This report describes our judgement of the quality of care provided within this core service by Nottinghamshire Healthcare 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 Nottinghamshire Healthcare NHS Trust and these are brought together to inform our overall judgement of Nottinghamshire Healthcare NHS Trust.
## Summary of findings

### Ratings

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall rating for end of life care</td>
<td>Good</td>
</tr>
<tr>
<td>Are end of life care services safe?</td>
<td>Good</td>
</tr>
<tr>
<td>Are end of life care services caring?</td>
<td>Good</td>
</tr>
<tr>
<td>Are end of life care services effective?</td>
<td>Good</td>
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<tr>
<td>Are end of life care services responsive?</td>
<td>Good</td>
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<tr>
<td>Are end of life care services well-led?</td>
<td>Good</td>
</tr>
</tbody>
</table>
# Summary of findings

## Contents

### Summary of this inspection

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall summary</td>
<td>4</td>
</tr>
<tr>
<td>Background to the service</td>
<td>5</td>
</tr>
<tr>
<td>Our inspection team</td>
<td>5</td>
</tr>
<tr>
<td>Why we carried out this inspection</td>
<td>5</td>
</tr>
<tr>
<td>How we carried out this inspection</td>
<td>5</td>
</tr>
<tr>
<td>What people who use the provider say</td>
<td>6</td>
</tr>
<tr>
<td>Good practice</td>
<td>6</td>
</tr>
<tr>
<td>Areas for improvement</td>
<td>6</td>
</tr>
</tbody>
</table>

### Detailed findings from this inspection

Findings by our five questions 7
Overall summary

The Trust provided two very different services for patients requiring palliative care and end of life care. The Trust did not provide the same level of service across the geography of the Trust, as the level of service and the quality of services were very different.

Patients living in Mansfield and Ashfield had access to an outstanding service in John Eastwood Hospice. The service was well led; they had clear vision and strategy to evolve the service. The service was responsive as they actively sought to provide specialist palliative care to patients of any diagnosis. Their practice was safe as guidelines and protocols had evolved through peer review networks and national guidelines. The service was caring; patients were helped to carry out their wishes and received emotional support. The service was effective as their comprehensive specialist palliative care team provided care for patients and their relatives.

Patients who live in the Bassetlaw area had a service which did not provide access to a multi-disciplinary specialist palliative care team. We found that staff at Bassetlaw Hospice were caring as staff responded to peoples’ physical and emotional needs. The service was not well known in the community and specialist palliative care nurses and therapy services were not available at the hospice. The service was not responsive as patients’ preferences were not always adequately recorded. They were required to improve their safety of medicines management. They required improvement in being well led as there was no clear leadership and strategy.
Summary of findings

Background to the service

John Eastwood Hospice is a purpose built facility that provides care for adults who require specialist palliative care for complex needs and end of life care. The hospice has 12 in-patient beds and a day care centre. The service also provides specialist palliative care teams to the community and King’s Mill Hospital.

Bassetlaw Hospice is a purpose built facility that provides care for adults who require palliative care and end of life care. The hospice has 6 in-patient beds and a day care unit. The service also provides specialist palliative care nurses to the community.

Services

- Specialist Palliative Care
- Palliative Care
- End of life care

The Trust has a total of two registered locations providing care in a hospice environment. The services provide in-patient care, day care units and community specialist palliative care teams.

Our inspection team

Our inspection team was led by:

**Chair:** Dr Paul Lelliott, Deputy Chief Inspector Hospitals (Mental Health and Substance Misuse), CQC

**Team Leader:** Jenny Wilkes, Interim Head of Inspection, Care Quality Commission

The team included Inspectors, Inspection Managers Mental Health Act commissioners, a Pharmacist Inspector and two Analysts. We also had a variety of specialist advisors which included: specialist nurses and experts by experience.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot mental health inspection programme.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 29, 30 April and 1 May 2014. 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 met with people who use services and carers, who shared their views and experiences of the core services we visited.

5    End of life care Quality Report 31 July 2014
Summary of findings

What people who use the provider say

Patients at both hospices told us that they were treated with kindness and they were involved with making decisions about their care. Patients and their relatives told us they felt involved in and supported by the compassionate care provided.

