Sheffield Teaching Hospitals NHS Foundation Trust

RHQ

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)
RHQNG	Northern General Hospital	NA	NA

This report describes our judgement of the quality of care provided within this core service by Sheffield Teaching Hospitals 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 Sheffield Teaching Hospitals NHS Foundation Trust and these are brought together to inform our overall judgement of Sheffield Teaching Hospitals 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?	**Requires improvement**	🟠

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Overall summary

Overall rating for this core service Good

We rated the community end of life service as good. We found patients were receiving care which was safe, effective and caring. However, we rated well-led as requires improvement.

Staff were encouraged to report incidents and near misses. They said it was easy to report incidents when they returned to their team bases. They said they were trained to carry out root cause analysis and discuss the lessons learned with colleagues at team meetings. Incidents were analysed across the palliative care and therapeutics directorate and discussed at their operational business and governance meeting.

Community nursing teams were able to access guidance for medicines management of community patients in last few days of life. A community infection control accreditation programme had been developed which set standards for infection prevention and control. The programmed aimed to assess and optimise infection prevention and control practices throughout community services.

Patient's pain and their nutrition and hydration needs were being effectively assessed.

We found many examples of good practice, for example, the introduction of electronic laptops which enabled community teams to record information at the time it was being delivered in patients' homes and send GPs electronic messages. The intensive home nursing service provided city wide care including respite care for people in the last days of life. Patients, relatives and staff working in other services spoke very highly about the service and the staff who provided it.

The trust had developed a range of mechanisms for responding to patients' needs during the working day and out of hours and relatives told us the intensive home nursing service responded to their needs quickly, offering examples of service which had been put in place the same day.

The service had developed guidance for the service to replace the Liverpool care pathway and were supporting staff to complete the end of life template developed by primary care. However, the guidance for staff caring for people at the end of life had been introduced recently and not all staff were clear how they should incorporate this into their clinical practice. Some staff were enthusiastic about using the end of life template on the electronic record system but the template did not include information about people's spiritual or emotional needs. The trust had developed guidance for staff assessing the spiritual needs of patients approaching the end of life.

The trust did not monitor whether patients died in their preferred place of care. This meant the service did not monitor one of the key indicators for the service. The information system used by the trust could capture this information and recording was encouraged however the information was not being collected and monitored.

There had been a number of changes to the structure and leadership of the service in 2015. Integrated pathway managers were appointed who were responsible for improving the pathways for patients between the hospital and community services. However, plans for achieving this had not been developed. Some services which had worked together were now managed in different directorates and staff were unclear about how they would communicate and develop together in future. Each directorate had a different method of reporting with different metrics, measures and definitions. Managers acknowledged the need for improved systems to monitor the effectiveness of services.

Summary of findings

Background to the service

Information about the service

Care for patients approaching the end of life was provided by the trust's community nursing teams. These are teams of district nurses, community nurses and community care staff trained to support people at the end of life.

Hospital and community services were amalgamated in 2012. The intensive home nursing service was managed as part of the Therapeutics and Palliative care Directorate and community nursing services were managed as part of the Integrated Community Care Directorate. New integrated service teams were created in 2015 led by integrated pathway managers who were responsible for developing pathways of care which span hospital and community services. Community nursing services work alongside other professional community staff such as therapists (occupational therapist and physiotherapists), pharmacists and podiatrists.

There were 23 community nursing teams including evening and night teams. These teams were organised into four localities across the city. The localities mirrored the GP localities in the local Clinical Commissioning Group (CCG); these were HASL, Central, West and North. Nursing services were provided 24 hours a day, 365 days of the year.

In 2014-2015 community nursing made a total of 84,000 visits to provide treatment in patients' homes. Approximately 6% of those visits were for patients at the end of life. Patients are referred to the community services teams by GPs (37%) and hospitals (42%). An analysis of community teams visits showed the number of palliative care patients had increased by 10% in 2015.

Community teams also worked with nursing and residential homes to support people at the end of life. Advice was available from the specialist palliative care team in the trust. This included access to palliative care consultants for advice about medicines or symptom management. Specialist palliative care nurses employed by St Luke's hospice worked alongside community nurses to make sure patients symptoms were well managed.

In addition to the care provided by community nursing teams, an intensive home nursing service (IHNS) provided one to one personal care for patients in the last few weeks of life, if the patient wished to die at home. The service was part funded by Marie Curie cancer care. The IHNS service provided varying levels of care depending on the needs of the individual. The service could provide 24 hour care, if required, when a patient was in the last days or hours of life. Referrals were accepted from health and social care professionals, in the community or hospital. The IHNS could also provide a respite service to relieve carers .Carers could access this service if the person they were caring for had a diagnosis of a life limiting illness. The service was also provided for people who were not yet in the terminal phase of their illness, but were experiencing an acute episode of illness whilst living at home. People who were in hospital or a hospice could also access this service so that they could spend some time in their own homes.

In addition, there was a complex case management team, also known as the 'one to one pilot' project. They assessed patients in hospital who wanted to be cared for at home. They also provided care for patients in the community working alongside local community nursing teams.

We inspected three services contributing to the care of patients at the end of life: the intensive home nursing service (IHNS), community-nursing teams based in four locations across the city and the complex case management team based at Weston Park hospital.

As part of our inspection, with patient's permission, we observed end of life care and treatment in patient's homes. We looked at 11 sets of patient care records, nursing notes and medicine charts. We also observed the complex case management service organise the discharge arrangements for patients returning home. We spoke with 30 staff including managers, team leaders and community staff. We also spoke with 10 relatives and six patients who were receiving care. Before our inspection, we reviewed performance information from and about the service.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Professor Stephen Powis , Medical Director

Head of Hospital Inspections: Amanda Stanford, Head of Inspection

The team included CQC inspectors and a variety of specialists: including consultants, specialist nurses, student nurses, community nurses, therapists, medical directors, nurse directors and experts by experience.

Why we carried out this inspection

We inspected this core service as part of our comprehensive inspection programme.

How we carried out this inspection

To get to the heart of patients' experiences 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 the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the hospitals. These included the clinical commissioning group (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), royal colleges and the local Healthwatch.

We held a listening event on 1 December 2015 at St Mary's Church and Conference Centre and attended focus groups in Sheffield for people with learning disabilities and older people to hear people's views about care and treatment received at the hospital and in community services. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who attended the listening events.

Focus groups and drop-in sessions were held with a range of staff in the hospital, including nurses and midwives, junior doctors, consultants, allied health professionals, including physiotherapists and occupational therapists. We also spoke with staff individually as requested. We talked with patients, families and staff from all the ward areas. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' personal care and treatment records.

We carried out an announced inspection on 7 to 11 December 2015 and an unannounced inspection at the trust on 23 December 2015.

What people who use the provider say

Relatives told us staff were compassionate and caring about patients and their families.

Summary of findings

Good practice

The intensive home nursing service provides support for patients and their families in the last days and hours of life. Relatives consistently praised the service and the staff who provided it. We found the staff were particularly committed and caring. Many of them had worked for the service for many years and felt the role they performed was an important service to the local community in which they lived. We heard several examples of staff who stayed on when their shift had finished to support a relative following a bereavement and service managers were flexible and responsive to the needs of families who used the service.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The trust must ensure there is an implemented strategy for the care of patients at the end of life.

