

Solent NHS Trust

R1C

Community end of life care

Quality Report

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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)
R1C03	Western Community Hospital		SO16 4XE
R1CF5	Jubilee House		PO6 3NH







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

Summary of findings

Ratings

Overall rating for the service	Good	
Are services safe?	Good	
Are services effective?	Good	
Are services caring?	Good	
Are services responsive?	Good	
Are services well-led?	Good	

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service

End of life care services at this trust was rated as good overall.

- Safety was rated as good. Patients were protected from avoidable harm; staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses and arrangements to minimise risks to patients were in place. Patients were protected from abuse. Staff had an understanding of how to protect patients from abuse, could describe what safeguarding was, and the process to follow if they suspected a patient was at risk of avoidable harm or abuse.
- We rated the effectiveness of this service as good. Patients received effective care and treatment that took account of current evidence-based guidance, standards and best practice. Patients had a comprehensive assessment of their needs, which included pain management, nutrition and hydration, and physical and emotional aspects of their care.
- Care from a range of different staff, teams and services was co-ordinated effectively. There was effective multidisciplinary working, with staff, teams and services at this trust and external organisations working in partnership to deliver effective care and treatment.
- Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005; this was reflected in the 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders reviewed during our inspection.
- The care provided to patients in end of life care services was good. Patients were truly respected and valued as individuals and were empowered partners in their care. Feedback from patients, relatives and carers was consistently positive and there were many examples of staff going 'above and beyond' when delivering care.
- We found the responsiveness of end of life care services to be good. Patient's needs were mostly met through the way end of life care was organised and delivered. However, the rapid discharge of those patients expressing a wish to die at home was not monitored. We could not therefore be assured this was happening in a timely way.
- We found the leadership of end of life care services was good. This was an evolving service which had differently commissioned service models across the two cities it served (Portsmouth and Southampton). There was a strong vision and a strong focus on patient-centred care. There were robust mechanisms in place to share learning locally across end of life care services.

Summary of findings

Background to the service

The Southampton palliative care support team provides care for patients registered with a GP in the Southampton area. This is a nurse led service, commissioned to provide care (including personal care) in the last 16 weeks of life.

The Portsmouth specialist palliative care team provides care for end of life for patients, in their last weeks of life, registered with a GP in the Portsmouth area.

Both services are supported by a specialist consultant led palliative care team and community nursing teams.

In Southampton the consultant-led team is provided by the local acute trust operating out of the Countess Mountbatten hospice. In Portsmouth, cover was commissioned by the trust and operated out of the Rowans hospice.

The service runs seven days a week. Community hospitals also provided end of life care services, and sometimes were the patients preferred place of care.

Our inspection team

Our inspection team was led by:

Team Leader: Joyce Frederick, Care Quality Commission

The team that inspected the end of life care service included one CQC inspector and three specialist advisors with specialist knowledge of end of life care. These were a palliative care doctor and two nurses.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before visiting Solent Trust, we reviewed a range of information we held about the trust and asked other organisations to share what they knew. The week before the inspection, we held two focus groups with a range of staff who worked within the service, such as nurses, healthcare assistants, doctors and administration staff.

We carried out an announced inspection from 27 to 30 June 2016.

During the inspection, we spoke with 31 staff including doctors, nurses, healthcare assistants, health advisors, pharmacist, receptionist, operations manager, matrons, the clinical governance lead, clinical director and the operational director. We attended seven meetings including staff handover meetings. We reviewed 13 care records and 18 medication records. We spoke with eight patients, 10 family members and carers, and observed eight patient consultations with the patients consent. We also received 21 comments cards from patients who had used the service.

Summary of findings

What people who use the provider say

The patients we spoke with were complimentary about the staff and told us staff were caring, friendly and sensitive to their needs. Staff from outside organisations also told us how kind and empathetic the staff were.

Friends and family test data for the trust had scored above the England average for recommending the trust as a place to receive care from October 2015 to March 2016. The trust average score was 94%, against the England average of 87%.

Areas for improvement

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

The trust **MUST** ensure they :

- Review the quality of mental capacity assessments in community wards.
- Ensure that patient records and care plans are completed fully, in a timely manner and used appropriately.

The trust **SHOULD** ensure they :

- Consolidate one recognised pain scoring tool across the service.
- Regularly review DNACPR forms.

Solent NHS Trust

Community end of life care

Detailed findings from this inspection

Good 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

By safe, we mean that people are protected from abuse and avoidable harm.

We rated safe as good, because:

- Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near-misses and where incidents had been raised actions were taken to improve processes.
- Safeguarding was given sufficient priority. Staff had an understanding of how to protect patients from abuse. Staff described what safeguarding was and the process to follow if they suspected a patient was at risk of avoidable harm or abuse.
- Arrangements to minimise risks to patients were in place with measures to prevent falls, malnutrition and pressure ulcers. We observed staff followed good infection prevention control practices.
- Staff recognised and responded to the changing needs of patients with anticipatory medications readily available, and care needs assessed and reviewed appropriately.

- There were appropriate arrangements for out of hours cover with close partnership working between the trust and external providers.
- Specialist equipment needed to provide care and treatment to patients in their home was appropriate and fit for purpose to keep patients safe. Syringe drivers were maintained and used in accordance with professional recommendations.

However ;

- There was variability in the completion of patient's records and care plans on the trusts various record keeping systems.
- There was not a clear protocol on the community wards for out of hours prescribing, which meant doctors were sometimes not immediately responsive to requests to review patients or make changes to medicines.
- There were inconsistencies with on-going review of do not attempt cardio pulmonary resuscitation (DNACPR) forms.

