

Oxleas NHS Foundation Trust

RPG

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)
RPGXG	181 Lodge Hill,	Barnard Colyers , Plumstead , Highpoint , Woolwich , Eltham , Charlton and Woolwich Forums	SE2 OAY
RPGX6	Greenwich Intermediate Care Unit	Greenwich Intermediate Care Unit	SE9 5DQ
RGPFD	Meadowview Unit	Meadowview Intermediate Care Unit	DA14 6LT

This report describes our judgement of the quality of care provided within this core service by Oxleas 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 Oxleas NHS Foundation Trust and these are brought together to inform our overall judgement of Oxleas NHS Foundation 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 we rated community end of life care services at Oxleas NHS Foundation Trust good.

This was because:

- We found staff provided focused care for dying and deceased patients and their relatives.
- Do not attempt cardio-pulmonary resuscitation (DNACPR) forms were generally completed in accordance with national guidance.
- Community health services had policies, guidelines and training in place to ensure that all staff delivered suitable care and treatment for a patient in the last year of their life.
- Community health services provided end of life care training for staff which was mandatory for community nursing staff.
- Community health services fulfilled the World Health Organisation definition of end of life care and met the National Institute of Health and Care Excellence's (NICE) guidance.

Summary of findings

Background to the service

Oxleas NHS Foundation Trust provided health and social care services in south London and Kent. The trust provided services to adults in the community in a variety of locations across the London Boroughs of Bexley, Bromley and Greenwich and in Kent.

End of life care was provided to patients who have been identified as having entered the last twelve months of their lives. The trust did not have a separate end of life care service. However, end of life care was integrated in all areas of the community health service and knowledge was shared in multidisciplinary teams across the different departments. Community teams worked closely with GPs and the palliative care team at the local hospice. From April 2015 to March 2016, 153 deaths were recorded as being on an end of life care plan at the time of death.

The trust provided a community nursing service 8am to 11pm seven days a week. An overnight nursing service

was provided by the hospice and an overnight sitting service could be requested from a charitable body, Marie Curie. The local hospice provided a 24 hour advice line for patients and healthcare professionals.

We visited services based at the following locations:

- Barnard Health Centre (Barnard Forum)
- Colyers Lane Health Centre (Colyers Forum)
- Plumstead Health Centre (Plumstead Forum)
- Memorial Hospital (Highpoint Forum)
- St Marks Medical Centre (Woolwich Forum)
- Manor Brook Medical Centre (Eltham Forum)
- Manor Brook Medical Centre (Charlton Forum)
- Queen Mary's Hospital (Meadowview Intermediate care and Neuro rehabilitation)
- Eltham Community Hospital

Our inspection team

Our inspection team was led by:

Chair: Joe Rafferty

Team Leader: Pauline Carpenter, Care Quality Commission

The team included CQC inspectors and a variety of specialists including a palliative care nurse and a specialist doctor.

Why we carried out this inspection

We inspected this provider as part of our comprehensive 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 we reviewed a range of information we held about the trust and asked other organisations to share what they knew. We evaluated results of patient surveys and other performance information about the trust. During the visit we observed the end of life care provided by staff in the community hospitals and in

Summary of findings

people's homes. We spoke with seven patients receiving end of life care and five of their relatives. We reviewed information received from members of the public who contacted us separately to tell us about their experiences.

We spoke with 32 members of staff including nursing staff, doctors and managers about their work and how

they were supported. We also checked 23 end of life care plans and eight do not attempt cardio-pulmonary resuscitation orders. We also checked other records and documents about the provision of the service, training and management of staff, and provision and maintenance of equipment.

What people who use the provider say

Patients and their relatives told us they were more than satisfied with the service they had received. Comments about staff included "the nurses are a blessing", "nothing is too much trouble", "they even put up with me when I

am having a grumpy day", "I am always able to contact them and they respond promptly", "they work very hard and need a pay rise", "good at assessing my pain level" and "good communicators."

Good practice

The community nursing teams were effective in their organisation of services to enable them to be responsive to end of life care patients especially those who were recognised as dying. The teams were able to access the necessary equipment with a central store and sufficient supply of syringe drivers at each location. Each team had end of life care champions who promoted best practice of their specialist area within the service. The champions maintained specific boxes which had the necessary supplies which were required for a patient who was

thought to die within the next few days or hours. It contained equipment for using a syringe driver, administering anticipatory medicines and personal care equipment.

The community teams had a daily handover Monday to Friday which ensured the clear communication process regarding a patient's individual needs and also ensured the safety of the team was monitored. This was embedded in their daily routine and all staff attended without fail and the commitment to attendance and positive attendance levels were notable.

Areas for improvement

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

The trust should:

- Consider how it regularly audits the end of life care service to monitor performance and drive improvement.
- Have systems to evidence of discussion of a patient's spiritual needs at the end of life.

- Have an executive director at board level responsible for end of life care services.
- Consider how it obtains formal feedback to capture bereaved relatives views of the delivery of care.
- Review the completion of 'Do not attempt cardio-pulmonary' orders to ensure full compliance with national guidance

Oxleas NHS Foundation 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

We rated community end of life care services at Oxleas NHS Foundation Trust good for safe. This was because:

- The service provided safe and effective care for patients who were recognised to be in the last 12 months of their life.
- Staff informed us they were encouraged to report incidents to enable learning as an organisation.
- There were robust systems and processes to ensure that a high standard of infection prevention and control was maintained.
- We observed the appropriate prescribing of medicines for patients who were on the end of life care plan.
- There was a mandatory training programme for all staff. This included training for the appropriate syringe driver and safeguarding adults and children.
- We saw that patients were risk assessed in key safety areas using nationally validated tools.
- The trust had an incident report writing policy and used an electronic incident reporting system. Permanent nursing, medical and administrative staff gave us examples of how they reported incidents. Staff told us the trust encouraged them to report incidents to help the whole organisation learn.
- The trust was unable to provide us with data about incidents specific to end of life care patients. End of life care was not a core service and data was not recorded separately.
- There were no 'never events' or serious incidents reported by the trust about end of life care patients from December 2014 to December 2015. Never events are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.
- All patient deaths were reported on the trust computerised incident management system. When an expected death was reported this was classified as Level 2 – Expected natural causes of death. Examples of death in this category were do not attempt cardio-pulmonary resuscitation (DNACPR) and palliative care. If there were queries regarding the cause of death, the patient safety team liaised with the coroner and updated the incident

Safety performance

Incident reporting, learning and improvement

Are services safe?

management system accordingly. All reported deaths were reviewed at the weekly trust mortality group meetings and by the chief executive officer and director of nursing.

