

Liverpool Community Health NHS Trust

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End of life care

Quality Report

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

Summary of findings

Ratings

Overall rating for End of Life Care Services

Good



Are End of Life Care Services safe?

Good



Are End of Life Care Services caring?

Good



Are End of Life Care Services effective?

Good



Are End of Life Care Services responsive?

Good



Are End of Life Care Services well-led?

Requires Improvement



Summary of findings

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Summary of findings

Overall summary

There were a number of measures in place to monitor patient safety and reduce the risk of harm to patients. There was evidence of dissemination of learning from incidents and complaints. In the patient records reviewed there was no evidence of risk assessments being completed, which related to issues around staff safety or the patients general living environment. The team relied on risk assessments being completed by community nursing.

The team had procedures based on other national and regional guidelines. The staff within the team followed guidelines from other organisations, such as the Macmillan Cancer Support and Marie Curie Cancer Care. There was effective communication and multidisciplinary team working. The staff within the team were highly trained and had a good understanding of existing end of life care guidelines and implemented these effectively.

Services were delivered by a hardworking, caring and compassionate staff. We observed that staff treated patients with dignity and respect and planned and delivered care in a way that took into account the wishes of the patients.

Staff had a good understanding of the needs of the local population and worked as part of multi-disciplinary teams and routinely engaged with local hospices, GP's, adult social care providers and other professionals involved in the care of patients. The team delivered comprehensive training to community nursing staff to ensure that care was responsive to people's needs.

There was an awareness about the trusts visions and strategies, but there was a disconnect between the team and wider trust. There was no audit schedule of key processes in place. Information relating to core objectives and performance targets was not readily available. There was confusion regarding line management within the team.

Summary of findings

Background to the service

The trust provided a specialist range of community based end of life care services for people living in Liverpool and Sefton community areas. The team was based centrally however staff operated in their specific localities. The aim of the service was to achieve the best quality of life for patients and their families whose disease was not responsive to curative treatment and to deliver training and educate clinicians.

We visited three patients, spoke with five relatives of patients, attended a Gold Standard Framework meeting and spoke with a range of staff. We reviewed comments from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Our inspection team

Our inspection team was led by:

Chair: Fiona Stephens, Clinical Quality Director, Medway Community Healthcare

Head of Inspection: Adam Brown, Care Quality Commission

The team included CQC inspectors, and a variety of specialists; School Nurse, Health Visitor, GP, Nurse, Therapists, Senior Managers, and 'experts by experience'. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

Why we carried out this inspection

Liverpool Community Health NHS Trust was inspected as part of the second pilot phase of the new inspection process we are introducing for community health

services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

How we carried out this inspection

To get to the heart of patients' experiences 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?

The inspection team always looks at the following core service areas at each inspection:

1. Community services for children and families – this includes universal services such as health visiting and school nursing, and more specialist community children's services.

2. Community services for adults with long-term conditions – this includes district nursing services, specialist community long-term conditions services and community rehabilitation services.
3. Services for adults requiring community inpatient services
4. Community services for people receiving end-of-life care.

Before visiting, we reviewed a range of information we hold about Liverpool Community Health NHS Trust and asked other organisations to share what they knew about the provider. We carried out an announced visit between 13 and 15 May 2014. During our visit we held focus groups with a range of staff (district nurses, health visitors and allied health professionals). We observed how people were being cared for and talked with carers and/or family

Summary of findings

members and reviewed personal care or treatment records of patients. We visited 23 locations including three community inpatient facilities ward35 Aintree Hospital, and wards 9 and 11 in the Alexandra Wing,

Broadgreen Hospital. The remaining locations included three walk-in centres and various community facilities. We carried out an unannounced visit on 13 May to the evening district nursing services.

What people who use the provider say

We visited three patients, spoke with five relatives of patients, overwhelmingly, the patients and relatives we spoke with were complimentary about staff attitude and engagement and commented that they thought the staff

were: “Second to none”; “Clear thinking and compassionate”; “They are marvellous”; One patient said “They explain everything” and “They have done an amazing job supporting me”.

Areas for improvement

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

- The trust should improve general oversight for managers with regard to the End of Life team’s prescribing to highlight any causes for concern.
- The trust should ensure staff record the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) status of patients.
- The trust should take measures to protect the safety of all staff, and in particular lone working staff, in a consistent way.

