Care Quality Commission

South Warwickshire NHS Foundation Trust

RJC

End of life care

Quality Report

Stratford-upon-Avon Hospital
Arden Street
Stratford-upon-Avon
CV37 6NX
Tel: 01926 495321
Website: https://www.swft.nhs.uk/

Date of inspection visit: 15 – 18 March 2016
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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RJC03	Stratford Hospital	Community End of Life CareCommunity End of Life Care	CV37 6NX

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

Summary of findings

Ratings

Overall rating for the service	Requires improvement	🟠
Are services safe?	**Good**	🟢
Are services effective?	**Requires improvement**	🟠
Are services caring?	**Good**	🟢
Are services responsive?	**Requires improvement**	🟠
Are services well-led?	**Inadequate**	🔴

Summary of findings

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Summary of findings

Overall summary

Overall, we rated the community end of life care service as requires improvement.

We rated safety and caring as good, effectiveness and responsiveness as requiring improvement and well-led as inadequate.

- There was not a strategy for community end of life care services. Staff were unsure of the trust wide direction for the future of the end of life services.
- The trust did not have a non-executive director who provided representation of end of life care at board level.
- There were no formal processes in place to gather feedback from patients or relatives.
- The individual plan of care for the dying person, which was a replacement for the Liverpool Care Pathway, was designed to be used for patients in hospital and community settings. However, this was found to be not used by the community teams.
- The trust did not monitor the number of end of life patients who were rapidly discharged from hospital to die. Following our inspection the trust held a 'rapid home to die workshop' in June 2016 to assess and identify difficulties with the capacity of the community based services and coordination of the services, including third sector providers, involved in delivering end of life care.
- For the period January 2015 to January 2016 there were 906 deaths, of which less than half 434, (48%) of patients died in their preferred place of care.
- The community specialist palliative care team (SPCT) did not have a local audit programme in place, which meant they were unable to measure the effectiveness and outcomes of the service.
- Advance care plans (a plan that documents patients' views, preferences and wishes about their future care) were not always in place for patients receiving end of life care and those we found, had not been consistently completed.
- We did not see evidence of how the service planned and delivered care to people in vulnerable circumstances,

- The SPCT did not carry personal protective clothing. This meant that staff and patients could be at risk of infection.
- Nutritional risk assessments were not always found in place. This meant there was a risk that patients would not receive the appropriate nutritional support and advice.
- The community SPCT were below the trust target for completion of mandatory training in eight of the 10 training requirements, including safeguarding children level one and two training. This meant that staff were not keeping their skills up-to-date and the service could not be assured that staff had the necessary knowledge in these areas.

However we also found:

- Patients were very positive about the service they received.
- Staff were committed to providing compassionate end of life care.
- Medicines were appropriately prescribed, administered and checked thoroughly and there was guidance available for staff on prescribing and the use of anticipatory medicines at the end of life.
- Staff working across end of life care community services used the same syringe driver; this ensured continuity of care and reduced the risk of medicine errors.
- Patients had access to equipment or aids they required. Community staff were able to arrange delivery of the equipment for patients who were returning home for their end of life care, on the same or the following day.
- The community specialist palliative care team (SPCT) provided services seven days a week. There was an on call consultant in palliative medicine available to provide telephone advice, to patients and professionals in community and acute settings, across Coventry and Warwickshire 24-hours a day.
- Do not attempt cardiopulmonary resuscitation (DNACPR) forms, indicated staff had involved the patient, or (if appropriate) relatives, in the decision.

Summary of findings

Background to the service

South Warwickshire Foundation NHS Trust had multidisciplinary specialist palliative care teams who provided palliative and end of life care in all settings across Warwickshire. They also provided support to its community health care teams in South Warwickshire, Rugby and Warwickshire North, together with hospital staff who provided palliative and end of life care in those settings.

The community specialist palliative care team had received 1613 referrals from January 2015 and January 2016. 1448 (90%) of those referred had a diagnosis of cancer. 165 (10%) of those referred had a non-cancer diagnosis.

The community palliative care nurse specialists (PCNS) provided expert clinical advice and support for patients with complex palliative care needs and their families and carers. They worked in partnership with GPs, integrated health teams, other community services and providers.

The PCNS role included:

• Assessment and care planning for patients with complex palliative care needs.

• Information on disease process, treatment, medicines, local and national services.

• Advising on symptom control.

• Psychological support for the patient and their carers.

Our inspection team

Our inspection team was led by:

Chair: Jenny Leggott, Former Director of Nursing and Midwifery at Nottingham University Hospitals NHS Trust

Head of Hospital Inspections: Bernadette Hanney, CQC

The team inspecting community health end of life services included a CQC inspector and two specialist advisors. The team worked closely with inspection teams visiting community hospitals and community teams across the trust.

Why we carried out this inspection

We inspected this core service as part of our planned comprehensive 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?

We visited the two community specialist palliative care teams, two community nursing teams and we also visited the Nicol Unit as part of the inspection. However, due to

an outbreak of norovirus (sickness and diarrhoea) at the time of inspection, we were advised not to inspect. With consent, we observed patients receiving services and accompanied staff on home visits.

We also:

• Looked at 21 clinical records and 11 DNACPR's.
• Spoke with 10 patients and 2 relatives.

Summary of findings

- Spoke with 31 staff across the service including the associated medical director, the trust lead for EoLC and clinical lead consultant for the community. We also spoke with palliative care nurse specialists and community nurses.

Prior to and following our inspection we analysed information sent to us by the trust and a number of other organisations such as local commissioners and Healthwatch.