Safety performance

- The end of life core service worked with, and across, many other community services and, as such, did not

Are services safe?

have a high number of incidents. A total of 202 incidents were reported by the palliative care teams (Southampton and Portsmouth) between April 2015 and February 2016. Of these incidents expected deaths /deaths where patients had pre-existing conditions, accounted for the highest number of incidents (120, approximately 59%). The next highest reported incident were unwitnessed falls (23, approximately 11%)

Incident reporting, learning and improvement

- The staff we spoke with were aware of the process for reporting incidents using the trust wide electronic system. All incidents, accidents and complaints were recorded using this system.
- Individual staff told us they were empowered to raise incidents and concerns with their managers.
- Staff told us they received feedback from incidents that had been investigated, and made changes where possible to prevent incidents from happening again. The staff felt this system worked well and they had the information they needed to learn from incidents.
- We looked at an example of an incident of poor communication between services which related to an end of life patient. Following an investigation, new processes had been put in place with improved management to ensure clinical records were improved with an audit timetable to ensure continued improvement. Staff involved in the complaint also received additional training with regard to communication with patients and relatives.

Duty of Candour

- The duty of candour legislation requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', as soon as reasonably possible. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred.
- We spoke with staff from all teams and they were able to describe the actions and responsibilities required by the duty of candour.

Safeguarding

- Staff demonstrated a thorough awareness of safeguarding procedures and understood how to escalate a concern to the local authority.
- Staff had received training in safeguarding vulnerable adults and children and understood what constituted a safeguarding concern for a person at end of life. We observed a community team handover meeting where a patient safeguarding concern was discussed. All the team participated in the discussion and it was clear all knew the procedure and when to escalate a concern.
- Safeguarding training was part of the trust mandatory training for staff. 88% of staff in the palliative care support team and the specialist palliative care team had received mandatory training in safeguarding adults (level 2) against the trust target of 85%.

Medicines

- The palliative care team staff did not hold supplies of medicines. However, they had a system for checking controlled drugs (CDs) that were prescribed and issued through the patient's GP. CDs are strong pain killers and sedatives used in end of life care that had been obtained for patients and were kept in their home.
- The community nursing teams had a system in place to check that CDs were being administered to patients appropriately. Records of administration of drugs were kept (such as the palliative care drug administration chart) when patients were being given medicines via a syringe driver.
- On our inspection we found that anticipatory medicines (just in case medicines) were prescribed and obtained in a timely way. These are medicines that patients may require near the end of their life to relieve symptoms such as pain and restlessness. The management and ordering of medicines was given priority by the teams. There was good liaison with both GPs and out of hour's services around prescription of medicines for end of life care.
- There were nurses in specialist palliative care teams who could independently prescribe anticipatory medicines and adjust prescriptions.
- On Jubilee ward there was no clear protocol for out of hours prescribing. Ward staff told us that out of hours

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doctors were sometimes not responsive to request to review patients or to change medicines. This was highlighted as a risk by community and hospital nurses and matrons. At the time of our inspection we were not made aware of any plans to mitigate the risk to ensure patients had access to medication in a timely manner.

- The trust had a pre-printed palliative care (end of life) medicines administration chart. This contained the prescription and administration record for prescribers. The chart also included stock recording for controlled medicines such as morphine. The use of the palliative care drug administration chart was limited to certain community hospitals and teams as it had only been introduced shortly before the inspection period. As part of our check of patient records, we reviewed 18 medicines charts and found them to be completed correctly.
- Medicines were stored and managed appropriately in the community hospital we visited, including CDs and medical gases. We saw that trust guidance on the administration, as well as the destruction of unused CDs was followed.
- The trust used only one model of syringe driver device. These devices are used in end of life care to deliver medicines to control pain and other symptoms continuously over 24 hours. There was a policy and protocol for the use of the device in order to reduce the risk of medicine administration error. Staff had attended training to ensure they were competent to use this device.

Environment and equipment

- Teams based in the community who provided end of life care for patients ordered any aids or equipment from an external provider. Types of equipment required to help end of life patients at home were hoists, electric profiling beds and commodes as well as special mattresses to help prevent pressure ulcers. This was accessed by senior nurses who assigned a priority to deliveries of equipment. The staff were able to arrange for same day/urgent delivery of equipment for patients who were returning home for their end of life care.
- Dedicated facilities for end of life care patients, and those close to them, were available on Jubilee ward. This location provided 'quiet' rooms for communication with patients and relatives.

- The general ward and patient rooms on the Jubilee Ward, although old and dated, were undergoing re-decoration during the inspection to improve the environment for patients and visitors.
- The ward was built around a central courtyard surrounded by gardens. Patients were able to sit in the gardens or view them from the communal areas within the ward, and we saw staff helping patients to do this during our inspection.
- The service conducted several local audits, such as environmental audits, audits of infection control practices and cleaning audits. There was evidence of improvement as a result of audit, for example, following a medicines management audit a ward had out of date British National Formulary guidance books replaced.

Quality of records

- We looked at 18 sets of patient records. There was evidence that advance care planning was being done, and the trust had introduced an Achieving Priorities of Care (APoC) document which enabled this to take place effectively. APoC was designed to guide care for people identified as being in their last days and hours of life. All patient records reviewed contained an APoC however the completion of this document was not consistent. The APoC itself was comprehensive but staff were not completing all sections and were not updating the APoC should the patients' circumstances change.
- Records we reviewed in patients' homes were comprehensively completed. Hand written care plans reflected the needs patients' and were personalised to reflect their preferences, for example, which name patients liked to be called or which relatives should be contacted in an emergency. They reflected patient's current care and were completed or updated after each appointment with the community nurses.
- Records in community hospitals were comprehensively completed. However, there were multiple paper records in use as well as an electronic patient record. There was a risk with these multiple records that staff may not have all the patient information available to them in one place. Staff we spoke with said that the trust had recognised this risk and begun a process to integrate records into one electronic version.

