Peninsula Community Health C.I.C

1-247215513

End of life care

Quality Report

CQC Registered Location
During this inspection we visited the follow registered locations:
CQC Location ID
Falmouth Hospital
1-303926236
Helston Hospital
1-303946611
Liskeard Hospital
1-303946965
Bodmin Hospital
1-303999240
Edward Hain Hospital
1-303998774
Fowey Hospital
1-303926348
This core service is also provided at the following registered locations which were not visited during the inspection:
CQC Registered Location
CQC Location ID
St Mary's Hospital
1-303985084
St Barnabas Hospital
1-303984801
Stratton Hospital
1-303985486
St Austell Community Hospital
1-303962531
Launceston Community Hospital
1-303946863
Newquay Hospital
1-303947227
Tel: 01726 627 930
Website: www.peninsulacommunityhealth.co.uk

Date of inspection visit: January 21,22,23,28,29,
Date of publication: 21/04/2015

Summary of findings

This report describes our judgement of the quality of care provided within this core service by Peninsula Community Health C.I.C. 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 Peninsula Community Health C.I.C and these are brought together to inform our overall judgement of Peninsula Community Health C.I.C

Summary of findings

Ratings

Overall rating for End of life care	Good	🟢
Are End of life care safe?	Requires Improvement	🟠
Are End of life care effective?	Good	🟢
Are End of life care caring?	Good	🟢
Are End of life care responsive?	Good	🟢
Are End of life care well-led?	Good	🟢

Summary of findings

Contents

Summary of findings

Overall summary

Overall rating for this core service GOOD

The Specialist Palliative Care team worked as part of a multidisciplinary team approach between community hospital and community based staff. Their role was to assess, support, deliver, monitor and evaluate end of life and palliative care provided by Peninsula Community Health CIC). They provided safe and coordinated care in collaboration with other providers. Some issues around the management of electronic records within the community created challenges for staff which the provider planned to address in the future. The provider used documents known as 'Allow a Natural Death Orders' (ANDOs) to define patients' medical wishes in the event of cardiac or respiratory failure. These documents were not completed consistently which meant there was a risk that patients' choices and preferences for care may not be met.

Practice around the assessment of mental capacity was variable between community hospitals and meant that the process for seeking consent under the Mental Capacity Act 2005 was not consistently managed. Records for pain control were duplicated and the provider's policy for anticipatory medicines for pain relief was not clearly accessible for staff to follow.

Patients and relatives told us that all staff were kind, considerate and helpful. They told us they treated people with dignity and respect and patients and relatives felt included and involved in decisions about care.

We found that end of life care was responsive to patients' needs at all stages of their illness. Patients were well supported to be able to be in their preferred place of care and support was available and accessible for patients and their relatives.

Nursing and care staff told us that they felt well led at a local ward and community level. They told us that they knew who to raise concerns with and considered that end of life care had 'a voice' at board level.

Summary of findings

Background to the service

Background to the service

End of life care was delivered where required by ward and community staff throughout Peninsula Community Health CIC. The Specialist Palliative Care Team (SPCT) provided support and advice for those patients who had complex needs and/or complex symptom management relating to end of life care.

The SPCT had been established in Cornwall for over 30 years. It was originally funded by Macmillan Cancer Support. In February 2014 the team formally removed the Macmillan designation from their title.

The team employed 19 nurses (18.6 whole time equivalent), divided into three teams, based geographically around the county and allocated to GP surgeries. Each team was managed by a team leader. The service was provided seven days a week between 8am and 5pm.

The SPCT formed part of Cornwall's Specialist Palliative Care service in partnership with Cornwall Hospice Care, Royal Cornwall Hospital Specialist Palliative Care team and St Luke's Hospice in Plymouth, Devon. They provided management and monitoring of persistent symptoms, management of complex emotional/psychological issues and management of complex social/family issues. They also provided end of life care, advice on all aspects of palliative care and palliative care education and training.

During our announced inspection we visited five patients in their own homes and spoke with them and their relatives. We visited Liskeard, Bodmin, Fowey, Falmouth and Helston community hospitals and spoke with seven patients and six relatives. During our unannounced inspection we visited Edward Hain Hospital and Helston Hospital. We spoke with patients and looked at end of life care records.

We spoke with members of the SPCT, district nurses and with staff at all levels in two community nursing teams. We also spoke to GPs who were working in the hospitals. In total we spoke with 46 members of staff, including medical and nursing staff, matrons and ward managers, allied healthcare professionals and healthcare support staff.

We looked at the records of nine patients receiving end of life care and 25 'allow a natural death' forms relating to resuscitation decisions.

Information about the Provider

Peninsula Community Health CIC provides NHS healthcare services to a population of almost three quarters of a million people in Cornwall and the Isles of Scilly. The demographics of Cornwall and the Isles of Scilly are broadly similar to England, although there is a slightly larger elderly population in Cornwall compared with England (6% higher in proportion). Deprivation in Cornwall and the Isles of Scilly is lower than the England average, although about 18.1% of Cornish children live in poverty. Life expectancy in Cornwall and the Isles of Scilly is slightly higher than the national average, standing at 79.5 for males and 83.5 for females compared with 79.2 and 83.0 nationally.

Our inspection team

Our inspection team was led by:

Chair: Dorian Williams, Assistant Director of Governance, Bridgewater Community Healthcare NHS Foundation Trust

Team Leader: Mary Cridge, Care Quality Commission

The team included CQC inspectors and a variety of specialists: district nurses, a community occupational therapist, a community physiotherapist, a community children's nurse, palliative care nurses, a director of nursing, a governance lead, registered nurses, a community matron and two experts by experience who had used services.

Summary of findings

Why we carried out this inspection

We inspected Peninsula Community Health CIC as part of our comprehensive community health services inspection programme.

Peninsula Community Health CIC is an independent organisation providing NHS services and therefore we used our NHS methodology to undertake the inspection.

How we carried out this inspection

During our inspection we reviewed services provided by Peninsula Community Health CIC across Cornwall and the Isles of Scilly. We visited community hospital wards, minor injuries units and outpatient clinics. We accompanied district nursing teams on visits to people in their homes where they were receiving treatment.

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

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

- Is it well-led?

Before visiting, we reviewed a range of information we hold about the core services and asked other organisations to share what they knew, this included Health watch. We carried out an announced visit on 21 – 23 January 2015. During 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 and talked with carers and/or family members and reviewed care or treatment records of people who use services. We carried out an unannounced visit on 29 January 2015.

What people who use the provider say

We spoke with seven patients and relatives. All spoke in the most positive and glowing terms about the kindness of the staff and the service they had received. These comments included,

- A patient in the community told us "all nurses are fantastic. They help us sort things out." Another patient told us "Nothing is too much trouble, very efficient."

- A relative of a patient in the community told us "We're really happy with the care. All the nurses are good."
- A patient at Liskeard Hospital told us "The care is wonderful. Everything I've wanted I've got."
- A relative at Bodmin Hospital told us "The care is personal and of good quality. They predict her needs well and are checking all the time to make sure she's comfortable."

Good practice

We observed and were told that the care and support provided by the Specialist Palliative Care Team was excellent. The care provided to patients at the end of their lives and receiving palliative care in the community was of a very high standard and we saw areas of excellent practice, including the management, assessment and planning of care by the community SPCT and nursing staff.