Good practice

John Eastwood Hospice actively sought to provide specialist palliative care to patients of long term conditions who did not previously have access to this type of care. They invited community matrons of long term conditions to hold therapeutic sessions in the hospice day centre and provided the services of the hospice team. The resulting benefits to patients were monitored and evaluated.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The Trust could make their medicines policy clearer to inform lone working registered nursing staff of their responsibilities when checking controlled drugs and administering controlled drugs at Bassetlaw Hospice.

Action the provider COULD take to improve

The Trust could provide supervision of the prescribing formulary at Bassetlaw Hospice.
The five questions we ask about core services and what we found

Are end of life care services safe?

By safe, we mean that people are protected from abuse

Summary of findings
Overall, patients received safe care and treatment; staff understood their responsibilities for infection control, reporting incidents and training. They had learnt from incidents and changed their practice as a result. John Eastwood Hospice had also developed guidelines and protocols through peer review networks and national guidelines.

At Bassetlaw Hospice, we were concerned that drugs prescribed at the service were not overseen by an external person or organisation. There was no clear policy on administering and checking controlled drugs when there was only one registered nurse on duty.

John Eastwood Hospice
Track record on safety

- Staff complied with the infection control policy, we saw that staff were bare below elbows, observed that staff washed their hands and used hand gel between patients.
- Staff used personal protective equipment such as gloves and aprons when appropriate.
- Essential training of staff was within Trust targets of 80%.
- Qualified nurses received up-dates to their training in palliative care.
- Half of the specialist palliative care nurses were nurse prescribers.
- The Hospice charity support staff to attend conferences to maintain relevant up-to date practice.
- The Trust provided funding for staff nurses to study palliative care to a degree level.
- The Hospice provided a rolling programme of teaching for new syringe drivers to Trust staff.

Learning from incidents and improving safety standards

- Staff told us they knew how to report incidents and they were encouraged to do so. We saw clear evidence of incident reporting at all levels.
- There had been four reported serious incidents since June 2013. All of the incidents were related to pressure

Nottinghamshire Healthcare NHS Trust
End of life care
Detailed findings from this inspection
ulcers. All of the incidents had been investigated and the outcomes were discussed at the Patient Safety and Effectiveness Committee, the Patient Safety Group and the Pressure Ulcer Monitoring group.

- Managers shared the learning from incidents with staff at all levels.
- Staff had changed their practice to as a direct result of learning from incidents. We saw that there was a modified falls tool implemented to meet the care needs of hospice patients. We saw that low beds and crash mats had been introduced to prevent people coming to harm from falls.
- There was a lack of evidence of sharing lessons learnt from incidents with Bassetlaw Hospice who were in the same Trust.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

- Staff we spoke with had completed their training in safeguarding of vulnerable adults; they could recognise signs that may indicate abuse and knew who to report it to.
- Staff followed Trust policies and guidelines for medicines, analgesia management and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR.)
- DNACPR forms contained clear guidance for staff. The forms were signed by a doctor and the reason for the decision was clearly documented. The discussions that staff had with patients about the DNACPR were recorded in their notes.
- One of the consultants in palliative medicine was actively involved with the East Midlands End of Life Network, and had particular interests Mental Capacity Act and DNACPR.
- Patient notes were promptly obtained on admission and shared community notes (SystmOne) used to ensure all information about the patient is available. Staff told us that there was sometimes a delay as not all GP’s knew how to share records electronically.
- End of life trainers were employed by the hospice to provide training to staff in the community about the Gold Standards framework, end of life and syringe driver training.
- The hospice provided training courses in communication that were available to healthcare and social care staff in all settings.

- Palliative network guidelines were followed to prescribe medication. These guidelines had been tested and were in use throughout the cancer network.

Assessing and monitoring safety and risk

- Patients received a holistic assessment on admission to the hospice.
- Patients were assessed for their risks, for example, falls, manual handling, nutrition and dehydration. Management of these risks were written in patients’ care plans.
- Risks had been identified in the use of the syringe drivers, the hospice had changed the type of syringe driver they used and now the new syringe driver was fully embedded into practice.

Understanding and management of foreseeable risks

- There were robust recruitment procedures for the selection and appointment of volunteers.
- Pressure relieving equipment was readily available and used for patients who had been assessed as at risk of acquiring a pressure ulcer.

