

# Worcestershire Health and Care NHS Trust

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## End of life care

### Quality Report

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Date of inspection visit: 19th January to 23rd  
January 2015  
Date of publication: 18/06/2015

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

# Summary of findings

## Ratings

Overall rating for End of life care	Good	
Are End of life care safe?	Good	
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

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# Summary of findings

## Overall summary

### **Overall rating for this core service Good**

This was a good service offering compassionate palliative care and treatment for patients in community hospitals, other community care settings or in their own homes.

The staff were passionate about their work and highly motivated to provide the best possible care to meet the needs and preferences of patients and their families.

We spoke with patients and their families and one relative said, “the care is excellent, I can’t fault it”

The service had improved documentation and processes for advance care planning.

They were working within a number of national programmes such as NHS Improving Quality approach set out in the document ‘One Chance to Get it Right’. The service was also improving the quality of service by implementing high impact actions for improving choices: ‘Where to die when the time comes’.

Staff were highly competent and were able to report incidents and learn from incidents and complaints to improve safety for patients. Staffing levels were good for and consultant advice and support was available out of hours. The community nursing teams offered a service seven days a week. The leadership of the service was committed and innovative and they collaborated well with local independent providers of hospice services.

# Summary of findings

## Background to the service

### Background to the service

The Primrose Unit at the Princess of Wales Community Hospital had six palliative care beds. The unit had six single rooms with ensuite facilities. The unit was calm and the patients and families we spoke with said that the staff were 'caring and responsive'. Family members were able to visit at any time and could also be accommodated overnight (on put-you-up beds) if they chose to stay. We found that admission and discharge to this unit could be arranged within 24 hours if required. The Primrose Unit worked in close co-operation with the local, independently run Primrose Hospice.

Community Nurse Specialists in palliative care worked from a 'hot desk hub' at the Princess of Wales Community Hospital. They visited patients in the community and in their own homes providing specialist care and support to them and their families.

The service also included a 4-bedded unit known as the Macmillan ward at Evesham Community Hospital. The unit worked collaboratively with the local, independently run St Richards's Hospice. Community Nurse specialists worked for this hospice and delivered palliative care and support to patients and their families in the community.

Palliative care was also offered to patients on other wards at the Community Hospitals.

## Our inspection team

Our Inspection team was led by:

Chair: Dr Ros Tolcher, Chief Executive Harrogate and District NHS Foundation Trust.

Team Leader: Pauline Carpenter, Head of Hospital Inspection, Care Quality Commission.

The team who inspected this service was a CQC inspector and two specialist advisors with specialist knowledge of palliative and end of life care.

## Why we carried out this inspection

We inspected this trust as part of our ongoing comprehensive mental health inspection programme.

## How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other

organisations to share what they knew. We carried out an announced visit on 20, 21, 22 and 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 patients. We observed how patients were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

# Summary of findings

## What people who use the provider say

Comments received from patients and relatives of those who used the service included:

- ‘The care is excellent, I can’t fault it.’
- ‘He is refusing everything now even the small amounts of water they offer. However, they clean his mouth, shave him and each morning he has fresh pyjamas and bed linen.’
- ‘I honestly can’t think of anything they could do better.’
- ‘Dignity and respect are important and they understand that here. The staff explain what they are doing and what the medication is for. We have all agreed we will not resuscitate and we are right about that.’
- ‘He has been moved into a side ward and I have been offered a bed and a shower.’
- “Our family were all involved in the decision not to operate”
- ‘They were kind and considerate and I was given enough information to make choices.’

## Good practice

- Bed-side handovers were carried out on the Primrose Unit and, where possible, patients were involved in the discussion and involved in decision making.
- We were speaking with a nurse on the Primrose Unit who noticed that a patient had woken up and was looking confused. The nurse excused herself and went over to reassure the patient and offered the patient a drink and some food and asked about pain and discomfort. She sat with the patient until they were more settled.
- Bereavement support services were available and delivered in collaboration with the hospice services. There were also spiritual, social and psychological services available to patients and their families.
- ‘Bite Size Learning’ sessions were available for ward, community nursing and therapy teams on subjects such as ‘Grief and Loss’ and ‘Palliative Care Emergencies’. The trust was also investing in training to develop advanced communication skills for colleagues working in palliative care.
- There had been an awareness training programme for all qualified nurses on advanced care planning delivered by the community nurse specialists. The programme included important issues like ‘peoples preferred place of death’, the advance planning document and how advance planning is not valid while the patient retains capacity.