We saw that there was learning from incidents at Bodmin Hospital and changes to practice made as a result.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve:

- Ensure that all ANDO are completed accurately to ensure patients' preferences, choices and best interests are accurately recorded.

Action the provider SHOULD take to improve

- Ensure that all documentation, including the Allow a Natural Death Order (ANDO) which requires consent supported by a Mental Capacity Assessment, is in place to ensure that the patient's consent and decisions around best interests are served.

- Ensure the current tools used to measure pain and inform pain management are consistently implemented and used. Current practice varies and a clear audit of monitoring and management of pain was not consistently available.

- Ensure guidance relating to the prescribing of anticipatory medicines in end of life care is available to all staff.

- Ensure all learning from incidents relating to end of life care is disseminated across the provider locations.

- Ensure monitoring of temperatures of all mortuary fridges is maintained and is seen to be at a safe level.

- Ensure that the electronic recording system enables staff to record and reference effectively. System 1 lacks capacity to capture multidisciplinary working needed for end of life care across the community.

- Ensure the roll out of the Five Priorities of Care of the Dying is implemented swiftly. Delays in roll out were evident since the withdrawal of the Liverpool Care Pathway in July 2014.

CareQuality Commission

Peninsula Community Health C.I.C
End of life care
Detailed findings from this inspection

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

Requires Improvement ●

Are End of life care safe?

By safe, we mean that people are protected from abuse

Summary

There were effective procedures in place to support safe care for patients at the end of their lives and we saw evidence of reflection, learning and changes arising from incidents. Medicines were provided in line with national guidance and we saw that patients were prescribed anticipatory medicines at the end of life. Access for staff to the policies relating to anticipatory prescribing was not always evident, with some hospitals not having direct access to this guidance. Appropriate equipment was available for staff to safely care for patients at the end of life and it was adequately monitored and maintained.

Records relating to end of life care varied as new documentation relating to the implementation of end of life care planning and the Gold Standards Framework was in its infancy. The GSF is an approach to formalising good quality end of life care to help staff identify the needs of patients at each stage of their care. On reviewing Allow a Natural Death Orders (ANDO) forms five of 25 forms seen were not completed consistently which meant there was a risk that patients' choices and preferences for care may not be met.

Incident reporting, learning and improvement

- Staff delivering end of life and specialist palliative care understood their responsibilities with regard to reporting incidents. Staff were open and honest about incidents. Any incidents reported were reviewed by the end of life lead and any learning was fed back to the relevant location teams. Shared learning across the three locations was not consistent. Staff told us that this depended on the staff member being at the right meeting to be sure that information was cascaded to the other members of the team. The lead person for end of life confirmed this to be the case.
- Serious incidents were reviewed by the Specialist Palliative Care Team leads at their monthly meetings and learning/actions were forwarded to the end of life lead to inform the board.
- There were changes in practice made following serious incidents. At Bodmin community hospital we saw an example of a serious incident relating to care after death. We looked at minutes illustrating the learning

that had been identified from meetings between matrons and ward managers, GP's, general staff and other associated professionals. A staff 'away day' was held to cascade learning and reflect on the incident.

- A further example of learning was the liaison with the national association of funeral directors and a review of the approach for removal of the deceased patient from hospital. Further learning included the provision of face to face verification of death training for nursing staff, a change from the previous online training that nursing staff had undertaken. We saw that six verification of death training sessions had been planned for 2015.

Duty of Candour

- New fundamental standards and regulation for the provider will come into force in April 2015 regarding Duty of Candour (Regulation 20 of the CQC (registration) Regulations 2009). The duty of candour explains what providers should do to make sure they are open and honest with patients when something goes wrong with their care and treatment.
- Staff demonstrated an understanding of their duty of candour. Senior management staff were able to describe how the duty of candour was part of their working life and how openness and honesty related to their practice.

Safeguarding

- Systems were in place to protect people in vulnerable circumstances from abuse. Staff were knowledgeable about their roles and responsibilities to ensure the safeguarding of vulnerable adults and children. Staff understood what constituted a safeguarding concern and could demonstrate easily the processes to follow to make a safeguarding alert.
- Staff told us of learning from a particular safeguarding alert that had been raised relating to a patient from a community hospital. Following investigation, learning had resulted in remedial action being taken.
- The Specialist Palliative care team told us they had all completed level 2 safeguarding training and were booked to undertake level 3 training.

Medicines management

- Medicines were well managed. Inpatients and community patients who were identified as requiring end of life care were prescribed anticipatory medicines. These 'as required' medicines were prescribed in

advance to ensure prompt management of increases in pain and changes in symptoms. The 2013 audit of outcomes for preferred place of dying identified that emergency medications needed 'as required' were prescribed pre-emptively in 58% of cases.

- There were guidelines on the hospital intranet for medical staff to follow when prescribing anticipatory medicines; however when questioned, medical and nursing staff were not always aware of this guidance and its availability. We were told by a range of staff that the British National Formulary (BNF), guidance from hospices and the algorithm that had been part of the Liverpool Care Pathway (LCP) were all in use to support anticipatory prescribing.
- We saw in practice in hospitals and in the community that those patients referred to the SPCT had their medicines reviewed during each visit to ensure they continued to meet their needs. This review also included other medical staff involved in the patient's care. When patients were discharged with anticipatory medicines a discharge planning meeting was organised. All parties involved in the patient's care, including family and carers, were invited to ensure a consistent understanding of how medicines were to be managed.
- We looked at the use the use of syringe driver monitoring charts on the wards. The charts included space for nursing staff to record the rate, check the site, check drug compatibility, check the dose against the prescription, check stock and check that the syringe driver was clean and functioning. We saw one example of a syringe driver in use and that four hourly checks were incorporated as part of the monitoring.
- We saw that the provider had Guidelines for the Self Administration of Medicines to support patients and staff to enable this level of independence safely. Staff in the hospitals told us that whilst they offered patients this option it was rarely taken up except for inhalers and some specific medicines.
- We observed processes on some of the wards for the receipt, storage, administration and disposal of controlled drugs and we saw that administration was recorded in a controlled drug register. There were separate controlled drug registers for stock and patients' own controlled drugs and these were checked on a weekly basis.
- When patients were discharged from hospital staff explained to them and their relatives the medicines to

be administered. For those patients with support from the SPCT and the District Nurse teams this support remained ongoing to ensure medicines were administered safely.

Safety of equipment

- Inpatient and community services had access to appropriate equipment to keep people safe and comfortable. The National Patient Safety Agency recommended in 2011 that all Graseby syringe drivers (a device for delivering medicines continuously under the skin) should be withdrawn by 2015. Peninsula Community Health CIC had withdrawn all Graseby syringe drivers. McKinley T34 syringe drivers were now in place throughout the service. Training and support for their use in the community hospitals and wider community was provided by the Specialist Palliative Care team. A policy (2012) was in place and accessible for staff reference for the use of these drivers and further training was provided as part of Peninsula's Community Health CIC Clinical Skills Week.
- Staff at St Marys Hospital, Isles of Scilly had all completed training to ensure competency with syringe drivers. Two drivers were available, one for the hospital and one for the community.
- Emergency equipment, including a resuscitation trolley, was available on each ward in the community hospitals. We looked at records of equipment monitoring associated with these and found them all to be correct.
- Nursing staff in the community told us there were no issues with ordering equipment for patients in the community who were receiving end of life care and that equipment was available promptly.
- In Helston and Liskeard hospitals there was no record of temperature checks on the mortuary fridges, however we saw completed maintenance records and were told that an internal temperature alarm was in use. We viewed maintenance records for the mortuary fridge at Liskeard Hospital and there was a system in place to manage the breakdown of the fridge, including a 24 hour on call maintenance team. In two hospitals no records were maintained to demonstrate that the fridge temperature in the mortuary was checked to ensure it was working correctly.