Bassetlaw Hospice

Trace record on safety

- Staff complied with the infection control policy. We saw that staff were bare below elbows and observed that staff washed their hands and used hand gel appropriately.
- Staff used personal protective equipment such as gloves and aprons when appropriate.
- Essential staff training was within Trust targets of 80%.

Learning from incidents and Improving safety standards

- Staff told us they knew how to report incidents and they were encouraged to do so. We saw clear evidence of incident reporting at all levels.
- There had been one reported serious incident since June 2013 which related to pressure ulcers.
- All of the reported incidents had been investigated and the outcomes and learning from incidents were discussed at ‘Closing the Loop’ meetings.
- Managers told us they shared the learning from incidents at the hospice with staff. However, staff told us that they did not receive any information about learning from incidents in the Trust.
Are end of life care services safe?

- There was evidence that managers shared the learning from incidents at the hospice with Bassetlaw Healthcare Partnership and Nottinghamshire Healthcare NHS Trust.

**Reliable systems, processes and practices to keep people safe and safeguarded from abuse**

- Staff we spoke with had completed their training in safeguarding of vulnerable adults; they could recognise signs that may indicate abuse and knew who to report it to.
- Staff had shared access to patient’s records via the community electronic records (SystmOne).
- Patients signed consent forms to allow staff to access their records and share information with other members of staff in the community teams.
- The policy in place to check controlled drugs was not clear. We spoke with staff and looked at duty rotas and found that there was only one registered nurse on duty at night. The Bassetlaw Healthcare Partnership policy was not clear what grade or training the staff should have to check controlled drugs or administer them at night. This issue had been identified and placed on the divisional risk register in March 2013, but there was no clear indication of the action that had been taken. This meant that the Trust had not clarified the procedures for checking medicines with one registered nurse.
- Visiting pharmacists worked with the in-patient team leader to manage stock levels of medicines and destroy unused or out of date medicines. The pharmacist did not check any medicine charts; this meant that there was no external supervision of the prescribing formulary.
- Palliative network guidelines were followed to prescribe medication. These guidelines had been tested and were in use throughout the cancer network.
- GP’s with a special interest in palliative care were contracted to provide medical care at the hospice. They provided a three hour presence a day in the hospice and 24 hour on call services.

- Registered nurses at the hospice were not trained as prescribers; this meant that there was not always a prescriber in the hospice to provide prescriptions for patients who required immediate symptom control. However, nurses could call the GP on call for the hospice to request a prescription.
- A consultant in palliative care medicine provided one session a week and was available by phone for advice on weekdays. This meant that the GP’s and nursing staff had access to specialist palliative care advice on weekdays.
- The hospice had their own bespoke end of life care pathway which guided staff to ensure that patients received care that was in line with national guidelines.
- There were systems in place to alert managers when nurses’ registrations were about to expire, or appraisals were due.
- Nursing and care staff were required to do the laundry as there was no system in place to provide this service. Staff told us that the laundry was time consuming and took them away from providing patient care. Staff were aware of the procedures to prevent infection and health and safety.

**Assessing and monitoring safety and risk**

- Patients received a holistic assessment on admission to the hospice.
- Patients were assessed for their risks, for example, falls, manual handling, nutrition and dehydration. Management of these risks were written in patients’ care plans.

**Understanding and management of foreseeable risks**

- There were robust recruitment procedures for the selection and appointment of volunteers.
- Pressure relieving equipment was readily available and used for patients who had been assessed as at risk of developing a pressure ulcer.
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 of findings
Services for end of life care patients were generally effective. Patients could easily access its services and there were enough staff with the right skills and supervision to care for patients’ needs. The facilities were purpose built with communal and private spaces for therapy and care. At John Eastwood, the specialist palliative care team provided all-round care for patients and their relatives.

At Bassettlaw Hospice services were limited to palliative care and end of life care, and patients only saw a GP with a special interest in palliative care, and a consultant in palliative medicine, once a week. Patients needing therapy services were referred to community therapists. The day care unit provided some wellbeing activities, but patients were referred to a charitable organisation for most wellbeing care.

