

Wirral Community NHS Trust

RY7

End of life care

Quality Report

RY701 St Catherine's Health Centre

RY7X3 Arrowe Park Hospital

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

The overall rating for this service was good.

The Wirral Specialist Palliative Care (SPC) /End of Life Care Team was established to ensure that systems and processes were in place as identified within the National End of Life Care Strategy (DH, 2008). They facilitated the delivery of high quality end of life care. End of life care helped all those with advanced, incurable illness to live as well as possible until they died. The team offered advisory support to both the patient and family throughout the last phase of life and into bereavement.

During the inspection we spoke on the telephone with six patients in their own home. We met and spoke with four patients and their carers living in the community and we spoke with six patients receiving day care in Wirral Hospice St Johns. We received overwhelming positive feedback from patients and relatives. They all told us they were appreciative of the support and care shown to them and their families. Patients and their informal carers told us they liked having the contact and lifeline with the nurses and the team of staff.

A telephone triage system had been introduced and proved successful. The system whereby a nurse received all the referrals and ensured a visit by one of the team was arranged within two working days for patient support in community settings and four hours for those in hospital.

All palliative care patients diagnosed as being in the last year of life were commenced on an advanced care plan in the form of a patient and carer assessment, Patient And

Care Assessment (PACA). The PACA was a comprehensive, holistic assessment which was in place to record the changing needs of patients and carers and their individual preferences. In their advisory role the SPC team supported patients to be pain free. They promoted the use of anticipatory prescribing to ensure analgesia was available when necessary.

On average each nurse had 20 to 25 patients on their case load at any one time. They saw approximately six patients per working day. Since April 2014 the team had been adopted by Macmillan, including the social worker, occupational therapist, physiotherapist and the administration staff. Since registering with Macmillan, the team had benefitted from professional development and the provision of on-going education and advice.

Multi-disciplinary Team (MDT) meetings were held weekly to discuss individual patient care. MDT meetings enabled co-ordination, communication and education. We saw that day centre facilities were available to support community patients at Wirral Hospice St John's. We met and spoke with patients at the day centre. The patients told us the care and support was excellent; faultless.

We heard and read many examples of the team offering exemplary compassionate and heartfelt care.

Survey questionnaires were given to patients and families when in contact with the specialist palliative care team. Although the team received a wealth of praise and recognition for their work the questionnaire return was poor. The staff felt this was due to the grieving process.

Summary of findings

Background to the service

A multi-disciplinary team of 24 staff currently based at Arrowe Park Hospital and St Catherine's Health Centre worked together to offer support and guidance to patients, families and other nursing colleagues. This included the management of pain and other symptoms and provision of psychological, social, spiritual and practical support.

18 nurses and other professionals work in partnership with local GP's and the Wirral Hospice St John's.

During 2013/2014 the team averaged approximately 147 referrals per month. Referrals for non-malignant cases had also gradually increased. The majority of referrals were received from Wirral University Teaching Hospital, 54%, followed by 46% received from across the community, 12% of which were from GPs.

The team whilst working with health and social care professionals ensured that advance care planning was offered in order to anticipate patient and carer needs. They educated health and social care professionals so that they were confident in providing high quality end of life care.

The team promoted the Wirral Integrated End of Life Care (EoL) Pathway and shared good practice through MDT meetings.

NHS and Care Home staff were encouraged to contact the team when they required support, education or guidance regarding implementation of any of the EoL Care. A future plan was to introduce designated link nurses to promote good practice and outcomes for patients.

Our inspection team

Our inspection team was led by:

Chair: Professor Siobhan Gregory, Director of Quality and Clinical Excellence, Hounslow and Richmond Community Healthcare NHS Trust.

Team Leader: Debbie Widdowson, Care Quality Commission

The team of 28 included CQC inspectors and a variety of specialists: District Nurses and Tissue Viability Specialists, Ward Matron, Community Matron and Nurse Practitioner, Health Visitor, Therapists, a NHS Managing Director with expertise in governance, GP and a Dentist and four experts by experience.

Why we carried out this inspection

We inspected the Trust as part of our comprehensive Wave 2 pilot community health services inspection programme.