Records and management

- Patients' care records were completed well. They were clear and provided an audit trail of decisions, treatment and care. We looked at nine sets of notes related to end of life care and all were fully completed and well maintained for staff to follow. Care plans were maintained for each patient and end of life care was included when needed. These records were stored at the patient's bedside for staff to follow.
- Detailed and sensitive discussions were recorded in an appropriate manner within the Gold Standard Framework assessment records. These assessment tools were used to identify if patients were considered to be in the last 12 months of care or nearing the end of their lives. Discussions by medical and nursing staff in relation to stopping unnecessary observations and non-essential medicines were recorded.
- An Audit of the Allow a Natural Death Decision (ANDO) forms was undertaken by the provider from August 2014 to October 2014 on 18 wards in 13 community hospitals. The policy of Peninsula Community Health CIC was that there would be an attempt to resuscitate any person in whom cardiac or respiratory function ceased, unless a valid ANDO decision had been made. Should a patient be admitted from another hospital or trust with a 'do not resuscitate' form in place they must be reviewed with 72 hours of admission and switched to the ANDO form.
- The audit demonstrated three Peninsula Community Health CIC hospitals achieved 100% completion of the ANDO forms. 102 out of 291(35%) inpatients had an ANDO decision in place. 48% of patients had been involved in the decision. Of 291 forms reviewed capacity was not recorded in 7% of cases and discussion with relatives was not always recorded. 45% of cases had no documented provision for review.
- We reviewed the ANDO form being used and saw that whilst there was a box to record the date of the review, there was no available space to identify what was reviewed. There was no space to record discussion with the patient and/or their relatives and there was no space to identify if the patient was still in agreement with the previous decision.
- We reviewed 25 Allow a Natural Death Orders (ANDO) forms of which all had been signed by a GP in line with the organisational policy.
- Five of the forms we reviewed had not been completed correctly. We saw on two forms the term 'medical futility' was used instead of a clear summary of the main clinical reasons why cardiopulmonary resuscitation (CPR) was inappropriate. In two cases there was no

detailed documentation of discussions with the patients' relatives and in another case we saw the use of an abbreviation on the form. This use of abbreviation may cause confusion about actual meaning.

- In Falmouth Hospital we observed an ANDO had been completed which stated the patient did not have mental capacity to be included in discussion about that decision. However the mental capacity assessment noted that the patient had improved and now had capacity. The ANDO had not been reviewed and updated to reflect this change in mental capacity. This meant that the patient's choice for care may not have been accurately reflected or recorded.
- The omissions in regard to recording a patients capacity may have led to a risk that a patient could be resuscitated when their wish was not to be or that a patient would not be resuscitated when a decision to resuscitate them may have been made had their capacity been assessed and a decision agreed.
- We saw one patient had two ANDO forms in place. The patient had an ANDO from a previous admission to Falmouth Hospital which was being used. This was despite a more recent ANDO from the local acute hospital trust having been completed. We spoke with staff who acknowledged this may have been an error in administration. The Allow a Natural Death (AND) Policy and Guidance Framework for Adults (2012) had a decision making framework taken from a joint statement, courtesy of the British Medical Association (BMA) Resuscitation Council (UK) and Royal College of Nursing (2007). The policy document was not clear around the review of patients and how and where these reviews were to be recorded.

Cleanliness, infection control and hygiene

- There were infection control and prevention systems in place to keep patients safe. The ward areas we visited were visibly clean. There were sufficient hand wash basins, liquid soap, paper towels, hand gels and protective equipment in wards and side rooms.
- Infection control procedures in the community were followed by staff. These included the use of hand gel, protective equipment and hand wipes.
- We visited the mortuaries at Liskeard Hospital, Fowey Hospital, Helston Hospital and Camborne Hospital and saw that they were mostly clean and well maintained, with hand washing facilities available.

- Staff would advise undertakers of any relevant infection control risk to ensure they could take account of any additional measures required.

Mandatory training

- Mandatory training was provided for all staff and was undertaken by all staff providing end of life care. Data produced by the provider stated 91% all of staff were compliant with the seven core mandatory training requirements. Staff confirmed that training provision was well managed and accessible.
- Education was provided by the SPCT on both a formal and informal basis to staff including some staff from external agencies. This included symptom control, communication and advance care planning.
- Staff we spoke with confirmed they had attended syringe driver training and those we spoke with about safeguarding confirmed they had received safeguarding training.

Assessing and responding to patient risk

- Staff assessed and managed patients' risks as part of an ongoing process. We observed good use of general risk assessments for patients receiving end of life care. This included the assessment of risk in relation to nutrition and hydration, falls, the use of bed rails and the potential for pressure area damage.
- Deterioration in a patient's condition was recorded and treatment amended as required. Advice and support from the SPCT regarding deteriorating patients was available in hospitals and in the community. We observed an occasion when this support was requested and saw the SPCT visit the ward to offer support and advice. Changes in a patient's condition were recorded in their daily notes by nursing, medical and therapy staff. Early Warning Scores were in place as part of care plan documentation but were not consistently used. They were evidently used in Edward Hain Hospital, Falmouth and Bodmin Hospital. Stratton and Bodmin Hospitals were part of a pilot scheme, not yet fully rolled out, which was looking at an adaption of the National Early Warning Scores (NEWS) chart template to be used in the community hospitals.
- We saw that in two patients' records when the Early Warning Scores had reached four and above (an indication that further medical help is needed) the doctor had been informed and the action taken was recorded.

- As part of the Priorities for Care initiative being implemented, a new end of life care plan format was being rolled out. The Leadership Alliance for the Care of Dying People (LACDP) published a new approach to caring for people in the last few days and hours of life, that focuses on the needs and wishes of the dying person and those closest to them, in both the planning and delivery of care wherever that may be. This approach details the five priorities of care. We saw a copy of this care plan available for each patient but did not see this completed in any of the hospitals with the exception of Helston Hospital where one form had been completed. Staff told us training around the use of the care plan had been arranged and that implementation was expected in the weeks following our inspection. They explained that the current lack of use was because the form was in its infancy. A post implementation audit was to be carried out to review the compliance and effectiveness of the new care plans, scheduled for October 2015.
- The Gold Standards Framework (GSF) was an assessment tool in use throughout the community hospitals we visited, with the exception of Fowey Hospital. The GSF assessment tools were used to identify if patients were considered to be in the last 12 months of care or nearing the end of their lives and are an approach to formalising good quality end of life care. By using an assessment process this may help staff to identify the needs of patients at each stage of their care.

Staffing levels and caseload

- Staffing levels were sufficient to ensure that patients received safe care and treatment. End of life care was provided in the community hospitals and community seven days a week. Specialist Palliative care was provided from 8am to 5pm seven days a week. Outside of these hours and weekends, end of life care was provided by ward staff with access to specialist support from a local hospice. This support from the hospice included advice from nursing, medical and consultant staff.
- The SPCT employed 19 nurses (18.6 whole time equivalent), divided into three teams, based geographically around the county and allocated to GP surgeries. Each team was managed by a team leader. The team was staffed by a combination of Band 6 and 7 nurses. Staff told us that currently staffing levels for the SPCT were acceptable to meet their workload.