- The trust should develop major incident plans for all services.
- The trust should develop regular one to one meetings and mechanisms within the end of life team to address poor performance.
- The trust should provide leaflets or booklets to patients or their relatives regarding information on end of life care, complaints or bereavement support.

Liverpool Community Health NHS Trust

End of life care

Detailed findings from this inspection

The five questions we ask about core services and what we found

Good 

Are End of Life Care Services safe?

By safe, we mean that people are protected from abuse

Summary

There were a number of measures in place to monitor patient safety and reduce the risk of harm to patients. There was evidence of dissemination of learning from incidents and complaints. In the patient records reviewed there was no evidence of risk assessments being completed, which related to issues around staff safety or the patients general living environment. The team relied heavily on risk assessments being completed by community nursing.

Incidents, reporting and learning

There were a number of measures in place to monitor patient safety and reduce the risk of harm to patients. There were no never events in the end of life care service during the past 12 months.

There were nine serious incidents reported to the end of life team by community nursing between 2013 – 2014, all of which were pressure ulcers (grades 3 and 4).

Due to the specialism of the end of life care team we found that they did not routinely provide direct care to a patient nor did they attend a patients home as frequently as the

community nursing team, as a result they were less likely to note such things as pressure ulcers. Therefore the majority of serious incidents would be more likely be reported by the community nursing team.

The end of life team monitored and minimised risks. Staff were aware of the process for reporting any identified risks to staff and patients; however staff confirmed that the majority of risks and reporting of incidents would fall upon the community nursing team to report. All incidents, accidents, near misses, never events, complaints and allegations of abuse were logged on the trust-wide electronic incident reporting system (Datix). All staff in the end of life care team had access to the electronic system and staff stated that reporting was encouraged.

Incidents were investigated and remedial actions were put in place to minimise reoccurrence, incident reports were reviewed and found that they had been investigated and appropriate actions had been taken. Evidence was seen which demonstrated learning throughout the team by means of weekly and monthly meeting minutes. For

Are End of Life Care Services safe?

example: updates regarding standards of documentation to ensure best practice was adhered to, together with ensuring documentation illustrated the quality of the teams work

Cleanliness, infection control and hygiene

Staff were observed to be using personal hand sanitising equipment when caring for patients, personal protective equipment was not available for the end of life care team; however we were told that the team rarely provided direct care to patients.

Maintenance of environment and equipment

All end of life care services were carried out within the community, patients were referred to the service and would be visited jointly by end of life and community nursing, during which an assessment of the patients' needs would be made. The responsibility for ordering specialist equipment would lie with community nursing as with the reporting of issues concerning the maintenance of environment and equipment. However, we saw an example whereby a more suitable wheelchair was ordered by a member of the end of life team.

Medicines

Within the end of life team there were 10 nurse prescribers, for those staff who were unable to prescribe clear guidance was in place and records viewed indicted that the policy was being adhered to. We witnessed medication being prescribed to a patient which was undertaken appropriately. We reviewed the policy for the 'Safer Management of controlled drugs' and found this was current and reflected guidance. The medicines management team review the team's prescribing and we were told will inform the nurse directly if there are any causes for concern, however the manager of the end of life team confirmed that there was no system in place which provided managers with a general oversight of this process.

Safeguarding

Staff received mandatory training in safeguarding children and vulnerable adults, which included aspects of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoL's). Staff understood the legal requirements of the MCA 2005 and we saw evidence to support staff training.

Staff placed alerts on the electronic records system which we witnessed in use. The team were informed about safeguarding alerts that had been generated by the

community nursing team verbally and we saw on the electronic shared record keeping system that if such an alert was placed on a patient's record it would be clearly displayed on screen. However there was no formal monthly report passed to the manager of the service by the community nursing team. This therefore meant that there was no managerial oversight regarding total numbers of safeguarding concerns.

Records

Records were kept both electronically and via paper. Electronic records were maintained appropriately and used by both the team and the community nursing team.