The Wave 2 inspection model for community health services is a specialist, expert and risk-based approach to

inspection. The aim of this testing phase is to produce a better understanding of quality across a wider range and greater number of service and to better understand how well quality is managed.

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 Trust and asked other organisations to share what they knew. We also received comments from people who had attended a listening event prior to the

Summary of findings

inspection. We carried out announced visits on 2, 3 and 4 September 2014. We also visited the trust unannounced out of hours on 3 September 2014. We visited health centres, dental clinics and walk in centres. We went on home visits with district nursing, health visitors and palliative care specialist nurses. During the visits we held

focus groups with a range of staff who worked within the service, including nurses, therapists and healthcare assistants. 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.

What people who use the provider say

People we spoke with told us that the nurses and support staff were very knowledgeable and they demonstrated a real confidence in what they were doing. They went out of their way to make sure they received what they needed and explained everything in layman's terms.

A relative we spoke with told us that the nurses made sure nothing was forgotten and that they knew what needed to be done. They felt that they had really good support and benefitted greatly from it.

Patients told us they and the whole family had been able to build a trusting relationship with the team; that they all felt as involved. They told us the nurses were very considerate, respectful and had nothing but praise for everyone involved.

One relative told us they had called the out of hours team and they had been very supportive too.

Good practice

- The team had developed their own nutrition assessment to support community patients.
- The staff were enthusiastic and receptive to change; they welcomed the new SystemOne records management.
- The feedback from families, patients and informal carers was exemplary.
- The staff demonstrated care practices that was the 'extra mile' for patients comfort and support going above and beyond the call of duty. Patient's told us that they never felt rushed and nothing was too much trouble.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- Although the trust is introducing SystemOne to the end of life team, record keeping and the review process should be improved to ensure that care and treatment is effectively documented.
- The working relationships with the hospice were on occasions disjointed and should be improved. Future plans were in place to improve the team morale and support networks.
- The use of link nurses within the hospital site had not been promoted; this is an area where the work of the specialist team could be cascaded; educating groups of staff for the benefit of the patient experience.

Wirral Community 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 safe?

By safe, we mean that people are protected from abuse

Summary

The documentation we saw considered patient safety through risk assessments and records of individual patient choice. The specialist palliative care (SPC) staff were aware that patients who were receiving palliative care could also be at risk of falls, pressure ulcers, and healthcare associated infection.

The provision of equipment was organised by the team's occupational therapist. They had contact with the trust equipment store and felt that the system generally worked well.

We identified that the incident reporting for the SPC team was low and also low grade. The clinical lead told us they would be reviewing the incidents and the reporting; training may need to be arranged. It was acknowledged that incidents were generally related to community incidents and not specific to the care or support delivered by the team.

The patients we spoke with told us they felt their safety was well managed and they had all the support that they currently needed.

Incidents, reporting and learning

- There were no serious incidents reported that related to the provision of EoL care.
- We discussed the low incident reporting from the trust. The staff had recently had improved access to Datix to report and record safety incidents, concerns and near misses, and allegations of abuse.
- There was evidence that incidents had been downgraded at the time of reporting due to the prompt action taken by the staff to rectify the problem.
- We were told that the system for reporting incidents would be reviewed to ensure the data collection demonstrated the workload and the input of the specialist team.
- The clinical lead told us that they were planning to train the staff to investigate incidents further and also promote robust feedback.
- Between December 2013 and June 2014 a total of two complaints were received about the service. Action had been taken to address both issues one related to poor communication and the other regarding the referral process.

Are End of life care safe?

- A telephone triage system had been introduced whereby a nurse received all the referrals and ensured a visit by one of the team was arranged within two working days for those in community settings and four hours for those in hospital. This Key Performance Indicator (KPI) was currently being met and had achieved 100%.
- The increase of pressure ulcers in the community had been identified and this was being overseen by the specialist team; undertaking a route cause analysis.