- Expected deaths were reported trust wide as incidents. In 2014 there were 54 and in 2015, 57. During this period all end of life care deaths were not recorded as incidents. These were being reviewed through the trust mortality group.
- Trust wide service users and their families were told when they were affected by something that had gone wrong. The trust apologised and informed people of the actions they had taken. When we spoke to staff they were able to describe the rationale and process of duty of candour.

Safeguarding

- Staff demonstrated a good knowledge and understanding of safeguarding vulnerable adults. Staff were able to name the trust safeguarding lead and knew how to access advice. The relevant local authority and social service numbers were available for staff.
- The trust had a safeguarding lead and policy. Safeguarding was part of mandatory training for all staff and this was monitored by managers. Trust wide data provided for safeguarding adults and safeguarding children level 1 was 99% each.
- Data showed there was 100% achievement for safeguarding adults and children level 2 for end of life care. However, as the trust did not recognise end of life care as a separate core service the data related to one person, the end of life care lead.

Medicines

- The trust had a medicines administration policy (2014). This was available for staff in a booklet form. The policy ensured that medicines were prescribed, stored, administered and managed safely according to current best practice.
- Patients in their own homes self-administered their medicines or were assisted by their carers. Medicines for end of life care patients were prescribed by the patient's GP or the palliative team at the hospice. Registered nurses in the community advised patients on the safe storage of medicines, undertook medicine administration and maintained syringe drivers where this was required. Where nurses administered medicines they completed records appropriately.

- There was trust wide guidance for the administration of medicines using the appropriate syringe driver which fulfilled the safety guidance by the National Patient Safety Agency Rapid Response Report (2010). The syringe driver is a portable battery operated device to help reduce symptoms by delivering a steady flow of injected medication continuously under the skin. It is a useful way of delivering medicines when the oral route cannot be used by an end of life care patient.
- The trust's adult end of life care policy and medicines policy contained clear guidelines for symptom management for patients. The guidelines were comprehensively set out and presented in an easy to follow manner. Practical guidance was provided for the use of syringe drivers including set up and medicines advice. We spoke with trained staff that were able to show us the guidance which was available on the intranet and in all teams' offices.
- We saw syringe driver charts in patients' notes and these were appropriately prescribed and completed in a timely manner.
- Staff told us and we saw in the trust wide controlled drugs (CDs) policy, two members of staff were to be present when CDs were administered. Patients' notes contained CD charts to record stock quantity totals and usage.
- Across the teams, we reviewed 23 patients' notes that contained prescription and administration charts for patients who were receiving end of life care. The charts showed that appropriate anticipatory medicines had been prescribed as stated by National Institute for Health and Care Excellence (NICE) Quality Standards guidelines. Anticipatory prescribing is designed to enable prompt symptom relief at whatever time the patient develops distressing symptoms. This allowed qualified staff to attend and administer medicines which may stabilise a patient or reduce pain and anxiety and prevent the need for an emergency admission to hospital. All patients who were assessed as being end of life were prescribed anticipatory medicines which ensured that streamlined care was maintained.
- All registered nurses and medical staff received training about the safe use of medicines for an end of life care patient and administering anticipatory medicines. The prescribing of anticipatory medicines and syringe drivers should reflect the needs of the individual patient as a patient's anticipatory needs may change during the course of their illness.

Are services safe?

- The Gold Standards Framework for Palliative Care states that an identified doctor or nurse must be responsible for ensuring that a regular review of the required medicines takes place at least once a month, and/or after any known change in circumstances.
- We saw inconsistencies regarding staff's understanding of the prescribing of anticipatory medications. The authorisation sheet for anticipatory medicines did not contain a review date. However, some staff told us that the authorisation sheet needed to be reviewed by a doctor every three months. We saw in one instance that a medicine was not administered until the patient had been reviewed, as it was past the three month stage. This resulted in a delay for the patient receiving their required medicine.
- Across the trust we reviewed 23 patient notes which contained individualised end of life care plans. We were shown the care plan library on the intranet. Nurses would either adapt an existing care plan or rewrite an individual plan for an end of life care patient.
- The trust had an electronic patient notes system and a portable version which allowed staff to update records in the home. Staff also completed a paper record in the home so that everyone who visited had an up-to-date record of any input. This meant there was duplication of records which was not ideal but was unavoidable. Staff were aware of the importance of ensuring that the written notes reflected the electronic records.