Paper patient records were reviewed with the majority of records being completed appropriately, the team manager also conducts a 'Records contents audit' yearly to ensure quality and consistency. During our review of records we noted that the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) status of the patient was not recorded in any of the records viewed, spiritual well-being was not routinely completed and there was no clear documentation included when a patient was discharged from the service. We discussed the issue of DNACPR with the manager of the team and were informed that it was planned to introduce a new paper record system that included DNACPR status, we viewed a copy of this new form with the status included.

We spoke to staff who told us that the current paper record templates were designed for patients requiring palliative care and were therefore not suitable for people requiring end of life care who do not need palliative care. When we reviewed these records we found that templates had either been amended or left blank, which meant in some cases that the records did not accurately reflect visits or care and advice given.

Lone and remote working

There was a lone workers policy in place and the majority of staff we spoke to, confirmed that they had mobile phones. During the inspection we accompanied staff undertaking visits to patient's homes, we did not witness regular contact being maintained, checking with staff or see a system in place to ensure the whereabouts of staff. Personal alarms did not appear to be in use.

Assessing and responding to patient risk

In the patient records reviewed there was no evidence of risk assessments being completed, relating to issues

Are End of Life Care Services safe?

around staff safety or the patients general living environment by the team. As previously mentioned the team rely on community nursing to ensure appropriate risk assessments were completed and stored on the electronic record keeping system. However there was nothing within the paper documentation which alerted staff that risk assessments may have been present in the electronic record keeping system.

Staff told us incidents and complaints were discussed during routine staff meetings which took place every Friday, documentary evidence of this was seen, for example we saw that the team maintained an updated list of serious incidents which we were told was discussed during weekly meetings. We saw evidence from team meeting minutes that learning took place within the team; however during our discussions we could find no formal mechanisms to share learning across other teams such as community nursing, other than via training the training the team provided to colleagues.

Staffing levels and caseload

Within the end of life team there were 14 Band 7 nurses and 4 Band 6 nurses, each member of the team had a caseload of between 20 – 30 patients at any one time, however due to the nature of the service this fluctuated on a day by day basis. Staff told us that they were able to manage their workload and ensure that patients received the appropriate care.

Managing anticipated risks

The end of life care teams we inspected were well placed within the localities they served. There was routine engagement with the district nurses, GP's, hospice staff and social workers so the staff were kept informed of patient's conditions and could make arrangements for patients that were awaiting referral for end of life care services.

There was a system and process in place to identify and plan for patient safety issues in advance. Where staff identified potential concerns relating to patient safety, these were assessed and placed on directorate risk registers, so the risks could be assessed and minimised through action plans. For example we looked at the risk register and noted that it contained two issues both of which were recorded in July and November 2013 respectively concerning medication and non-attendance of community nursing staff at education sessions. We have viewed evidence that confirms risks associated with their services were incorporated into adult services directorate risk registers.

In line with their service specification staff did not carry out risk assessments to identify patients at risk of harm. Risk assessments for venous thromboembolism (VTE), pressure ulcers, nutritional needs, falls and infection control risks were conducted by the community nursing team.

Major incident awareness and training

There was no major incident plan in place for the team at local level; staff had not received major incident training.

Are End of Life Care 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

The team had procedures based on other national and regional guidelines. The staff within the team followed guidelines from other organisations, such as the Macmillan Cancer Support and Marie Curie Cancer Care. There was effective communication and multidisciplinary team working. The staff within the team were highly trained and had a good understanding of existing end of life care guidelines and implemented these effectively.

Evidence based care and treatment

The trust's end of life care procedure was based on the Liverpool Care Pathway for the Dying Patient (LCP). Patient records showed that this was correctly implemented by staff. The trust planned to phase out use of the LCP by July 2014. We saw that the end of life team was piloting a new pathway 'End of Life Plan'. Staff told us they were awaiting the publication of national guidance and internal procedures to replace the pathway.

The team had procedures based on other national and regional guidelines, including the Preferred Priorities for Care (PPC), the Gold Standards Framework (GSF) and the Merseyside and Cheshire Palliative Care Network Audit Group Standards and Guidelines. The palliative care nurses also followed guidelines from other organisations, such as the Macmillan Cancer Support and Marie Curie Cancer Care. The staff within the team were highly trained and had a good understanding of existing end of life care guidelines and implemented these effectively.