John Eastwood Hospice
Assessment and delivery of care and treatment
- Referrals to the Specialist Palliative Care team could come from the patients, families, healthcare or social care professionals. Most referrals came from healthcare professionals.
- Referrals were received via the single point of access and systems were in place to ensure that the right health professional received the referrals promptly.
- Patients received a holistic assessment of their needs and care was provided within End of Life Care national and local guidelines.
- Regular multidisciplinary meetings were held to discuss patient care; decisions made at these meetings were discussed with patients and their families.
- The day care unit provided therapeutic care for up to 60 patients a week.
- Patients could access the hospice for advice at any time.
- Specialist palliative care nurses used the distress thermometer to measure patient’s psychological well-being at different stages of their care.

Outcomes for people using services
- Patients using the day care unit were assessed before and after their course of therapeutic care.
- Patients were asked by volunteers for their feedback, the results showed that patients who used the day care unit found the experience to a positive one. One patient spoke of having renewed meaning to their lives and the ability to take part in family life.
- Healthcare professionals in hospitals and the community could access the hospice at any time to seek palliative care advice for their patients.

Staff, equipment and facilities
- The hospice employed three consultants in palliative care medicine.
- Staffing requirements changed daily according to in-patient occupancy. There were trained bank staff available to meet patient’s needs.
- The hospice provided three teams of specialist palliative care nurses to the community (Newark and Sherwood) and (Mansfield and Ashfield) and King’s Mill Hospital, with consultants from the hospice providing in-patient to the multi-disciplinary meetings and community ward rounds. There was no service level agreement with King’s Mill Hospital.
- Specialist palliative care nurses provided training to other hospice staff.
- Staff received peer support including access to psychological, spiritual and clinical supervision.
- All staff trained had received training in communication skills; most of the in-patient staff had received intermediate communication.
- The hospice had 12 in-patient beds, comprising of two bays of four beds and four single rooms.
- The day care centre provided large communal areas inside and in the garden. There were cooking facilities, a café and meeting rooms to allow patients, relatives and medical staff to speak in confidence.
- Physiotherapy and occupational therapists were prominent members of the palliative care team.
- The hospice provided a social activities co-ordinator for day care and in-patient care. We observed that patients were baking cakes on the day of our inspection.
Are end of life care services effective?

- There were pressure relieving equipment and mobility aids available. The hospice had beds that could be lowered closer to the ground and crash mats to help prevent harm from falls.
- There was a translation service available, hospice staff told us that they very rarely needed to use the service, but when they had, they found in practice it was difficult to set up.
- The hospice provided the satellite store for community equipment such as commodes and wheelchairs for use by patients of the Trust.
- The Trust had responded to a risk alert about equipment and managed the change of a brand of syringe driver. A new brand of syringe driver is now in use at the hospice, training had been provided and the use of the new syringe driver had been embedded.

**Multi-disciplinary working**

- Multi-disciplinary team (MDT) meetings were regular, well planned and had representation from all disciplines. We attended a MDT meeting and found that the patients’ named nurse provided information to update the team. All members of the team took an active part in the discussion about patient care.
- Specialist palliative care nurses in the community (Newark and Sherwood) and (Mansfield and Ashfield) had direct access to the multi-disciplinary team at the hospice.
- Specialist palliative care nurses in community were involved in the integrated community teams weekly MDT, where patients on virtual wards who required specialist palliative care were discussed.

**Mental Health Act (MHA)**

- All patients were assumed to have capacity to make decisions about their own care.
- Where patients were assessed for their mental capacity to make decisions relating to their care, these were recorded in their notes.

**Bassetlaw Hospice**

**Assessment and delivery of care and treatment**

- Patients were holistically assessed on admission to the hospice and care was planned.
- Staff discussed plans of care and preferences with patients and their family.

**Outcomes for people using services**

- Patients received therapeutic care in the day care unit that helped them live with their illness.
- Patients received care in the in-patient that helped provide relief from symptoms and prepare themselves for living at home, or end of life care.