Environment and equipment

- Staff told us they did not experience any issues with obtaining or maintaining equipment for end of life care patients.
- The trust had a central store which contained the necessary equipment needed for an end of life care patient. For example: pressure relieving mattresses and moving and handling equipment. Larger items such as profiling beds and suction machines were ordered from equipment services. We saw evidence that this was a quick service and the majority of items ordered Monday to Friday were delivered on the same day.
- Each team in the community had a supply of syringe drivers. We saw that these were serviced annually. The syringe drivers were cleaned between patient use as per the trust's syringe driver and infection control policies.
- Each health centre had a specific box which had the necessary supplies required for an end of life care patient who was in the dying phase. It contained equipment for using a syringe driver, administering anticipatory medicines and personal care equipment. This meant that the teams were prepared for a patient who was identified as having significant changing needs when dying. The boxes were easily accessible, including weekends, and this would avoid a delay for the patient who may require additional medicines or personal care needs. These boxes were maintained by the end of life care champions.
- **Quality of records**
- The hand written patient folder kept in the patient's home contained specific care plans, record of visits, medication prescriptions and instructions and records of administration. The electronic system contained a more in-depth assessment and plan of care. However the hospice palliative team and the trust used different computer systems. The computerised notes completed by the hospice palliative clinical nurse specialist were not accessible to the community nursing teams. Recommendations of changes to medicines or plans of care had to be communicated by telephone call or fax.
- We observed staff completed electronic records during their time with patients. We saw that some staff completed this in the presence of the patient and others completed them when they returned to their cars. We were told this enabled them to focus more on the patient and/or carer while in the home.
- Agency nurses did not have access to the electronic system in community settings. They recorded the content of their visit on a pre-printed record which was scanned into the patient's notes by administration staff.
- The patients we saw in Eltham Community Hospital and Queen Mary's Hospital had separate medical records and bedside notes. The records contained patient specific care plans, skin assessments, mobility assessments and charts for bowels, pain, fluid and nutrition.
- We saw the record on the electronic system of a patient's preferred priority for care (PPC) who was under the care of the community team based at the Barnard Health Centre. PPC is a voluntary process that is appropriate for people who may want to make specific statements about their wishes as they approach the end of their lives. This demonstrated that the trust was encouraging patients to plan their care in advance.

Are services safe?

Cleanliness, infection control and hygiene

- The trust had an infection prevention and control policy and a care of the deceased – infection control precautions policy. All staff received training in infection control as part of their induction and mandatory training. We spoke with staff in the hospitals, clinics and home settings and all staff had a good understanding of infection control practices.
- We saw staff caring for patients on the end of life care plan complying with the trust's policies and guidance on the use of personal protective equipment. We observed staff were bare below the elbow, sanitised their hands between patient contacts and wore aprons and gloves when they delivered personal care to patients.
- All staff in the community carried a bag that contained hand gel, soap, cream and paper towels. These were provided by the trust and were for use when appropriate washing facilities were not available in the patient's home.
- We found the hospital wards and clinics we visited were visibly clean and tidy. Cleaning schedules were kept which outlined daily, weekly and monthly cleaning tasks and we saw evidence of these being audited in the hospitals.

Mandatory training

- The trust had a mandatory training policy and programme of mandatory training for all staff. We saw evidence and records of this training. Mandatory and statutory training for all staff trust wide was 95%.
- The trust had a trust wide induction policy and induction programme for permanent and temporary staff. The required mandatory and statutory training plan involved classroom and e-learning. This ensured that all those joining the organisation were appropriately supported to function effectively and safely in their role. All new starters had to participate in local induction and complete the induction checklist. Mandatory training included conflict resolution, equality and diversity, fire safety, health and safety, infection control, information governance, personal safety, basic life support and safeguarding adults and children.
- Agency staff received induction locally. The trust received assurances of the staff competencies and

training from the agencies. The team leader at Woolwich Forum told us that the same agency nurses were used frequently to provide continuity for staff and patients. The team leader assessed their competencies.

- Training for syringe drivers was mandatory for permanent nursing staff. We saw that the training records of attendance for staff were held centrally and on individual training records. As of April 2016 100% of community band 6 and band 7 nurses and 84% of band 5 nurses had been assessed as competent to use the syringe driver.
- Syringe driver training was defined by the trust's medical devices training policy and was updated every two years. All staff authorised to use the syringe driver attended the three day end of life care course, received local training and were assessed as competent in the procedure by staff who had undertaken the 'train the trainer' course. Train the trainers received refreshers from manufacture of the syringe driver.

Assessing and responding to patient risk

- Risk assessments were completed in relation to both the patient and their environment. We saw information was recorded which would assist staff or other health professionals to understand the patient's needs and provide care, treatment or support in such a way as to mitigate any danger.
- In the community hospitals we saw staff used a Modified Early Warning Score. This tool is used to aid recognition of deteriorating patients and is based on physiological parameters, which are taken when recording patient observations. An aggregated score is then calculated which may activate an escalation pathway.
- We saw that patients were risk assessed in key safety areas using nationally validated tools. For example we saw that the risk of malnutrition was assessed using the malnutrition universal screening (MUST) tool and the risk of pressure damage was assessed using the Waterlow scoring tool.
- We saw in patients records 'This is me' booklet. This is a simple and practical tool that people living with dementia can use to tell staff about their needs, preferences, likes, dislikes and interests.
- Risk assessments were also completed in people's homes in order to keep staff safe and ensure that equipment could be accommodated and used without it presenting a risk to the patients or staff.

Are services safe?

- Any changes in a patient's health or vulnerability were recorded and any additional preventative measures were put in place. For example pressure reducing mattresses or therapies to improve mobility or combat eating or other disorders.

Staffing levels and caseload

- Most community teams acknowledged that they did not have a full complement of staff and most teams used agency nurses on a daily basis.
- The community nursing teams had vacancy rates for qualified nursing staff higher than the trust average of 15%. The community team based at the Manor Brook Medical centre had the highest vacancy level of 28% with 238 shifts filled by bank or agency staff.
- The twilight team (who worked 5pm to 11pm) had the highest number of shifts filled by bank and agency staff and a nursing assistant vacancy rate of 75%. The trust average was 14%.
- The community team based at the Memorial Hospital had two agency nurses working Monday to Friday on a regular basis. The disadvantage to this, according to staff was the agency nurses did not have access to the electronic notes system.
- Staff in all areas we visited during the inspection told us they were busy, but they felt they had sufficient time to provide a meaningful and quality experience for the patients. Patients told us that with very few exceptions staff were unhurried and willing to spend time explaining procedures and health issues with them.

- During our inspection we asked team leaders about their staffing levels and whether they felt adequate staff were available when caring for patients on an end of life care plan. Staff told us that recruiting staff was a main concern but they were aware of the trust's efforts to manage the situation. Eltham Community Hospital told us that agency staff were supplied for caring for a patient who as at the end of life if required.