## Areas for improvement

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

- The trust **SHOULD** devise a more robust system for monitoring and maintaining drugs available for end of life care out of hours.
- The trust **SHOULD** review its operational guidance for the maintenance and management of the in-house mortuaries at Evesham and Princess of Wales Community Hospitals.

# Worcestershire Health and Care 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

Incident reporting had improved with a new electronic reporting system and a culture that had become more open to learning from incidents. A new audit process, delivered by peers, was producing a new energy and motivation about fundamental aspects of nursing care such as infection control, record keeping, risk assessment and medicines management.

Staffing levels were adequate and caseloads were manageable. Patients and relatives said that the atmosphere was relaxed and staff did not seem overly stretched. Consultant and GP cover was comprehensive with a consultant providing an out of hour's service. Advice was available 24 hours a day seven days a week.

### Incidents, reporting and learning

- The local operational quality leads reported that previously the culture was closed and defensive. However, the willingness to report incidents has improved and people feel supported and able to learn lessons from incidents to make care and treatment

better for patients. This was attributed to the Ulysses reporting system being user-friendly and able to produce better quality reports to identify risks, trends and enable the trust to take action to reduce future risk

- The trust incident reporting rate is increasing. The trust is the third lowest reporter against 15 community NHS trusts. However each trust operates different reporting criteria. Incident reporting is monitored by the Quality and Safety Committee.
- The national safety thermometer recorded four falls with some harm caused in end of life care between October 2013 and October 2014.
- There had been one serious incident reported in the 12 months to November 2014 involving a patient on the Primrose Unit with a grade four pressure ulcer. The route cause analysis identified aspects of good practice including the use of pressure relieving equipment and regular photography, and safer practice issues relating to correct grading on admission and documentation of deterioration. The incident was included in the January 2015 quality and safety committee report

- Learning from incidents was shared on notice boards and incidents were discussed at the monthly clinical nurse specialist (in palliative care) meetings and the weekly incident forums. Overall we found that the incident reporting culture was improving and that the trust was taking steps to share the learning from incidents in order to improve the care and safety of patients.

### **Cleanliness, infection control and hygiene**

- The wards we visited at the Princess of Wales and Evesham Community hospitals were clean and uncluttered and we saw that both staff and visitors were using the alcohol gel provided on the wards and when they visited patients in their own homes.
- All eligible staff caring for end of life patients in the Princess of Wales community hospital were 100% compliant in their infection control.
- The Primrose Unit had achieved 100% compliance on all six elements of the nursing metrix since August 2014. This included cleaning the patients' bed space, the dress code policy, MRSA screening undertaken on admission and infection control log books up-to-date.
- The mortuaries at the two community hospitals were clean, with surfaces were wiped clean and the floors mopped. The cleaning schedule was up-to-date and signed and the viewing areas were ready for use.

### **Safety of equipment**

- The Primrose Unit at the Princess of Wales community hospital included six single rooms with ensuite facilities. Each of the rooms had a profiling bed, air conditioning, fridge, and TV. There was also a kitchen and sitting room and access to the hospital garden. Overnight facilities were available on the unit for visitors.
- Community staff told us that they could get the equipment they needed, such as syringe drivers, pads and special beds and mattresses and there had been an improvement in timely access to equipment out of hours.
- The portable equipment in use on the Primrose Unit had been tested for safe use and there was documentation to demonstrate resuscitation trolley had been checked on a daily basis

- Fridge temperatures were being monitored in both and checks were signed and dated by the porters.