What people who use the provider say

Patients we spoke with were positive about the staff that provided their care and treatment.

They told us they had confidence in the staff they saw and the advice they received.

Their comments included "amazing, supportive, always answers all my questions", "friendly and caring" and "They give 120%, they do a terrific job".

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should ensure that the use of the Individual Plan of Care for the Dying Person is embedded within the community teams.

- The trust should ensure that staff complete mandatory training at the required intervals.

- The trust should ensure that staff comply with infection prevention and control guidance.

- The trust should ensure that there is an integrated strategy for end of life care services.

- The trust should monitor the number of end of life patients who are rapidly discharged from hospital to die, to identify potential difficulties with the capacity and coordination of the community based services.

- The trust should ensure that the community specialist palliative care team has a local audit programme in place, to measure the effectiveness and outcomes of the service.

- The trust should ensure that advance care plans (a plan that documents patients' views, preferences and wishes about their future care) are in place for patients receiving end of life care.

- The trust should ensure that nutritional risk assessments are carried out to ensure that patients received the appropriate nutritional support and advice.

CareQuality Commission

South Warwickshire NHS Foundation Trust
End of life care
Detailed findings from this inspection

Good ●

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated end of life services as good for safe.

- Staff working across end of life care community services used the same syringe driver; this ensured continuity of care and reduced the risk of medicine errors.
- Staff we spoke with demonstrated an understanding of safeguarding and understood the types of abuse that patients might experience.
- Medicines were appropriately prescribed, administered and checked thoroughly and there was guidance available for staff on prescribing and the use of anticipatory medicines at the end of life.
- Patients had access to equipment or aids they required. Community staff were able to arrange delivery of the equipment for patients who were returning home for their end of life care, on the same or the following day.

However we also found:

- The community SPCT performance for completion of mandatory training was below the trust's target in eight of the 10 training requirements.
- The SPCT did not carry personal protective clothing. This meant that staff and patients could be at risk of infection.

- There were some omissions in the documentation contained within the patients' healthcare records, for example, the patient's preferred place of care was not always stated.

Safety performance

- The trust monitored safety performance and reported incidents to the relevant authorities. Serious incidents, known as 'never events,' are largely preventable patient safety incidents that should not occur if the available preventative measures had been implemented. End of life care (EoLC) community services, had not reported any never events or serious incidents in the last six months.
- The trust reported patient safety incidents to the National Reporting and Learning System (NRLS). During the period February 2015 to February 2016, the trust reported 12 incidents relating to EoLC in the community. In 11 of the incidents, the severity of harm was classed as resulting in no harm and one was classed as resulting in low harm.
- Community nurses also delivered the end of life service across a number of teams, therefore, it was not always possible to distinguish when safety information related to patients receiving end of life care.

Are services safe?

Incident reporting, learning and improvement

- The SPCT reported 12 incidents in the period February 2015 to February 2016. The category of incidents included, four related to medicines, three lack of referral to community teams and two classed as communication issues. The majority of the incidents were related to issues outside of the SPCT, for example, a nursing home that were unable to care for patients with syringe driver administered medicine and required district nursing support. Overall, the incidents demonstrated the importance of communication and coordination of services to deliver end of life care in the community. Issues appeared to have been escalated to mangers of services where appropriate. However, there may be other incidents reported by district nurses working in the community that may relate to patients who were receiving end of life care. The information received from the trust regarding incidents reported by adult services in the community did not indicate if they related to patients who were receiving end of life care specifically.
- Staff were aware of the process for reporting incidents using the trust wide electronic system. However, some of the staff we spoke with told us that they had never reported any incidents. This meant that we could not be assured that all incidents had been reported.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- We found that some staff were unfamiliar with the term Duty of Candour, but most were able to describe the need to be honest and open with patients and their families about mistakes.

Safeguarding

- Staff demonstrated an understanding of safeguarding and understood the types of abuse that might be found. Staff knew how to access information via the intranet about safeguarding and where they could get advice about potential safeguarding concerns.

- Policies for safeguarding adults and children were available for staff on the trust's intranet.
- Safeguarding adults and children training was part of the trusts mandatory training programme and different levels of training were provided according to the job role. The community SPCT needed to complete safeguarding children training as they may come into contact with children when providing care to adults in their homes. The trust's target was 95% of clinical staff having completed the appropriate level of training. The community SPCT were below the trust target for safeguarding children level one and two training. 83% of clinical staff had completed safeguarding children level one however only 45% had completed level two (March 2016). However, 95% of clinical staff had completed safeguarding adult training (March 2016).

Medicines

- Community PCNS and community nurses told us that the management and ordering of medicines were given priority by the teams and that there was good liaison with GPs. This was to ensure that patients who required anticipatory drugs received these. Patients we spoke with confirmed this.
- Some PCNS within the community SPCT had completed the relevant training to become non-medical prescribers and could independently prescribe medicine and adjust prescriptions.
- The community nurses checked that controlled drugs (CDs) were being administered appropriately in patients' homes. Prescription sheets were kept in patients' homes, and the stock level was checked and recorded on each visit.
- The trust used one model of syringe driver. The syringe driver was used in end of life care to deliver medicines to control pain and other symptoms continuously over a 24-hour period. The trust had guidelines in place for the use of the syringe driver, to reduce the risk of medicine errors.
- Staff reported four incidents related to medicines, one of which related the use of a syringe driver. All four incidents were related to opioid analgesia (strong pain relief) and rated as resulting in no harm. The incidents demonstrated that staff checked the preparations and administration of these medicines thoroughly.