We were told that the team does not collect information Commissioning for Quality and Innovation (CQUIN) Payment Framework for end of life care measures as there was no national requirement to collect data for a CQUIN. However we were told Preferred Place of Care (PPC) was audited locally, but when we asked for further clarification it was stated that this information was not monitored by the end of life team and any audit of this information would be conducted by community nursing.

Pain relief

Within the team there were 10 nurse prescribers, for those staff that were unable to prescribe clear guidance was in place and records viewed indicated that the policy was

being adhered to. We witnessed pain relief medication being prescribed to a patient which was undertaken appropriately and witnessed discussions regarding dosages. We spoke with patients all of whom confirmed that they were given adequate levels of pain relief.

Patient outcomes

Patients received care according to national guidelines. Clinical audits included monitoring of National Institute for Health and Care Excellence (NICE) and other professional guidelines. The end of life team completed four clinical audits during the past year against a target of two.

Patients receiving end of life care were managed effectively. Patients received effective support from a multidisciplinary end of life care team, which included specialist palliative nurses, consultants and therapists. Multidisciplinary staff meetings took place on a routine basis to ensure any changes to patients needs could be addressed promptly. The end of life care teams engaged with other community healthcare professionals, such as GP's and local hospice staff. This meant that staff could act swiftly to referrals to ensure patients received an effective service.

Evidence also confirmed that staff met as a clinical review group weekly, during which staff had the opportunity to discuss relevant issues.

The patients and relatives we spoke with told us they were happy with the end of life care and support provided by the team.

Performance information

The team measured itself against information received via the patient survey undertaken during August – September 2013, which showed that overall patients were extremely happy with the service provided by the team.

It was explained that quality was monitored via the national audits that had been undertaken, but no specific data regarding outcomes for people using the service was captured on a monthly basis by the team.

Are End of Life Care Services effective?

Performance of the team was measured by means of two documents, the first relating to the numbers of referrals the team received during each month and the associated activity and an overarching document which monitored such things as, complaints, compliments and staff sickness.

In line with the teams service specification the team provides training to groups such as community nursing, which can contribute to 50% of the work undertaken by each team member. We saw evidence that confirms this area of performance is monitored monthly.

Competent staff

Appraisals were being undertaken and staff spoke positively about the process. We were provided with appraisal data for March 2014 which demonstrated 100 % of staff in the Liverpool area team and 83% of staff in the Sefton area team had undergone yearly appraisal. We also saw that 94% of staff in the Liverpool area team and 97% of staff in the Sefton area team had completed their mandatory training.

Staff spoken to reported induction to the team was a positive experience.

In previous years the end of life team bought services from Macmillan, such as training packages, more recently this had ceased and it was evident on speaking to staff that they considered the loss of input from Macmillan to have had a detrimental effect on their levels of knowledge which they considered to be vital for their learning and

development. We discussed this current situation with managers who confirmed that this situation was being reviewed and they were hopeful that the team would re-establish links with Macmillan.

We saw evidence which demonstrated that staff had regular access to clinical supervision delivered by a consultant from Marie Curie.

Staff did not have regular one to one meetings and we could not identify mechanisms within the team to address poor performance.

Multi-disciplinary working and working with others

There was effective communication and multidisciplinary team working. We visited a Gold Standards Framework (GSF) meeting with a member of the team and saw multi-disciplinary working in practice during a home visit with both community nursing and Marie Curie staff. Each team routinely conducted staff meetings and we saw evidence of shared learning. There was evidence to demonstrate multidisciplinary meetings at least weekly involving palliative care nurses and consultants to ensure that staff had up-to-date information about patient risks and concerns. The end of life care team also engaged with district nurses, GP's, acute trust staff and social workers to ensure care was coordinated across other organisations within their localities.

Are End of Life Care Services caring?

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

Summary

End of life services were delivered by a hardworking, caring and compassionate staff. We observed that staff treated patients with dignity and respect and planned and delivered care in a way that took into account the wishes of the patients.

Compassionate care

Patients were treated with compassion and empathy. We observed staff speaking with patients and providing care and support in a kind, calm, friendly and patient manner. The patients and relatives we spoke with were complimentary about staff attitude and engagement. We saw patients that had difficulty with their speech were listened to patiently and staff responded to their queries appropriately. The comments received from patients demonstrated that staff cared about meeting patients' individual needs.