**Staff, equipment and facilities**

- The hospice had an in-patient unit that could provide for 6 patients and a day patient unit that could provide care for up to 12 patients a day. There were communal spaces and a garden.
- There was free parking available to visitors.
- The hospice medical care was provided by four GPs with a special interest in palliative care, all had a diploma in palliative care.
- The hospice had recently implemented access to a consultant in palliative care medicine at Bassetlaw Hospital, who also provided one session a week at the hospice for MDT, ward round, advice and supervision.
- The nursing staff within the in-patient unit had palliative care experience and training.
- There was a vacancy for a team leader in the day care unit that was due to be advertised.
- There were no nurse prescribers available in the hospice service.
- The day care unit arranged for outside agencies to provide informal talks in subjects such as claiming benefits, making wills and weight management.
- There were no physiotherapists or occupational therapists available in the hospice. Patients who required therapies were referred to the community therapists via the single point of access.
- There were no chaplaincy services available at the hospice; staff would contact patient’s own minister, if they had one.
- There was a team of three specialist palliative care nurses providing care in the community. One of the nurses had been seconded to the hospice for six months which had caused higher workloads for the nurses in the community, but benefited the hospice by introducing therapeutic care into the day care unit.
- Nursing staff at the hospice had relied on the specialist palliative care nurse that had been seconded to the day
Are end of life care services effective?

care unit for clinical supervision and support. Staff expressed concern to the inspector that until the team leader was replaced that there would be no provision for clinical supervision and support.
• The specialist palliative care team ensured that out of hours GPs and the 111 service had information about patients who may call them for care or treatment out of hours.
• Volunteers provided support with refreshments and activities in the day care unit. Some of the volunteers provided complimentary therapies and hairdressing. There were no allocated volunteers for the in-patient unit.
• Volunteers were supervised by the nursing staff and received mandatory training.
• Activities and well-being care was not provided by the hospice, staff referred patients to a local charity.

• The Trust had responded to a risk alert about equipment and managed the change of a brand of syringe driver. A new brand of syringe driver was now in use at the hospice and training had been provided and the use had been embedded.

Multi-disciplinary working

• The specialist palliative care team attended Gold Standards Framework (GSF) meetings in the community with the aim of preventing re-admissions and achieving patient’s preferred place of care.
• Integrated community teams attended monthly hospice MDT meetings to help with the support of symptom control.

Mental Health Act (MHA)

• All patients were assumed to have capacity to make decisions about their own care.
• Where patients were assessed for their mental capacity to make decisions relating to their care, these were recorded in their notes.
Are end of life care services caring?

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

Summary of findings
End of life services for adults were caring. Staff treated patients, their visitors and each other with respect, and responded to people’s physical and emotional needs. Patients and their families were involved in planning their care, and patients received emotional support as well as help to carry out their wishes.

Services provided patients, relatives and staff with psychological and pastoral support.

A variety of methods were used to gather feedback from people who used services, and their comments were responded to. People were referred to the appropriate services for counselling and bereavement care.

John Eastwood Hospice
Kindness, dignity and respect
• We observed that all staff treated patients, their visitors and each other with respect.
• Patients’ privacy and dignity were maintained by the use of do not disturb notices when providing personal care and the provision of quiet rooms to allow private conversations to take place. Patients told us that all staff ensured that their privacy and dignity were maintained at all times.
• Staff responded to peoples’ physical and emotional needs. We saw that people’s symptoms were managed; staff provided treatment promptly when patients experienced pain or discomfort.
• Patients told us that staff took time to listen to them. We observed all staff interacting with patients in a caring and compassionate way.
• The hospice had open visiting and provided practical comfort for those visitors who wished to stay with the patient overnight.
• Staff had provided practical and emotional support for important occasions, such as weddings, at the hospice
• Staff responded to patient’s wishes for example, where a patient wanted to listen to the rain, the staff wheeled the patient out under a canopy and provided umbrellas for the relatives.

People using services involvement
• Patients and their visitors were able to provide feedback about their care in a number of ways.
• At the entrance of the in-patient area there was a board where people could write their comments about the hospice. The board was titled ‘You said…We did’. Patients had suggested the availability of daily newspapers and Wi-Fi. We saw that these had been provided.
• Patients and their families were involved in the decision making of planning their care.
• Where patients had been assessed as not having the mental capacity to make decisions about their care, best interest meetings were held and recorded in patient’s notes.