Are services safe?

- The trust had guidance for staff regarding the safe removal or destruction of unwanted CDs from the patient's home. The guidance included the importance of healthcare professionals recording any actions taken in the patient's records.

Environment and equipment

- Patients admitted to community hospitals for end of life care were prioritised to be cared for in a single room. There was one 'flexible' bed allocated specifically for palliative care patients at the Ellen Badger Hospital and Nicol Unit at Stratford Hospital.

- Patients had access to equipment or aids from an external provider. Types of equipment that were required to help end of life patients at home included hoists, electric profiling beds, commodes and special mattresses to prevent pressure ulcers. These were ordered via the community nurses, as PCNS did not have the permission to order equipment. Staff told us that the system worked well and did not lead to unnecessary delays. The community staff were able to arrange delivery on the same or next day, for patients who were returning home for their end of life care. Patients we spoke with told us that equipment arrived quickly.

- There were guidelines available for staff for setting up and changing the syringe driver pump for adult patients. We saw that this had been approved on November 2013 and we saw in SPCT meeting minutes that staff had been identified to review this guidance in November 2015. Team meeting minutes we reviewed did not confirm if this had been completed.

- The trust provided details of the syringe drivers available across the community services. This recorded the location, when it was commissioned and last maintained. It demonstrated that the electro-biomedical engineering (EBME) department had maintained 92% of syringe drivers used in the community in 2015 and 2016.

- All staff working across end of life care services used the same syringe driver; this ensured continuity of care and reduced the risk of medicine errors. Training in the use of the syringe driver was delivered to staff that needed to use the equipment.

Quality of records

- The trust used a combination of electronic and paper healthcare records. Staff attending to patients in the community, completed paper records, which were held at the patient's home. This meant that when healthcare staff visited they had an up-to-date record of the patients' care and treatment. Community nurses would also update their patients' records electronically. The community PCNS did not have access to electronic notes and would update the records that were held at their bases. This meant that there was a duplication of records and a risk that information contained in each, may not be consistent. Staff were aware of the importance of ensuring the paper or electronic notes, also reflected the records in patients' homes.

- We looked at 12 sets of patient notes kept by the community PCNS and found they were completed relatively consistently. We saw the assessment documentation identified the patients' wishes, symptoms were scored and details of medicines and symptom control were recorded. However, we found that not all the notes had the level of intervention recorded, to identify the level of support the patient required. The patient's preferred place of care (PPC) was only recorded in five of the records. This meant that patient's PPC was not being consistently recorded. On one record where the PPC had not been entered, we saw there was a record of a discussion between the community PCNS and the patient, who wanted to delay making a decision, so they could involve their family.

- We looked at nine sets of healthcare records used by the community teams. We found that advance care plans (a plan that documents patients views, preferences and wishes about their future care) were either not in place or inconsistently completed. Two of the nine records had the patient's preferred place of care recorded. However, nursing assessments, including pressure area and nutritional assessments had been completed on the majority of patients. Overall, the records reflected the patient's care and had been updated by the community nurses or community PCNSs at the time of the visit.

- We looked at five sets of healthcare records in a community hospital, including one set relating to a patient who had recently died. We found that in all but one record, the nursing assessments and care plans had been completed. Advance care plans were held on the file but had not been completed and there was no

Are services safe?

evidence of decisions related to any limitations of treatment. This meant that discussions about patients views, preferences and wishes about their future care where not consistently documented.

- We reviewed 11 do not attempt cardiopulmonary resuscitation (DNACPR) forms. We found that there were clear reasons recorded in the DNACPR documentation and evidence that patients and or their families had been involved in the discussion. Community staff told us that GPs would visit patients if they had discussed DNACPR with them.

Cleanliness, infection control and hygiene

- We visited the Nicol Unit at Stratford Hospital. However, due to an outbreak of norovirus (sickness and diarrhoea), we were advised not to inspect.
- Staff adhered to good practice regarding hand washing in patients' homes.
- We observed that community nurses carried personal protective clothing, such as gloves and aprons when providing care for patients. These were changed appropriately between activities.
- The SPCT did not carry personal protective clothing. Staff advised us that if they provided hands-on care to patients, they would wash their hands at the patient's home using soap, water and kitchen towel. Alternatively, they may use personal protective clothing that the community nurses carried, if they were supporting them at a patient's home. This meant that staff and patients could be at risk of infection.
- Infection control was part of the staff mandatory training. The trust's target was 85% of clinical staff having completed the training. The community SPCT were below the trust target with 67% of the team having completed infection control training. This meant the service could not be assured the staff had the necessary knowledge in this area.

Mandatory training

- Staff were aware of the mandatory training they were required to undertake. We were told that this was mainly available electronically.

- The trust's mandatory and statutory training programme covered fire, health and safety, infection

prevention control, manual handling, information governance, life support (levels one and two), safeguarding adults, safeguarding children (levels one and two), conflict resolution and equality and diversity.

- We examined the training records for the community SPCT and found mandatory training compliance was below the trust target (85%) for fire training(67%), health and safety (67%), infection control (67%) and life support level one (62%). However, the compliance was above the trust target for conflict resolution (89%) and equality and diversity (89%). The trust also had a target of 95% for information governance, child safeguarding and adult safeguarding training. The community SPCT were below the trust target for all of these; safeguarding children level one (83%) and level two (45%), safeguarding adults (82%) and information governance (82%). This meant that staff were not keeping their skills and practice up-to-date and the service could not be assured that staff had the necessary knowledge in these areas.