Are services safe?

- We reviewed 13 do not attempt cardio pulmonary resuscitation (DNACPR) forms. All the forms were completed appropriately on admission to the Jubilee ward: however we found that the forms were not always being reviewed following initial completion. For example, one DNACPR form stated that a patient had no capacity but a mental capacity assessment (MCA) had not been completed. The form stated the reason for no capacity was due to the patient being unwell; no review date had been set. During the admission the patients' condition had changed but this DNACPR form had not been subsequently reviewed.
- The trust was not auditing the DNACPR forms to ensure their appropriate use or that patients and or their relatives were informed and understood the decisions that were being made. The trust could not be wholly assured that decisions were being appropriately made, monitored and assessed.

Cleanliness, infection control and hygiene

- The Jubilee ward was visibly clean and hygienic for people who were receiving end of life care.
- Staff were observed following infection control procedures and protocols in the hospitals and patients' own homes. During visits with community staff to patient homes we observed that staff washed their hands before and after patient contact. This included the use of personal protective equipment, such as disposable gloves and aprons when administering care to patients.
- Staff we saw followed the trust 'bare below the elbow' policy. Hand washing facilities and hand sanitising gel were available in all of the areas where care was carried out in the areas we visited.
- Equipment had been cleaned and labelled to indicate it was ready for use. The service conducted several local audits, such as environmental audits, audits of infection control practices and cleaning audits

Mandatory training

- Mandatory training covered a range of topics which included fire safety, health and safety, basic life support, safeguarding, manual handling, hand hygiene, communication, consent, complaints handling and information governance. Staff in the palliative care teams were up to date with their mandatory training

and had achieved a completion rate of 92% for the palliative care team in Southampton and 91% for the specialist palliative care team in Portsmouth against a trust target of 85%.

- There were systems to ensure staff had training to enable them to carry out their roles effectively, such as e-mailed reminders to complete training.
- Staff told us the majority of mandatory training was provided on-line and said on-line training did not take account of variations in learning styles. Staff said that, despite the high take up rate, they found it difficult to find the time required to undertake training.

Assessing and responding to patient risk

- Community hospital staff, palliative care team nurses and community nurses and other members of the multidisciplinary team (MDT) had regular meetings to discuss their patients, their level of need and any risk that had been identified. We observed a virtual ward meeting which discussed end of life patients, their pain needs and care plans.
- The palliative care teams provided care for patients up until 10pm at night. Out of hours, doctors via the 111 service were used for urgent medical attention, and the specialist palliative care service offered telephone advice across 24 hours.
- Patients identified as requiring end of life care had a holistic assessment after referral to the palliative care team, admission to community hospital or admission to the case load of the community nursing service. However, on admission to Jubilee ward, nursing staff told us that could be delays in being seen by a doctor due to the hours covered by the duty GP. Should ward staff have any concerns regarding a patient they were able to liaise directly with the specialist palliative care team who were co-located in the same building. In addition, palliative care consultants were available to provide guidance by phone, or in person if needed.
- Patients who were admitted to the community hospital for end of life care had advance care plans. This was to prevent the risk of transfer to hospital if their condition deteriorated.
- Staff in the palliative team were encouraged to telephone the team base if they were delayed in a

Are services safe?

patient's home due to crisis or rapid deterioration. This allowed other visits they had scheduled to be re-allocated to other staff to allow them the time to spend with that individual.

Staffing levels and caseload

- The trust did not use a recognised tool to calculate required staffing levels for end of life care services. Caseload management in the palliative care teams was undertaken by the nurse in charge of the service, and was based solely on experience and judgements. At the time of the inspection, the Southampton based palliative care support team caseload was between 10 and 12 patients. This had, on occasion, risen to 15 patients. The Portsmouth based specialist palliative care team were receiving 42 referrals per month on average. Staff told us that they worked beyond their capacity on occasions. However, at the time of our inspection this service did not have a waiting list.
- The rates of sickness in the palliative care team were at 4.11%, slightly lower than the trust's overall reported sickness rate of 4.45%.
- Medical staffing cover on the Jubilee ward was provided by a duty GP service which ran Monday to Friday.

Patients admitted to the ward in the afternoon were not always seen by a doctor when they were admitted, and would sometimes have to wait until the following morning. Specialist palliative care consultants from the local hospice provided telephone support 24 hours a day, seven days a week. They also attended the ward during the week where their workload allowed.

Managing anticipated risks

- Staff in the palliative care services teams provided care until 10pm, and along with community nursing teams were involved in lone working: they also travelled to patient's homes at night. There were appropriate safety systems in place, staff checked in with each other or with hospital security staff during shifts, and individuals carried personal attack alarms.
- We spoke to staff about how they would continue to provide a service in the event of adverse weather. Community hospitals had a rota of staff that lived locally; this was used to provide core staff. Community nurses told us they prioritised the work that could not be delayed and staff checked in to a central point to co-ordinate what resource was available.

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

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.

We rated this service as good for effective, because:

- End of Life care was planned and delivered in line with best practice guidance. The trust had responded to the withdrawal of the Liverpool Care Pathway by introducing a new communication care plan around end of life care.
- Patients had continual pain assessment and staff were responsive to patient needs.
- The service had participated in national and local audits which included the national audit of the dying in hospitals in England and a local mental capacity assessment audit. Information was collected on the effectiveness of treatment and reflective practice contributed to improvements.
- Staff had access to relevant training and support. All the teams we spoke with valued the expertise of the specialist palliative care team and used this service often as a learning resource, and for referrals where patients had complex symptoms that were difficult to manage.
- Our observation of practice, review of records and discussion with staff confirmed there was effective multidisciplinary team (MDT) working practices. Staff worked collaboratively to understand and meet the range and complexity of people's needs
- Despite some limitations in accessing patients' records across the trust, the palliative care teams had access to records in the acute trust as well as community hospitals and teams.
- Staff had a good understanding of Mental Capacity Act (2005) although some were still awaiting formal training, and recording of decisions needed to be more detailed. Best interest decisions were sought where patients had been assessed as not having capacity for a decision.