### **Medicines management**

- The storage of medication was appropriate on the Primrose Unit. Medicine cupboards and drug trolleys were locked and keys signed for at handover. Drugs fridge temperatures were maintained and checked.
- Staff had received syringe driver training and the majority of the community nurse specialists (in palliative care) in the community hospitals were trained as non-medical prescribers.
- We noted that the community and palliative care staff were monitoring their palliative care drug stocks as they were concerned about timely access to medicines out of hours and had been exploring alternatives arrangements for storing and accessing medicines for end of life care.

### **Safeguarding**

- At the multi-disciplinary meetings we attended at both locations staff demonstrated a good knowledge of the consent policy, the mental capacity act, deprivation of liberty safeguards and best interest decision making.
- The end of life team informed us that safeguarding training was mandatory. Records confirmed that the end of life team staff had undertaken training in safeguarding for adults and children.
- Staff we spoke with were able to describe the process of advance care planning to enable patients to make choices that would improve their end of life care. This included being able to made advance decisions to refuse treatment and setting out presences for their property, affairs and welfare.

### **Records and management**

- We were informed by the matrons that new draft operational guidance for the maintenance and management of the in-house mortuary's at Evesham and Princess of Wales Community Hospitals was already in use. However, at both locations we found that members of staff who had roles and responsibilities within the operational guidance were unaware of this and therefore were not fulfilling their assigned roles. As a result, at both locations, we found that deceased patients had remained in the on-site mortuary for

considerably longer than the four working days specified in the guidance without any escalation for appropriate action. We brought this to the attention of the matrons.

- The end of life team were using 'SystemOne' electronic patient record system and this was also used by the local hospices but not by the GPs. Nurses and managers we spoke with said that they found the system easy to use and it enabled them to share information. For example, we saw that a letter was generated in a multidisciplinary meeting using 'SystemOne' and then sent to the GP immediately after the meeting.
- We also saw that there was a page on each patient's electronic record where they had either given or withheld their consent to share information. We saw that one record could not be opened by the nurse who was showing us the records because consent had been withheld. The electronic records included the patients 'preferred place of death' and we also saw appropriate documentation relating to best interest decision making in the notes involving the GP and the family.
- We observed the 'Greensleaves' project which involved colleagues from the Health and Care and Acute Trusts, local hospices, GPs, commissioners, local care providers and patient representatives. Green sleeves was an idea adopted from another trust using a different colour wallets to hold the Advance Care Planning documentation and the Do Not Attempt Cardiopulmonary (DNACPR) form to identify them clearly as they moved between care organisations.
- At a multidisciplinary meeting at Evesham Community hospital, of the 19 patients discussed, 7 had DNACPR forms in place. We looked at three copies of this form which were completed correctly with the signature of the most senior healthcare professional available at the time. If the GP or the consultant was not available a nurse had signed the form and it was checked and counter-signed by the GP or consultant at the first opportunity.

### **Lone and remote working**

- We saw a copy of the trust's Lone worker policy. The community nurse specialists (in palliative care) and administrative assistant we spoke with were fully aware of the procedures to follow.

- When we asked two community nurse specialists (in palliative care) separately about the application of the policy. They both confirmed that they used an electronic diary so that colleagues could see their visits and they planned and assessed the risks of visits carefully, particularly at weekends. They told us that they avoided a first visit at the weekend. However, when we asked if they always checked-in or telephoned at the end of their visits they were not as clear.

### **Assessing and responding to patient risk**

- We looked through 4 records electronically and found that each of them had appropriate risk assessments for issues including mobility, tissue viability (using the waterlow assessment tool).

### **Staffing levels and caseload**

- There were different organisational and staffing arrangements in each ward and the community due to local arrangements with GPs and hospices so staffing levels for the service were difficult to quantify. However, staff and patients we spoke with indicated that staffing levels were adequate and consultant or GP support was available when required.
- The community nurse specialists (in palliative care) provided a service over seven days and they told us that back up is always available. The consultants provide advice 24 hours seven days a week.
- Consultants and GPs offered support to in-patients and patients cared for at home or in the local hospices. They also held a number of clinics for respiratory, heart and renal conditions.

### **Managing anticipated risks**

- The trust overall, including palliative care, was trying to improve the management of pressure damage and had identified that the main area requiring improvement was documentation particularly the description in the notes of the type of wound and the dressing applied. Training was on-going to improve the accuracy of descriptions in patient records.