Cleanliness, infection control and hygiene

- The staff adhered to the community trust hand hygiene and infection prevention policy.
- We saw staff using hand washing facilities and hand gel. Patients also confirmed that they saw staff washing their hands and using hand gels.
- The staff wore trust uniforms and adhered to the trust uniform policy when working in the community.
- The trust buildings we visited were well maintained and clean.

Maintenance of environment and equipment

- An occupational therapist worked within the SPC team. Their role was to ensure patient safety, with the support of relevant equipment and appropriate risk assessments.

Medicines management

- The management informed us that one area of concern related to delayed medication administration in the hospital. On several occasions the SPC team had been asked for advice by the ward staff and then a delay in administering the analgesia had been reported.
- The team referred concerns and sought advice from the trust pharmacist and the hospice out of hours.
- Anticipatory medicines were stored in patient's houses when necessary. Lockable medication bags and relevant prescribing documentation were provided for seven day cover. Only community nurses had access to these bags which had coded lockable tags.

Records systems and management

- All palliative care patients diagnosed as being in the last year of life had an advanced care plan in the form of a

patient and carer assessment (PACA). The PACA was a comprehensive, holistic assessment which was in place to record the changing needs of patients and carers and their individual preferences.

- We saw evidence of this document being used in a person's home and a care setting.
- There was a record made regarding individual resuscitation status.

Lone and remote working

- Staff told us about the trusts lone working policy and how they ensured the team knew where everyone was located within the community.
- The office staff made sure that each person had called in to the office during and at the end of the working day.

Staffing levels and caseload

- 24 members of staff worked in the specialist palliative care/EoL team. Currently they did not use agency or bank staff to cover absence. The team supported each other by covering extra time on the rota.
- There were 18 nurses within the team; 14 WTE band 7 nurses and 4 WTE band 6 nurses, all with various hours. One band 7 nurse was permanently based within the hospital setting.
- One physiotherapist, a dietician, an occupational therapist, a social worker and administration staff were also part of the team.
- The staff told us they were very busy and constantly in demand by the wards and the community settings. The staff prioritised their work to ensure that patients and other staff groups felt supported.
- On average each nurse had 20 to 25 patients on their case load at any one time. They saw approximately six patients per working day.

Managing anticipated risks

- The triage nurse accepted calls via the Palliative Advice and Information Line (PAIL); they triaged the referrals and allocated the case to the team. The patient then received a face to face visit from a SPC nurse.
- The staff were able to discuss how they supported people in the community during a period of extreme or severe weather. Plans were put in place to ensure patients' needs were safely met.
- The trust quality, patient experience and risk group developed guidance to provide a framework within which a registered nurse may safely verify an expected

Are End of life care safe?

death of an adult in the community setting. These guidelines ensure all deceased individuals, their families and carers were dealt with in a dignified and respectful manner

- Staff had attended an 'emergency preparedness session'.
- A regional guideline book (known as the purple book) was available for the staff to refer to in the office and especially when manning the triage telephone.

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

To ensure their input was effective the specialist palliative care team completed a standardised advanced care planning assessment tool for each patient. The PACA recorded the outcome of interventions made with regard to a person's symptom control and any changes. They also recorded the patients and carers insight of the situation and the effect on their quality of life.

Patients told us they felt that the document was a good record of their visits, thoughts and plan of care.

During 2013/2014 the team averaged approximately 147 referrals per month. Referrals for non-malignant cases had also gradually increased. The majority of referrals were received from Wirral University Teaching Hospital, 54%, followed by 46% received from across the community, 12% of which were from GPs.

Evidence based care and treatment

- In 2011 the National Patient Safety Agency (NPSA) put forward a recommendation that all Graseby syringe drivers should be removed by the end of 2015. The trust had replaced these with McKinley syringe drivers and training had been undertaken to ensure staff competence and patient safety.
- The staff were aware of the National Alliance report and the phasing out of the Liverpool Care Pathway. The report called 'One Chance to Get it Right' identified five priorities for care of the dying person.
- The Wirral EoL Care Quality Group have incorporated elements of the five priorities for care of the dying person in to the PACA.
- The Gold Standard Framework was followed to enable people to receive co-ordinated care.
- Preferred Priorities of Care (PPC) promoted open discussions between the patient, family and health and social care workers to ensure that people's wishes were achievable.
- The EoL care followed national guidelines including:
 - NICE EoL Quality Standards (2011)
 - EoL Care Strategy (DH 2008)
 - Preferred Priorities for Care (2007)
 - Wirral EoL Care Plan