However, we also found:

- There was inconsistency in the use of pain assessment tools, and the type of tool used across the service.
- Patient records and care plans recorded care and treatment but did not reflect patient's individual needs.
- Access to speech and language therapy for nutritional assessment could vary for patients.
- There were inconsistencies in the completion and subsequent review of mental capacity assessments for patients.

Detailed findings

Evidence based care and treatment

- Staff provided care to patients which took account of national guidance, such as National Institute for Health and Care Excellence (NICE) guidelines, and were aware of recent changes in guidance. We saw evidence of discussion on NICE guidelines in patients' health care records such as guidelines related to the management of diabetes, heart failure and stroke.
- Policies were accessible for staff and were developed in line with national guidelines, such as the pressure ulcer prevention and management policy. Staff we spoke with were aware of these policies. Patient records we reviewed showed risk assessments and care plans for patients who were at risk of developing pressure ulcers.
- Care plans were in place for individuals to reflect their choices and wishes. However, of the 18 records we reviewed, only five had been fully completed and were personalised to reflect the patient's individual needs. Care plans and journal entries in the patients' record reflected that appropriate care and treatment was given.
- The expertise of the specialist palliative care team was used widely and highly valued by staff in end of life care within the trust.
- Patients who were in the last days of life or in a rapidly deteriorating state were identified in a timely way, and their care was reviewed. They had their needs met in at appropriate intervals, with escalation of their needs to the 'out of hours' services. Patients who were in the last

Are services effective?

days of life had a comprehensive plan of care in place, including a communicated DNACPR status. This met NICE guidance on care of dying adults in the last days of life (NG31), published December 2015.

- Staff in the palliative care service had access to the Palliative Care Handbook.

Pain relief

- Patients who had been identified for end of life care were prescribed anticipatory medicines. These 'as required' medicines were prescribed in advance to properly manage any changes in patients' pain or symptoms. We saw that these medicines had been prescribed and administered appropriately.
- Palliative medicines (which can alleviate pain and symptoms associated with end of life) were available at all times. Ward and community nurses had adequate supplies of syringe drivers (devices for delivering pain medicines continuously under the skin) and the medicines used with them.
- Pain symptoms and the use and effectiveness of medicines to control pain were discussed every day at staff handover meetings. We observed two handover meetings during our inspection where it was evident that observation of a patient's pain and the effectiveness of medicines was reported back to the team.
- The end of life care plan contained specific interventions for the management of symptoms such as pain. Patients' relatives told us the management of pain and symptom control were good across the end of life teams.
- Pain relief was available to patients at end of life. The nursing staff in the community teams were skilled at ensuring that patients were using their pain relief medicines, and monitoring their effectiveness. If these were ineffective this was escalated to the patients GP. However, there was not a consistent pain assessment tool in place. For example, in one setting, we saw patients were asked to give a pain score from zero to three. In another setting we saw a pain score from one to ten being used. Where these were found, they were used effectively to record the type, location and measure of pain.
- All teams were pro-active at communicating with medical staff if a patient's pain relief was not adequately controlling their pain.

- Advice about pain relief was available by telephone 24 hours a day from the specialist palliative care team.

Nutrition and hydration

- Food and drink were available for patients and relatives in community hospital settings. Patients' care needs around food and drink were assessed. Symptoms such as nausea were well-managed, and this was recorded in the 18 records we reviewed.
- Staff used the Malnutrition Universal Screening Tool (MUST) scale to help identify patients who may be at risk of malnutrition. We saw MUST charts in patient's records and these were completed at appropriate intervals and contained relevant information. Where a patient's score had increased (the patient was at increased risk) appropriate actions were taken and recorded in the notes.
- There was access to specialist assessment from a speech and language therapist (for swallowing difficulties) and dietitian if required. However staff we spoke with said that this therapy service was not always able to cope with the demand and resource was not always available: this meant assessments did not always happen in a timely way.
- Staff we spoke with were aware of the General Medical Council (GMC) guidance for doctors in the support of nutrition and hydration for patients at end of life. Local hospice ran training courses on nutrition and hydration and staff were able to attend. At the time of inspection, the trust did not record which staff had attended this course.

Patient outcomes

- The End of Life Care Audit – Dying in Hospital was commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. HQIP is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices. Its' aim is to promote the use of clinical audit to help drive quality improvement in healthcare.
- As Solent is a community trust, there was no requirement to participate in the audit. The trust however did submit data to the audit, although their data was excluded from the overall participation figures. The trust compared well against the other trusts who had participated in the audit. The number of cases the trust submitted was small compared to those of larger

Are services effective?

trusts; however the trust were using the audit findings to develop their end of life care strategy. For example, they were reviewing their spiritual care strategy, as this was featured in the audit and was an area the trust wished to further develop.

- The trust had conducted several local clinical audits such as medicines management, end of life virtual ward and ambulance anticipatory care plan and pressure ulcer audit. The service had developed action plans in response to these audit outcomes and these were being implemented and monitored. For example, the pressure ulcer audit noted that patients without a care plan were most at risk of developing pressure ulcers. The recommendation and action plan included the roll out of intentional rounding in community teams. We saw that this had been implemented effectively within the palliative care community teams. We saw evidence that this was regularly audited by the palliative care team. The results of the audit had been displayed on the team “productive” board.
- The latest trust audit of patients dying in their preferred place of care was 81%: this is higher than the average for England. This means that patients are given sufficient opportunity and resources to be cared for in the dying phase of their illness in their preferred place.