Assessing and responding to patient risk

- We found there were risk assessments completed for patients at end of life. These included risk of falls, venous thromboembolism (VTE) and pressure ulcers.
- Community palliative nurses attended weekly consultant-led multidisciplinary meetings to discuss their patients' level of need and any risks that had been identified.
- Community PCNS, community nurses and GPs had regular meetings to discuss their patients and their level of need. The community SPCTs discussed complex cases daily.
- Advice about symptom management was available to patients through a 24-hour consultant advice line. The consultants provided cover for patients being cared for in the Myton Hospice specialist palliative care beds, out of hours.
- The community SPCT worked seven days a week and was available from 9am and 5pm. At weekends and bank holidays, the team mainly dealt with urgent and complex palliative care needs.

Staffing levels and caseload

Are services safe?

- The community specialist palliative care team (SPCT) was made up of one whole time equivalent (WTE) band eight lead nurse, 10 WTE band seven palliative care nursing specialists (PCNS), and 3.2 WTE band six PCNS. There were no vacancies in the team.
- The community SPCT had access to a 0.4 WTE consultant clinical lead for the community, who was based in a local hospice.
- The community SPCT had access to a 0.6 WTE clinical psychologist working across the trust in the hospital and community. They also offered psychological support to staff.
- The average caseload for a community PCNS was 20 patients at a time. Caseloads were discussed each day and new patients were triaged to assess the urgency to see them. New cases were allocated to the lead community PCNS for the patient's GP service.
- Information provided by the trust for March 2016, showed that across 10 integrated health teams, community nurses were supporting 37 patients in the community who were receiving end of life care.

- The community SPCT supported the community nurses with patients who were identified as at end of life (those with a life expectancy of less than a year). Community nurses confirmed that they worked closely with the community SPCT when supporting patients who required end of life care.

Managing anticipated risks

- The trust had plans in place in the event of pandemic influenza and major incidents, which included staff working in the community.
- We spoke with staff about how they would continue to provide a service in the event of adverse weather. Community nurses told us they would prioritise patients and would check in with one another to coordinate what resource was available.
- Conflict resolution training was available as part of mandatory training. The trust's target was 85% of clinical staff having completed the training. Within the community SPCT, 89% of clinical staff had completed the training. This meant that staff had the training to manage challenging situations.

Are 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

We rated end of life services as requiring improvement for effectiveness.

- The individual plan of care for the dying person, which was a replacement for the Liverpool Care Pathway, was not being used by the community teams.
- The community SPCT did not have a local audit programme in place, which meant they were not able to measure the effectiveness and outcomes of the service.
- We found that advance care plans (a plan that documents patients views, preferences and wishes about their future care) were either not in place or inconsistently completed.
- Nutritional risk assessments were not always in place. This meant there was a risk that patients would not receive the appropriate nutritional support and advice.

However, we also found:

- The community SPCT received regular clinical supervision and had access to ongoing professional development.
- Syringe driver training was provided to community nurses and they were assessed as being competent to use them.
- There was evidence of multidisciplinary working across the community teams, who provided end of life care.
- Do not attempt cardiopulmonary resuscitation (DNACPR) forms, indicated staff had involved the patient, or (if appropriate) relatives, in the decision.

Evidence based care and treatment

- The community specialist palliative care team had received 1613 referrals from January 2015 and January 2016. 1448 (90%) of those referred had a diagnosis of cancer. 165 (10%) of those referred had a non-cancer diagnosis.
- The trust had a replacement for the Liverpool Care Pathway (LCP). It was called the individual plan of care for the dying person and it aimed to provide guidance for healthcare professionals supporting patients in the last hours or days of life. It was designed to be used for

patients in hospital and community settings. However, at the time of our inspection, the community teams were not using the document. Staff explained there were concerns about the document. This was because it contained detailed information for healthcare professionals, which was felt to be inappropriate to be left in patient's homes.

- We looked at nine sets of healthcare records used by the community teams. We found that advance care plans (a plan that documents patients views, preferences and wishes about their future care) were either not in place or inconsistently completed. Two of the nine records had the patient's preferred place of care recorded.
- The community nurses and SPCT referred to a document called 'general principles for prescribing for the dying patient', which had been produced by the trust to advise them on medicines prescription and symptom control.
- The trust did not participate in any national accreditation schemes such as the Gold Standard Framework (GSF). The GSF provides training in relation to end of life care and an accreditation scheme for trusts that consistently meet national guidance. Staff told us there were no plans to introduce the GSF at the trust. However, this was used by some GP practices in the Warwickshire area.
- Staff had access to the trusts the policies and procedures via the intranet and we saw these were based on national guidance.

Pain relief

- Pain relief was available to patients at end of life. Staff regularly assessed patient's pain and administered appropriate pain relief. The patients we spoke with told us the PCNS discussed their medicines regularly and any changes were agreed with them.

One patient told us that their pain had been better managed by the community PCNS than their GP.

- Where appropriate, patients had syringe drivers, which delivered measured doses of drugs at pre-set rates. Community nurses were trained by the SPCT in the use of the syringe driver and pain management.

Are services effective?