- One SPCT clinical nurse specialist (CNS) we spoke with told us their caseload was manageable and enabled them to spend adequate time with patients in order to properly assess their needs and liaise with other professionals to manage their symptoms.
- The SPCT started work each morning from their office bases to review the allocation of referrals and existing caseload. When sufficient Peninsula Community Health CIC and trained nurse staff were not available agency staff were used. Agency staff were never used within the SPCT and the team shared workloads to cover sickness and annual leave. Some concerns were identified that agency staff may not have the specialist training needed.
- Ward staff told us that staffing levels varied but for patients receiving end of life care extra staff could / would be provided as required to ensure they received the specialist support and care they needed.
- Staffing levels on the Isles of Scilly were reported as not sufficient. A representative for Peninsula Community Health CIC on the Islands explained that by the end of April 2015 they would be 80 hours short of their establishment and were now advertising nationally. This meant that staff from the mainland sometimes travelled over to cover shifts and staff worked extra hours to cover shifts. It was not evident that this shortage impacted on end of life care.
- Medical cover for each hospital was provided by an allocated local GP and in most cases provided a consistency of service. Within the community, medical cover was provided by the patient's own GP. The GP took lead responsibility for end of life and palliative care provision, with advice and support available from a consultant at the local hospice in Cornwall. Should the patient have a medical consultant this was specifically linked to any other illness than the palliative care they may be receiving, the consultant would be from a local trust. Out of hours medical cover for hospitals and community was met by the out of hours doctor service. Patients and staff told us of delays in accessing these services through the current 111 on call system. This had evidently impacted on patients who sometimes waited a long time to see a doctor or in more acute circumstances, needed to call an emergency ambulance as an alternative to waiting.

Managing anticipated risks

- There were systems in place to support staff to manage risks safely. Over the last 18 months Peninsula Community Health CIC had worked closely with the National Gold Standard Framework centre and a community hospitals accreditation training programme had been taking place. This focused on the organisational and system changes needed to improve the coordination and quality of care. Twelve wards had since progressed to accreditation and a further four wards were working towards accreditation in 2015. Further policy development was ongoing. Fowey Hospital had yet to start working towards accreditation.
- The implementation of the Gold Standard Framework meant that admission documentation, care plans and coding used to identify changes in condition supported proactive care planning for people with changing end of life care needs.
- All patients, who had a GSF code to indicate current health status in place or not, were given a leaflet on advanced care planning and were offered the opportunity to complete an advanced care plan. We saw descriptions of what this meant to the patient on wards and side rooms. This was a voluntary process of discussion and review to allow a person with capacity to make choices about how they wished to be cared for and the treated should they lose capacity in the future to make decisions. The provider used a document called 'Thinking Ahead and Preferred Priorities of Care', allowing patients to decide which format of advance care plan they wished to use to identify their choices and preferences.

- Policy guidance for staff in advance care planning (2014) was available to staff and set out their responsibilities to support patients with advance care planning.
- Guidance was available for patients should they wish to make an advanced decision to refuse treatment. The advance decision would only come into effect if and when the patient lacked capacity to consent to or refuse treatment.
- In order to manage anticipated risks, weekend and out of hours plans were made as part of the multi-disciplinary process. This enabled patient care to be planned to meet their needs and supported good communication between all members of the multidisciplinary team.
- Staff in the community told us about plans in place to reach patients who were less accessible in the event of poor weather, such as snow or flooding. Hard copy records were maintained to enable staff to access records and so spread the workload to staff with more weather suitable vehicles. Staff told us that they were used to the inclement weather and would reallocate visits as needed to ensure priority patients were visited.
- Staff also took into consideration seasonal fluctuations and the extra time that may be needed to move around the county during busy holiday periods.
- Staff had a clear understanding of the lone working policy. They followed safe systems to ensure when working alone in the community they informed colleagues of their whereabouts and 'checked in' regularly.

Are End of life care 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

Treatment provided was mostly effective. We saw areas of excellent practice including the management, assessment and planning of care by the Specialist Palliative Care Team.

Pain assessment tools were in use, although there were a number of different tools and it was not always clear which was being used. As a result, pain assessments were not always clearly documented.

Allow a Natural Death (ANDO) decisions relating to not attempting cardiopulmonary resuscitation did not consistently include mental capacity assessments in situations where patients had been identified as lacking mental capacity.

The Gold Standards Framework (GSF) was being widely implemented throughout the organisation. The GSF is an approach to formalising good quality end of life care to help staff identify the needs of patients at each stage of their care. The GSF was being used to develop good quality end of life care and most wards we visited had achieved accreditation, with the remaining wards working towards it (with the exception of Fowey Hospital). We looked at care planning documentation that was based on the Leadership Alliance's Priorities for the Care of Dying People that had been developed and was due for full implementation in the coming weeks.

Evidence based care and treatment

- The SPCT delivered care in line with evidence based guidance such as Improving Supportive and Personal Care for Adults with Cancer developed by the National Institute for Health and Clinical Excellence (NICE).
- In response to the withdrawal of the Liverpool Care Pathway (LCP) in July 2014 and following the release of the national guidance One chance to get it right, a working group of staff from community hospitals and the SPCT had been formed. They had developed a strategy entitled Five Priorities for Care of the Dying Patient which was launched in January 2015 which was some months since the LCP was withdrawn. Training for all staff was to be provided by the SPCT with information, support and a planned annual audit put in place.
- The Liverpool Care Pathway (LCP) had been phased out nationally in July 2014 and staff confirmed that it had not been used since this time. While we did not see the LCP in use on the wards we did see documentation, including admission forms and advanced care planning documents that made reference to the LCP. Staff assured us this was simply because the documentation had not been updated.
- We saw that the Gold Standard Framework (GSF) was in use to develop good quality end of life care based on the wishes and preferences of the individual. It was used to help staff identify the needs of patients at each stage of their care through detailed assessment.
- The provider used Allow a Natural Death Orders (ANDO). These records were used to document discussions with patients and their relatives about the 'ceilings of care' (which treatments would or would not be appropriate when a patient's condition deteriorates).

Pain relief

- There were tools in place to assess and monitor pain, and pain control was a priority in palliative care. Nursing staff used an assessment tool to provide a score to identify the severity of a patient's pain. There were prompts for staff to identify when patients were not able to articulate their needs, for example, if patients had a level of dementia or cognitive impairment. There was a specific Pain Assessment in Advanced Dementia (PAINAD) form in use for patients with cognitive difficulties.
- The pain management review was duplicated on an assessment tool, care plan and medication record. It was unclear which assessment tool was being followed and in most instances each was partially filled out but not fully completed. Staff told us that the medication administration record demonstrated that at each medicine round the patient was asked if they had any pain and the treatment was recorded. We saw that this was not consistently done and in some cases the

Are End of life care effective?

medication record demonstrated analgesia had been given but there was no record of how this pain level had been ascertained. Staff confirmed that patients were asked about pain each time care was provided. Not all of these reviews were scored in the same place to identify any patterns of pain and so focus pain management to meet patients' needs. This lack of consistency and continuity of pain management plan did not provide a clear audit trail of how the patient's pain was being managed.