- Wirral Community NHS Trust Protocol for EoL Care Tools

Pain relief (optional)

- Patients in the community told us that they had received good pain relief which was well managed with appropriate advice.
- Within the PACA each patient had their pain assessed and recorded at every visit. This assured the patient they would be pain free and gave the nurses good continuity of care.
- In their advisory role the SPC team supported patients to be pain free. They promoted the use of anticipatory prescribing to ensure analgesia was available when necessary.
- Patients were referred to the pain clinic at the hospice when pain control was unstable or staff felt that they would benefit from a second opinion. We were told that nerve blocks could be arranged for some pain cases.
- Counselling was available for patients in pain with contributing anxiety issues.

Nutrition and hydration (optional)

- Each patient had a nutritional screening assessment recorded - Malnutrition Universal Screening Tool (MUST) completed. This identified patients at risk of malnutrition and a nutritional care plan was commenced when risks were identified. To support this the team also used a locally developed screening tool more appropriate for some patients.

Approach to monitoring quality and people's outcomes

- The Trust reported that all the EoLC Quality Goals for 2013/2014 were achieved.
- 90% of patients had been offered a preferred priority of care document which was recorded in health care records.
- 90% of patients who died on the Wirral EoL Care Plan had agreed variances.
- 90% of patients had a current PACA.
- 90% of informal carers for EoLC patients were offered an information leaflet.

Are End of life care effective?

- SystemOne was currently being introduced; a centralised clinical system that provided healthcare professionals with a complete management system including electronic patient records. This process was welcomed by the staff but there had been a delay in the roll out programme; training was scheduled.
- 65% of records had evidence that for patients who were not on a syringe driver, OOH had been informed monthly using an OOH handover form.
- 78% of records had evidence that of the patients/carers who requested Marie Curie Nurses, a referral form was completed.

Patient outcomes performance

- March 2014 Integrated Performance report stated that in relation to the SPC team over the last six months, the percentage of patients on an EoL Pathway had fallen significantly at the time of death. It was reported that there were a number of factors which were out of the organisation's control in relation to this target and the performance had been queried with the CCG. The reasons included patients or their family refused and clinicians had not placed patients on the pathway when admitted in to hospital.
- The trust integrated performance report in April 2014 stated that 38% of patients on service list were on an EoL pathway at their time of death against target of 90% and was RAG rated Red.
- The EoL care Assessment and Management Audit (September 2013) showed that:
 - 92% of records had evidence that the patient had been assessed using an PACA.
 - 88% of records had evidence that the patient's spiritual / religious needs had been assessed.
 - 73% of records had evidence that once a patient was assessed using the PACA, the PACA was updated at each visit.
 - 83% of records had evidence that the patient's pain had been assessed and recorded at each visit (even if the patient had no pain) on the patient and carer assessment or pain assessment chart.
 - 80% of records had evidence that the PACA or Trust DNAR form included the Do Not Attempt Cardio-Pulmonary Resuscitation (DNAR) status of the patient.
 - 95% of records had evidence that the patient had been assessed using the Pressure Ulcer and Nutritional Risk Assessment
 - 86% of records had evidence that a discussion was offered regarding advance care planning if there was no evidence of Preferred Priorities for Care (PPC).
 - 84% of records had evidence that for patients who are on a syringe driver, Out of Hours (OOH) had been informed weekly using an OOH handover form.

- An action plan, following this audit, was drawn up and shared with clinical audit team in February 2014. It was decided that the audit would be repeated in quarter one 2014/2015, however we saw no evidence that this had taken place.