# 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 service was offering evidence based care and treatment delivered in the context of appropriate national frameworks. The approaches were based on personalised care and advance care planning so that patients were able to make choices and express preferences for their end of life care.

The trust accepted that their new guidelines for the operation of the two in-house mortuaries required further work to refine the process, engage the relevant staff and to embed them as the standard routine.

The trust scored well for the quality of care on the national bereavement survey and patient outcomes were improving in relation to skin care and preventing pressure ulcers.

Multi-disciplinary working was effective and working well in the interests of patients particularly the joint working with colleagues from social care and the independent sector run hospices.

## Evidence based care and treatment

- Since the Liverpool Care Pathway was discontinued, the service was aligning its work to the NHS Improving Quality approach set out in the document 'One Chance to Get it Right'. This approach set out five priorities and the trust had assessed its work against those priorities. This meant the service was introducing an early assessment with the concept of 'recovery uncertain' to recognise that sensitive discussions about the patients' needs and wishes should take place well before the end of life.
- In addition, the service was aligning its work streams with the National Institute for Health and Care Excellence (NICE) quality standards. An example of this is the trust had moved away from the practice of using generic protocols and towards a more personalised care plans based on the individual preferences of the patient.
- The trust had also aligned its new mortuary operating guidelines to the NICE guidance on 'Care after Death'.

- The trust was also using the High Impact Actions programme and makes reference to NHS, Marie Curie and Macmillan guidance in its Advance planning and policy documents.

## Pain Relief

- We noted that the trust had recently issued guidance and offered training to nursing staff in the use of a syringe pump to administer small amounts of medication continuously in palliative and end of live care. We saw that the trust had specific medicine administration records for the documentation of medication via a syringe pump for patients unable to tolerate oral medication and required continuous pain relief

## Patient outcomes

- The trust had a plan of continual audit on mortality rates within the trust, place of death and any unexpected or sudden deaths. The Palliative Care and End of Life Network Group reported 'Good success supporting more people out in the community'.
- The trust scored in the top 20% of trusts in West Mercia in the national bereavement survey for the quality of care in relation to out of hours and GP services, district and community nurses, care home and hospital nurses.

## Competent staff

- We noted that the trust had recently issued guidance and provided training to all qualified nurses in the use of a syringe pump and that 82% of nurses had training within the first year.
- The palliative care team leader informed us that a range of training and development opportunities that were available in end of life care. The community nurse specialists confirmed this and we saw evidence of implementation of one of the high impact actions of the programme originally initiated by the NHS Institute for Innovation and Improvement.
- Events were held in 'Dying Matters' week in 2014 to raise awareness across the trust of issues in palliative care and of resources available on the Trusts website and

## Are End of life care services effective?

intranet. In addition, we saw that a range of 'bite size learning' sessions were available for ward, community nursing and therapy teams on subjects such as 'grief and loss' and 'palliative care emergencies'. The trust was also investing in training to develop advanced communication skills for colleagues working in palliative care.

- The MCA/DoLS training is classed as 'essential for certain staff groups' and is classified as such on the training and development website. It's called MCA/DoLS awareness training and is classified as essential for all practitioners who have face-to-face contact with patients and who may be required to complete a Mental Capacity Assessment during the course of their working practice. The palliative care team were just below 100% compliant but all staff had training booked.

### **Multi-disciplinary working and coordination of care pathways**

- We attended multi-disciplinary meetings at both of the locations we visited. The meeting at Evesham Community Hospital was attended by a range of partners working collaboratively from the NHS and the independent sector, providing hospice care. The arrangements were integrated with community nurse specialists providing NHS care but based at St Richard's Hospice.
- Several of the patients were identified as end of life patients or the end of life pathway was instigated. There were notes including 'refusing medication – give comfort and dignity' another patient's entry read 'not to be transferred to acute hospital at family's request'.
- The advanced nurse practitioner informed us that, although there were four palliative care beds at Evesham Community Hospital, there were also patients on other wards receiving end of life care and that patients were not moved from the ward onto which they were originally admitted even if the end of life pathway was instigated subsequently.
- The clinical locality manager said 'the hot desk hub at Princess of Wales Community Hospital has improved joint working across the nursing and therapy teams'.
- Both of the palliative care consultants told us about the Palliative Care and End of Life Network Group. This was a quarterly meeting involving commissioners, acute and community hospital trusts, hospices, consultants, pharmacists, local care providers, user representatives GPs and nurses. We saw the notes of these meetings and saw that it provided an opportunity for county-wide strategic and operational discussions for all those involved in palliative and end of life care.