- We looked at the records of a patient at Bodmin Hospital. It was documented that they had been in pain but multiple pain charts had not been completed. The patient's prescription chart included a completed evaluation of their pain and we saw from their nursing and medical records that their analgesia had been reviewed but it was unclear which assessment method had been used. There also appeared to be a number of days' time lag between nursing staff recording the need for review and the patient's analgesia being amended.

- We reviewed nine sets of records and noted that most patients' pain was well controlled. We observed a community specialist nurse assessing patients' pain levels in the community. They used a pain assessment scale and assessed the type and duration of pain, as well as what made the pain better or worse. We observed three community visits when the community specialist nurse was making arrangements to increase or amend patients' analgesia.

Nutrition and hydration

- Nutrition and hydration were assessed and monitored. We saw that patients were assessed using the Malnutrition Universal Screening Tool (MUST) which is used to identify nutritional risks. A care plan was then put in place and documented identified risks and how they were to be managed, whilst taking into consideration the patient's choices and preferences in relation to food and drink. We saw that when a patient's nutrition and hydration was identified as presenting a risk, their food and fluid intake was recorded.

- We saw that drinks and snacks were available by each patient's bed and staff described recent occasions when requests for specific food items were sourced. Helston Hospital provided a fridge for family members to store food they had supplied for their relatives which they could access at all times. At Liskeard Hospital we saw that the matron spoke with a patient who wanted an

alternative to the food being offered in order to ensure their nutritional needs and preferences were being met. We saw that patients in the last days of life were able to eat and drink as they wished. There was guidance for staff around this and the need for patients to be able to make informed choices even when a risk of choking had been identified

- Specialist dieticians were available for advice from the local NHS trust.

- We were unable to observe how nutrition and hydration were managed at the end stages of life but staff described how each patients' end of life needs were evaluated and staff supported them to be as comfortable as possible. A new fluid monitoring tool was in use at the bedside which was person centred and easy to use which supported staff to identify why a person was not drinking. Staff told us this tool may be useful for patients receiving end of life care, particularly around the cultural dilemmas for eating and drinking.

- We looked at care records that demonstrated the use of regular mouth care and comfort sips for patients who were no longer able to eat and drink without support.

Approach to monitoring quality and people's outcomes

- The use of the Gold Standard Framework (GSF) was audited and showed that in July 2014 62% of patients on the GSF were supported to make advance care plan decisions. Of the patients audited, 60% died with an end of life care plan in place and 80% of carers were offered bereavement information and support.

- The National Survey for Bereaved People aims to assess the quality of care delivered in the last three months of life for adults who die in England and to assess variations in the quality of care delivered to patients across different parts of the country. The survey showed that Peninsula Community Health CIC scored well for involving people in decisions about care and the help and support provided by the healthcare team at the time of death.

Outcomes of care and treatment

- Outcomes for patient care and treatment were routinely recorded. Eighty-one per cent of patients referred to SPCT died in their preferred place of care, when this had been identified. Seventy-seven per cent of patients identified their preferred place of care, which exceeded the provider's 75% target. Eighty- three per cent of

bereaved main carers were contacted within a week of death, under the 90% target. Under performance in this area was identified during the year as a data collection error, that when addressed resulted in the final five months of the year achieving 93%.

- The National End of Life Intelligence Network had analysed deaths in Cornwall for 2010-2012 and benchmarked the local Kernow Clinical Commissioning Group (KCCG) with all other areas in England. This comparison showed that within the county a lower rate of patients died in a hospital setting (45%) and a higher percentage of patients died at home (24%), in care homes (24%) and in a hospice setting (5%).

Competent staff

- End of life care and palliative care was provided by well trained and competent staff. The Community Specialist Palliative care Team produced a performance summary April 2013 to March 2014. This summary informed about staffing levels, training undertaken and supervision records and noted a positive patient experience response.
- Ward and community staff we spoke with told us the specialist palliative care nurses acted as a resource and point of contact for advice and participated in delivering training in end of life care. Staff was able to contact a specialist palliative care consultant at the local hospice for advice around symptom management.
- Planned training sessions for community nursing teams to develop the Five Priorities for Care of the Dying patient was provided by the Community Specialist Palliative Care Clinical Nurse Specialists. Education was provided by the team on both a formal and informal basis within Peninsula Community Health CIC and to external providers on aspects of palliative care such as communication skills, advanced care planning and symptom control. We saw training records that demonstrated syringe driver and verification of death training was mandatory for ward based nurses.
- There were end of life 'link' nurses and healthcare assistants who were based on the wards in the community hospitals. They provided information and support to their colleagues. We saw evidence of link meetings attended by the link staff and general ward staff told us that the link staff took a special interest in end of life care initiatives and communicating with other staff about these.

- Staff at St Marys Hospital on the Isles of Scilly told us that they felt supported by the SPCT on the mainland. We spoke with the SPCT lead for St Marys Hospital who explained that she visited the island once a month or more if end of life care support was more complex. The SPCT provided training, support and advice both by telephone and in person. Staff at St Marys Hospital were keen for us to know that they were proud of the way they supported end of life care. The senior nursing staff all held diploma level qualifications in palliative care.
- The SPCT hosted student nurses, medical students, trainee GPs and allied health professionals to help them develop their palliative care skills. Peninsula CHC advised that currently this data was not captured in quantifiable terms.
- Clinical supervision was offered by the team to members of Peninsula Community Health CIC staff. This supervision was for district nurse teams. Supervision of the SPCT was undertaken by the team's managers. 100% of staff had completed an annual appraisal linked to specialist palliative care competencies within the previous year and this included a personal development plan.
- GPs were responsible for medically reviewing patients at the end of life within the community hospitals and we saw that they attended monthly meetings where they would participate in reviews and learning from patient incidents. This medical cover did not include an out of hours service.

Multidisciplinary working and coordination of care pathways

- There was a good approach to multidisciplinary working in end of life care. The SPCT audit for 2013 demonstrated that the county had a lower rate of patients dying in a hospital setting and a higher rate of patients dying in other settings. To achieve this, coordination was required and the involvement of a wider multidisciplinary team.
- Multidisciplinary working took place during inpatient admissions and continued in the community setting. The multidisciplinary team included hospital medical and nursing staff, therapists, the SPCT, GPs, pharmacists and discharge planning leads. Daily teleconference meetings were held with senior staff across the community hospitals to manage admissions, discharges and other aspects of multidisciplinary working. On inpatient wards these meetings enabled a wider team to

Are End of life care effective?

discuss each patient requiring end of life care. End of life consultants from a local hospice did not routinely attend these meetings and the lead medical role was undertaken by the GP covering the hospital. The medical consultant was available by telephone if required and was included in decisions about care and treatment.

- Access to general medical cover varied across community hospitals, with a mixture of GP, staff grade, consultant and junior doctors. Out of hours medical cover was provided by the out of hours primary care service via the 111 service. Hospital and community staff reported concerns about the responsiveness of the service, with some reporting waits for a call back for up to an hour.

- In the community the multidisciplinary meetings took place at the local hospice where the medical consultant attended and led the reviews. These were attended by the SPCT for Peninsula Community Health CIC

- GSF meetings were held in the community at GP practices and attended by the SPCT nurses to discuss the care and treatment of individual patients at the end of life.

- We saw that when end of life had been identified as imminent a pre-notified death form had been completed and sent to the on call service to ensure that there was continuity of information in preparation for any care needed out of hours.

- Weekend plans were developed following multidisciplinary discussions. These recorded potential problems which may occur over the weekend and actions for staff to take to ensure that the plan of care was followed.