Emotional support for care and treatment
• Patients’ needs were holistically assessed which included emotional distress, pain and other symptoms.
• Day care staff had undergone level 2 training in psychology which meant they could provide care and support at the day care unit and refer patients to the psychologist based at the hospice if required.
• Day care staff provided interventional goal setting and occupational therapy to help patients live with their illness. The psychologist had provided a session for ‘managing unhelpful thoughts’.
• Staff were skilled at building therapeutic relationships which enable them to provide care to meet patients’ needs. The staff had a motto, ‘see the person’.
• The chaplain provided spiritual support for patients and their visitors. We observed that the chaplain was available when people needed them.
• The hospice employed a nurse to care for the needs of the carer (families)
• Volunteers at the hospice were sponsored by the end of life board to make a difference in palliative care by looking at what relatives and patients needed. The hospice recognised that volunteers often saw what the healthcare team didn’t always see, such as the ‘heartache'.
Bassetlaw Hospice
Kindness, dignity and respect

- We observed that all staff treated patients, their visitors and each other with respect.
- Patients’ privacy and dignity were maintained by the use of do not disturb notices when providing personal care and the provision of quiet rooms to have private conversations. Patients told us that all staff ensured that their privacy and dignity were maintained at all times.
- Staff responded to peoples’ physical and emotional needs. We saw that people’s symptoms were managed; staff provided treatment promptly when patients experienced pain or discomfort.
- Patients told us that staff took time to listen to them. We observed all staff interacting with patients in a caring and compassionate way.
- The hospice had open visiting and provided practical comfort for those visitors who wished to stay with the patient overnight.
- Staff researched information for individual patients who had cultural or religious requirements. Staff also discussed patient’s needs with the patient and their families.

People using services involvement

- A local charity was used to survey people in January 2014 about their experiences of using the hospice. 31 people were interviewed and the results showed that overall the feedback was positive. The areas of improvement required were around improving communication and discussions around the care plans. An action plan had been devised by the charity which had been given to the hospice for consideration. We found that staff had discussed care plans with patients.
- Patients chose activities and made suggestions which were taken up and provided by the day care unit at the hospice.

Emotional support for care and treatment

- The day care unit provided an assessed for their suitability for the drop in centre which provided activities and counselling. Staff arranged for the patient to visit the drop in centre to introduce the service.
- There is no provision for bereavement or counselling, all patients were referred to local charity drop in centre
- There was no access to a hospice chaplain; patients were referred to their own contact in the community.
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 of findings**
Services were generally responsive to patients’ needs, both at the hospice and community setting. Services were accessible. The hospice actively provided specialist palliative care to patients of any diagnosis, and admitted patients regardless of their postcode or GP. Teams worked closely with the community teams to identify patients who would benefit from specialist palliative care.

All members of the specialist palliative care team were available seven days a week and healthcare professionals could contact the hospice at any time to ask for specialist palliative care advice. At Bassetlaw there did not seem to be sufficient awareness of out of hours services which meant patients who might need care in a crisis at night were not supported.

At Bassetlaw we found some instances where patient records were not complete as they did not contain their care plans or detail regarding patient preference.

**John Eastwood Hospice**

**Planning and delivering services**

- Most patients who were referred to the hospice for control of symptoms and support had a cancer diagnosis. The hospice recognised that their skills could help many more patients and were looking to increase the number of patients that did not have a cancer.
- The hospice had actively engaged the community matrons for long term conditions to use the hospice therapeutic day care and facilities. The hospice had gathered detailed feedback, which showed that this service was valuable and provided therapeutic benefit to people with long term conditions.
- Patients had access to all therapies as these were available within the palliative care team.
- Complimentary therapy was provided for patients and carers by volunteers with the right competency and skills.
- The hospice had a social worker funded by the local authority; the service was dedicated to palliative care patients.
- The hospice provided seven day access to all disciplines within the palliative care team.
- Families had access to a nurse whose role was specifically to care for the carers.
- All families had access to bereavement counselling.

**Right care at the right time**

- Admission to the hospice was available seven days a week. The criteria for admission was the assessment of any patient who had physical, psychological or sociological need. The hospice was available to all regardless of their patient’s geographical location or GP registration.
- The specialist palliative care team used the Gold Standards Framework to work with the community integrated teams to identify patients who may be in their last year, month or week of life who may require specialist palliative care or therapy.
- The specialist palliative care team used the Devon tool with the community integrated teams to identify patients at risk of admission to hospital due to co-existing conditions or symptoms related to their illness; who may require specialist palliative care or therapy.
- There were barriers to care which the hospice had identified, such as the reluctance of secondary care to engage with the hospice, due to lack of understanding of the role of the hospice.