The trust should develop a system for monitoring patients whether patients died in their preferred place of care.

The trust should review the template on the electronic record system to ensure staff are capturing all the necessary data for monitoring the quality of service provided.

The trust should consider auditing the use of the guidelines for the care of the person who may be in the last hours to days of life.

Sheffield Teaching Hospitals 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 found safety in end of life care to be good because:

- Staff were encouraged to report incidents and near misses. They said it was easy to report incidents when they returned to their team bases. They said they were trained to carry out root cause analysis and discuss the lessons learned with colleagues at team meetings.
- Incidents were analysed across the palliative care and therapeutics directorate and discussed at their operational business and governance meeting.
- Community nursing teams were able to access guidance for medicines management of community patients in last few days of life. This gave staff guidance about medication for the five key symptoms which can occur in the last days of life to ensure there was no delay in effectively treating their symptoms
- A community infection control accreditation programme had been developed which set standards for infection prevention and control. The programmed aimed to assess and optimise infection prevention and control practices throughout community services.
- Community staff used electronic laptops to update records whilst they visited patients. This ensured patient records were always up to date and meant staff could access information wherever they were working including the patient's home.

However, we also found:

- Mandatory training including safeguarding training was below the trust target of 90%.
- Information provided by the trust showed there were 40 reported incidents for patients at the end of life being cared for in the community between December 2014 and November 2015. 96% of the incidents were classified as either insignificant or minor severity. These were all reported by community nurses working in the city's four integrated community teams.
- The majority of incidents related to pressures sores for patients being cared for at home or in nursing homes. Other incidents reported related to communication issues following patient's rapid discharge from hospital or between community teams and GPs.
- There were no never events in the period October 2014 to October 2015 and no serious incidents reported.

Good ●

Are services safe?

Incident reporting, learning and improvement

- Community teams were encouraged to report incidents and near misses. They said it was easy to report incidents when they returned to their team bases.

- Incidents were investigated by community staff carrying out a root cause analysis. This is a process healthcare organisations use to analyse what has happened when an incident occurs and what can be learned.
- However, the notes of management team meetings stated there was a backlog of clinical incidents awaiting investigation. In September 2015, there were 362 incidents across all community services which required investigation. This meant there may be more incidents relating to end of life services than we are aware of.
- Incidents which occurred most frequently were reviewed to identify ways of improving practice. For example, further analysis of medicines incidents was planned and a project had been set up to look at ways of reducing pressure ulcers. A member of staff had been released to look at all pressure ulcer related incidents.
- Incidents were analysed across the palliative care and therapeutics directorate and discussed at their operational business and governance meeting.

- We saw an example of an incident involving a pressure sore which had been investigated. The report described the type and location of pressure ulcer, the root cause, and anything which might have contributed to the pressure ulcer including lapses in the care provided by community staff. The report highlighted the need for community staff to ensure they had carried out all the appropriate risk assessments, for example, the person’s fluid intake. The person had not always done as community staff advised and staff were encouraged to complete incident reports when this happened. Several steps were taken as a result of the investigation which included ordering a different type of pressure relieving mattress, referral to a team specialising in tissue viability and further education and advice offered to the patient and their carers.

Duty of Candour

- Duty of Candour is a legal duty on NHS trusts to inform and apologise to patients following incidents which resulted in moderate or significant harm.
- Community staff were aware of the principles of duty of candour and the importance of being honest with patients if an incident had occurred. We saw examples of duty of candour issues which had been discussed at the palliative care and therapeutics directorate governance meeting.

Safeguarding

- Staff received training in safeguarding adults against the risk of abuse as part of their mandatory training. However only 44% of nursing staff in the community had completed this training against a trust target of 90%.
- A team leader told us about a recent safeguarding issue they had referred to the safeguarding team and had good knowledge about the process for referring safeguarding concerns. We saw examples of safeguarding records for referrals the team had made.
- Other community staff we spoke with had a good understanding of safeguarding and could give examples of the types of abuse they needed to look out for.
- For vulnerable patients, staff completed a Vulnerable Adults Risk Management Model (VARMM) assessment form.

Medicines

- Community nursing teams were able to access guidance for medicines management of community patients in last few days of life. This gave staff guidance about medication for the five key symptoms which can occur in the last days of life to ensure there was no delay in effectively treating their symptoms. The guidance covered the use of syringe drivers, subcutaneous administration of medicines and alleviation of symptoms including pain, shortness of breath, restlessness, nausea and respiratory tract secretions. The guidance was produced by the trust’s clinical lead for palliative care in 2014 and the clinical commissioning group which meant the same document was used by primary care and services provided by the hospital. Community staff were familiar with the guidance and used this to guide their practice in the community.
- The guidance described the rationale for discontinuing medicines if the patient experienced difficulty taking oral medication. Staff were encouraged to assess patient’s needs and consider alternative routes for essential medications, for example syringe driver, to administer regular pain relief and anti-sickness medicines.

Are services safe?

- Community nursing staff could access advice from the pharmacy team in community services. Nursing staff told us this was helpful because the administration of medicines differed slightly from the protocols followed by hospital staff.
- Community staff accessed a palliative care formulary on line which provided guidance on the medicines recommended for dealing with particular symptoms.
- We reviewed six patients' medicines records which we found were fully completed.

Environment and equipment

- McKinley syringe pumps were used in the community. These are electronic machines used to administer medicines precisely. Planned maintenance programmes were in place for syringe pumps. 89% of pumps were serviced within a month of the due date compared with the target of 90%.
- Syringe drivers were cleaned and checked by engineering staff inbetween different patients. We saw the record book used to maintain records of returned pumps and their checks.
- District nursing teams kept two syringe pumps in each team base so these could be delivered to patient's homes quickly if needed. Staff had received training for using syringe pumps. We saw records of the workbooks completed by community staff which showed their competencies were assessed. Each district nursing team had two trainers who assessed district nurses competencies annually.
- Patients, carers and staff told us the service had provided beds, mattresses and other equipment for example to help people shower or have a bath. A relative said the equipment they needed had all been delivered to their home before the person was discharged from hospital. Staff had advised them about what they might need and the equipment was delivered within a few days. Everyone we spoke with said the equipment service was good.

Quality of records

- Clinical nursing guidelines had been developed for end of life patients and nurses could refer to these on the trust intranet.

- Some community nurses were using a template developed in primary care to record information about patients approaching the end of life. This was being used by community staff in two localities. This meant community nurses and GPs were capturing and sharing the same information. Community staff felt this was a positive development. The templates and training was being rolled out to staff. However, not all community staff were aware of the templates. We saw the templates did not include capturing information about people's spiritual and emotional needs. The trust had developed guidance for staff assessing the spiritual needs of patients approaching the end of life.

- Community staff used electronic laptops to update records whilst they visited patients. This ensured patient records were always up to date and meant staff could access information wherever they were working including the patient's home.

- Community staff completed records for syringe pumps used in patient's homes for administering medicines. These pink forms provided an easily recognisable document for recording information about the medicines the patients received. We looked at four sets of records kept in patient's homes and saw these contained appropriate information.
- Patient records were audited annually to ensure these were being completed to a high standard.
- Care assistants who worked for the intensive home nursing service did not have electronic tablets for updating patient records. They updated the records kept in patients homes and called the office at the end of each shift to update the office records with information about on the person's condition. They said this was also an opportunity to discuss any concerns they had about the person's care or any difficulties they had encountered during the shift.

