of community services at higher levels in the trust.
- There were monthly team meetings. We were told staff were rostered so that as many as possible could attend.
- We observed effective and enthusiastic leadership in the delivery of end of life services and staff we spoke with confirmed this. The senior manager told us that they were seeking national recognition of the teams.
- There were community walkabouts by senior managers including a member of the board.
- We were told that the out of hours manager worked with the Macmillan team one night every six weeks.
- Mangers told us that they understood what improvements in service delivery were required and took action to address these. For example there was a plan for all Macmillan nurses to undertake a non-medical prescriber's course which had commenced.
- We saw that local nurse leaders had the knowledge, capability and integrity to lead the end of life care services. The patch team leaders and Macmillan end of

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life lead were well thought-of by staff and were visible and approachable. We found that these leaders encouraged supportive working relationships amongst the teams.

- 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.
- We saw evidence of the SPCT providing end of life care leadership across all services within the trust, extending to external services such as care homes.
- A matron, who was the lead for adult specialised community services, managed the SPCT. The matron had clinical responsibility for the Macmillan nurses, the Macmillan healthcare team, the out of hours community nurses and the unscheduled care team.
- An operational matron, who was the lead for planned adult community services, managed the patch.
- The trust had a non-executive director with responsibility for end of life care. Senior staff we spoke with, told us that this provided challenge and support at trust board level.

Service vision and strategy

- The trust had been involved in the development of a multi-agency end of life strategy that encompassed the whole of the local health economy. Following ratification of the end of life care strategy, the trust had developed seven work streams with senior staff from the service having overall responsibility for a sub-working group. These included education, bereavement, palliative care, do not attempt resuscitation, long-term conditions, children and neonatal and IT. Each group met separately and had developed action plans at meet the required outcomes of the strategy.
- We saw that some of the working groups had developed a vision for their area of responsibility.
- Multi-agency end of life strategy groups were held regularly. The terms of reference (TOR) for membership included the deputy chief nurse, deputy medical director and the associate nurse for community and therapies which allowed an integrated approach to care.
- Staff we spoke with were aware of the vision for palliative care and that the provision of high quality care for patients and their relatives was important.

- Senior staff told us there was some difficulty in getting a whole of Lincolnshire approach to end of life care as there were different clinical commissioning groups (CCG's) who commissioned services.
- Community staff told us senior specialist palliative care staff continually tried to develop the service to meet the ongoing needs of patients and their families.

Governance, risk management and quality measurement

- There were clear governance arrangements in place. Staff understood their roles and who they were accountable to.
- There were clear arrangements for the cascading and sharing of information with all staff. For example there had been an incident with a mobile phone when at the end of shift a member of staff had forgotten to transfer the phone to the next member of staff and the following day was not on duty. The staff member realised the following day and made staff aware. They later highlighted the risks with other staff and the directorate are now looking at working in hubs and having access through a single point of access portal to reduce the risk. There was a risk a patient or their family may not be able to contact the palliative care team on duty.
- There was a separate risk register for end of life care. We saw that the lack of strategy was the only risk on this risk register. We did see that some risks had been identified on the action plans of the sub-working groups. Following our inspection, we received information that indicated that these risks would be added to the overarching risk register for the service.
- The services had regular team meetings which looked at performance, referrals, incidents, complaints, compliments and audits. There was an end of life dashboard which was shared and discussed with staff. Information included caseload information, preferred place of death, advanced care planning, admissions and GP callout avoidance.
- Community end of life services were in the community and therapies directorate of the trust and reported in to the trust governance and assurance committee.
- We viewed minutes from monthly SPCT meetings and the strategy implementation group. Monthly SPCT meetings included standard agenda items such as

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training and education, admissions from the community to hospital and the future of SPCT services. Updates on workstreams were discussed and updates on key stakeholders.

- We viewed minutes of board meetings and saw that end of life care had been discussed in relation to mortality reviews in March, June, July and September 2016.
- Plans discussed at the mortality reviews included; the delivery of teaching sessions to GPs on end of life issues for patients with chronic obstructive airways disease, and; a proposal for care of elderly consultants to review care home patients to initiate end of life care in the community. There was a record of issues regarding patients being admitted to hospital at the end of life because they are unable to access other services.

Culture within this service

- Staff were enthusiastic about the service they provided. Patient care was seen as a priority by the staff.
- There had been a period of recent sickness in the SPCT and staff told us that management had mitigated this by the addition of two extra band 5 staff nurses.
- Staff were encouraged to raise any concerns they had about patient care and there was an open culture to report incidents without fear of recriminations.
- Staff worked well together and well with other disciplines, we observed good working with district nurses, GPs and allied health professionals.
- A senior manager told us that they were proud of the teams they managed.
- Staff told us how support workers were recruited to the Macmillan healthcare team and how important it was to recruit staff with the right values.
- Some staff told us that senior executive members did not always acknowledge community issues. For example they told us it was rare that community services received staff awards.

Public engagement

- Information from the clinical notes audit showed evidence of discussions with patient and relatives. The service scored 100% for discussions with patients.
- We saw that there was patient representation on the multi-agency end of life strategy group and minutes of strategy group meetings we reviewed made reference to how the representatives could be utilised to maximum effect.

- We observed patients and relatives being actively involved in the decision making about their care and treatment. This included comments about the electronic holistic needs assessment.
- The service took part in the national service evaluation of bereaved relative's satisfaction with patient's end of life care 2016.
- Staff could apply for funds, from the charitable trust fund, to assist with the purchase of specific items for end of life patients.
- The trust had held a 'Dying Matters' roadshow at a number of venues in May 2016. This had been advertised as an event to provide advice and signposting to members of the public on all aspects of planning end of life care, bereavement, dying, organ donation and will writing.
- The trust had a range of leaflets available for patients and their loved ones including information relating to specific conditions, tissue and organ donation. There was also a recently updated bereavement booklet which gave advice and support for relatives following a bereavement.
- We saw that there was a public website which outlined end of life services and contact details for the Macmillan team.

Staff engagement

- Staff told us that senior managers were available and would attend team meetings. We saw evidence of this in the team meeting minutes we looked at. Feedback was given at team meetings.
- Staffing was discussed at the team meetings and updates on recruitment were discussed.
- Staff felt part of the trust and information was shared through the trust intranet, by email and newsletter.
- Staff told us they felt involved in the planning and delivery of the service. They told us they had met with commissioners to discuss the service and what they thought went well and what needed to improve. We saw that staff had been involved in the planning and implementation of the end of care plans rolled out across the trust.
- There were team forums where staff shared learning. For example, staff would share learning from attending palliative care training with GPs. Staff have used the forum to share learning about the last days of life document and have looked at oncology emergencies in the community.

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- Staff told us they were encouraged to complete the staff survey and results from the survey were discussed at team meetings.
- We found that at this inspection there had been an improvement in staff understanding of end of life services as a whole and that there was now a strategy.
- We saw that in the community there had been effective roll out of the last days of life document which included road shows across areas.
- There had been a series of roadshows to raise awareness of unscheduled care services which included rapid assessment time limited service (RATL) which bridged acute to community services.

Innovation, improvement and sustainability

- We saw the development of a multi-agency end of life care strategy group which had oversight of palliative care services over the community, acute services, hospices and care homes.
- We saw an effective and well-designed strategy which planned the needs of community, individual patients, their carers and the staff who delivered their care.
- We saw the development of a seven day working service to improve the access and timely treatment given to palliative care patients.
- The specialist palliative care team were focused on continually improving the quality of care and we observed a commitment to this within the community nursing teams and Macmillan healthcare teams we spoke with.