# Are End of life care services caring?

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

## Summary

The patients and their relatives we spoke with said that the care was compassionate and sensitive. The dignity, respect and privacy of patients were observed and patients and their relatives were involved in the delivery of care and decision making. Relatives were provided with emotional support to help them with grief and loss.

## Compassionate care

- The palliative care service recognise that in many cases, enabling the individual to plan for death should start well before a person reaches the end of their life and should be an integral part of personalised and proactive care.
- We observed a nurse on the Primrose Unit notice that a patient had woken up and was looking confused. She reassured the patient and offered him a drink and some food and asked about pain and discomfort. She sat with the patient until they were more settled.
- A relative we spoke with said, 'the care is excellent, I can't fault it'.
- Another relative said, 'he is refusing everything now even the small amounts of water they offer. However, they clean his mouth, shave him and each morning he has fresh pyjamas and bed linen.'

## Dignity and respect

- Dignity and respect for patients was measured via the nurse's metrics. We saw that 100% had been achieved on the Primrose Unit since August 2014 for appropriate curtains for privacy and dignity, call bell within reach, care rounds completed, drink within reach, patient modesty maintained, name visible above bed and preferred name documented on admission.
- We saw that staff treated patients and their visitors in a caring manner. The discussions we heard at the multi-disciplinary team meetings were respectful and sensitive. Staff were keen to understand and observe the patient's choices and preferences for end of life care.

- The patients were treated with kindness and respect throughout. One patient said, 'I honestly can't think of anything they could do better.'
- Another relative said, 'dignity and respect are important and they understand that here. The staff explain what they are doing and what the medication is for. We have all agreed we will not resuscitate and we are right about that.'

## Patient understanding and involvement

- We observed a bed-side handover on the Primrose Unit and saw that, where possible, patients were involved in the discussion and in decision making.
- Family and friends were also involved in the care and in decision making. One relative said, "Our family were all involved in the decision not to operate". Another relative said, 'they were kind and considerate and I was given enough information to make choices'.

## Emotional support

- Bereavement support services were available and delivered in collaboration with the hospice services. There were also spiritual, social and psychological services available to patients and their families.
- The relative of a patient on the Primrose Unit said, 'sometimes I get overwhelmed and I go to the staff, they are honest with me and I feel grounded again.'

## Promotion of self-care

- A patient's relative said that the staff are, 'always on hand to provide support but it is unobtrusive and they are careful not to rush in'.
- We saw that the palliative care team were investing time in promoting self-care and enabling patients and their families to express their choices for the type of care and treatment they wanted at end of life and choices about the preferred place of death. This was demonstrated by the effort put into developing the advance planning documentation and the training offered to staff in communication and all aspects of palliative care.

# 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

The service was responsive to the needs of patients and able to adjust to the changing demands of the local population.

Admission, referral and transition arrangements were timely and rapid discharge was enabled for patients approaching the end of life and wanting to die at home.

Complaints were handled effectively and the whole service shared the feedback and learning.

## Service planning and delivery to meet the needs of different people

- Evesham Community Hospital was training nursing staff in order to respond to the growing number of patients requiring rehabilitation after stroke.
- The trust was increasing the provision of psychiatric service in response to the number of older adults with mental health issues and/or dementia.
- Training was available for staff in meeting the needs of specific groups of people such as those with learning disabilities, dementia and anxiety and depression.
- Interpretations services were available for patients and their families whose first language was not English.
- The average length of stay was monitored in the in-patient units and was just under eight days on the Primrose Unit and in the community length of care was measured and this ranged from 20 to 50+ days.
- 79% of patients who died while in the trusts care from October to December 2014 were known to the palliative care team. Preferred place of death was discussed with 51% of these, and of those who had had the discussion, 74% died in the place of their choice.