Cleanliness, infection control and hygiene

- A community infection control accreditation programme had been developed which set standards for infection prevention and control. The programmed aimed to assess and optimise infection prevention and control practices throughout community services. The programme acknowledged that community staff could not always control the processes in patient's homes but recommended those policies and protocols such as hand hygiene, protective clothing, health care waste management and aseptic technique would promote a good standard of infection prevention and control.

Good ●

Are services safe?

- Community nursing staff had a yearly infection control hand washing assessment using the light box test.
- Relatives we spoke with confirmed staff always used aprons and gloves and washed their hands regularly.

Mandatory training

- Mandatory training rates were 64% overall for community staff who provided care for people at the end of life. The trust target was 90%. The areas with the lowest percentage rate were moving and handling and basic life support. A total of 83% of community nurses had completed mandatory training in health and safety, 78% had completed equality and diversity training, 86% had completed conflict resolution and 68% had completed resuscitation training.
- Minutes of the integrated community services directorate showed the management team were tracking levels of mandatory training, recognising these needed to improve. Community staff told us they were able to access mandatory training online and were trying to fit the training in around their workload.
- An electronic system was used to monitor and manage mandatory training. Information was transferred from electronic staff records into the personal achievement and learning management System (PALMS). This allowed managers to monitor staff training monthly.
- We reviewed a sample of four staff training records out of 68 staff working in the intensive home nursing service. These showed those staff had completed the required training.
- The trust had developed guidance for all staff caring for patients at the end of life. The guidance identified care of the dying as mandatory training for staff who may be required to provide end of life care.

Assessing and responding to patient risk

- We saw examples of completed nursing assessments in patient's records. These included for example skin assessments for pressure ulcer risk and hydration assessments
- Guidance for the care of people in the last days of life encouraged staff to review the patient's condition daily and anticipate their needs if their condition deteriorated, for example by ordering anticipatory medicines. We observed the community staff handover in two locality bases where clinical and other risks were discussed.
- Staff told us they discussed people's care and the risk of falling and the need for an occupational therapy assessment. Community staff recognised the importance of identifying and reducing risk to patients.
- Community staff were able to use their electronic tablets to send messages to GPs. They could also take photographs, for example of a patient's wound, which could be viewed and assessed by the person's GP.
- Community teams were able to access medical advice 24 hours a day from specialist palliative care medical staff employed by the trust and from specialist nurses employed by St Luke's hospice.

Staffing levels and caseload

- There were few vacancies in the integrated care teams; one team told us they had a full establishment of nursing staff. The mid year report on community nursing showed there were only two staff vacancies In October 2015. They said caseloads had increased and so had the complexity and dependency of patients.
- A system for assessing and managing community teams' caseloads has been tested in one of the team areas and was being rolled out to the other three teams. The level of care required by patients was collected and used to identify the skills required to provide the appropriate level of care. The information was used to match the staffing to patients' needs. The trust was participating in the annual benchmarking programme for community services and contributed to work on the development of a safer staffing tool for community nursing.
- Another team leader told us they had a caseload of 280 patients between nine community nurses. The team had 10 patients approaching end of life on their team's caseload. The team were caring for people at the end of life with cancer and a range of other conditions The team leader reviewed their teams caseloads to check patients still required the care in order to manage the caseloads.
- The team covered gaps caused by sickness with relief or bank staff. The service employed relief staff to cover for staff off sick or attending training courses.
- The trust also provided us with figures which showed the use of agency staff in each locality. The last figures were for June 2015. The north team used the highest number of bank hours (6.2%) whilst HASC used the least (3.2%).

Good ●

Are services safe?

- There were for 1.6 wte end of life care facilitators who worked across the trust and provided training support to community nurses and care home staff.

Managing anticipated risks

- Plans had been developed to deal with major incidents or events that would disrupt the delivery of care.
- We saw the integrated community nursing service were organising a table top planning exercise for a major incident.
- Community nursing staff told us about their plans winter weather. In the event of snow, they were able to use four by four vehicles from the GP out of hour's service to reach patient's homes.

Good ●

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 found the effectiveness of community end of life service was good. This was because:

- The service had developed guidance for the service to replace the Liverpool care pathway and were supporting staff to complete the end of life template developed by primary care.
- Patient's pain and their nutrition and hydration needs were being effectively assessed.
- Community staff could access clinical policies on the trusts intranet and these provide staff with guidance which was reviewed and kept up to date.

However we also found:

- The guidance for staff caring for people at the end of life had been introduced recently and not all staff were clear how they should incorporate this into their clinical practice. Some staff were enthusiastic about using the end of life template .The template did not include information about people's spiritual or emotional needs.
- The service was not using an electronic palliative care co-ordination system (EPaCCs). This is a system for co-ordinating people's wishes and end of life care across organisations. A palliative care coordinating system project (SPCCS) was planned which would provide a centrally coordinated system to support the identification of end of life patients.

Evidence based care and treatment

- Policies used by the service were available for staff to access on the trust intranet. These included a range of pathways and guidance, for example, a pathway for the care of deteriorating patients, guidelines for the use of syringe pumps, managing medicines, communicating with patients as they reached the end of life and oral care.
- However, not all community staff we spoke with were aware of the guidance added to the system in November 2015. Some staff told us not all the pathways and guidance had been adapted for use in community services.
- Community nursing staff met with GPs and other healthcare professionals to plan and review the care provided for patients. They used the national Gold Standards Framework (GSF) to co-ordinate and plan the care provided. The GSF provides clinical staff with a range of tools they could use to help them provide effective care. For example, the service used a recognised palliative care checklist. This promoted staff to ensure they were checking a range of things which were important for people approaching the end of life. These included the persons physical symptoms, emotional needs, personal issues such as spiritual or religious needs, social support, information patients and carers might need, control for example where the person preferred to die, out of hours arrangements, what happened in the last hours of life and after death. We saw examples of these checklists which had been completed for patients.
- The service was no longer using the Liverpool care pathway. Community and hospital staff could access guidance they could use for planning end of life care following the end of the Liverpool care pathway. The guidance covered making an appropriate care plan, how different groups of staff should work together, regular reviews of the person and the decisions required. The guidance was issued by the trust in October 2015 to help health care professionals fulfil the five priorities for care developed by the Leadership Alliance for the Care of Dying People (LACDP). The LACPD is a coalition of 21 national organisations who have worked together to develop guidance on end of life. The LACPD was formed following the review of the Liverpool care pathway and reviewed a range of evidence and spoke with patients, carers and clinical professionals.
- The policy developed by the trust provided staff with evidence based guidance on the conversation staff should have with the person and their family or carers when they believe a person is dying. The guidance covered what community staff should do when they believed the person was dying, observations which should be carried out regularly, usually daily, advice on medicines, spiritual care, nutrition, pain and breathing.

Good ●

Are services effective?

- Community staff followed guidance developed by the trust for the use of syringe drivers used in patient's homes for administering medicines. The guidance was based on national guidance produced by the Medicines and Healthcare Products Regulatory Agency and the National Patient Safety Agency.
- The out of hour's service used guidelines developed by the trust's palliative care service developed in May 2015. The guidelines provided primary care and community staff with guidance on medicines and the five priorities of care for the dying person. The five priorities of care included recognising when the person was going to die and making sure their wishes were included in a plan for their care during the last period of their life.