Dignity and respect

When visiting patient's homes we observed staff treated patients with dignity and respect, we saw that staff asked for privacy to discuss issues in private with patients and patients we spoke with confirmed that staff always treated them with dignity and respect.

Patient understanding and involvement

Staff had the appropriate skills and knowledge to seek consent from patients or their representatives. The staff we spoke with were clear on how they sought verbal informed consent and written consent before providing care or treatment. We looked at records which showed that verbal or written consent had been obtained from patients or their representatives and that planned care was delivered with their agreement.

Staff respected patients' right to make choices about their care. We observed staff speaking with patients clearly in a way they could understand. We saw staff discussing options relating to areas such as equipment or medication to allow patients to make an informed decision. The patients and relatives we spoke with told us the staff kept them involved.

During our visits we saw that no information leaflets or booklets were provided directly to patients or their relatives regarding information on end of life care, complaints or bereavement support. However we did speak with relatives who told us that staff were very knowledgeable about any services they may wish to access or coordination of services for them.

Emotional support

Patients and relatives we spoke with confirmed that staff provided emotional support to them and we also witnessed staff providing emotional support during a visit. We witnessed staff awareness of people's beliefs and witnessed how they changed their approach accordingly by communicating with patients and relatives using terminology and language relevant to the situation.

Although no specific information leaflets or booklets were provided people told us that staff informed them about local services such as counselling services and services providing assistance with anxiety and depression.

Promotion of self-care

During visits to patient's homes we saw that staff promoted self-care wherever possible and this was confirmed during our discussions with staff, patients and relatives.

Are End of Life Care Services responsive to people's needs?

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

Summary

Staff had a good understanding of the needs of the local population and worked as part of multi-disciplinary teams and routinely engaged with local hospices, GP's, adult social care providers and other professionals involved in the care of patients. The team delivered comprehensive training to community nursing staff to ensure that care was responsive to people's needs.

Service planning and delivery to meet the needs of different people

The trust provided a range of end of life care services across the communities it served.

The staff we spoke with had a good understanding of the needs of the local population. Staff worked as part of multi-disciplinary teams and routinely engaged with local hospices, GP's (through local gold standards framework meetings), adult social care providers and other professionals involved in the care of patients. We saw that staff were involved with specific projects such as 'end of life care for the homeless'.

The team delivered comprehensive training to community nursing staff to ensure that care was responsive to people's needs in such areas as, preferred priorities for care and communication skills for palliative care.

Staff were responsive to patients' needs and provided the right level of care and support. Staff monitored patients using nursing care and end of life care pathways in line with national guidance. Staff communicated daily with community nurses and we observed regular checking of patients' electronic records. Patient records we looked at for the end of life team did not include specific risk assessments but these were present in community nursing records at patient's homes to which staff had access to.

Access to the right care at the right time

The staff we spoke with told us they were confident patients could access the end of life care services when needed together with colleagues in community nursing who could telephone the team directly for advice. The team routinely engaged with GP's, local hospices and adult social care providers so patients could be referred promptly.

Staff told us patients were referred to the end of life care services through a number of routes including via GP or consultant referral, or they could visit local hospices or access the service via outpatient appointments. We were told there was no waiting times for patients awaiting specialist end of life care services and patients would be seen promptly upon referral.

The majority of patients were able to speak English. Where this was not possible, staff could access a language interpreter if needed and we were told of situations when an interpreter had accompanied staff on home visits. Where a patient was identified with learning disabilities, staff could contact a trust-wide specialist nurse for advice and support.

Meeting the needs of individuals

We saw that people who used the service were asked about their spiritual, ethnic and cultural needs as well as their medical and nursing needs. We witnessed staff taking these needs and wishes into account when caring for patients. We saw staff adjust the personal approaches when discussing care with patients and it was clear that on each occasion this was the appropriate level.

Moving between services

We visited a patient who had moved from another area of the country, we reviewed their records which demonstrated clear communication and spoke with the relatives of the patient about their view of the transition who commented favourably about the process.