Competent staff

- 100% of staff in the palliative care teams had completed an appraisal. The appraisal system was reported by staff as a positive and useful process; all of the staff we spoke with had been appraised in the last year.
- Staff grade nurses (band 5) were encouraged to continue their professional development in end of life care with courses accessed through the appraisal process. Training in end of life care was provided through the local hospice and from the specialist palliative care team.
- Staff told us that they were able to access the education and training they needed. However, staff told us they found it difficult to find the time to undertake training.
- Staff received individual formal clinical supervision every four to six weeks within both the community nursing and palliative care teams. Staff also received group clinical supervision on a more informal and ad-hoc basis. Staff reported this supervision worked well and was very supportive.
- Staff who worked in end of life care were not required as part of their mandatory training to undertake training in

subjects specific to their area of practice, such as management of symptoms, dementia care for end of life patients and communication. However they were encouraged to do so.

- Additional palliative care training covered a range of topics including achieving priorities of care, symptom control, communication and difficult conversations, syringe driver awareness, verification of death, and pain management. The trust had an on-going programme of monthly, annual and bi-annual training to deliver these courses. Staff attended courses based on needs identified on their personal development plans.

Multi-disciplinary working and coordinated care pathways

- During the inspection we attended handover meetings at community hospitals and community teams. These included detailed discussions about patients’ physical health and also their psychological wellbeing and the impact of their condition on relatives and carers. We observed examples of effective interdisciplinary working in an MDT meeting. Staff working in the palliative care team and community teams worked closely in liaison with community nurses looking after patients with long term conditions.
- We observed an MDT meeting during which patients at Jubilee Ward (including an end of life patient) were discussed. The meeting was attended by the hospital GP, ward nurse, therapists and representatives from the specialist palliative care team. The MDT also discussed complex patients on the ward and their care plans.
- Patients received therapy support at home from occupational therapists and physiotherapists. The input of these therapists was seen by the community nursing teams as providing essential elements of end of life care. We saw examples of effective communication between nursing and therapy staff in team meetings and in day to day liaison. We saw patient -specific MDT notes filed in patient records and updated care plans based on these notes.
- Other specialist services provided within the community also assisted in the early identification of patients who were approaching end of life. For example, the heart failure team were able to assist GPs with the decision that a patient’s condition was no longer treatable and offer their opinion as to whether the patient was reaching the end of life.

Are services effective?

Referral, transfer, discharge and transition

- There was good liaison between the community matrons who looked after patients with long term conditions and end of life care services. These services worked together to ensure that patients were referred to end of life care services in a timely way.
- There was a clear pathway to refer patients to the palliative care team from the community or acute hospitals for patients identified as requiring end of life care. This service, in consultation with the patient's GP, referred to the specialist palliative team if advice or consultation were required.
- The heart failure team referred patients who had exhausted all specialist treatment options for assistance in the management of symptoms. They referred patients to the palliative care teams or community nurses for end of life care.
- The specialist palliative care team accepted referrals from the palliative care teams, community nursing teams and GPs. Staff were observed in a daily, multi-disciplinary triage meeting effectively prioritising new referrals. For example, new patients who had complex or considerable needs were seen promptly.
- Referral to other disciplines was straightforward and effective, such as occupational therapists or physiotherapists to help patients cope with symptoms such as breathlessness.
- Discharges from hospitals were managed efficiently, and mostly were timely to allow the patient to be cared for in their preferred place of care. The trust recorded data relating to delayed transfers of care (DToc) and used this information with their strategic partners to develop the service. Sometimes the delays were beyond the control of the trust, for example the availability of carers or suitable care home placements.
- Referrals from the local acute trust in Southampton were managed by a discharge co-ordinator employed by the trust. This role was not part of the trusts budget for the palliative care team, but the trust recognised the benefit this dedicated role had in facilitating and managing the referrals. In the 3 months prior to inspection, the referral process had been refined and improved by the introduction of an electronic referral system through a generic email portal. Administration staff, who received the initial referral, and the discharge

co-ordinator, confirmed this had improved the process by eliminating errors in completion of the referral documentation and speeding up the triage of referrals received.

Access to information

- There was an electronic patient record system used in community teams, palliative care teams and community hospitals.
- Staff also used paper records to record community visits (which were left in patients' homes) and also in community hospitals for nursing and medical records.
- The trust acknowledged they used multiple record systems in some areas but were implementing a system where records were consolidated on one electronic system.
- The electronic patient record provided information about where the DNACPR form was stored to ensure this could be accessed by emergency services. For example in a patients home, in a particular location such as the fridge or by the front door.
- The use of the electronic records system meant that, in theory, patient information was accessible to be shared across services. However this was not always possible with some restrictions to access. Access to GP or acute trust records was restricted to those which used the same system as the trust; approximately one third of GPs could not access this system. Clinicians sometimes had to request copies of patient records to ensure that they had all current information.
- The palliative care team had access to acute hospital records via a separate information system which helped them respond to urgent discharge requests. Community hospitals used the same patient record system as the palliative care teams so that records were easily shared.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards (just 'Consent' for CYP core service)

- Nursing staff were knowledgeable about processes to follow if a patient's ability to give informed consent to care and treatment was in doubt. Staff demonstrated a good understanding of consent in relation to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards. We observed community staff gained informed consent appropriately prior to carrying out any procedures during a home visit.

Are services effective?