Pain relief

- Patient's records showed they were regularly asked if they were experiencing pain and how severe the pain was. Patients in the last days for life had their pain assessed at every visit.

- We observed care being provided in a patient's home. Nurses were able to help the person with the pain they were experiencing. They had arranged for them to be admitted to a hospice on occasions when their pain needed stabilisation. Specialist nurses from the hospice also visited daily. The person needed two syringe pumps to deliver the medicines they needed and two nurses attended to change the patient's medicines. A GP also attended and district nurses discussed the person's care and their medicines.

Nutrition and hydration

- The trust had developed guidelines for nursing staff which replaced the Liverpool care pathway. These included guidelines for hydration, mouth care, nutrition, nausea and vomiting. The guidelines emphasised the importance of respecting patient's religious and cultural needs.

- Nursing staff were advised to develop plans for nutrition and hydration to support the person's wishes. Nurses were alerted to the importance of managing the care of patients at the end of life is they had diabetes. Separate guidelines were available for staff if they had difficulty managing the patient's blood sugar levels including seeking the advice of the diabetes specialist nurses. The guidance stressed the importance of identifying and addressing any factors preventing nutrition and hydration which could be addressed, for example nausea or difficulty swallowing. Staff we spoke with were aware of the guidelines and the importance of developing a nutrition and hydration plan to support the patients wishes and preferences, involving and informing the family and carers.

- We observed community staff discussing nutritional and hydration needs with people as part of the assessment process. We asked community staff about the guidelines in place for staff to follow. Staff told us they used the Malnutrition Universal Screening Tool (MUST). This was recommended by NICE as the tool to be used for assessing people's nutritional needs and protecting people from the risk of malnutrition.
- Records showed that community nursing teams used the (MUST) to assess patients at risk of malnutrition. These completed to a good standard.
- Staff working in the intensive home nursing service were trained to monitor saline infusions for people who were at risk of dehydration.

Technology and Telemedicine

- Community nursing staff had electronic tablets which they could use to update patient's records on line and use them to consult professional colleagues via skype.

Patient outcomes

- The trust did not have a system in place for monitoring patients preferred place of care and where they died. This meant the service did not monitor one of the key indicators for the service.

- We saw examples of audits completed by community teams. These included an audit of handwashing practice and audit of leg ulcer assessment and a community clinical records audit completed in 2015.

- Community teams undertook local audits, for example auditing pressure sores. We saw the results of a recent audit completed in October 2015. The results highlighted where earlier intervention could have been effective in reducing the severity of a pressure sore. GPs told us a variance in GP prescribing had been identified through an audit resulting in 12 intensive training sessions for GPs provided by one of the trust's consultants in palliative care medicine.

- An external evaluation of the Complex Case Management Service found the service supported around 20 patients a month. Once assessed by the service patients on average waited for less than a day to return home. The service was supporting patients to return home sooner than would be expected without the service. The service continued to support the patient once they had returned home, possibly preventing re-admission. The service helped ensure patients received integrated, coordinated care, which took account of their wishes. Patients and their carers report high levels of satisfaction with the service.

Competent staff

- Support workers in the Intensive Home Nursing Service completed two full induction training days. The training was provided by senior registered nurses (Band 6 and 7s) in the service and by the training administrator. A member of the office staff was responsible for monitoring training and ensuring staff completed the courses. The course covered medicines management, medical devices including syringe pumps, hand hygiene, infection control, conflict resolution, record keeping, equality, diversity, and mental capacity. Staff completed written assessments following the training to test their understanding. Other training was provided in addition to the two day course. This covered level 2 safeguarding training, basic life support, fire, manual handling, violence and aggression and food hygiene.
- Appraisal rates had increased during 2015 to 83.7% at the time of our inspection. Team leaders in the IHNS appraised members of their teams with each responsible for between 15 and 20 staff. We reviewed a sample four appraisal records and showed these had been completed this year.
- Some nurses were trained to administer subcutaneous fluids for patients who were unable to receive fluids by mouth. These were provided based on individual patient need. The trust were in the process of updating guidelines for this.

- We saw the assessment tool used for assessing staff competency for administering medicines.

- Support workers in the intensive home nursing support service monitored infusion pumps in use at patient's homes. A competency assessment had been developed to check staffs understanding of the checks they should carry out. Grade 2 support workers checked to ensure syringe pumps were working correctly when the visited, but did not set new pumps up or administer medicines via the pumps.

- District Nursing teams were led by a District Nurse team leader. These are registered nurses who have completed a degree or higher master's degree to become a specialist community practitioner. They were supported by deputy team leaders who are also qualified community practitioners or are nurses who will be studying to qualify as community practitioners. Community staff nurses and health care assistants provide the core service to patients in the community.
- Each team had a community matron. Community matrons specialise in supporting people with long term conditions and are able to provide specialist advice to community nursing staff.
- A competency based training pack was developed for all band 2 support workers. The roles support workers undertake were identified following a review of community staff caseloads.
- Community staff had recently had half and full day education events in palliative and end of life care. The majority of the team had attended these practice learning initiative events.
- The end of life care facilitators within the trust had organised training events for nursing staff. Eight events were held starting in early November 2015. These were designed to develop nursing staff's knowledge and skills in the care of the dying person based on the five priorities of care developed by the Leadership Alliance. The workshops covered recognition of the dying person, formulating a personalised care plan, managing symptoms in the last days of life and communication with the person and those close to them. The training events was organised by an end of life facilitator based in the trust.

- We spoke with a district nursing team leader who told us they had been sponsored by the trust to train as a community specialist practitioner. They told us they carried out joint home visits with nurse specialists from the local hospice to agree a joint care plan.
- We saw examples of competency assessments completed by community staff in medicines administration. Two staff in each community team trained other staff to use syringe pumps checking staff competencies annually.

Good ●

Are services effective?

- The trust had developed training courses for support workers which was being provided to staff in the trust and to staff from other organisations across the region.
- Evening shift and night community staff spent time at the trusts palliative care centre to gain experience in palliative and end of life care.
- One team leader told us clinical supervision for their team was not taking place. They said staff within the team supported each other and they were able to access the 'workplace wellbeing' service if they needed to access a counselling service.
- Community staff participated in Sage and Thyme training. This is an approach used by healthcare professionals to engage in conversations with people who may be distressed.
- An end of life facilitator provided community staff with education and training to support people at the end of life. Plans had been developed for evening and night community staff to work in the Specialist Macmillan Palliative Care Unit based in the trust to enhance their skills in pain management, symptom control supporting people with emotional and psychological issues.
- Community staff were able to access emotional support from their managers and specialist staff in the hospice when they were caring for patients whose condition was distressing.
- The trust had introduced new recruitment processes which involved running large recruitment and selection events. Candidates who had the appropriate qualifications or experience were recruited to work for the trust, but might not know much about the service they were being recruited to. For example, some new staff recruited to the intensive home nursing service had not realised they would be supporting families at the end of life and felt uncomfortable with the role.