Referral, transfer, discharge and transition

- Patients were referred and transferred appropriately. The discharge or transition to an alternative place of care was a multidisciplinary process which included the input of ward nurses and doctors, therapists and external support agencies who would be involved in providing end of life care at home.

- All discharge documentation for patients identified as approaching the end of their life included the Gold Standard Framework coding indicator. If a patient due for discharge was coded 'yYellow' or 'rRed', the staff would telephone the GP and the District Nurse prior to the patient going home.

- This information was then forwarded to the patient's GP with an explanation of what it meant.

- As part of the discharge process from the community hospital all patients coded 'amber' or 'red' on the GSF indicator tool would receive appropriate anticipatory prescribing to ensure the medicines they had in place were tailored to their condition and their likely disease progression.

- Equipment and care packages were put in place in a timely fashion through a 'fast track' system. If any delay was identified, staff of Peninsula Community Health CIC would look at other options in order to achieve the patient's wishes of getting home. Equipment on the Isles of Scilly for end of life care was retained to enable any future needs to be managed quickly.

- Fast track discharge provision was in place. Staff explained that while safety was a priority, every effort was made to ensure that a patient requesting to go home was enabled to do so safely.

- Some difficulties were identified for discharges back to the Isles of Scilly. This was around timings related to transport and the arrangement of suitable transport, for example, an aeroplane with a stretcher facility. Consideration was being given to a short admission to St Marys Hospital to ensure the home setting was set up and suitable for end of life care before travel was undertaken to the more remote islands.

- We observed a discharge to a community hospital which was not well communicated or planned. This meant that the ward were not fully aware of the patient's needs. This had been rectified by staff at the community hospital. We reviewed the patient's notes and saw that every effort was made by the hospital staff to ensure the patient's needs were met and that the patient and family were well supported.

Availability of information

- Staff had access to relevant patient information. We saw that risk assessments and care plans were in place for patients at the end of life. Patients who were identified as being in the last year of life were assessed using the format recommended by the GSF. The use of the GSF provided a framework for ensuring information about patients' wishes and preferences was incorporated into their plan of care.

Are End of life care effective?

- We viewed care records that included sections for test results. Staff told us that test results were available promptly and that in the community there was access to shared systems where information was stored.

- Records in the community were kept in both paper and electronic formats. The implementation of an electronic recording system was problematic for some staff and additional systems had been put in place to ensure safety for patients. These included the addition of paper records in patients' homes and a paper record being maintained in offices in case of poor weather. This was because staff were sometimes unaware from the electronic information available, of the outcome of any previous recent visits. Further safeguards, such as staff being contacted by telephone each morning to confirm visits, had been implemented. This was because the electronic system had experienced some delays in uploading. The provider told us that further changes and training were planned in the near future to improve the electronic system in place so that it was more workable for community staff.

- Electronic systems for records varied across community services providing end of life care. The systems did not link to provide information for all staff involved. The hospital system did not link to the community system, which did not link to the GP system. This meant the duplication of records and increased work for staff. The Isles of Scilly were not linked electronically to the mainland and all information was in paper format.

Consent

- Staff considered the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards during multidisciplinary working. Staff completed online training for the Mental Capacity Act 2005. Minutes from a monthly professional practice forum in November 2014 noted that an update of all staff training in this area and the Deprivation of Liberty Safeguards was to be reviewed as not all staff had completed the training.

- We looked at advanced care planning documentation for preferred priorities of care which included a 'best interest' version. The standard version incorporated details of the patient's wishes and the best interest version included details of who was consulted and their views on what was considered to be in the best interests of the patient. We saw that patients were asked if they had an advanced directive on admission.

- Peninsula Community Health CIC provided staff with a best interest assessment document for end of life care decision making. This document described how a clear decision could be made on behalf of someone else. This document detailed the process of a mental capacity assessment and a best interest assessment and included the principles to follow. This document stated 'An assessment of an individual's capacity relates to a particular decision at a particular time. It can fluctuate and needs to be reassessed for each new decision and if it is felt that the patient's condition has changed.

- Nursing staff were knowledgeable regarding the processes to follow should a patient's ability to provide informed consent to care and treatment be in doubt. We looked at three records at Edward Hain Hospital and Helston Hospital and saw that mental capacity and best interest processes had been followed and documented. We saw these three records identified when and which relatives/representatives had been involved in decisions and the date of the best interest decision.

- Medical staff we spoke with told us they did not routinely complete a mental capacity assessment for patients who they considered did not have capacity when making an ANDO/ CPR decision. This may mean that the decisions made may not be fully understood by the patient and decisions made may not be what they would want.

- An audit of ANDO forms in 2014 demonstrated three Peninsula Community Health CIC hospitals achieved 100% completion of the ANDO forms. 102 out of 291(35%) inpatients had an ANDO decision in place. 48% of patients had been involved in the decision, with 45% recorded as having capacity to do so. Capacity was not recorded in 7% of cases we viewed four ANDO forms where decisions not to attempt CPR were recorded where the patients lacked mental capacity. We did not see completed mental capacity assessments for any of these patients.

- We saw that where patients were unable to consent to discharge, to a place of care other than their home due to a lack of mental capacity, best interest decisions were made following a mental capacity assessment. We saw another ANDO form had been completed without discussion with the patient, who had been identified as having capacity to make the decision. A further ANDO had been completed which identified the patient did not have capacity. The supporting mental capacity

Are End of life care effective?

assessment was with reference to discharge planning and not the completion of an ANDO form. This may have caused some confusion about decisions the patient had capacity to make.

- Deprivation of Liberty procedures were followed when identified. We saw these were clearly recorded with a date for reassessment / renewal.

- A resuscitation officer role was in place to support staff around discussions and decisions relating to resuscitation. This staff member also offered training around the completion of the ANDO documentation.

Are End of life care caring?

Good 🟢

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

Summary

Patients and relatives spoke positively about the compassion and care they received from staff in community hospitals and in the community. We observed kind and caring interactions between staff, patients and relatives. Spiritual, pastoral and bereavement services were available as an on call arrangement in the community hospitals and palliative care specialist nurses provided emotional support and advice in the hospitals and community.

Dignity, respect and compassionate care

- Patients were treated with dignity, kindness and compassion. Without exception, everybody we spoke with, both in the hospitals and the community, considered staff to be empathetic, professional, supportive and kind. We observed care being provided and saw that staff were always respectful and included family and carers in the care they provided.
- In the National Survey for Bereaved People the service scored highly for dignity and respect provided by nurses and doctors both in hospitals and in the community.

- Most patients receiving end of life care were given the privacy of a single room, or if that was not possible privacy was considered at all times. Staff spoke about end of life care with understanding and demonstrated a passionate desire to ensure the care provided was right for the individual person.
- Chaplaincy services were in place but had been amended as of January 2015. Services varied from hospital to hospital, dependent on the patient's choice and local arrangements. A volunteer coordinator was available and there were also spiritual and pastoral volunteers who visited the wards to provide support.
- Staff were mostly clear about what route to take to access chaplaincy services or specific faith requests. However no local numbers were available and staff were advised to contact the Bishop's office directly to contact the interfaith advisor. Out of hours arrangements could be made through the nearby trust switchboard that held

a list of 'some chaplains available across Cornwall'. Staff told us that mostly patients in the hospitals had access to their local chaplain and it would be unusual to have to follow the route through the Bishop's office.
- We saw that some hospitals had a prayer room/chapel and these could be used as multi-faith rooms. There was no access to private prayer rooms or ablution areas for staff or patients.
- Hospital mortuary facilities varied. Some hospitals did not have any mortuary facilities and so direct contact with undertakers was made after death. The relatives of deceased patients were asked for their preference. Should that not be possible a local undertaker was called and the deceased patient remained in their care until a decision was made.
- The hospitals with mortuary facilities held records of when facilities were used and by whom.
- St Mary's Hospital had a mortuary and a non-denominational chapel of rest. All burial funerals were managed on the island by a local undertaker.