- Staff understood how to act when restriction or restraint might become a deprivation of liberty. Staff were aware of the trust's policy if any activities, such as physical or pharmaceutical restraint, met the threshold to make an application to the local authority to temporarily deprive a patient of their liberty.
- On the Jubilee Ward, we reviewed 13 patient records: not all patients had a formal mental capacity assessment carried out when they had been admitted with confusion or appeared to have problems with

cognitive function. Where patients had been assessed, this was not always documented appropriately or regularly reviewed. On two of the patient records we reviewed, we found inconsistencies regarding the patient's capacity in the nursing and medical records compared to the admission documentation. However, for patients assessed as not having mental capacity to make decisions, best interest decisions were sought by talking with the patients' family.

Are services caring?

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

Summary

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

We rated caring as good because:

- Staff across all teams we visited described with passion how they were committed to providing compassionate person centred end of life care and saw it as a vital service to patients.
- Staff treated patients with dignity, respect and kindness. We saw examples where staff had provided patients with care which was above expectation.
- Relatives we spoke to told us that staff delivered compassionate care and that staff were very attentive to their needs and that of the dying person.
- Relatives spoke very highly of the staff saying they were caring, gentle and always treated people with dignity and respect.
- Relatives said they were kept fully informed and were involved in decisions about care.
- Patients and relatives received emotional support from the nursing staff and were appropriately signposted to external sources where required.
- Interactions between staff and patients demonstrated a respectful, kind and compassionate approach.

Detailed findings

Compassionate care:

- Throughout our inspection we observed patients were treated with compassion, dignity and respect. Staff we spoke with showed an awareness of the importance of treating patients and their families in a sensitive manner. For example, on a home visit to a patient, we saw holistic care undertaken by a community nurse. The nurse provided good support and showed kindness and gave the patient the time they needed.
- Relatives of patients spoke very highly of the staff and the service that their loved ones had received. They said staff were very caring and gentle and always treated people with dignity and respect. For example, one

relative told us, “Happy, kind, caring staff who are respectful and make me feel very welcome.” Another relative said, “They have shown kindness and care to all of the family.”

- During our inspection we heard staff were responsive and sensitive to patients and relatives when they called for support and advice.
- The Friends and Family test results for community inpatient services March 2016 showed very positive feedback, with 96% of responders extremely likely/likely to recommend the trust.

Understanding and involvement of patients and those close to them

- Patients and their relatives told us they received a high standard of care, and were involved in decisions as much as they wanted to be. For example, during a home visit we observed community teams giving clear explanations of care to be given and patients provided consent. Treatment stopped when patients asked for it to stop.
- Relatives told us that staff communicated to them in sensitive and unhurried way to ensure they could understand the information being given to them.
- We observed home visits with patients which were not rushed, giving plenty of time to ensure that patients were able to articulate their needs.
- Patients and family members told us they were involved in the patients’ plan of care and treatment. They expressed that their level of involvement was what they chose.
- The needs of family members who were caring for a dying person were always considered. This included assessment of carer stress and support for arranging respite care. Feedback from relatives highlighted how important this aspect of end of life care was to them.

Emotional support

- Emotional support was provided to patients and their families through a variety of services, including the voluntary sector.

Are services caring?

- The trust did not have a chaplaincy service: however, they were developing a spiritual strategy aimed at meeting the needs of all patients. The strategy documentation we reviewed showed that the trust was committed to developing a comprehensive strategy.
- Patient's spiritual needs were assessed on admission and, for example, if any patient was a regular attendee of a particular religious organisation, they were encouraged to be involved for the entirety of the patients stay.
- We reviewed 10 thank you cards sent to the community teams which all contained very positive feedback. They included comments such as: "Thank you for your kindness, compassion and love."
- Staff from the specialist palliative care team contacted bereaved relatives to offer support. Staff attended funerals where appropriate, and if invited.
- The specialist palliative care team send information to the local hospice to enable the bereavement team from the hospice to contact the bereaved family.

Are services responsive to people's needs?

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

Summary

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

We rated responsiveness as good because:

- The trust met with their commissioners, GPs, and local hospices as well as their own end of life care staff to plan services to meet the needs of local people.
- Community hospitals provided facilities and care appropriate to deliver end of life care: this included provision for family members to be able to stay with the patient.
- Equipment was available to support end of life care in patients' own homes. Equipment in community hospitals was suitable to meet the needs of individual patients at the end of life.
- There was access to translation services for patients whose first language was not English.
- The environment in community hospitals were designed to be suitable for the needs of people living with dementia.
- Vulnerable people were identified and effective multidisciplinary team working helped ensure that their needs were met.
- Some nurses had received training in the verification of expected death; this increased a family's choice when making arrangements for a patient after death.
- The needs and preferences of patients and their relatives were central to the planning and delivery of care with most people achieving their preferred place of care.

Detailed findings

Planning and delivering services which meet people's needs

- The palliative care service in Portsmouth had weekly meetings with the local hospice. This was attended by managers and staff from the specialist palliative care team. Caseloads and individual patient's needs were discussed so that services could be planned.
- The palliative care service in Portsmouth attended local GP events to promote the services they provided. Staff

who attended these events provided feedback to the team via team meetings, and they told us how useful these events were to enable them to network with GPs and practise nurses in their locality.

- The trust had appointed a specialist nurse from within the palliative care service as a thematic lead for the palliative care service. In addition to their existing role as a senior team leader, this role was reviewing the palliative care service across the trust, with a view to identifying any gaps in service provision.
- The palliative care service provided care for cancer and non-cancer patients, with approximately 19% of referrals received for non-cancer patients. The service used attendance at local GP events to promote their ability to accept both cancer and non-cancer referrals. Staff in the palliative care service told us that some practices were still unaware that they would accept both types of referrals.
- The community hospitals provided appropriate facilities for the delivery of end of life care. This included the ability to provide space for relatives who wished to stay with the patients.
- The trust had developed an early palliative care clinic for those patients identified as being in their last year of life, rather than just last days or weeks of life. The clinic had only recently been introduced prior to the inspection, but it was hoped this would improve the patient's pathway through the end of life service.
- The palliative care teams triaged referrals daily, and those patients identified as rapidly deteriorating or with a changing condition were prioritised. These patients were given same day appointments or visits where appropriate, which enabled early assessment of their needs.
- Palliative care teams carried a mobile phone which ensured that patients and relatives had access to telephone advice and request assistance from the teams. The teams were well connected with other end of life care services which included community nursing, Macmillan Cancer Care and Marie Curie.
- Equipment was provided to support patients who wished to die at home. This was delivered by an external

Are services responsive to people's needs?

provider. Staff confirmed that the service was responsive, and that equipment was delivered quickly to patients' homes to facilitate discharge or prevent admission to hospital.