Multi-disciplinary working and coordinated care pathways

- The service was not using an electronic palliative care co-ordinations system (EPaCCs). This is a system for co-ordinating people's wishes and end of life care across organisations.
- Community staff told us about a pilot project which was planned, the Sheffield palliative care coordinating system project (SPCCS) which would provide a centrally coordinated system to support the identification of end of life patients. The aim was to improve communication about all aspects of end of life care and support GPs to keep information about patients. This would enhance care of patients in their last year of life.
- We saw an example where the intensive home nursing service had provided care 24 hours a day when needed. As the patients condition improved district nurses provided care and the patient and relatives also received support from the specialist nurses based at St Luke's hospice. Relatives reported they felt care was well co-ordinated.
- Community nurses attended meetings held in GP surgeries to contribute to the co-ordination of care for patients at the end of life. The meetings known as Gold Standard Framework (GSF) meetings is a mechanism used widely in primary care to manage patients care at the end of life.
- District nurses described their involvement with multidisciplinary meetings in the hospital and the hospices to discuss patient's discharge, particularly if it was complex. The patient and their family sometimes attended these meetings to discuss the arrangements for returning home. A nurse told us they had been involved in planning someone's discharge who wanted to be at home for an event. Community staff had met the family and were able to introduce themselves and discuss the support the family needed.
- Community pharmacists were integrated into community nursing teams and the active recovery team. Their main function was to review patient medication, provide governance, for example reviewing standard operating procedures and to provide staff with education and training.

Referral, transfer, discharge and transition

- Community teams received referrals for patients through the single point of access (SPA) service who recorded and forwarded information to community staff on a computer based form. Community staff said they sometimes also received a communication through the system they used for recording information about the care provided to patients. This could be from a GP or other healthcare professionals.
- Referrals for the intensive home nursing service are taken from any health or social care professional, either community or hospital based, such as District Nurses,

Good ●

Are services effective?

Social Workers, General Practitioners and Hospital Liaison Departments. The service was enhanced by partial funding from Marie Curie Cancer Care, a charity which provides free nursing care to cancer patients and those with other terminal illnesses in their own homes.

- A Transfer of Care (TOC) team co-ordinated rapid discharge of patients from hospital so that patients could go home if they wished. The team organised fast track continuing health care funding, referral to community nursing and the intensive home nursing service for night care. They organised medicines and community equipment. For patients being discharged to a care home, the team looked for vacancies and put the necessary placement arrangements in place. The team referred patients with highly complex needs to the Macmillan complex case managers for short term additional support following discharge.
- We observed a multi-disciplinary review of the person's needs and the complex care manager developed a plan which addressed the person's wishes, which minimised the risk to the patient and their family if they went home.
- There was a system in place for patients who attended the emergency department to ensure they could return home if they preferred to be cared for at home.
- We also observed the multi disciplinary palliative care team at Weston Park discuss patients who had recently been discharged home for palliative or end of life care. The patients follow up needs, symptoms, social and spiritual needs were discussed. The team agreed follow up plans for each patient including some who had returned home to areas some distance from Sheffield.
- There was also a system in place for the hospital to let district nursing staff know if someone had been admitted to hospital.

Access to information

- An electronic letter called 'e- discharge' was sent to GPs and printed out to give to community nurses when patients were discharged. This meant information about end of life care needs was passed to other teams.
- Community staff could record information about end of life patients on a system which had been developed by GPs in primary care. This meant information was shared to help the co-ordination of patient's care.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We looked at four sets of records kept in patient's homes and saw these contained information about the person's resuscitation status. The do not resuscitate forms (DNACPR) were fully completed following a discussion with the patient.
- Where the patient lacked the mental capacity to agree to a DNACPR being completed, a mental capacity assessment was in place and this was recorded on the DNACPR form. The trust had revised the DNACPR policy which was being rolled out across all services in the Trust.
- Community nursing staff had a good understanding of the need to discuss and complete DNACPR authorisations with patients and liaised with patients GPs to ensure these were completed.

We found the effectiveness of community end of life service was good. This was because:

- The service had developed guidance for the service to replace the Liverpool care pathway and were supporting staff to complete the end of life template developed by primary care.
- Patient's pain and their nutrition and hydration needs were being effectively assessed.
- Community staff could access clinical policies on the trusts intranet and these provide staff with guidance which was reviewed and kept up to date.

However we also found:

- The guidance for staff caring for people at the end of life had been introduced recently and not all staff were clear how they should incorporate this into their clinical practice. Some staff were enthusiastic about using the end of life template.The template did not include information about people's spiritual or emotional needs.
- The service was not using an electronic palliative care co-ordination system (EPaCCs). This is a system for co-ordinating people's wishes and end of life care across organisations. A palliative care coordinating system project (SPCCS) was planned which would provide a centrally coordinated system to support the identification of end of life patients.

Good ●

Are services effective?

Evidence based care and treatment

- Policies used by the service were available for staff to access on the trust intranet. These included a range of pathways and guidance, for example, a pathway for the care of deteriorating patients, guidelines for the use of syringe pumps, managing medicines, communicating with patients as they reached the end of life and oral care.
- However, not all community staff we spoke with were aware of the guidance added to the system in November 2015. Some staff told us not all the pathways and guidance had been adapted for use in community services.
- Community nursing staff met with GPs and other healthcare professionals to plan and review the care provided for patients. They used the national Gold Standards Framework (GSF) to co-ordinate and plan the care provided. The GSF provides clinical staff with a range of tools they could use to help them provide effective care. For example, the service used a recognised palliative care checklist. This promoted staff to ensure they were checking a range of things which were important for people approaching the end of life. These included the persons physical symptoms, emotional needs, personal issues such as spiritual or religious needs, social support, information patients and carers might need, control for example where the person preferred to die, out of hours arrangements, what happened in the last hours of life and after death. We saw examples of these checklists which had been completed for patients.
- The service was no longer using the Liverpool care pathway. Community and hospital staff could access guidance they could use for planning end of life care following the end of the Liverpool care pathway. The guidance covered making an appropriate care plan, how different groups of staff should work together, regular reviews of the person and the decisions required. The guidance was issued by the trust in October 2015 to help health care professionals fulfil the five priorities for care developed by the Leadership Alliance for the Care of Dying People (LACDP). The LACPD is a coalition of 21 national organisations who have worked together to develop guidance on end of life. The LACPD was formed following the review of the Liverpool care pathway and reviewed a range of evidence and spoke with patients, carers and clinical professionals.
- The policy developed by the trust provided staff with evidence based guidance on the conversation staff should have with the person and their family or carers when they believe a person is dying. The guidance covered what community staff should do when they believed the person was dying, observations which should be carried out regularly, usually daily, advice on medicines, spiritual care, nutrition, pain and breathing.
- Community staff followed guidance developed by the trust for the use of syringe drivers used in patient's homes for administering medicines. The guidance was based on national guidance produced by the Medicines and Healthcare Products Regulatory Agency and the National Patient Safety Agency.
- The out of hour's service used guidelines developed by the trust's palliative care service developed in May 2015. The guidelines provided primary care and community staff with guidance on medicines and the five priorities of care for the dying person. The five priorities of care included recognising when the person was going to die and making sure their wishes were included in a plan for their care during the last period of their life.

Pain relief

- Patient's records showed they were regularly asked if they were experiencing pain and how severe the pain was. Patients in the last days for life had their pain assessed at every visit.