Managing anticipated risks

- The trust had a policy for the protection of lone workers with control measures in place to minimise risks to staff who worked alone. This ensured the safety of staff. A high proportion of home visits to end of life care patients was conducted by two members of staff and enabled a degree of clinical supervision.
- End of life care patients were flagged up to out of hours services and to ambulance services so that appropriate advice or treatments could be given if patients deteriorated.
- Anticipatory medicines were discussed with GPs in relation to patients in their care and these were kept in people's homes if prescribed so that qualified staff could administer them to prevent delay in reducing pain or other symptoms.

The service did not have any issues on the trusts risk register at the time of the inspection.

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 community end of life care services at Oxleas NHS Foundation Trust good for effective. This was because:

- The trust had implemented standards set by the National End of Life Care Strategy 2008 published by the Department of Health, NICE End of Life Quality Standards for Adults (QS13) and 'One Chance to Get it Right' by the National Leadership Alliance for the Care of the Dying Person. The trust was committed to upholding the Alliance's five Priorities for the Care of the Dying Person. We saw there was an audit programme of the standards
- Alternative end of life care guidance had been developed in response to the national withdrawal of the Liverpool Care Pathway. The trust used individualised care plans and the Alliance's five Priorities of Care to put people and their families at the centre of decisions about their treatment and care.
- Each community team had at least one end of life care champion who promoted best practice of their specialist area within the service.
- Patients' pain, nutrition and hydration needs were monitored in accordance with national guidelines.
- Guidelines included prescribing anticipatory pain relief alongside guidance for other common systems.
- The trust had a programme of end of life care training that was delivered by specialist palliative care practitioners. However, the National Care of the Dying Audit 2014 recommended that staff received mandatory training in the care of the dying.
- There were trust wide guidelines for do not attempt cardio-pulmonary resuscitation (DNACPR) and forms were completed for appropriate patients. However we found there were inconsistencies and varied practice in the completion of DNACPR forms across the community teams.
- We saw evidence of good care and treatment for adult patients who were identified as end of life care from Oxleas NHS Foundation Trust in the community.
- The National End of Life Care Strategy 2008 published by the Department of Health, sets out the key stages for end of life care, applicable to adults diagnosed with a life limiting condition. NICE End of Life Care Quality Standard for Adults (QS13) sets out 16 standards what end of life care should look like for adults diagnosed with a life limiting condition. Eleven of the 16 quality statements were relevant to Oxleas NHS Foundation Trust and the services they provided.
- Community nursing teams worked closely with GPs, the majority of who used the national Gold Standards Framework (GSF) to assess and review patients at or nearing the end of life. The GSF developed within primary care focuses on improving communication, continuity of care, advance care planning and patient care and support. Staff told us they attended the monthly GSF meetings.
- Following the withdrawal of the Liverpool Care Pathway and the publication of 'One Chance to Get it Right' in 2014 by the National Leadership Alliance for the Care of the Dying Person, the trust was committed to upholding the five Priorities for the Care of the Dying Person. The priorities define that the possibility a person may die within the next few days or hours is recognised and communicated clearly. Decisions were made and actions taken in accordance with the person's needs and wishes, these were regularly reviewed and decisions revised accordingly.
- The trust used individualised care plans and the Alliance's five Priorities of Care to put people and their families at the centre of decisions about their treatment and care. The individualised care plans we saw centred care on individual needs rather than following a set format. Care plans contained the elements which would be expected to include such as pain management, breathlessness and nausea with guidance on eating and drinking, bowel and bladder function and spirituality.

Evidence based care and treatment

Pain relief (always include for EoLC and inpatients, include for others if applicable)

Are services effective?

- Effective pain control was an important part of the delivery of effective end of life care. End of life care patients in the community remained under the care of their GP who was responsible for prescribing their medicines. Consultants were available within acute hospitals and the hospice to provide advice and guidance to GPs on the most effective treatments.
- GPs and community nursing teams supported patients by liaising with the hospice palliative care team regarding best practice in relation to care and treatment including pain management.
- The five Priorities for the Care of the Dying Person supported the effective management of pain in the dying patient. Guidelines included prescribing anticipatory pain relief alongside guidance for other common systems.
- We reviewed patients' notes and prescription and administration charts and saw that patients had regular assessments for pain and appropriate medicines were prescribed and given frequently and as required.
- Where appropriate patients had syringe drivers which delivered measured doses of prescribed medication. All qualified nursing staff were trained in the use of syringe drivers.

Nutrition and hydration (always include for Adults, Inpatients and EoLC, include for others is applicable)

- On admission to the community hospitals or during home care assessments, malnutrition universal screening tool scores were taken which helped staff identify patients at risk of malnutrition or those who were obese. Where required food and liquid intake was recorded and patient weight monitored.
- Patients were encouraged by staff to maintain a healthy lifestyle, this included advice on diet and drinking. During their interaction with patients we heard staff discussing diets and reminding patients to drink plenty of fluids. Staff were able to seek advice or make referrals to dietitians and speech and language specialists who specialised in eating and drinking disorders.
- The five Priorities for the Care of the Dying Person had clear guidelines for the assessment of mouth care, hydration and nutrition. The end of life care records we observed showed that these were being completed and updated by staff.
- We observed staff in the community hospital and in patients' homes give patients drinks and mouth care.

- The personalised care plan included prompts to ensure that the patient and their family's views and preferences around nutrition and hydration at the end of life were explored and addressed.