- We saw that records used by the community PCNS included pain assessment tools. This meant that they were able to assess pain levels and respond to the patient's need for pain relief.
- Patients in the community receiving end of life care were ultimately under the care of their GP, who was responsible for prescribing medicines. Community PCNS told us that they would review the patient's medicines and make recommendations to the GPs, who would issue the prescription. Not all of the community SPCT were non-medical prescribers, which meant that they could administer but not prescribe medicines.
- The trust had a document called the 'general principles for prescribing for the dying patient', for prescribing palliative medicine and guidance for the use of anticipatory medicines at end of life. Anticipatory medicines refer to those prescribed in anticipation of managing symptoms, such as pain and nausea, which are common near the end of a patient's life; these medicines can then be given if required, without unnecessary delay. The document also provided guidance on general principles of prescribing for the dying patient, the use of continuous subcutaneous infusion (syringe driver medicines), the use of opioids for pain and dyspnoea (shortness of breath or distress in breathing), management of restlessness and agitation, management of respiratory tract secretions and the management of nausea and vomiting. It also contained useful information references. We saw that community palliative care nurse specialists (PCNS) and community nurses referred to the document. Staff told us that the GPs could also access the document.
- We spoke with one of the three GPs that provided cover to one of the community hospitals where patients received care at the end of their life. They were unaware of any guidance for prescribing anticipatory medicines and had not received training in symptom management for patients receiving end of life care. However, the trust told us that palliative care consultants provided training sessions to GPs, including an introduction to the prescribing anticipatory medicines.

Nutrition and hydration

- Nutritional risk assessments were found in four of the 12 records we reviewed. This meant that there was a risk that patients would not receive the appropriate nutritional support and advice.

- Patients we spoke with advised us that the community PCNS would ask them about what they were eating and drinking.
- Staff we spoke with told us how they would support patients and families in understanding why food and fluid intake changes, for people who are in the dying phase of their life.
- Staff told us they were able to access speech and language therapist for swallowing difficulties and dietitians if required. A patient told us that staff had referred them to a dietitian.

Patient outcomes

- The community SPCT did not have an audit programme in place, which meant they were unable to measure the effectiveness and outcomes of the service. However, they collected data regarding documenting of patients preferred place of care in healthcare records. For the period October to December 2015, the level of recording the patients preferred place of care in records used by the SPCT was 91%. The Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. The trust had CQUINs for patient's preferred place of death and fast track end of life care in 2014 and 2015. However, there were no current CQUINS associated with end of life care.

Competent staff

- Information provided by the trust, shows that 83% of all clinical staff working within end of life specialities (including the community team) had an appraisal in the previous 12 months (March 2016). We requested the appraisal rate for the community palliative care team. However, this was not provided by the trust as the acute and community end of life team information was amalgamated.
- The community SPCT had received regular clinical supervision, by a clinical psychologist, which was provided at least every six weeks. Staff advised they also had access to occupational health and counselling.
- There was a practice development clinical nurse specialist who did not hold a clinical caseload. This role was to raise both awareness and the profile of end of life care, as well as providing education to the end of life teams and across the trust.

Are services effective?

- Staff told us they were able to access education and training, as they needed. Over the last 12 months, members of the team had attended training including, advanced symptom control, planning seven day services, setting the record straight and advances in cancer pain management.
- The community SPCT provided syringe driver training to the community nurses and assessed their competence to use the syringe driver. In North Warwickshire, the community SPCT also ran regular teaching sessions for community nurses in for example, pain management and fatigue.
- The community SPCT also provided training to nursing home staff regarding end of life care in North Warwickshire and Rugby. This training was provided in four sessions to nine nursing homes.
- The trust held a 'Dying Matters Week' in January 2015, across the acute and community healthcare services in Warwickshire, as a means to raise awareness of end of life issues to the staff and general public.

Multi-disciplinary working and coordinated care pathways

- The community specialist palliative care team (SPCT) attended weekly multi-disciplinary (MDT) meetings with the clinical lead consultants to discuss the current caseload and share information. In the community palliative care nurse specialist' notes, we often saw there was a record of the outcome from the discussion at the MDT meeting.
- The community SPCT based in North Warwickshire worked alongside community nurses, and other specialists, for example continence services, occupational and physio therapists and GPs. Staff told us that being based together made MDT communication easier and quicker.
- Records held in patient's homes were multidisciplinary and ensured there was good communication between the community nurses and the community PCNSs, this meant that patients care was co-ordinated.
- The community SPCT and community nurses attended regular gold standards framework (GSF) or quality and outcome framework (QoF) meetings with GPs to assess and review patients at or nearing the end of life. Depending on the GP practice, these would be monthly or alternate months.

- The community teams worked closely with third sector organisations that also provided care to patients in their home, such as the Myton Hospice at home service and Marie Curie nurses, who provided a night sitting service.

Referral, transfer, discharge and transition

- Patients were referred to the community SPCT through self-referral, hospitals, community nurses, GPs and nursing homes. The community SPCT provided care and support for more complex patients. If patients' needs changed over time, they may be discharged from the service, with their continued care and support being provided through community nurses and GPs. Records we reviewed demonstrated that patients were discharged and were re-referred to the service.
- There was a process in place to rapidly discharge patients to their preferred place of death in the final days or hours of life. Support was provided following discharge by community nurses and the hospice at home service, who coordinated the visits between them. Community nurses advised us that if the hospice at home service did not have capacity, the community emergency response team would provide support.
- The community SPCT allocated new referrals on a daily basis and followed up non-urgent referrals within five days and urgent referrals within two days. There was no waiting list. During the period January 2015 to January 2016, a total of 1613 patients were referred to the team. Of these 89% were patients who had been diagnosed with cancer.
- The referrals to the community nursing team came mainly from the GPs or via hospitals. During the period September 2015 to January 2016, there were 143 referrals to the community nurses.