- We observed care being provided in a patient's home. Nurses were able to help the person with the pain they were experiencing. They had arranged for them to be admitted to a hospice on occasions when their pain needed stabilisation. Specialist nurses from the hospice also visited daily. The person needed two syringe pumps to deliver the medicines they needed and two nurses attended to change the patient's medicines. A GP also attended and district nurses discussed the person's care and their medicines.

Nutrition and hydration

- The trust had developed guidelines for nursing staff which replaced the Liverpool care pathway. These included guidelines for hydration, mouth care, nutrition, nausea and vomiting. The guidelines emphasised the importance of respecting patient's religious and cultural needs.

- Nursing staff were advised to develop plans for nutrition and hydration to support the person's wishes. Nurses were alerted to the importance of managing the care of patients at the end of life is they had diabetes. Separate guidelines were available for staff if they had difficulty managing the patient's blood sugar levels including seeking the advice of the diabetes specialist nurses. The guidance stressed the importance of identifying and addressing any factors preventing nutrition and hydration which could be addressed, for example nausea or difficulty swallowing. Staff we spoke with were aware of the guidelines and the importance of developing a nutrition and hydration plan to support the patients wishes and preferences, involving and informing the family and carers.
- We observed community staff discussing nutritional and hydration needs with people as part of the assessment process. We asked community staff about the guidelines in place for staff to follow. Staff told us they used the Malnutrition Universal Screening Tool (MUST). This was recommended by NICE as the tool to be used for assessing people's nutritional needs and protecting people from the risk of malnutrition.
- Records showed that community nursing teams used the (MUST) to assess patients at risk of malnutrition. These completed to a good standard.
- Staff working in the intensive home nursing service were trained to monitor saline infusions for people who were at risk of dehydration.

Technology and Telemedicine

- Community nursing staff had electronic tablets which they could use to update patient's records on line and use them to consult professional colleagues via skype.

Patient outcomes

- The trust did not have a system in place for monitoring patients preferred place of care and where they died. This meant the service did not monitor one of the key indicators for the service.
- We saw examples of audits completed by community teams. These included an audit of handwashing practice and audit of leg ulcer assessment and a community clinical records audit completed in 2015.
- Community teams undertook local audits, for example auditing pressure sores. We saw the results of a recent audit completed in October 2015. The results highlighted where earlier intervention could have been effective in reducing the severity of a pressure sore. GPs told us a variance in GP prescribing had been identified through an audit resulting in 12 intensive training sessions for GPs provided by one of the trust's consultants in palliative care medicine.
- An external evaluation of the Complex Case Management Service found the service supported around 20 patients a month. Once assessed by the service patients on average waited for less than a day to return home. The service was supporting patients to return home sooner than would be expected without the service. The service continued to support the patient once they had returned home, possibly preventing re-admission. The service helped ensure patients received integrated, coordinated care, which took account of their wishes. Patients and their carers report high levels of satisfaction with the service.

Competent staff

- Support workers in the Intensive Home Nursing Service completed two full induction training days. The training was provided by senior registered nurses (Band 6 and 7s) in the service and by the training administrator. A member of the office staff was responsible for monitoring training and ensuring staff completed the courses. The course covered medicines management, medical devices including syringe pumps, hand hygiene, infection control, conflict resolution, record keeping, equality, diversity, and mental capacity. Staff completed written assessments following the training to test their understanding. Other training was provided in addition to the two day course. This covered level 2 safeguarding training, basic life support, fire, manual handling, violence and aggression and food hygiene.
- Appraisal rates had increased during 2015 to 83.7% at the time of our inspection. Team leaders in the IHNS

appraised members of their teams with each responsible for between 15 and 20 staff. We reviewed a sample four appraisal records and showed these had been completed this year.

- Some nurses were trained to administer subcutaneous fluids for patients who were unable to receive fluids by mouth. These were provided based on individual patient need. The trust were in the process of updating guidelines for this.
- We saw the assessment tool used for assessing staff competency for administering medicines.
- Support workers in the intensive home nursing support service monitored infusion pumps in use at patient's homes. A competency assessment had been developed to check staffs understanding of the checks they should carry out. Grade 2 support workers checked to ensure syringe pumps were working correctly when the visited, but did not set new pumps up or administer medicines via the pumps.
- District Nursing teams were led by a District Nurse team leader. These are registered nurses who have completed a degree or higher master's degree to become a specialist community practitioner. They were supported by deputy team leaders who are also qualified community practitioners or are nurses who will be studying to qualify as community practitioners. Community staff nurses and health care assistants provide the core service to patients in the community.
- Each team had a community matron. Community matrons specialise in supporting people with long term conditions and are able to provide specialist advice to community nursing staff.
- A competency based training pack was developed for all band 2 support workers. The roles support workers undertake were identified following a review of community staff caseloads.
- Community staff had recently had half and full day education events in palliative and end of life care. The majority of the team had attended these practice learning initiative events.
- The end of life care facilitators within the trust had organised training events for nursing staff. Eight events were held starting in early November 2015. These were designed to develop nursing staff's knowledge and skills in the care of the dying person based on the five priorities of care developed by the Leadership Alliance. The workshops covered recognition of the dying person, formulating a personalised care plan, managing symptoms in the last days of life and communication with the person and those close to them. The training events was organised by an end of life facilitator based in the trust.
- We spoke with a district nursing team leader who told us they had been sponsored by the trust to train as a community specialist practitioner. They told us they carried out joint home visits with nurse specialists from the local hospice to agree a joint care plan.
- We saw examples of competency assessments completed by community staff in medicines administration. Two staff in each community team trained other staff to use syringe pumps checking staff competencies annually.
- The trust had developed training courses for support workers which was being provided to staff in the trust and to staff from other organisations across the region.
- Evening shift and night community staff spent time at the trusts palliative care centre to gain experience in palliative and end of life care.
- One team leader told us clinical supervision for their team was not taking place. They said staff within the team supported each other and they were able to access the 'workplace wellbeing' service if they needed to access a counselling service.
- Community staff participated in Sage and Thyme training. This is an approach used by healthcare professionals to engage in conversations with people who may be distressed.
- An end of life facilitator provided community staff with education and training to support people at the end of life. Plans had been developed for evening and night community staff to work in the Specialist Macmillan Palliative Care Unit based in the trust to enhance their skills in pain management, symptom control supporting people with emotional and psychological issues.
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the trust, but might not know much about the service they were being recruited to. For example, some new staff recruited to the intensive home nursing service had not realised they would be supporting families at the end of life and felt uncomfortable with the role.

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- Referrals for the intensive home nursing service are taken from any health or social care professional, either community or hospital based, such as District Nurses, Social Workers, General Practitioners and Hospital Liaison Departments. The service was enhanced by partial funding from Marie Curie Cancer Care, a charity which provides free nursing care to cancer patients and those with other terminal illnesses in their own homes.
- A Transfer of Care (TOC) team co-ordinated rapid discharge of patients from hospital so that patients could go home if they wished. The team organised fast track continuing health care funding, referral to community nursing and the intensive home nursing service for night care. They organised medicines and community equipment. For patients being discharged to a care home, the team looked for vacancies and put the necessary placement arrangements in place. The team referred patients with highly complex needs to the Macmillan complex case managers for short term additional support following discharge.
- We observed a multi-disciplinary review of the person's needs and the complex care manager developed a plan which addressed the person's wishes, which minimised the risk to the patient and their family if they went home.
- There was a system in place for patients who attended the emergency department to ensure they could return home if they preferred to be cared for at home.
- We also observed the multi disciplinary palliative care team at Weston Park discuss patients who had recently been discharged home for palliative or end of life care.