Patient understanding and involvement

- Care provided by hospital and community staff included the care of relatives and carers. We observed staff including patients in the care being provided. We also saw records of conversations and decisions in which the patient and their relatives had been included. Staff told us about occasions when carers of patients with a learning disability, dementia or other cognitive impairment were supported to stay at the hospital to support the patient and minimise any distress. Visiting for families of patients receiving end of life care was unlimited and hospitality and support was provided by staff.
- We saw the use of the GSF on wards and we were told by the specialist palliative care nurse that this was widely used in the community for patients in the last year of life. The GSF was geared towards involving people in the planning of their care and we saw evidence of patient agreed goals and outcomes being identified.
- We looked at documentation about advanced care planning and saw that patients were asked about advanced wishes on admission to the community hospitals.

Are End of life care caring?

- Staff undertook training in communication. We were told by staff and saw evidence of a communication skills training day to support staff to communicate well with patients and relatives to support end of life care.
- We saw areas of excellent practice, including the management, assessment and planning of care by the community nursing staff. We observed patients in discussion with the SPCT. These discussions included initial assessments and planning of ongoing care. We saw difficult conversations were managed sensitively and practically and that the care plans put in place met the patients and family's needs.

Emotional support

- Staff had a good knowledge of local support networks. Bereavement support was provided by three different external providers which were referred to by the SPCT. The SPCT contacted relatives within seven days after death and advised of the services available. A standard letter could be sent out within six weeks after death; however the SPCT preferred to ring families and discuss what support was needed. After each death the SPCT would inform the patient's GP to enable ongoing support for the family members.
- Staff told us they felt they had the time to spend with patients to support their emotional needs. We observed hospital and community staff spending time with patients and their relatives to establish emotional support needs and provide appropriate support and advice.
- Helston Hospital had a separate facility for relatives to stay overnight. This also allowed staff to assess if they would be able to provide the support and care needed overnight to enable their relative to go home.
- Staff in Falmouth Hospital described how pets were able to visit the ward should patients find this therapeutic. Recently dogs had visited patients who missed them and found comfort from seeing them.

Promotion of self-care

- We observed care being provided within the community and saw that promotion of self-care took place. We saw patients and relatives being actively involved in their plan of care; they were supported to ask questions, make suggestions and decline suggestions and treatment that they did not want. We saw that staff let the patient take the lead in decisions about issues such as diet, exercise and medication arrangements.
- We observed patients on the wards being supported to take the lead in their own care as appropriate. This included inclusion in decisions about staying in bed and bathing.

Are End of life care responsive to people's needs?

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

Summary

Services were planned and delivered to meet people's needs, including those people in vulnerable circumstances. The community Specialist Palliative Care Team were responsive to people's needs and contact following referral to the team was in line with identified targets. Learning and changes as a result of complaints was achieved through reflection and cascade of information. Staff reported that there had been some issues with the responsiveness of out of hours medical support.

Planning and delivering services which meet people's needs

- Services were planned and delivered to meet patients and relative's needs. Staff described how important 'community' was in Cornwall and how location was always considered so that end of life care was delivered as close to home, family and friends as possible. We spoke with a staff member who told us that if a patient lived near Falmouth, somehow that would be the hospital they would go to. Every effort would be made to ensure discharges from other hospitals met the right geographical need of the patient.

- In 2013 the SPCT had 1470 new patient referrals and 412 patients having new episodes of care, 92% of patients were contacted within 2 working days of referral and triaged, exceeding the 90% target. The provider told us that these figures when added to current ongoing caseload management of patients resulted in the team undertaking 1610 assessment visits and 6193 follow up visits during 2013 .

- The SPCT worked with patients and carers to identify their preferred place of care. The provider data for preferred place of death from 2013 showed that this place was identified for 77% of patients, the preference was achieved in 81% of cases.

- The Community SPCT carried out audits in order to demonstrate that the implementation of national NHS end of life care strategies locally had influenced care and outcomes for patients. The SPCT audit for preferred place of death for 2013 demonstrated that the county had a lower rate of patients dying in a hospital setting and a higher rate of patients dying in other settings. Of the patients cared for by team 22% died in a hospital setting (acute and community), 48% died at home, 11% died in care homes and 19% died in a hospice setting.

- The SPCT had established links with the local hospice and used this service for out of hours support. Three consultants at the hospice were available to provide the ongoing support, treatment and care to patients in the wider community. One consultant was available at the local NHS trust to provide that service to patients being discharged from the trust to the community hospitals and the wider community.

- We observed care being delivered in the community. We saw staff made every effort to ensure that people's needs were met, including medicines being delivered, equipment being provided and support for relatives being put in place.

Equality and diversity

- We saw that all patients receiving end of life and palliative care were treated as individuals. Equality and diversity training was delivered to all staff during induction and then updated/refreshed every three years.

- We viewed multi-faith rooms at Bodmin and Liskeard Hospitals that had information relevant to people from different faiths. These rooms were neutrally decorated to provide a space appropriate for the use of people from multiple faiths.

Meeting the needs of people in vulnerable circumstances

- We saw that the Gold Standard Framework (GSF) was in use to develop good quality end of life care based on the wishes and preferences of the individual and was used to help staff identify the needs of patients at each stage of their care through detailed assessment.

- Hospital and community staff had support and advice from a link nurse for people with dementia. The SPCT worked with the dementia link nurses to provide care to those patients with both end of life needs and an encroaching dementia. There was recognition by staff that an individualised approach was needed to support patients with dementia as they approached the end of

Are End of life care responsive to people's needs?

life. There was also awareness that time was important to ensure patients' needs and choices were identified before there was a loss of capacity and so sensitive discussions were undertaken.

- We saw that patients were offered the information about attending a memory café to support patients with short/long term memory loss. A magazine was also available The Weekly Sparkle which provided reminiscence and current information for patients.
- Hospital and community staff had support and advice from the learning disability nurse. Some wards had used care passports when patients had brought them in and in some instances their own carers had stayed with the patient to support their needs. We saw that some signs, for example one providing information about protected mealtime service was also available in easy read format.
- Staff were able to clearly explain the challenges of caring for patients approaching the end of their life who were part of the homeless community and what this involved.
- We saw that translation services were available by telephone. This service involved dialling the advised number and the translation taking place by telephone. Staff confirmed this was used and had been successful.

Access to the right care at the right time

- The SPCT responded to referrals from consultants, GP's, hospital and community staff for adult patients who had complex support/complex symptom management

needs during end the end of their lives. They responded within 24 to 48 hours of receiving the referral and the support requested included the support to families of the patients referred.

- The 2013 audit – Community Specialist Palliative Care Team outcomes for preferred place of dying identified that of the 28% acute admissions in the last six weeks of life, 84% of these admissions were thought to be clinically appropriate.
- Ninety-two per cent of patients referred to the SPCT were contacted within 48 hours of referral and triaged. Staff on the wards told us that SPCT nurses would see patients within 24 hours if needed and they responded to requests for telephone advice on the same day. We looked at patient records and saw evidence of review by members of the specialist palliative care team as needed.