Equality and diversity

- The trust told us that requests for written information to be provided for patients in other languages would be dealt with on an individual basis. Staff had not received any such requests, and so could not tell us how responsive this service would be and if it would cause a delay for patients.
- The services of an interpreter could be provided if required. Staff were aware of how to access this service but had rarely had the need to use the service.
- Cultural, religious and spiritual needs of end of life care patients were sought, assessed and planned for. We saw a patient who had a visitor from their local church and they prayed together in the privacy of their own room.

Meeting the needs of people in vulnerable circumstances

- Jubilee ward was dementia friendly, with high contrast fittings in toilet and bathroom areas, and visual signage. Patient rooms were also identified with pictures as well as numbers.
- Staff understood that patients at end of life were increasingly vulnerable. Staff had good relationships with other agencies such as the local authority and continuing health care when additional support was required.
- A small number of patients managed by the palliative care team also had a diagnosis of dementia. The needs of patients living with dementia were assessed individually with appropriate involvement of family and carers. Staff had undertaken dementia training and were able to describe when they might need to make adjustments.
- The end of life care teams had access to Admiral Nurses for advice and guidance. Admiral Nurses are specialist dementia nurses who give expert practical, clinical and emotional support to families living with dementia to help them cope. They are registered nurses, and have significant experience of working with people with dementia before becoming an Admiral Nurse
- The trust did not have their own bereavement information leaflets but used those supplied by

Macmillan. They planned to gain feedback from a patient group at the local hospices, to ascertain what information they should include when developing end of life care and bereavement information leaflets.

Access to the right care at the right time

- The trust provided data for the number of patients who died in their preferred place of care. They achieved a result of 81% against the trust target of 100%.
- Services were responsive in getting end of life care patients' home from hospital, although the service did not measure their rapid discharge timelines. However the availability of social services home care sometimes led to some people not being able to return to their preferred place of care.
- We observed care delivered in the community. Staff made every effort to ensure that people's needs were met, which included medicines being delivered, equipment being provided and support for relatives being put in place. At the time of inspection we did not see any evidence that the service was measuring delayed discharges from acute trusts.
- The trust had out of hours cover across the service. In Portsmouth there was telephone access to palliative care consultants and GP cover for the wards. In Southampton there was a city-wide rapid response team on-call until 10pm, seven days a week. After 10pm, in Southampton, patients and relatives utilised the 111 service for emergencies. The trust provided evidence which showed they monitored the provision of out of hour's services in order to assure themselves patient's needs were responded to in a timely way.
- Specialist palliative care advice was available by telephone to staff day and night; this was provided by the local hospice or acute trust hospice.
- The palliative care teams assessed the capacity of the teams and this was discussed daily to take into consideration the numbers of patients requiring two staff to visit. However, there was no specific tool in place to measure the level of care required for each patient, so the teams used their experience and judgement when allocating staff for visits. The palliative care team told us that they currently had no waiting list.
- The community nursing services were often aware of patients with the diagnosis of a terminal illness before the need for any care, as they had effective communication and good relationships with GPs. This meant they could make contact with the patient before

Are services responsive to people's needs?

they required any input from the nursing team. The community teams we spoke with said that early contact was very effective for patients, who were empowered to refer themselves back to the team when they felt ready to accept support. GPs provided support to patients and staff and were also involved in the decision for patients to seek help from the community nurses. We saw that end of life care for patients was given priority in all the services we visited.

- Staff in the community nursing teams in both Portsmouth and Southampton had undertaken verification of expected death training to support timely verification and certification of death. This meant that when patients died at home, the family had control of when to contact the funeral director to remove the deceased patient.

Learning from complaints and concerns

- Staff were able to describe the complaints procedure. Relatives of patients we spoke with felt confident to

raise issues with the staff. Staff told us they dealt with issues and concerns raised by patients and relatives quickly, which they said led to the small number of complaints about end of life care services.

- Complaints relating to end of care were received infrequently. The trust's own data found that there were four complaints related to end of life care services for the period 1 March 2015 to 29 February 2016. The trust categorised the themes of the complaints as staff attitude, care and communication, and procedural. At the time of the inspection two complaints were still ongoing. Of the other two, one had been fully upheld and the other partially upheld. In both cases responses had been sent, which were signed by the CEO, apologising for the family's experience and confirming where appropriate changes had been made to procedures or where further training had been given to staff.
- Feedback on the experience of relatives after a death was routinely collected with the after death analysis. The comments we saw from relatives about end of life care were all positive.
- Information on how a patients or relative could make a complaint was displayed on the ward we visited.

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 have rated this service as good for well-led. This is because:

- The service leads had worked with the Clinical Commissioning Groups (CCGs) for each city (Portsmouth and Southampton) to develop the service strategy.
- The trust had engaged with staff through the annual staff survey and had developed comprehensive action plans based on the responses received.
- The end of life care service had a robust and effective governance structure.
- Staff told us that support from local managers was good.
- Individual teams had good clinical leadership arrangements in place. There was an open and supportive culture with staff being very engaged, open to new ideas and interested in sharing best practice in end of life care.
- Friends and Family test results recommending the service were high.
- The service was formally represented at board level by the chief nurse. Board minutes showed evidence of regular reporting on the quality of end of life services to the board.