Patient outcomes

- All end of life care patients would be known to the palliative services at either the hospice or hospital, which would make referrals to the trust.
- From April 2015 to March 2016, 153 deaths were recorded as being on an end of life care plan at the time of death. The trust did not collect data determining how many deaths and/or referrals were related to cancer and non-cancer patients. This meant the trust were not able to fully assess if the wider definition of end of life care was being fully considered
- The trust did not audit whether patients in the last days of life were identified in a timely way. They told us this was because many patients were referred to the trust for care further down the end of life care pathway.
- The trust told us they had been piloting a new process for recording end of life care patients and they were aware there was some under recording as they embedded the new system. From April 2015 to March 2016 there were 153 end of life care deaths. Of these 73 had preferred place of death and 60 had actual place of death recorded. Of those 60, 41 died in their preferred place of death. From January 2016 to March 2016, 67 Bexley patients died with 59 dying in their preferred place of death. This demonstrated the trust was recognising patients' individual wishes. However the trust did not seek to understand why patients' had not died in their preferred place of death.
- An audit of NICE End of Life Care Quality Standard for Adults (QS13) was carried out on 51 patient records in 2016 in the adult community services directorate and was a duplication of the audit carried out in 2014.
- The 2014 audit showed 88% of patients and their carers were provided with information about end of life care. In 2016 this figure was 97%. The 2016 audit showed an initial assessment was completed in 100% of cases and included cultural and spiritual needs, physical and psychological wellbeing and social circumstances. A care plan that incorporated current and/or future pain management according to physical needs was in 94% of cases. A psychological need was identified in two cases and there was a care plan to address this. One hundred per cent of patients in their last days of life had their

Are services effective?

care delivered according to their care plan. However, the audit showed only 7% of cases was a carer's assessment considered or discussed. Also in only three cases a bereavement visit had been documented.

- The audit recommended family and carers needs and preferences should routinely be assessed and referred if appropriate. It was also recommended that community nurses offered a bereavement visit. These identified areas were recorded in an action plan with defined implementation dates.
- National guidance was provided on all aspects of care following death and included options to take account of cultural and religious beliefs, of the deceased or their relatives, whilst observing any legal requirements. All the staff we spoke with were able to describe the processes and how they would support relatives and signpost them to other support services.
- The trust had an advance care planning policy which included advance decisions and advance statements. This explained staff's role and the importance of healthcare professionals involving patients and their families in decisions about care and respecting decisions that had been made and documented earlier. Healthcare professionals working within the trust were expected to document an individual's advance statements or decisions in the patients computerised record in relation to end of life care. We saw documentation of these statements and decisions in patients' records.

Competent staff

- The trust had a programme of end of life care training that was delivered by specialist palliative care practitioners. All nurses had attended a three day course and health care assistants a two day course. For nurses this included current legislation and national competencies, identifying patients as end of life care, advanced care planning, symptom control, spiritual care and care after dying. There was a one day annual update. End of life care was not part of mandatory training for all staff. The National Care of the Dying Audit 2014 recommended that staff received mandatory training in the care of the dying. Although the trust did not participate in this audit, this is an indication of best practice.
- Individual training needs were followed up in one-to-one meetings, in clinical supervision and through an ongoing competency programme.

- The hospice had training sessions every six weeks that all staff were able to attend. Staff told us they often went even if it was their day off as the sessions were very interesting and informative. The sessions also involved an aspect of clinical supervision.
- The end of life care lead told us they were in the process of corroborating and collating all training undertaken by staff. This could be highlighted on the computerised off duty and would show the competencies of each individual member of staff.
- Each area had at least one end of life care champion who promoted best practice of their specialist area within the service. This was achieved by them supporting the work of the trust lead whilst promoting and maintaining engagement at all levels so that end of life care remained a valued priority within the workplace. The champions we spoke with were very passionate and committed to their role.
- The end of life care lead told us about a module at the local university regarding palliative care. This was to start in September and the lead had received a lot of interest from all teams.
- Staff told us that the trust was very supportive of nursing staff and their Nursing and Midwifery (NMC) revalidation. They had been supported with the evidence gathering, reflective writing, continual professional development and recording of clinical hours. The necessary interviews had been arranged.
- Trust wide the appraisal rate for all non-medical staff was 96% for community health services adults and 91% for community inpatients. We saw evidence that staff in the community had participated in annual appraisals and had personal development plans.

Multi-disciplinary working and coordinated care pathways

- Oxleas NHS Foundation Trust did not have a specialist end of life care service. However end of life care was practiced across the different departments of the trust. The community nursing teams, specialist COPD and heart failure teams were made up of a multidisciplinary workforce that included doctors, nurses, nurse specialists and health care assistants.
- The integrated community teams had a good working relationship with the palliative care team based at the local hospice. There were two end of life care facilitators that were employed by the local hospice who linked with the trust.

Are services effective?

- A palliative clinical nurse specialist from the hospice worked with the cardiac team three days a week. The cardiac team attended the GSF meetings.
 - Community staff had formed close and mutually helpful working relationships with other clinical specialist teams. For example podiatry, Parkinson's clinical nurse specialist and the tissue viability nurse.
 - There were daily handovers for each community team Monday to Friday. This was a formal process and all staff attended. We saw that agency staff were encouraged to attend the daily handovers. At the daily handovers there was opportunity for staff to discuss matters and receive support from peers.
 - We saw the documentation that all teams had regular monthly meetings. Community nursing teams had monthly forum meetings. This enabled staff across all the forums to network and have group meetings.
 - The band 7's trust wide had meetings every six weeks and an away day twice a year. The last meeting was in April 2016 and covered care planning and streamlining the community nursing hours.
 - The inpatient unit at Eltham Community Hospital had regular multidisciplinary meetings and team meetings every four to six weeks when complaints and incidents were fed back to staff.
 - The mental health team visited the inpatient unit at Eltham Community Hospital twice weekly on Monday and Friday and chaplaincy visited weekly. Inpatient staff told us they had good links with the community services.
 - We were told of a good example of multidisciplinary working in St Mary's Hospital. A patient was recognised as in the last days of life. Discussions had taken place and recorded with the patient and their relatives and the end of life protocol started. Specialist advice was sought from the palliative care team at the hospice and the community nursing team provided a syringe driver. The patient was moved to a side room and the family were able to stay. The records showed there were discussions regarding spirituality and after death arrangements. Relatives were signposted to bereavement services.
- assessment, 26 (10%) awaiting public funding, 115 (44%) awaiting residential or nursing home placement, 18 (7%) waiting for a package of care and 9 (3.5%) were awaiting equipment.
- Trust-wide from January 2015 to December 2015, there were 5816 days delayed in transfer of care. The highest proportional increase was due to delays that were the responsibility of social care. A total of 2,811 (48%) were awaiting residential or nursing home placement. We were unable to ascertain how many of these delays specifically related to this core service.
 - Discharge procedures using fast track continuing healthcare funding were well embedded into the trust. Patients could be transferred home from hospital, if that was their wish. This would be evident when it became apparent that care at home was appropriate or that no further interventions were available in a hospital setting which prolonged their lives.
 - The care needs of end of life care patients can be complex and likely to be provided by multiple provider services. The majority of patients were entitled to provision of care funded by continuing healthcare. Most end of life care patients were discharged to local boroughs. The boroughs had varying protocols for approving and providing care and there was wide variation in the speed of both.
 - These patients may also be cared for by support teams from the local hospice. Greenwich Care Partnership was a service provided by the hospice for end of life care patients in the Greenwich area. They provided personal care, up to six visits a day, for patients who were in the dying phase. This service was not available for patients living in the Bexley area whose personal care was provided by the community nursing teams.
 - Eltham Community Hospital told us about a patient who had been recognised as end of life but home was not suitable for discharge, which was the patient's wish, they had to be admitted to hospital. The trust did not have a rapid response end of life care team. Any patients ready for discharge from the acute hospital would be managed by the relevant community team. They told us they would always aim to do this as quickly as possible but this was not audited.