Are services effective?

The patients follow up needs, symptoms, social and spiritual needs were discussed. The team agreed follow up plans for each patient including some who had returned home to areas some distance from Sheffield.

- There was also a system in place for the hospital to let district nursing staff know if someone had been admitted to hospital.

Access to information

- An electronic letter called 'e- discharge' was sent to GPs and printed out to give to community nurses when patients were discharged. This meant information about end of life care needs was passed to other teams.
- Community staff could record information about end of life patients on a system which had been developed by GPs in primary care. This meant information was shared to help the co-ordination of patient's care.

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- Where the patient lacked the mental capacity to agree to a DNACPR being completed, a mental capacity assessment was in place and this was recorded on the DNACPR form. The trust had revised the DNACPR policy which was being rolled out across all services in the Trust.
- Community nursing staff had a good understanding of the need to discuss and complete DNACPR authorisations with patients and liaised with patients GPs to ensure these were completed.

Good ●

Are services caring?

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

Summary

We found caring in the community end of life service was good because:

- Relatives told us staff were compassionate and caring about patients and their families.
- We observed care being provided in people's homes where they treated patients sensitively and provided emotional support for carers.
- Staff who worked for the intensive home nursing service told us they regarded it as a privilege to support families at such an important time and felt proud to feel they were contributing to the community where they lived.

Compassionate care

- Each person supported by community staff had an individualised plan which described the care they would receive in the last days and hours of life. This included plans for ensuring the person received appropriate food and drink, mouth care, medication for symptom control. We observed community staff discuss people's needs to ensure they were not in pain or experiencing other distressing symptoms. They also discussed people's psychological needs and showed compassion for the person and their family.
- We spoke to one carer who told us, "I couldn't have wished for better care as the nurse stayed with my relative and me until she died despite the fact that they were due to finish their shift an hour earlier". They said their relative "wanted to be cared for and die at home and I really appreciate her wishes being met. She died with dignity and was pain free; it is really an excellent service."
- One carer told us the intensive home care service was, "A godsend and they were outstandingly caring and thoughtful." One carer told us their relative had received care 24 hours a day for four weeks from the intensive home nursing service. The patient had been told when they were discharged from hospital they only had days to live but they had improved when they got home. The relative said the service was better than anything they had experienced at home before and the managers were responsive. They said their relative was treated with respect and had commented on how good staff were.

Understanding and involvement of patients and those close to them

- We visited a patient at home with the community nursing service. They told us they were very happy with the care they were receiving. The patient's relatives said, "The support we have received from the district nurses has been fantastic." They said they knew the district nurses and hospice nurses well and how they were all helping them keep their relative at home which is what they wanted.
- Another relative spoke about the intensive home nursing service. They said they felt supported as well as the patient and said, "They are not just people doing a job they are special people."
- Patients and their relatives stated there was continuity of care.
- We observed community staff speaking sensitively to patients and their relatives about the person's condition, what to expect and some of the choices they would have to make as they approached the end of life. They provided people with information, answered questions, provided reassurance and encouraged patients and relatives to make plans for the persons future care.

Emotional support

- Community staff recognised the importance of patients and carers emotional wellbeing and the need to support people to cope with the person's deteriorating condition. They encouraged people to ring them if they needed support. A relative told us how comforting it was to know someone was available to provide advice and support over the phone. Community staff said they could also access support for patients through the hospice.

Good ●

Are services caring?

- A nurse team leader told us staff visited the family after a patient died to offer condolences, collect equipment and care plans and discuss any bereavement support the family might need.
- Four community nurses had qualified as psychological wellbeing practitioners (PWPs). This was part of a project aimed at improving people's wellbeing through physical exercise.

Good ●

Are services responsive to people's needs?

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

Planning and delivering services which meet people's needs

- Staff from the service contributed to a city wide end of life planning group led by the local Clinical Commissioning Group (CCG).
- There had been a review of the district nursing service which resulted in a change in the core service hours to 8am to 6pm in order to meet the needs of the patients.
- An intensive home nursing service (IHNS) provided one to one personal care for patients in the last few weeks of life, if the patient wished to die at home.

Equality and diversity

- The intensive home nursing service produced a monthly report which included information about patient visits including people's age and ethnicity. This was used to review ways of improving the responsiveness of the service and identifying any training needs staff might have.

- Staff were aware of cultural differences. They told us about the patient information leaflets available in different languages.
- Staff could access interpreting services. Interpreters were available to translate over 80 languages and a telephone based interpreting service was available in 240 languages.

Meeting the needs of people in vulnerable circumstances

- Community nursing teams had a link nurse for dementia. Staff we spoke to had done dementia training and could describe how they provided extra support for patients living with dementia. Staff used wipe boards in patient's homes to leave reminders for the patient and to communicate with the family and other carers.
- Community staff told us about the dementia friends programme run by the Alzheimer's Society's which enabled people to learn about what it's like to live with dementia and consider how best to help people.
- Community nursing staff had good local knowledge of support groups in the community and encouraged patients to join. They referred patients to community support workers who could support patients to get involved.

Access to the right care at the right time

- Care was available 24 hours a day, seven days a week from the intensive home nursing service. Patients reported to us that the service was good and we saw examples of responsiveness to patient need such as the prompt organisation of a hospital bed for a patient.

- Patients at the end of life who needed to access services outside the hours of 9am-6pm could also contact an out of hours service staffed by community nurses and intensive home nursing care support staff. The out of hour's service based on the Northern General hospital site employed seven advanced nurse practitioners. The out of hours GP service was also part of the service.

- We saw examples of the intensive home nursing service being put in place on the same day patients were assessed. Relatives said they had been very impressed at how quickly the service had responded.
- Community nursing teams kept a store of two syringe pumps which they could take to a patient's home quickly when needed. This meant patients who were discharged from hospital did not have to wait for important items of equipment to arrive.
- The trust did not have a system in place for monitoring patients preferred place of care and whether they died in their preferred place of care. This meant the service did not monitor one of the key indicators of the service .

Learning from complaints and concerns

- Team leaders investigated and responded to complaints as required by the trust's complaints policy. Communications between staff and patients, and withdrawal of the service on completion of treatment accounted for the majority of complaints received. Team leaders were familiar with the complaints procedure, tried to resolve problems at service level but knew how and when to escalate complaints when necessary.

Good ●

Are services responsive to people's needs?

- The outcomes of investigations into complaints were discussed at locality team meetings and the palliative care and therapeutics directorate operational business and governance meeting to ensure learning.