However,

- Service leads articulated a vision and priorities for end of life care services across the trust, but this had not been shared with all staff. Staff were unsure of a trust wide ambition and direction that would be necessary to drive improvements.
- Following structure changes in the service, some staff were not clear about who their new line managers were, and this had led to some uncertainty and concern.
- Quality metrics for the end of life care service were in early stages of development by the senior management team and not widely available or used by teams.

Detailed findings

Service vision and strategy

- The end of life care service was commissioned by separate CCGs for each city (Portsmouth and Southampton) and as such the plans on which each city-based team operated reflected the different commissioned models.
- The different commissioned models made it difficult for some frontline staff to be able to articulate the strategic vision for development and improvement of end of life care services. Some staff were unsure of the trust's ambitions and direction in relation to end of life care. However, the locality leads and community matrons were able to articulate the purpose of their service, to provide care and support for patients in their last year of life, and their role within the integrated locality team. All staff, including very senior managers, understood the importance of end of life care.
- The trust had a well communicated set of core values across services which were based on the word HEART: Honesty Everyone counts Accountable Respectful Teamwork. Staff had helped define the values and these were actively used in the appraisal process.

Governance, risk management and quality measurement

- Governance arrangements were in place for risk events and staff told us that they received feedback after incidents had been investigated. Staff also felt confident that incidents led to learning and changes being made, although we were not given any specific examples of where this had happened.
- Staff and managers were able to describe robust governance structure within the palliative care service. A review of governance meeting minutes confirmed there was an effective structure. Patient outcomes and incidents had been discussed at these meetings and the trust had good lines of communication between managers and frontline staff.

Are services well-led?

- There were team meetings, in both Portsmouth and Southampton based teams, to look at patient feedback, audit results and incidents. We observed team meetings in both localities, and previous meeting minutes, during which these topics were routinely discussed.
- Patient care was monitored by teams in both localities and information was included in the trust's clinical governance reports. Included in this report was a review of incidents, complaints, general patient safety information, infection control review, sharing from incidents and information
- Senior managers within the end of life care service told us they had started to identify areas of concern and agree metrics to measure performance against standards. However there was little evidence that key performance indicators or data were used to inform clinical leaders at team level about how well they were performing.
- The trust had a Mortality Review Policy, which had been in place since early 2014. The mortality process was being reviewed at the time of our inspection and was awaiting the outcome of an independent review of its approach to quality and governance.

Leadership of this service

- Most staff in the palliative care teams knew of and had met the leadership team for end of life care services.
- Senior managers were relatively new to the service but were able to articulate a clear commitment to develop the end of life care services at this trust.
- Staff told us that there was good local support and leadership for end of life care from managers. They had confidence in their managers to provide expertise and training to improve end of life care for patients. However, staff told us that due to changes the trust had made with regard to team structure they were unclear of leadership lines. They told us this led to some uncertainty and upset, some staff had not met new line managers despite them being in post.
- The chief nurse represented the end of life care service at board level.
- Strategic leadership for end of life care was provided at board level by locality directors and the chief nurse and head of quality. The locality director also had a significant portfolio of other services, and staff told us they were not always visible to staff at service delivery level..

Culture within this service

- Staff we spoke with in the community hospitals and in the community teams were committed to providing high quality end of life care.
- We found an open and supportive culture in end of life care services with staff being highly engaged, open to new ideas and interested in sharing best practice in end of life care.
- The community nurses we spoke with told us that end of life care was always considered a high priority for them. They also stated that end of life care was an intrinsic part of their work for patients. They spoke with pride about the importance of helping individuals achieve a comfortable and pain free death.
- Teams were supportive of each other and aware of the emotional stress of working in end of life care. The handover meeting was seen as a time for checking on team wellbeing.
- There were systems to ensure that staff affected by the experience of caring for patients at end of life was supported. There were opportunities for formal debriefings as well as informal support.
- In addition the teams arranged social events and had 'away days' which staff told us helped to develop a supportive culture within their teams.

Public and staff engagement

- The trust had a website that people could use to find out information regarding services offered. However, it was not easy to find information about end of life care services which could lead to some delay for people trying to access services.
- The trust actively sought feedback from patients through patient surveys and it was clear that this was valued by the trust. Friends and Family Test for the period 1 July 2015 to 30 June 2016 showed a response of 96% for those patients or relatives who were extremely likely to recommend the service.
- The teams also used the comments on thank you cards as feedback.
- Following the trustwide staff survey, the trust had developed detailed action plans from the responses and comments received. For example, responses to different questions in the survey highlighted a theme regarding incident reporting. There was a perceived negative culture to reporting, meaning staff were reluctant to report. In response, the trust increased clinical

Are services well-led?

supervision for staff, improved the feedback to staff following report investigation and provided further training for managers reviewing incidents to improve the overall process. Staff in the palliative care service told us about the changes that had been made and that they were enabled to report incidents following these changes.

Innovation, improvement and sustainability

- The Southampton palliative care support team had developed its own internal team metrics, specific to their locality and team, which was called The Productive Board. The manager and the team measured service specific indicators that as a team they felt would benefit

from improvement. These included Southampton palliative care support team internal staff survey, results of the Friends and Family survey (specific to their team) and results of notes and careplan audits. They monitored these indicators monthly and made changes to practice where appropriate. For example, the team developed an intentional rounding form, based on a form used in hospitals, for use when performing home visits. An audit of these forms showed that there was nowhere on the form to show if a district nurse had been contacted if there was a concern regarding a patients pain level. The form was amended and this provided immediate improvement to the process.