**Care Pathway**

- The hospice used national guidelines to help plan care and provide opportunities for patients to discuss and choose their care.
- The day care unit provided patients with the opportunity to optimise their physical and emotional health whilst remaining at home.
- Bereavement counselling available to the families of patients’ family who had used the services of the palliative care team.
- On admission and discharge to the hospice information was shared via SystmOne. Patients gave their consent to share records. Staff told us that this worked well on discharge, but not all GP’s knew how to electronically share records. Patient held records were supplied on discharge.
Are end of life care services responsive to people’s needs?

Learning from concerns and complaints
- Feedback from in-patients, day care users and relatives were received regularly. All the feedback we saw was positive and any suggestions that were made were taken up and monitored.

Bassetlaw Hospice
Planning and delivering services
- Referrals to the hospice by healthcare staff in the community were made via the Single Point of Access (SPA) service which was available 7am to 9pm, 365 days a year.
- Patients were referred to the service from a range of cancer and long term conditions diagnosis.
- Referrals by the out of ours GP service could be made to the on call GP for the hospice, however, the hospice GP told us that this never happened. The hospice GP believed that the out of hours GPs were not aware of the palliative care service available at night.
- The criteria for admission was summarised by the GP, who told us that patients were admitted who had problems dealing with symptoms or have a crisis at home, or at end of life. Patients were also admitted from the hospital for symptom control. The hospice was available to all patients in the Bassetlaw area.
- The hospice did not provide specialist palliative care advice to the community.

Right care at the right time
- Admission to the hospice was available seven days a week. The criteria for admission was the assessment of any patient who had physical, psychological or sociological need. The hospice was available to all patients in the Bassetlaw area.
- The specialist palliative care team used the Gold Standards Framework to work with the community integrated teams to identify patients who may be in their last year, month or week of life who may require specialist palliative care or therapy.

- There were barriers to care which the hospice had identified, such as the reluctance of secondary care to engage with the hospice and the lack of referrals from out of hours services due to lack of understanding of the role of the hospice.

Care Pathway
- On admission and discharge to the hospice information was shared via the electronic patient record (SystmOne). Patients gave their consent to share records. Staff told us that this worked well on discharge, but not all GP’s knew how to electronically share records. Patient held records were supplied on discharge.
- Patient held records contained patients’ contact list, prescription and their DNACPR form; information about patients plan of care or preferences were not included. Information about patients care was available on the shared electronic records which community teams should have access to; however, staff told us that the systems were not in place for all members of the community team to access the electronic records.

Learning from concerns and complaints
- Where there had been concerns with delays in acquiring transport for palliative care patients, the hospice provided training to ambulance staff to resolve the issue.
- The staff at the hospice provided examples where patients had received resuscitation from ambulance crews because their DNACPR form was not available. We saw that patients receiving day care did not have their DNACPR forms and the hospice did not keep a duplicate. This meant that there was a risk that patients who had a DNACPR in place may be taken to hospital inappropriately.
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 of findings

Services were generally well-led. The service was effective in identifying risks and improving its services. There was a clear vision of where the service was going and at John Eastwood, there was a comprehensive strategy of how it would be achieved. We did see a similar strategy at Bassetlaw which could hinder the process of developing the service and GPs and management working together. Staff were respectful and listened to each other. We saw services working closely with the community teams to provide specialist palliative care to all patients in the area that required it. It had also started to engage with the community teams, commissioners and speciality doctors to raise awareness of the services it provided.

John Eastwood Hospice

Vision and strategy

• Managers had a vision to break down barriers between hospitals, community integrated teams and palliative care settings and staff. Inviting the long term conditions teams into the hospice had been successful, the hospice were preparing a bid to provide this service as part of their core service.
• The hospice were working towards further integration with the community to be more visible in care homes, as they had been identified as not accessing palliative care. The hospice employed two end of life care trainers to assist care homes with information and training.
• To increase the skill of the specialist palliative care nurses to train in advanced assessments and diagnostics.
• To increase access to the hospice for patients that did not have cancer.
• To create a professional development post.
• To create a nurse led assessment and prescribing clinic.