Complaints handling (for this service) and learning from feedback

- Complaints and concerns were listened to and learning was used to improve services. The SPCT had received four complaints and 14 plaudits for the care they had provided over the previous year. We looked at three of these complaints and responses and saw that they had all been investigated and responded to within an appropriate timescale. In each case investigation and explanation had been provided.

Are End of life care 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

The vision and strategy for end of life care was evident through the behaviour and attitude of staff throughout the hospitals and community services. Governance systems were in place to monitor the quality of the service provided.

Leadership of end of life services by the specialist palliative care team was clear to staff throughout the hospital and community services. All staff we spoke with valued the expertise and leadership of the Specialist Palliative Care Team.

We saw that innovation was welcomed to develop the services provided. Staff had an open approach to learning and developing the service.

Service vision and strategy

- There was a vision and strategy for end of life which was being rolled out across the service. The strategy had recently been updated to incorporate the provider's Five Priorities for the Dying Patient. The development of these priorities took into account guidance published by the Leadership Alliance for the Care of Dying People (LACPD), outlining a new approach to caring for people in the last few days and hours of life, which focusing on the needs and wishes of the dying person and those closest to them.
- Staff we spoke with told us they felt the organisation had sufficiently prioritised end of life care and that there had been senior management representation at planning meetings relating to end of life and palliative care.
- The Specialist Palliative Care service retained links with the South West Strategic Clinical Network to enable discussion on processes and implementation of new priorities.

Governance, risk management and quality measurement

- Governance systems were in place to monitor the quality of end of life services. The SPCT leaders held monthly meetings which recorded discussions and

issues raised. An action log was maintained to identify priorities and responsibilities. Minutes of the December 2014 meeting identified completion of previous tasks and plans for the future to include a satisfaction survey.
- The professional Practice Forum held monthly meetings. The minutes of the meeting held in November 2014 demonstrated that end of life care was represented and discussion around guidance and practice took place. The forum reported to the Safety and Quality Committee and ultimately to the board.
- Mortality reviews took place following all patient deaths. An audit of shortfalls was compiled and an action plan of learning had been taken from these reviews. We saw that GPs who worked within Peninsula Community Health CIC received an update document to highlight areas for review. Mortality reviews formed part of that update to develop practice.
- The SPCT were also represented within a clinical forum led by the local Clinical Commissioning Group. This forum provided an opportunity to look at the full scope of services and included local trusts and ambulance services. This forum enabled feedback to the SPCT on practice issues around end of life care.
- Audits for end of life care were part of the providers annual clinical audit programme including GSF audits and ANDO audits which were reviewed by the Head of Governance and contributed to the monthly board report.
- There were two items on the corporate risk register related to end of life, both of which were being investigated and action plans were pending.

Leadership of this service

- There was good leadership at local and service level for both hospital and community end of life services. There was no board member or non-executive board member with a specialist interest in end of life care. Communication between ward and board had several routes. A Safety and Quality Committee was responsible for ratification of guidance and policies around end of life and reported to the board.
- Each community hospital had an end of life link nurse who was linked to the end of life programme facilitator.

Are End of life care well-led?

The link nurse role was to disseminate information and provide training to the ward team around the GSF. The end of life facilitator linked directly to the end of life lead for the service who was a locality manager for the west locality of Peninsula Community Health CIC. The end of life lead reported to the board for Peninsula Community Health CIC twice a month. The transfer of information from board to ward was accessed by this route.

- The SPCT worked throughout the service and had a lead role for each of the three geographical areas of care provision by Peninsula Community Health CIC. The SPCT lead reported to the end of life lead and information was conveyed to the board and back via this route. Staff throughout the service, both hospital and community, said the SPCT were visible, approachable and accessible. Staff told us that they valued their input and expertise. Staff on the wards providing end of life care and the SPCT told us they felt supported and well led at their level.

- The medical consultant cover for the SPCT was not provided by Peninsula Community Health CIC and some issues around clarity of responsibility for consultant cover was ongoing by the Medical Director for Peninsula Community Health CIC. However, staff told us that the consultants were accessible, approachable and provided leadership of care when needed.

Culture within this service

- Staff told us that they worked well as part of their teams. All hospital and community staff spoke clearly and passionately about the importance of the quality end of life care for patients and relatives. They spoke about the importance of multidisciplinary working to enable the patient's preferences and choices to be met.

- All staff involved in end of life care were clearly proud of the work they performed and told us that Peninsula Community Health CIC was a good employer. They felt listened to and supported. Staff told us that felt valued and respected by the provider. Policies were in place to promote the safety of staff including a lone working policy to ensure systems were in place to protect staff working in isolated locations.

- We saw a group clinical supervision session took place; this was facilitated by the SPCT and was for district nurses and community staff. This supervision supported

staff by providing an opportunity to discuss practice concerns and issues. Staff told us that this supervision was valuable and they took learning and support from the sessions.

Public and staff engagement

- There was a perception amongst the team that the public and patients were confused due to changes in the title of the palliative care service. Previously the service was known as Macmillan Cancer Support. The SPCT team lead was considering how best to ensure the change in tittle of the services was to be communicated to the public and patients.

- The Friends and Family test undertaken by Peninsula Community Health CIC was well publicised within the hospital. There was a plan to roll this out to the community for April 2015. The results on hospital wards were all positive and feedback was evident in the form of praise and thanks. Any scores which were less than 100% were accompanied by an explanation and an action plan.

- A patient experience metrics had been created by the district nurses. Results from that metrics were shared with ward teams to enable changes to be made as necessary and provide feedback for staff.

- We were told by the End of Life lead that monthly patient experience forms were sent out and there were further plans for March 2015 to implement a patient experience audit.

- A staff satisfaction audit was planned for April 2015.

Innovation, improvement and sustainability

- A Care at Home service had been developed in the mid part of the county. This involved 17.8 whole time equivalent healthcare assistants providing personal care for patients approaching the end of their life. There was no data available to identify if this service enabled patients to remain at home. However, the end of life lead was positive about the service they provided in the community and the continuity of care it enabled.

- The End of Life Lead Facilitator explained that a syringe driver library had been set up. This enabled nursing and care homes in the local area to sign up to training in the use of syringe drivers and then enable those locations to access a driver from the provider's stock as needed. These drivers were then serviced and maintained by Peninsula Community Health CIC. The Facilitator explained that this had proved to be successful in

Are End of life care well-led?

reducing the need for sub subcutaneous injections for pain relief and enabled the same driver to stay with the patient throughout their end of life care. No data was available to enable this to be confirmed.

- Further tools were being developed to monitor food and fluid intake for patients at the end of their lives. This tool was currently being trialled at Falmouth Hospital.

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records How the regulation was not being met: The registered provider did not ensure that patients were protected against the risks of unsafe or inappropriate treatment arising from a lack of proper information about them by means of maintenance of An accurate record including appropriate information and documents in relation to the care and treatment. We saw six Allow a Natural Death Orders (ANDO) which were not completed correctly. Shortcomings included an unclear abbreviation and a lack of up to date information about the patient's current condition. In two cases a limited description of the reason for the decision having been made and in two instances discussions with the family were not recorded. Regulation 20 (a)