Access to information

- Paper records were kept at patients' homes for all the people involved in the persons care to document their actions, conversations and the patient's wishes and outcomes. This meant that all healthcare professionals involved in the patients' care had up-to-date information and knew of any changes or developments in the patients' health.
- Do not attempt cardio pulmonary resuscitation (DNACPR) forms were held at the patient's home. In order to direct emergency services to the DNACPR form,

Are services effective?

they were stored at the front of the patients' notes in a green plastic envelope (green sleeve). This meant they were easily identifiable. The green sleeve was seen in use during the inspection.

- Patient investigation results were accessible electronically, including blood tests and imaging reports.
- Staff had access to policies and procedures via the trust's intranet.
- Staff had access to CASTLE website (Care and Support Towards Life's End - the palliative care website of the clinical implementation group of Coventry and Warwickshire). This website was primarily for health and social care professionals working in the fields of palliative and end of life care within Coventry and Warwickshire. It provided up-to-date information, local contact details (including primary care, care homes, hospitals and hospices), clinical tools, guidelines and information about education events.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We were told that all staff undertook Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training as part of their mandatory training. 95% of clinical staff had completed safeguarding adult training (March 2016). This met the trust target.
- In the community, we observed that the staff would check patients' consent and recheck whilst discussing treatment and ongoing support.
- We reviewed 11 DNACPR forms. There was evidence that patients or their families had been involved in the discussion.
- A patient we spoke with told us that the community PCNS had discussed the completion of the DNACPR with them and they had decided that they did not want to have the form in place at that point.

Good ●

Are services caring?

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

Summary

We rated end of life services as good for caring.

- Patients we spoke with were positive about the service they received.
- Staff we spoke with were passionate about delivering end of life care and they were committed to providing caring end of life care.
- Patients and relatives were informed and involved in planning their care.
- We observed that home visits with patients were not hurried, giving plenty of time to ensure that patients were able to discuss their needs.

Compassionate care

- We observed patients being treated with dignity, respect and compassion across the community services. On visits to patients' homes, we observed staff gaining permission to enter the room, gain their consent to receive treatment and asking patients if they preferred to have their treatment with a loved one present.
- On visits to patients, who were meeting the PCNS for the first time, we observed that the conversation was set at a pace that the patient was comfortable with. The patient was given information about the role of the community PCNS and community nurses. This meant that the patient was aware of who was responsible for which aspect of their care.
- Staff providing end of life care to patients, were sensitive to their needs and of those close to them. We were given different examples of how the SPCT and community nurses had supported patients and their loved ones during this time.
- Patients we spoke with were very positive about the service they received. Some of the comments received included 'the staff are wonderful', 'lovely, can't praise (them) highly enough', 'part of the family' and 'very impressed with the support; absolutely amazing'. We

saw thank you cards and letters received by the SPCT and community nurses. Staff were described as 'kind and caring' and relatives thanked them for making the last few days of their loved ones lives comfortable.
- Staff we spoke with were passionate about delivering end of life care and felt it was a privilege to support patients in the last months or days of their lives.

Understanding and involvement of patients and those close to them

- Patients told us they were impressed with the level of care they received. Staff would frequently visit for about an hour and half and would ring patients weekly if they did not need a visit.
- We observed that home visits were not hurried, giving plenty of time to ensure that patients were able to discuss their needs. Patients told us that they could discuss anything and felt able to ask questions and staff provided peace of mind.
- Patients told us that their relatives had also been involved in their plan of care and treatment. They felt that the level of involvement was what they (the patient) chose. A patient told us, they and their loved one had 'no secrets and they have been involved in everything'. They explained 'it gave us time to talk'.

Emotional support

- Staff offered emotional support to patients and their families. A patient we spoke with told us staff had 'not just helped myself but helped my husband, who was struggling to come to terms with things'. They also told us staff had arranged counselling for their children. Staff also gave us similar examples, of how they had supported the patients and families with referrals to different services and voluntary sector providers.
- We found that the support of families, partners or next of kin was routinely considered.
- Psychological support and complimentary therapies were available to patients in the community receiving end of life care, through the Macmillan information and support centre at Warwick Hospital.

Are services responsive to people's needs?

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

Summary

We rated end of life services as requiring improvement to be responsive to people's needs.

- The trust did not monitor the number of end of life patients who were rapidly discharged from hospital to die.
- For the period January 2015 to January 2016 there were 906 deaths, of which less than half 434, (48%) of patients died in their preferred place of care.
- The trust was not able to provide evidence of information they provided to patients and people important to them, about the generic community services available for those who required end of life care.
- We did not see evidence of how the service planned and delivered care to people in vulnerable circumstances,

However we also found:

- The community SPCT, provided services seven days per week. There was also an on-call consultant in palliative medicine available, to provide telephone advice to professionals in community and acute settings, across Coventry and Warwickshire 24-hours per day.
- The community SPCT offered end of life care training to community nurses and care staff working in nursing homes in north Warwickshire.
- There were no formal complaints attributed to end of life care services in the community.

Planning and delivering services which meet people's needs

- There were processes in place so that patients could be rapidly discharged from hospital to their preferred place of death. However, the trust did not monitor the number of end of life patients who were rapidly discharged from hospital to die. Following our inspection the trust held a 'rapid home to die workshop' in June 2016 to assess and identify difficulties with the capacity of the community based services and coordination of the services, including third sector providers, involved in delivering end of life care.