Requires improvement ●

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 found the leadership of community end of life care required improvement because:

- There was a lack of clarity about the strategy and leadership of the service.
- We found some staff were not clear about using the electronic record template for end of life care and some staff were not sure how to use the guidance used the trust for developing care plans.
- Not all staff had accessed or were aware of the training on the trust's new end of life care plan guidance and the five priorities of care.
- The service was not measuring whether patients were receiving care in their preferred place of care. The trust did not have a system in place for monitoring whether patients died in their preferred place of care. This meant the service did not monitor one of the key indicators for the service. The information system used by the trust could capture this information and recording was encouraged however the information was not being collected and monitored.
- Directorate managers were aware there was a backlog of incident reports which had not been investigated.
- There was a recognition that pathways between acute and community services needed improvement but plans were not in place to achieve this.
- The community nursing and intensive home nursing services worked together to support people at the end of life in the community but they were part of different directorate structures. This meant services which had historically developed together and used the same policies and guidelines were now located in different directorates. Staff told us they were concerned about maintaining effective communication and jointly monitoring the quality of care provided. Some staff said they were not sure how to incorporate recent developments into their clinical practice.

We also found:

- Good progress had been made re-structuring the service and re-locating community teams.
- Representatives from the trust played an active part in the development of city wide strategies for end of life care.
- Guidance had been developed to replace the Liverpool care pathway and staff were able to access training to ensure they were aware of the guidance and the five priorities of care.
- There were many examples of innovation and staff participated in a number of regional and national quality improvement forums.

Service vision and strategy

- An end of life strategy group were responsible for providing the vision and strategy for end of life services in hospital and community services. The group were in the process of developing a strategy for the service based on the five priorities for care. The group had reviewed complaints and concerns about the service and looked at the Parliamentary and Health Service Ombudsman report into complaints about end of life care published in 2015 to identify issues which should be considered for the strategy. The group found many similar themes between local complaints and the themes of the report for example problems with communication. Representatives from the trust had participated in the development of the strategy for end of life developed by the local clinical commissioning group. Managers told us they were waiting for the publication of the National Institute for Care Excellence (NICE) guidance on end of life care before they completed the strategy.

- We also saw a five year strategy for community services developed in 2012-2013. We saw some of the issues highlighted had been addressed for example the inadequacy of accommodation for team bases. Some of the objectives were still relevant for example developing systems for measuring patient outcomes and the dependency of patients. A new structure had been implemented since the strategy was completed and some of the objectives had been superseded or were out of date.

Are services well-led?

- The trust had developed a five year plan for all clinical services (2012-2017) however, it was not clear how progress towards achieving the five year plan leading up to 2017 was measured and few if any staff working in the service were aware of it.
- Community staff we spoke with did not understand the trust's vision for end of life care but most had attended the recent end of life training days. They were aware the training was based on the five priorities of care and some were aware of the electronic end of life care template which they thought had been developed as part of the trust's strategic approach to end of life care.
- The key developments for community end of life care included the introduction of advanced care planning and a plan to introduce some of the underpinning principles of the AMBER bundle across the trust including community settings, a sustainable model of consultant staffing and medical leadership for specialist palliative and end of life care issues, improved the links between hospital and community services with smoother transitions and better support for patients being discharged from hospital or admitted to hospital with complex palliative care needs.

Governance, risk management and quality measurement

- The trust's medical director was the executive lead on the trust board for end of life care.
- A risk register was in place and community staff knew how to identify risks which were discussed at monthly governance meetings. We saw the minutes of governance meetings which showed the actions to reduce risks were discussed.
- There had been a number of changes to the structure and leadership of the service in 2015. Staff spoken with were unsure who provided leadership on end of life care for community services. They said there had been a lot of change, but they were not sure about the vision and leadership of the service. They said the principle of integration was a good one, but they were less confident about senior managers understanding the role of community services in a trust which predominately provided acute hospital based services.
- Staff who supported people at the end of life reported through three directorates – integrated community teams (ICT), primary care and interface services and the palliative care and therapeutic directorate. All three directorates reported to the Combined Community and Acute Group Executive which was responsible for developing integrated services.
- However, staff in the IHNS were unclear how their clinical policies would be developed in future. Managers were aware of the issue and to try an overcome this a practice development nurse was appointed who was responsible for supporting staff and ensuring they followed appropriate guidance.
- Integrated pathway managers were appointed who were responsible for improving the pathways for patients between the hospital and community services.Community teams had also been brought together into new bases.
- Staff told us they had been completing a diary of patient contacts over a two week period as part of a benchmarking project but they were unsure about the purpose of the project and who was leading it.
- The governance arrangements were still being developed following re-organisation of the directorate structures. Care was provided by integrated community teams for people at the end of life in the community. The care was delivered as part of the overall workload of the community teams which made it difficult to monitor the quality and effectiveness of the service overall.
- The trust board received divisional performance management reports but there were no measures for the community end of life service included in the reports.
- Each directorate had a different method of reporting with different metrics measures and definitions and managers acknowledged the need for improved systems to monitor the effectiveness of the services.Managers told us the development of the therapeutics and palliative care directorate brought specialist palliative care and end of life services together for the first time under a single management structure and felt this would enable improved pathways to be developed.
- We asked about an annual audit programme and were informed there were no specific community end of life audits programmes planned or in place.

Requires improvement ●

Are services well-led?

- We saw clear evidence that incidents occurring in the community were being reported and investigated some of which related to end of life care. Directorate Managers were aware there was a backlog of incident reports which had not been investigated however a plan was in place to address the backlog. The number of incidents in September 2015 stood at 139 and as of December 2015 the figure had reduced to 37.
- Team leaders told us they were confident about picking up risks and concerns which were discussed at their team meetings. We saw examples of these issues being discussed at team meetings and staff said they were confident about raising issues at team meetings.

Culture within this service

- Community nursing teams said they felt well supported by colleagues and their team leaders. Some staff said they had concerns about staffing levels and the rising workload of the teams and felt managers were not discussing these issues.
- Community nursing staff also spoke positively about teams being brought together. Some staff working in the intensive home nursing service told us communications with the district nursing service was not as good since the two services were managed in different directorates. Previously the services had been managed in the same directorate. Intensive home nursing had worked alongside community nurses and worked to their protocols and guidance. Staff had built up good working relationships and believed this helped overcome any communication problems that arose.

Public engagement

- The intensive home nursing service has developed a patient feedback questionnaire, introduced in March 2015. The questionnaire asked about the amount of information provided, privacy, hand hygiene, confidence and trust, respect and dignity and areas where the service could be improved.

Staff engagement

- An annual staff survey was undertaken and managers developed an action plan for addressing issues highlighted by the 2015-2016 staff survey. The actions included visits to wards and departments to improve the visibility of senior managers, developing a performance and values based approach to staff appraisal and giving long service and thank you awards.We saw an example of the communication sent to staff highlighting the issues staff had raised and manager's response.

Innovation, improvement and sustainability

- Four community nurses had qualified as psychological wellbeing practitioners (PWPs). This was part of a project aimed at improving people's wellbeing through physical exercise.
- Staff were involved in a range of external groups which meant the service could compare practice with the services provided in other areas.For example, involvement in an NHS England expert reference panel for workforce planning and a national community and primary care nursing forum.
- A new Band 5 development post has been established to support staff working in the intensive home nursing service. The post holder will carry out quality checks on the care provided and ensure staff have the skills required to perform their role effectively.Support workers from the intensive home nursing service were asked to write their reflections on the service they provide by writing about a day in their life. The reflective work they have undertaken has been powerful and useful information which has been used during meetings as well as a supportive process for the staff.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 Systems and processes must be established and operated effectively to: (a) assess, monitor and improve the quality and safety of services How it was not being met: There was no end of life care strategy. There was no monitoring of preferred place of death.