Responsible governance

• The Governance Lead was the Director of Nursing, Quality and Patient Experience.
• All the policies were shared from Nottinghamshire Healthcare NHS Trust policies; the hospice also had local operating procedures.

• There were systems in place to report to the quality boards and receive feedback from them.
• A consultant in palliative medicine attended the Trust’s monthly mortality meetings.
• The chaplain chaired the clinical ethics committee which included discussions and decisions of policy on DNACPR, complex discharges and patient consent.
• There was no link with Bassetlaw Hospice regarding sharing good practice, links with the consultants or end of life care planning.

Leadership and culture

• The hospice provided placements for palliative medicine registrars and GP doctors.
• The Hospice provided placements for student nurse and was included in the induction for district and community nurses.
• The chaplaincy was easily accessible; they provided input into the ethics committee and resuscitation committee.
• All staff at the hospice valued each other’s roles.
• Staff were encouraged to access supervision, including clinical supervision and one to one meetings.
• Staff reported that human resources department was helpful and supportive.
• Staff said that Nottinghamshire Healthcare NHS Trust was positive place to work, as there was so much opportunity for professional development.
• Staff said they were proud to work at the hospice as the care was of a high standard.

Engagement

• There was a close working relationship with the clinical commissioning group end of life lead.
• There was joint working with the clinical commissioning groups to build integrated care wards.
• The hospice had introduced closer working with community matrons for long term conditions.
• Community nurses were encouraged to work at the hospice on bank shifts to help improve their palliative care skills.
• Specialist palliative care nurse prescribers were supporting their fellow district nurse prescribers.
Are end of life care services well-led?

- Regular presence at integrated community teams MDTs raised awareness and understanding of palliative and end of life care.
- The hospice was open to discussions with secondary care, community healthcare and social care organisations.
- The hospice was a member of the local cancer network.
- Public had access to information about the hospice's services via a website. The information was not comprehensive and did not explain that the care was provided by the NHS Trust.

**Performance Improvement**

- Since a new manager commenced in July 2013 bed occupancy has increased as admissions were now accepted seven days a week. Furthermore, there was more awareness of the service.

**Bassetlaw Hospice**

**Vision and strategy**

- The strategy for the hospice was to develop a model where patients were the hub for the palliative care services in the healthcare partnership. The hospice had begun to build relationships with the commissioners, GPs and acute trusts.
- To provide clear pathways to the palliative care service, especially at night.
- To set up a register of palliative care patients.
- To set up a rapid response team for palliative care patients in crisis, the team would include physiotherapists and occupational therapists.
- To visit people in the community to assess them for referral to the hospice.
- To change perception of the hospice from a place to die, to a place to help learn to live with illness.
- To provide palliative care education to community staff.
- To provide a palliative care outreach service.

**Responsible governance**

- Hospice representative attended local governance meetings and reported to the Head of Governance.
- Hospice GPs received appraisals at their contractual GP practice.
- The hospice was represented on the Clinical Quality Review meetings.

**Leadership and culture**

- The hospice manager reported to the general manager of Bassetlaw Health Partnership reported to the Chief Operating Executive Community Services of Nottinghamshire Healthcare NHS Trust.
- The Clinical Director had a GP and mental health background with an interest in palliative care.
- The GP’s who provided the on-call service and the manager of the hospice believed they could lead and steer the hospice to become more consultant supported and provide integrated palliative care. However, although they had the same vision, they were trying to achieve this independently of each other.
- There was no link with John Eastwood Hospice regarding sharing good practice, links with the consultants or end of life care planning.

**Engagement**

- The hospice had begun to build relationships with the Clinical Commissioning Group, GPs and acute trusts to improve the access for patients who required palliative care services, including the development of a register of all palliative care patients.
- The community teams had end of life champions who linked with the specialist palliative care nurses for updates.
- The GPs with a special interest in palliative care were building relationships with respiratory and heart failure consultants in the acute sector.
- The GPs at the hospice were integrating the hospice with the developing community services.

**Performance Improvement**

- During the last six months, the hospice had seconded a specialist palliative care nurse to the day care unit to change the emphasis from a meeting place to a therapeutic care centre. The outcome of the change was that patients had received information and enable and empower patients to live with their illness, and patients were now referred to a local charity for wellbeing services.