- There was a regional strategic partnership group (made up of other NHS providers and hospices). We saw that the DNACPR documents and care of the dying documents had been devised to be used by the services who were part of this group.
- The community PCNS had a portfolio of GP practices. This continuity allowed them to build up a relationship with patients while supporting them in their own home, build relationships with their GPs and have a greater understanding about the needs of the local population the practice served.
- The community SPCT offered end of life care training to community nurses and care staff working in nursing homes in north Warwickshire.
- Equipment was provided to support patients who wished to die at home. This was delivered by an external provider quickly to patients' homes, to facilitate discharge or prevent unnecessary admission to hospital.

Equality and diversity

- We did not see any evidence of publications for patients at the end of life being available in languages except for English.
- The trust was not able to provide evidence of information they provided to patients and people important to them, about the generic community services available for those who required end of life care.
- The services of an interpreter could be provided if required. Staff were aware of how to access this service.

Meeting the needs of people in vulnerable circumstances

- Advance care plans were not always in place, for individuals to reflect their choices and wishes. We found that when they were in place, they had not been consistently completed.
- Patients could be referred to the Macmillan benefit advice service, which assisted patients with financial matters. This was run through Macmillan cancer support and the citizen's advice bureau.
- We did not see evidence of how the service planned and delivered care to people in vulnerable circumstances, for example those living with dementia.

Are services responsive to people's needs?

Access to the right care at the right time

- The community SPCT provided services, seven days a week from 9am to 5pm. At weekends and bank holidays, two community PCNS provided an emergency service to patients with urgent and complex palliative care needs. The service was initially set up for professionals to access and had been opened up for patients and their relatives in February 2016. Not all the patients we spoke with were aware of the service and those that did, had not used the service, as they had not needed to.

- The community SPCT allocated new referrals on a daily basis and followed up non-urgent referrals within five days and urgent referrals within two days. However, we looked at 10 sets of patients' notes kept by the community PCNS and found that of the 19 referrals, including patients who had been re-referred to the service, there were four occasions when patients waited more than six working days to be contacted by the community SPCT. This meant that not all patients were being followed up within five working days. Whilst the majority of patients were visited within three days of the first contact with a community PCNS, there were five occasions when patients waited from five and eleven days for their first visit. We also saw that on three occasions patients were discharged from the service without having been seen.

- The community SPCT discharged patients from their caseloads if they reached a stage where their condition was stable. Records we reviewed showed that some patients had been referred and discharged from the service up to four times. This demonstrated that patients' care needs were being reviewed regularly.

- An on-call consultant in palliative medicine was available to provide telephone advice to professionals in community and acute settings across Coventry and Warwickshire 24-hours per day. This was commissioned and provided jointly by South Warwickshire Foundation NHS Trust and other local providers. The hospice nurses also provided out of hours advice to patients, families, and healthcare professionals.

- The community SPCT monitored the number of patients they had supported, who died in their preferred place of care. For the period January 2015 to January 2016, there were 906 deaths, of which 48% (434) of patients died in their preferred place of care. Across the three localities, patients died in their preferred place of care in South Warwickshire 35 % (132), North Warwickshire 52% (192) and in Rugby 65% (110). This meant that less than half patients died in their place of choice overall.

Learning from complaints and concerns

- The service had a complaints procedure. Patients we spoke with said that they would feel able to raise any issues with staff. Staff told us that if patients or relatives had any complaints they would try to deal with them quickly.

- The trust provided details of four formal complaints received related to end of life services from April 2015 and January 2016. However, none of these complaints were related to the end of life services provided in the community.

Are 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

We rated end of life services as inadequate for well-led.

- The trust did not have strategic plan for end of life care. The service told us at the time of inspection, they were not working specifically to a strategic plan for end of life care.
- Staff were unsure of the trust wide direction for the future of the end of life care services.
- The trust had a replacement for the Liverpool Care Pathway (LCP), called the individual plan of care for the dying person. It was designed to be used for patients in hospital and community settings. However, we found that it was not being used by the community teams. This demonstrated the lack of integration of the end of life care services.
- The service did collect information on the percentage of patients who died in their preferred location. However, this did not include all patients referred into the service so the trust was unable to monitor if they were honouring patient's wishes or if they needed to improve this.
- The directors identified to provide representation for the service at board level, did not attend end of life care meetings and were unable to evidence that they were knowledgeable about issues that affected end of life care.
- The end of life care team did not have a direct reporting structure to board level.
- The trust did not have a non-executive director who provided representation of end of life care at board level.
- There were no formal processes in place to gather feedback from patients or relatives

However we also found:

- There was an established end of life operational group who met monthly.
- Staff were proud to work for the trust and were enthusiastic about the care and services they provided for patients.
- Staff were committed to delivering compassionate end of life care.

- The staff demonstrated an understanding of the trust guidance regarding lone working.

Service vision and strategy

- At the time of the inspection, the vision was to develop an integrated end of life service that incorporated both the community and acute services. The trust did not have a strategic plan for end of life care.
- One WTE consultant in palliative medicine had been appointed in January 2016 to work clinically in the acute hospital and to lead on end of life care strategy for the trust. Prior to this appointment, there had been an 18-month gap in palliative and end of life care consultant provision to the acute trust. Following the appointment of a consultant to the Acute Hospital Palliative Care Team the whole team (acute and community) planned to undertake a comprehensive audit programme.
- There was an established end of life operational group. This group had devised a draft action plan for 2015-16, based on the five priorities of care for the dying patient. The Priorities of Care for the Dying Person was published in June 2014 by the Leadership Alliance for the Care of Dying People. The five priorities were to recognise, communicate, involve, support, plan and do. This action plan was devised before the appointment of the palliative consultant lead and formed the plan of activities for the current year. However, there were no timescale dates for completion or action updates on items identified on the action plan.
- The trust told us that they planned to hold end of life care strategic group meetings, to which the operational group would report. At the time of the inspection, there was no specific date for the start of the end of life care strategic group.