## Access to the right care at the right time

- Patients could be admitted onto Primrose Unit very quickly in a crisis or emergency situation. We spoke with

a relative who said that her husband was referred to the Unit on Friday and was admitted and treatment began on the Monday. This relative said, "Their response to everything has been first rate".

- We spoke to a relative who said, "the nursing staff are doing two hourly checks". The relative said that she could not give that level of care at home.
- One patient said, 'they also answer my call bell immediately'.

## Discharge, referral and transition arrangements

- The trust was monitoring 'preferred place of death' and had been involved in the provision of rapid access to trained carers in the patient's own home in order to facilitate rapid discharge for those patients at the end of life who wish to die at home.
- Transitional arrangements were effective and we were informed by the chief executive that one of the trust's localities, the Wyre Forest, had the highest rate nationally of deaths of people in their own homes.

## Complaints handling (for this service) and learning from feedback

- The service had received three complaints in the last six months. One was about the supply of continence equipment; the second was about a delay involving the out of hour's service and the third involved the transfer of a patient to the acute hospital.
- We were told that the complaints all came through the patient liaison service and were then passed to the relevant unit or ward for investigation and resolution. The whole service was involved and informed of any learning from the feedback. For example, the complaint about the out of hour's service was upheld and adjustments made to improve the responsiveness of the service as a result.

# 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

The vision and overall direction of the service was coherent and clear. There were effective governance arrangements for the identification, management and mitigation of risk and systems were in place for the measurement of quality and patient safety.

The leadership of the service was well respected and there was a clear emphasis on peer and patient feedback to improve performance. There was a culture of compliance and continuous improvement.

## Vision and strategy for this service

- We were informed by two members of staff that there was no single document containing the written vision and strategy for the service. However, the Palliative Care and End of Life network group were involved in providing a clear direction for the service both across organisations and county-wide. This group also discussed and agreed on key aspects of the vision and strategy.
- The service also relied upon a number of national frameworks such as the NHS Improving Quality approach set out in the document 'One Chance to get it Right', NICE guidance and the High Impact Actions programme. These were well known across the service and staff were clear about the overall direction.

## Governance, risk management and quality measurement

- We found evidence of effective governance and arrangements for the management of risk. Incident reporting was improving since the adoption of the Ulysses system and risks were being analysed and mitigated at regular meetings held weekly and monthly.
- The nursing metrics were being used to improve quality and standards and the monthly quality and safety report offered a valuable analysis and source of material to support quality improvement.

## Leadership of this service

- Leadership and management arrangements differed in each locality and the boundaries of the service were undefined. This made for fairly complex structures across the service which were well known within each locality but more difficult to describe generically.
- The leaders of the service were described as 'approachable and supportive'.

## Culture within this service

- We found that staff were passionate about their work and about delivering high quality compassionate care and treatment for patients.
- Whilst we saw evidence of a culture of compliance senior staff also referred to what they described as 'embedded cultures'.
- Peer auditing process and the nursing metrics were reported to have helped to inspire and motivate staff who may have 'relaxed a little too much' in their day to day practice. We saw that the metrics had improved the performance in areas like tissue viability, observations and infection control.

## Public and staff engagement

- There were active bi-monthly locality forums attended by members of the public in each of the three localities. We saw the agenda and notes of these forums on the trust's web-site and we saw that members of the public could suggest agenda items and speakers. The forums were well attended by members of staff and the public.
- Items discussed at the last forum included the employment of specialist Parkinson's nurses and how their time was used. There was also discussion of the 'co-production strategy'. This is an initiative at the trust to engage local people in the working of the local healthcare system to collaborate to create a new joint integrated delivery model for health and social care.

## Innovation, improvement and sustainability

- Examples of innovation practice and improvement included the new advance planning documentation and the nursing metrics.

## Are End of life care services well-led?

- In addition, we saw evidence of effective collaborative working with the independent sector providing hospice services.