Competent staff

- The SPC team had all received advanced communication skills training.
- They received clinical supervision sessions with the trust consultant, the clinical lead and during one to one sessions.
- The staff received support and advice from the oncology service at Clatterbridge Cancer Centre.
- The staff's clinical competencies were checked and signed off by the clinical lead.
- Since April 2014 the team had been adopted by Macmillan, including the social worker, occupational therapist, physiotherapist and the administration staff. Since registering with Macmillan the team had benefitted from professional development and the provision of on-going education and advice.

Use of equipment and facilities

- Equipment was requested from the hospital trust equipment store and delivered to the patient in the community.

Multi-disciplinary working and coordination of care pathways

- Multi-disciplinary Team (MDT) meetings were held to discuss individual patient care. MDT meetings enabled co-ordination, communication and education.
- In line with cancer standards, weekly MDTs occurred every Wednesday for community cases and every Friday for hospital cases.
- The team offered a seven day service between the hours of 9.00 and 17.00.
- OOH support was available from the staff at Wirral Hospice St John's. OOH palliative care communication handover forms were completed and faxed to the local hospice to improve communication and coordination of

Are End of life care effective?

care. These forms were updated and faxed monthly to the local hospice or when any changes in a patient's clinical need had been identified. When a patient had commenced on a syringe driver the communication form was completed weekly or more frequently depending on the patient's needs.

- The SPC team and EoL team were being brought together to work from one office.

- In line with NICE cancer standards for continuity of patient care patients are allocated to a named nurse caseload. The staff work to the key worker policy.
- Two nurses covered weekends and bank holidays, based in the hospital. Only hospital or urgent cases were actioned over the weekend.

Are End of life care caring?

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

Summary

The staff we met and spoke with from the specialist palliative care and EoL team were welcoming and friendly. They were passionate and enthusiastic about their role. We heard from patients about the teams kind, caring nature and compassionate support.

Staff told us they felt well supported in the team and able to discuss any issues or concerns openly. We heard about the multi-disciplinary team meetings (MDT) which were held. This was where the team discussed patient care and treatment to ensure that they could support the individual in the best possible way.

Patients we spoke with told us they felt involved in their care and they had been treated with dignity and shown respect. Relatives told us that the team treated everyone as an individual and took time to consider people's emotions and general well-being.

Compassionate care

- We heard and read many examples of the team offering exemplary compassionate and heartfelt care.
- The community trust arranged a Christmas memorial service for families, carers and staff to attend at a local church.
- In the Clinical Commissioning Group (CCG) review it was identified that of the 302 people who had died during 2014 - 75% had died in their preferred choice as documented in their PPC. Reasons for not meeting a patients request were considered and may be due to a hospital admission or lack of time.
- Following the death of a patient the main carer/relative was offered a bereavement visit by a registered nurse within the first month. This was recorded in the patient's records to explain why this had or had not been achieved.

Dignity and respect

- Patients told us they were treated with dignity and shown respect. Relatives told us that the staff were very professional and sensitive.
- The team received a wealth of thank you cards showing genuine appreciation from relatives and informal carers.

Patient understanding and involvement

- All patients were offered a Preferred Priorities for Care document (PPC) and this was recorded in the patients' health records.
- Patients told us they felt involved in their care and had been given plenty of opportunities to express and discuss their concerns, worries or fears.
- We saw information leaflets which were given to patients when they referred to the team.
- The PACA included the resuscitation status of the patient. The decision to not be resuscitated was discussed with the patient and carer and the patients GP. The GP then had the responsibility to inform North West Ambulance (NWA) Service of the 'Do Not Actively Resuscitate' status (DNAR). The original copy of the DNAR form was stored at the front of the patient's health records as the NWA service would not accept photocopies of the DNAR form.

Emotional support

- All patients approaching the EoL were offered spiritual and religious support appropriate to their needs and preferences. We saw this recorded in patient PACA's.

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

Patients referred to the Specialist Palliative Care (SPC) team were seen within 48 hours in the community and four hours within hospital. The team triage system assisted the team to work to their best potential, putting the most critical patient first.

We were told by patients that the staff were very responsive and dealt with stressful situations professionally and calmly.