Referral, transfer, discharge and transition

- Trust-wide from January 2015 to December 2015, 261 patients were delayed for discharge into the community. Forty seven (18%) were due to awaiting completion of

Access to information

Are services effective?

- We saw patients were provided with an information leaflet about the syringe driver. This explained information explaining the reason for its use, how it worked and safety advice.
- The offices of the community nursing teams had notice boards with areas dedicated to end of life care information. This included who was the end of life care champion for the team, advance care planning information, priorities of care for the dying patient and NICE positive practice prompts.
- We saw Eltham Community Hospital had patient information boards around the wards.
- Coordinate My Care (CMC) is a clinical service which coordinates care giving patients choice and improved quality of life. It was developed to help people with life limiting illnesses express their wishes and preferences for how and where they are treated and cared for as they near the end of their life. It ensures that any health professional legitimately involved in a patients care had access to this information especially in an emergency situation. All community nursing teams had been trained in the use of the system. However CMC was controlled by GPs and commissioner led. Community teams in the Bexley area were able to access the system but this was 'read only'. This meant they were not able to record discussions with patients.
- We saw staff always introduced themselves and sought consent before treatment.
- The trust had a Mental Capacity policy (2016) which incorporated Deprivation of Liberty Safeguards (DoLS). The policy had clear guidance that included the Mental Capacity Act 2005 legislation. This set out the procedures staff should follow if a person lacked capacity including best interest meetings.
- Staff we spoke with understood the do not attempt cardio-pulmonary resuscitation (DNACPR) decision making process and described decisions with patients and families. There was a trust wide guideline for DNACPR which was a standard form and travelled with the patient.

While visiting the inpatient and community teams we viewed eight DNACPR forms. We saw that all decisions were recorded on a standard form, kept in the front of the patient's notes, and had evidence there had been discussion with relatives.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- The trust had a policy for consent to examination or treatment (2016). This was based on the model developed by the Department of Health. The policy included the process for consent, documentation, responsibilities for the consent process and use of information leaflets to describe the risks and benefits. The policy also included consent for advance decisions, guidance for lasting power of attorneys and mental capacity.
- The trust informed us Mental Capacity Act training was not a mandatory training course for staff. Data provided by the trust showed one member of the end of life care service had received Mental Capacity Act training and they were up-to-date. However, as the trust did not recognise end of life care as a separate core service this related to the end of life care lead.
- There were inconsistencies and varied practice in the completion of DNACPR forms across the community teams in the trust which did not fully follow national legislation and guidance. For example two of the forms we reviewed had not been counter signed by a senior professional and one of these forms had been signed by an advanced community practitioner and not a consultant.
- The DNACPR form of a patient seen by the community nursing team at the Barnard Health Centre clearly stated that the decision was final and not for review. This is at variance to recommendations of good practice. The Resuscitation Council (UK) guidelines 2015 state a DNACPR is 'indefinite unless a definite review date is specified or there are improvements in the person's condition'. However, it also states 'the decision should be reviewed whenever the patient is transferred from one healthcare setting to another'. These robust arrangements ensure the DNACPR remains current and appropriate. Staff told us GPs in some areas automatically rewrite DNACPR forms from the acute setting when a patient returns to the community. This demonstrated that the GPs were following guidelines and reviewing patients and their individual needs.

Are services caring?

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

Summary

We rated community end of life care services at Oxleas NHS Foundation Trust good for caring. This was because:

- Staff provided sensitive, caring and individualised personal care to patients who were at the end of their life.
- Patients and relatives spoke positively about the care they had received.
- On the wards we visited and in people's homes we observed compassionate and caring staff who provided dignified care to patients who were at the end of their lives.
- Patients and their relatives were involved in their care and were given adequate information about their diagnosis and treatment. Families were encouraged to participate in the personal care of their relatives with support from staff.
- Emotional support was provided by staff in all areas. Staff knew who to signpost relatives to for bereavement care.

Compassionate care

- Throughout our inspection we visited patients at the end of their life in their homes as well as inpatient areas. We saw that in all areas of the trust how staff interacted with patients they cared for. Staff were polite and courteous. Patients appeared genuinely pleased to see staff and in respect of home visits staff were treated almost as family by patients and their relatives or carers.
- Staff told us that end of life care was a vital part of their role and they enjoyed the relationships they formed with patients and their relatives. During our inspection we observed end of life care that was sensitive, dignified and caring by all staff.
- Teams provided us with a sample of cards and letters thanking the team for their support and care. Comments from a GP included "This patient's care demonstrated what can be achieved when everyone works together". A response from the trust's deputy chief executive acknowledged the dedication and skill of the

team and the very high quality of care that the patient received. Other comments from relatives included "thank you all once again for everything you have done for our mum" and "you were wonderful".