Governance, risk management and quality measurement

- The trust had a replacement for the Liverpool Care Pathway (LCP). It was called the individual plan of care for the dying person and it aimed to provide guidance for healthcare professionals supporting patients in the last hours or days of life. It was designed to be used for

Are services well-led?

patients in hospital and community settings. However, we found that the community teams were not using it. This demonstrated the lack of integration of end of life services. The trust was aware that the care plan was not being used in the community and had planned to review the document. This was discussed at the end of life operational group meeting held in February 2016. The meeting minutes showed that a task and finish group was to be organised to review and update the individual plan of care for the dying person. This issue had not been identified on the risk register.

- The lead consultant and lead palliative nurse for community services attended monthly end of life operational meetings. The deputy director of nursing chaired the meetings. The minutes of the last six meetings (including February 2016) were provided. They showed that relevant staff attended including community palliative care consultant, patient advice and liaison service (PALS), chaplains, GPs and Macmillan staff. Governance issues were discussed, for example, it was noted in the December 2015 meeting, that there had been medicine incidents reported by community end of life staff. However, they acknowledged that staff involved were often external to South Warwickshire Foundation NHS Trust (SWFT). One particular incident was being highlighted to the general manager of integrated adult services, so that an action plan could be devised.

- The community SPCT monitored its performance through their annual report. We saw a copy of the Specialist Palliative Care Annual Report 2014 – 2015 (dated July 2015). This information was presented at the end of life care meeting, which then provided feedback and raised concerns to the clinical governance risk committee who then in turn reported to the executive board.

- The community SPCT did collect information on the percentage of patients who died in their preferred location. However, this information did not reflect those patients who had not been referred to the community PCNS were being supported by community nurses and their GPs. Without this information, the trust was unable to monitor if they were honouring patient's wishes or if they needed to improve this.

- There was a risk register for the integrated and community care division. There was one risk entry concerning lack of capacity and coordination of the multiple agencies involved in delivering end of life care

in the community. The risk had been scored as a medium risk. We saw that control measures and staff responsibilities had been identified, with completion dates from December 2015 to February 2016.

Leadership of this service

- The community SPCT was part of Warwickshire adult community services and was accountable to the integrated and community care division of the trust. The integrated and community care division held audit and operational governance group (AOGG) meetings, which considered performance within the division and relevant new publications. The AOGGs were accountable to the clinical governance committee and provided a quarterly divisional report. The clinical governance committee then reported to the trust board.

- There were two board members responsible for end of life care. The director of nursing and the medical director shared the responsibility as board representatives for end of life care. Staff were aware of who the board members were. However, the end of life care meeting was chaired by the deputy director of nursing rather than the executive board representatives. This meant the end of life care service did not have a direct reporting structure to the board to enable end of life care issues raised and discussed at the end of life care meeting to be addressed.

- The trust did not have a non-executive director representing end of life care.

- There was a lead consultant and lead nurse for community end of life services.

- The community staff we spoke with were aware of who their immediate managers were and they were aware of the roles of the senior management team in the division. Staff told us that they felt supported by their line managers and their peers.

Culture within this service

- Staff told us they were proud to work for the trust and enjoyed working in the community. They were enthusiastic about the care and services they provided for patients. They described the trust as a good place to work. Some staff had worked for the trust for a number of years. However, staff were concerned about the future of the community services because there was uncertainty whether South Warwickshire Foundation

Are services well-led?

NHS Trust would keep the community services contract. This process was outside of the trust's control and was being led by South Warwickshire Clinical Commissioning Group.

- Patients we spoke with acknowledged a positive and caring culture within the service and were happy with their care.
- We observed staff treating each other with respect.
- The trust had guidance for staff who work alone and we saw that the guidance had been reviewed in June 2015. The SPCT had lone working procedures in place, which were ratified in July 2015. Staff in the community SPCT provided care 9am until 5pm Monday to Friday, at weekends and over bank holidays. There were systems in place with staff checking in with each other to ensure they were safe. Staff we spoke with described the system they used, which reflected the lone working procedures that were in place.

Public engagement

- The community SPCT supported Warwick Hospital during the national 'Dying Matters Week' with display boards and leaflets. This was to raise awareness about end of life care to staff, patients and those close to them. During the week, information stands were also in place at district nurse team bases across Warwickshire, which were supported by the community SPCT.

- There were no formal processes in place to gather feedback from patients or relatives. We saw no evidence of surveys undertaken by the community SPCT, to gather feedback from patients and relatives' about the services they provided for those receiving end of life care.

Staff engagement

- Staff we spoke with said they had not been involved in the discussions about plans for integration of the community end of life care with the acute service.
- The latest national NHS staff survey results for SWFT (2015) indicated that overall staff were highly engaged and the score was above (better than) average when compared to similar trusts. The surveys did not specifically identify community end of life team results.

Innovation, improvement and sustainability

- The community SPCT were working with nursing homes in North Warwickshire and Rugby by providing training to staff on end of life care.
- The community SPCT were responsible for delivering training on syringe drivers to community nurses. Teaching sessions were also provided to community nurses in North Warwickshire.
- The trust had plans to take part in the national 'Dying Matters Week' in May 2016.

Requirement notices

Action we have told the provider to take

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

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