Children's end of life services are provided by the local children's hospital, we asked about transition between this service and adult end of life service. It was explained that the staff from the trust communicate directly about patients and a decision is made about which service will lead, it was explained further that in the majority of cases the local children's hospital will continue to provide this care.

Are End of Life Care Services responsive to people's needs?

Complaints handling (for this service) and learning from feedback

There had been no complaints regarding the service during the past 12 months. We were told that all complaints would be recorded on a centralised trust-wide system. The clinical leads would investigate formal complaints relating to their specific team.

Complaints we were told would be discussed during the weekly team meetings or on an individual basis. However the team had not had any complaints over the past 12 months.

We found that information regarding how to make a complaint was not given to patients when they entered the service.

The National Bereavement Survey 2011 showed that community NHS trusts within Merseyside area performed within the expected ranges for the majority of indicators. Performing in the top 20% in the area for pain management.

Are End of Life Care 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

Staff had an awareness about the trusts visions and strategies however there was a disconnect between the team and trust. There was no audit schedule of key processes in place. Information relating to core objectives and performance targets was not readily available. There was confusion regarding line management within the team.

Vision and strategy for this service

There was a clearly defined strategy for the service and staff were clear about the services they provided. The team had a clear understanding of their roles and responsibilities and where they fitted in as part of the multidisciplinary care process. Staff in each team were aware of the challenges and key risks to the services they provided. Although staff we spoke to had an awareness about the trusts visions and strategies there was a disconnect between the team and trust. There was no evidence of the trust's strategies and vision at the office we visited.

Governance, risk management and quality measurement

There was a clinical effectiveness group in place which met on a monthly basis, the purpose of the meeting was to ensure that quality was measured across the directorate, and we saw evidence that demonstrated attendance from across the directorate including end of life care. We discussed this meeting with the manager of the team to determine how the meeting influenced quality within the team. We were told that the manager did not take any information to this meeting nor were asked to provide any data and could not provide examples of how the clinical effectiveness group influenced quality within the team.

The team did not have an audit schedule of key processes in place. Information relating to core objectives and performance targets was not readily available. We were told that patient safety data such as pressure ulcers and falls data was collated by the community nursing team but there were no meetings between managers of the end of life and community nursing teams during which information could be shared. There was evidence to

demonstrate that the end of life team had attended the district nurse team leader meeting but we were told that this attendance is irregular and their role would be as guest speaker.

Leadership of this service

The team is led by two people who job share for two and three days a week respectively, one of the managers also undertakes a team leader role for three days a week with a different member of staff working part time providing team leader support for the outstanding two days. On speaking with staff we found that there was confusion about this line management structure. We were told that shortly this would be simplified and there would be one team leader five days a week with two managers job sharing for two and three days. It was not clear what mechanisms were in place, such as regular meetings or handover proforma, for providing management continuity for the service.

Culture within this service

Staff were highly motivated and positive about their work. The staff we spoke with told us they received support from their line managers. The majority of staff were aware changes to the trust's executive team and were positive about the direction for the trust.

Public and staff engagement

The trust was either better than or similar to the average for community trusts in 17 of 28 indicators from the 2013 survey of NHS staff, and worse than average for 11 indicators. The bottom five ranking scores the trust received from staff where: Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell; Percentage of staff appraised in last 12 months; Percentage of staff believing the trust provides equal opportunities for career progression or promotion; Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month and Staff motivation at work. The trust had an action plan in place to improve the issues identified by the staff survey.

The majority of staff we spoke with told us they had good access to training, including specialist external courses and they were supported by their line managers. Staff told us that they were supportive of the changes to the new

Are End of Life Care Services well-led?

approach in delivering training, which was delivered in three day blocks rather than training spread throughout the year. However, staff we spoke to considered that the loss of support from Macmillan Cancer Support service was detrimental to their knowledge and skills.

There were no concerns relating to staff sickness in the areas we inspected. There was a low rate of staff turnover, which meant staff had good relationships and knowledge of end of life care processes within the team.

The patients and relatives we spoke with were complementary towards the staff and had received good care.

Innovation, improvement and sustainability

The end of life care services worked effectively as a team and they engaged with other professionals to ensure patients received the required level of care and support.

The trust also planned to implement electronic patient records system for the end of life team in the near future, in order to improve the quality of patient records and communication.