- Patients and their relatives we spoke with gave positive feedback about the way they were cared for.
- We saw a letter to staff from a relative of an end of life care patient who had died in Queen Mary's community hospital. The relative thanked staff for their caring approach and were positive about the care their relative had received.
- We heard staff in handovers discuss how best to support a patient without unduly disturbing them and maintaining their comfort.

Understanding and involvement of patients and those close to them

- The NHS friends and family test for a place to receive treatment, in community health services, was equal to or above the England average for the six month period August 2015 to January 2016. Patient numbers who would not recommend the trust were low and similar to the England average.
- We spoke with seven patients and five of their relatives. They told us staff providing end of life care were caring and professional. They felt involved in their care and were given adequate information about their diagnosis and treatment. They felt they had time to ask questions and that their questions were answered in a way they could understand.
- We observed staff introducing themselves to patients and their relatives.
- Relatives were encouraged to participate in the care of patients. For example, we observed relatives assisting with mouth care and personal care for end of life care patients.

Emotional support

- All end of life care patients were allocated a named nurse so that they had a single point of contact but patients told us that they had found all the staff either in person or on the telephone to be equally as helpful and friendly. Some patients did say that having a named nurse was reassuring to them.

Are services caring?

- Staff told us how they involved carers and relatives in discussions about care and support and how this involved helping them, as well as the patient, to understand and come to terms with their condition. We saw evidence of this involvement and support when we observed members of the team during home visits where patients, carers and other family members were present. We saw how staff were friendly and chatted with patients and their relatives but were professional and caring in their practice.
- We saw how emotional support was provided not only to patients and their families but also to staff within the teams. One member of staff told us, “To work as a healthy team, you have to look after each other. If someone is upset we have a safe environment for them to be upset in.”
- Community nurses were encouraged by the trust to record bereavement visits to relatives. Bereavement support was not specifically provided by the trust. Relatives were signposted to the hospice and relevant agencies that could support them.
- The trust did not carry out surveys looking specifically at patient experience at end of life care. They considered this to be done by the hospice and did not have access to this information.

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 community end of life care services at Oxleas NHS Foundation Trust good for responsiveness. This was because:

- The community teams provided a service that reflected the needs of the local population and ensured flexibility, choice and continuity of care.
- Discharge procedures using fast track continuing healthcare funding were well embedded into the trust.
- The inpatient units at Eltham Community Hospital and Queen Mary's Hospital made arrangement to meet the needs of patients at the end of life.
- Services were planned, delivered and coordinated to take account of people with complex needs and engage with people who were in vulnerable circumstances.

People who used the service were encouraged to make a complaint or raise concerns. Lessons were learnt and action was taken to improve the quality of care.

Planning and delivering services which meet people's needs

- The trust did not have a dedicated end of life care service. However they worked closely with the local hospice and GPs. Patients who were recognised with end of life care needs may be referred by their GPs or from an acute hospital setting. Patients were supported by the general ward staff in the community hospitals and the community nursing teams in their homes.
- The inpatient units at Eltham Community Hospital and Queen Mary's Hospital offered patients and their families open visiting and side rooms dependent on availability and suitability. Queen Mary's Hospital site had facilities for relatives of end of life care patients to stay.

Equality and diversity

- Spiritual and cultural training was in the three day end of life care training and addressed in individualised care plans. Oxleas NHS Foundation Trust community patients did not have access to spiritual care providers.

Clinicians would seek to help the patient identify a chaplain in their local community if appropriate. However, the patient records we saw in the community setting did not record the patients' spiritual needs.

- The trust wide adult end of life care policy quotes the Department of Health's overriding aim to ensure high quality care for all people approaching the end of life, irrespective of age, gender, ethnicity, religious belief, disability, sexual orientation, diagnosis or socioeconomic status. It should enhance choice, quality, equality and value for money. This was embedded in the end of life care individualised care plans and staff training.
- The trust had access to translation services via telephone or could be booked through a centralised booking system.
- We saw in patients records 'This is me' booklet. This is a simple and practical tool that people living with dementia can use to tell staff about their needs, preferences, likes, dislikes and interests.

Meeting the needs of people in vulnerable circumstances

- Patients who were in their last days of life were offered increased home visits by the community nursing teams as necessary.
- Equipment was provided to assist in caring effectively for the patients, for example moving and handling equipment which ensured the safety of patients and staff.

Anticipatory medicines were prescribed and administered to aid symptom control as required.

Access to the right care at the right time

- Community nursing teams provided a service for end of life care patients seven days a week 8am to 7pm. Two twilight teams based at the Memorial Hospital provided a service 5pm to 11pm.
- A night nursing service was provided every night 11pm to 8am. This was provided to Bexley residents by a qualified nurse and a health care assistant employed by the trust. Greenwich residents were covered by a service level agreement with Marie Curie.

Are services responsive to people's needs?

- A night sitting service could be requested for patients who were in the last days of life from Marie Curie. This could be booked in blocks of three days. This was funded by the trust.
- The local hospice provided a 24 hour advice line for patients and healthcare professionals.

Learning from complaints and concerns

- There was a trust wide Patient Advice and Liaison team. The community hospitals displayed 'your views matter' poster addressing complaints and relatives' issues.
- Complaints were not recorded separately for end of life care. However staff were able to provide two examples of lessons learnt from complaints.
- The first example related to delay in the provision of equipment especially at the weekend. This had resulted in a central storage of equipment that could be accessed 24 hours a day.
- The second example related to a change in practice. Staff told us and we saw documentation of an action plan regarding complaints received about continence products. This led to change in the provision of service and the quality of products. The service had received over 300 complaints about the introduction of a less absorbent and effective pad. Each complaint required a visit from the community nurses to reassess the patients. Practice was changed so that assessments regarding continence products were managed by the trust wide incontinence service and not community nurses.
- Managers and staff told us how complaints were shared amongst teams during handovers and team meetings. We saw minutes of management and team meetings where complaints were seen to be a standing agenda item.
- Complaints which impacted on the trust were cascaded to teams through the intranet newsletter and team meetings so that staff had an understanding of issues throughout the trust.