Service planning and delivery to meet the needs of different people

- The SPC team responded to telephone calls during the hours of 9.00 and 17.00. The Clinical Commissioning Group (CCG) review found that call-back to professionals over a weekend could be delayed. Having the team based in one location was thought to reduce the need for the current telephone approach and be more effective and timely over the weekend.
- The EoL care assessment and management audit (September 2013) showed that 94% (97) of records had evidence that medication for anticipatory prescribing as

clinically indicated was in place for pain. This also showed 94% (97) of records had evidence that medication for anticipatory prescribing as clinically indicated was in place for nausea and vomiting.

- Patients told us they could call the team for advice whenever they required it.

Access to the right care at the right time

- The EoL care assessment and management audit (September 2013) showed that 82% (84) of records had evidence that the patient had been offered their Preferred Priorities for Care (PPC) document. We saw advice leaflets which were given to patients.
- We saw that day centre facilities were available to support patients at Wirral Hospice St John's. We met and spoke with patients at the day centre. The patients told us the care and support was "excellent; faultless".

Discharge, referral and transition arrangements

- The EoL care assessment and management audit (September 2013) showed that 83% (79/95) of records had evidence that the carer's holistic assessment within the Patient and Carer Assessment (PACA) was offered. It also showed that 93% of records had evidence that following the death of a patient, the family/main carer were offered a bereavement visit.

Are End of life care 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 Specialist Palliative Care and End Of Life Team clinical lead was newly in post but had already shown strong leadership which was welcomed by the staff. The operations manager and clinical lead were impressed by the staff professionalism and efforts to support patients in the community.

Staff were encouraged to take their stories to the board meetings to discuss their role and responsibilities and raise any pertinent issues they may have encountered. The staff were all monitored for their competencies and followed their own guidance based on St Christopher's Hospice.

Vision and strategy for this service

- The staff told us they attended the business planning day to understand the trust objectives.
- Individual objectives were set alongside these to ensure individuals met personal goals through appraisals.
- Management supervision took place every six weeks.
- The team discussed the trust objectives, audit results and audit progress at team meetings.
- The EoL group meeting was held to support staff and discuss cases in an educating way.

Governance, risk management and quality measurement

- A May 2014 review of the service undertaken by Wirral Clinical Commissioning Group provided an overview of the SPC team commissioned by Wirral CCG from Wirral Community NHS Trust. The focus of the review was on its integration between the three settings of the community, hospital and hospice and it also looked at the activity of the PAIL jointly provided by Wirral Community NHS Trust and Wirral Hospice St John's. The recommendations following this included improved communication and further integrated working.
- Survey questionnaires were given to patients and families when in contact with the SPC team. Although the team received a wealth of praise and recognition for

their work the questionnaire return was poor. The staff felt this was due to the grieving process and as a team, they were considering ways in which this return rate could be improved.

Leadership of this service

- The leadership of the SPC team had been reorganised and was in its first month. The impact so far was positive and staff told us they appreciated the new guidance and support.
- The clinical lead hoped to take the team forward with improved communication and improved records using the SystemOne tools.
- The staff we spoke with spoke highly of the board and their visibility.

Culture within this service

- We recognised that the SPC and EoL team were passionate about their work and went above and beyond their duties to ensure their patients were well cared for and safe. The team also showed concern for each other as a team of staff and supported each other in the community.
- The staff told us they had seen the senior managers and the director of nursing on the walkabouts and valued their interest in the specialist teams. The staff told us they felt listened to. One person told us about the staff council and how issues were raised and the board actioned their requests.
- The staff acknowledge their excellent peer review process and the monitoring of their own activity.
- Staff told us about the 'open door' policy of the senior management and executives.
- Staff were aware of the whistleblowing policy known as 'speaking out safely' – they were encouraged by management to use it and they felt confident that staff would if necessary.

Innovation, improvement and sustainability

- We were told of a working group to support patients that were EoL, yet homeless or no fixed abode. Patients were identified within hostels and supported by the community staff.

Are End of life care well-led?

- The staff are invited to attend mortality meetings.
- To further enhance feedback from patients, informal carer experiences were gathered from three carers as part of the CCG review. One carer could not praise the nurse involved with their father's care enough.