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 community end of life care services at Oxleas NHS Foundation Trust good for well-led. This was because:

- The end of life care lead and the community nursing teams had a vision to ensure that end of life care was consistent with a trust wide approach
- The vision, values and strategy were being developed with all who were involved in end of life care.
- The trust was committed to delivering excellent end of life care for all patients. The leadership of the teams delivered care of a high standard and were proud of the service they provided.
- Although end of life care was not an individual core service in the trust there was an effective governance framework to support the delivery of the strategy of good quality care. The trust's end of life care lead worked cooperatively and was responsible for education and development across the trust.
- The trust culture encouraged candour, openness and honesty. Staff and the public's views and experiences were gathered and acted on to shape and improve the services and culture. Feedback was discussed at team meetings.

Service vision and strategy

- Managers in all the locations we visited were passionate about the service their teams provided. They were proud of the achievements that had been made and there was a clear wish to continue to improve the service for the benefit of the patients.
- The end of life care lead told us they recognised that the trust needed to identify the dying patient earlier and keep end of life care as the focus. As end of life care was not a core service they needed to continue to embed end of life care engagement within the directorates.

Governance, risk management and quality measurement

- We saw there was clear clinical oversight and involvement with patients throughout their care.

Systems were in place which ensured that managers understood their workforce and their workload. Audits were completed and information shared with teams to show performance and highlight targets.

- Weekly and monthly team meetings took place in all the teams we met with. Standing agenda items included incidents, complaints, compliments and policy updates. Staff at all levels told us the meetings were a useful source of information and encouraged staff to engage with issues and enabled learning to be passed across the teams and the trust. We looked at minutes of meetings and saw what staff had told us was reflected in the notes.
- There was a trust wide adult end of life care policy and end of life care operational group meetings. We saw six copies of minutes of meetings from February 2014 to March 2016. In the meetings matters arising to do with training and the development of policy and work streams were discussed. The group did not report to the trust clinical effectiveness group and reported through the medical directorate. The end of life care lead told us this gave them better engagement across the directorates.
- Policies relevant to end of life care were agreed by the end of life operational group and were available on the intranet. The policies were promoted by the champions at local level.
- The end of life care lead told us there was not a risk register specific to end of life care as it was not a core service. There was a trust wide risk register. There were items on the risk register relevant to end of life care for community services. These included the progress and implementation of the computerised system, staff vacancies and retention of staff, improving communication channels between GPs and community nursing teams and pastoral care no longer available at Queen Mary's Hospital. All had allocated owners, progress updates and expected completion dates.

The band 7 nurses were part of a 'task force' to assess and action plan areas of improvement in the service. An example we were told about where a recently recruited band 7 assessed and monitored staffing levels and agency

Are services well-led?

nurse usage. Before the audit the team had six agency staff a day and this had been reduced to two a day. This has enabled the team to run more efficiently and had given the band 7 the confidence to decide on agency provision in a more proactive manner.

Leadership of this service

- The trust wide end of life care operational group monitored the implementation of the policy to ensure consistency and equity. They encouraged the provision of high quality care to patients through the promotion of palliative care education and worked in partnership with other delivered services.
- The trust wide board of directors had overall responsibility for all aspects of the operation, performance and effective governance of Oxleas NHS Foundation Trust. The end of life care lead worked cooperatively and was responsible for education and development across the trust. We found the end of life care lead was visible and effective in promoting good end of life care.
- The lead confirmed that end of life care was not recognised as a separate service of the trust and therefore there was no board representation. Although the trust did not participate in the 'The National Care of the Dying Audit of Hospitals (NCDAAH)' this audit states "all trusts should have a designated board member and a lay member with specific responsibility for care of the dying" and this was an indication of best practice.

Culture within this service

- There was a clear sense of pride and belonging amongst staff at all levels within the community teams who provided end of life care. Each person's role was seen as being equally as important as the next. Staff appeared to have genuine respect for each other which allowed them to concentrate on their role within the team.
- Daily discussions about patients' needs and staff skill mix ensured that patients received the best possible response and that staff were supported to provide it.
- Staff told us they were supported by their line managers and department heads in all aspects of their work including training and supervision of their work. A member of staff told us that the trust was "the best, they were open, honest and supportive."

Public engagement

- The trust had a patient experience group that provided assurance and was established to improve patient experience across the services. This was to ensure they got comprehensive feedback from service users and their carers about their experiences. The feedback was translated into action plans to improve and influence changes
- The trust collated information from patients, families and carers using the friends and families test. We also saw evidence of public engagement at trust level in relation to changes to services; however these had not included provision of end of life care.
- Individual end of life care teams provided information for patients and their families as and when patients came into their care. Guidance leaflets and information about health issues relating to people's diagnoses were available.
- Having been identified either in the community or in one of the trust's hospital settings as requiring end of life care, patients and their families were encouraged to discuss their treatment and care and could influence their own treatment and care.
- The trust used recognised sources of patient feedback such as complaints, compliments, PALS and incident analysis.
- There was no trust wide bereavement survey. Community nursing teams would make a bereavement visit if appropriate and would signpost to the hospice.

Staff engagement

- The 2015 National NHS staff survey rated Oxleas NHS Foundation Trust as better than the average for staff recommending the trust as a place to work, receive treatment, staff motivation at work and staff ability to contribute towards improvements in work. The response rate for the survey was 49% which was above the average for other similar trusts in England. However, the survey showed there had been an increase in the response of staff working extra hours and this was worse than the national average. In 2014 the response was 73% and in 2015, 75%.
- Staff at all the locations we visited were proud of the effectiveness of their multidisciplinary working. A constant thread throughout the inspection was that every member of each team felt engaged and valued.

Innovation, improvement and sustainability

Are services well-led?

- Staff were supported by the trust to develop their skills. We saw evidence that staff attended an 'enhanced clinical assessment skills' course at the local university. This was one day a week course over a period of ten weeks.
- The community teams as a multidisciplinary team used the resources of the wider multidisciplinary team to ensure the continued individualised care for patients at the end of their lives.