Southern Health NHS Foundation Trust

RW1

Community end of life care

Quality Report

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Date of inspection visit: 27 March to 31 March 2017
Date of publication: 28/07/2017

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)
RW1YM	Lymington New Forest Hospital		
RW170	Petersfield Hospital	<Placeholder text>	<Placeholder text>
RW194	Alton Community Hospital	<Placeholder text>	<Placeholder text>
RW158	Gosport War Memorial Hospital	<Placeholder text>	<Placeholder text>
RW1AC	Parklands Hospital	<Placeholder text>	<Placeholder text>
RW1FY	Romsey Hospital	<Placeholder text>	<Placeholder text>
RW178	Fordingbridge Hospital	<Placeholder text>	<Placeholder text>

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

Summary of findings

Ratings

Overall rating for the service

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

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Overall summary

We have not rated community end of life care services for Southern Health NHS Foundation Trust

Overall we found:

- The trust end of life care strategy was due to be launched in April 2017, shortly after the inspection. This included the introduction of the individualised end of life care plan for use by community teams for people living at home. Although, on inpatient wards in the trust's community hospitals an individualised end of life care plan had already been implemented and had been in use since 2016.
- At the time of inspection no evaluation of the provision of end of life care had taken place.
- Staff were familiar with the incident reporting process, however, not all staff we spoke with could confirm if incidents relating to care of end of life patients had been reported. The trust analysed and reported incidents but there was no analysis of end of life care incidents or complaints.
- There were delays in the provision of beds for end of life patients. The trust had identified equipment issues on the divisional risk register and was working to improve the situation.
- There was no single patient record to enable all community staff to access patient information in one record, this meant staff did not always have access to up to date information.There was a delay in updating records and inconsistency in the use of paper and electronic records between community teams. We saw care plans and risk assessments were not always up to date.
- Although medical support out of hours was available at the community hospitals, staff at Romsey hospital said timely medical intervention was not always available when needed We found not all do not attempt cardio-pulmonary resuscitation (DNACPR) forms we reviewed were fully completed in line with national guidance.
- Staff said they had undertaken end of life care training and syringe driver competency training. However, the competencies were stored on staff personnel files and the trust did not collate data centrally to monitor how many staff were required to complete the training and what proportion had completed the training.
- Appraisal rates for community nursing staff was lower than the trust target, 65% against 90%.

However,

- Data showed that between February 2017 and April 2017, 93% of patients who died, achieved death in their preferred place of care, and this exceeded the trust target of 80%.
- In the year April 2016 to March 2017, 92 patients required an end of life assessment in the same period and 100% had these completed. Ninety six per cent of patients at end of life were seen within the trust target of two hours where a rapid response was needed.
- Staffing levels in the specialist palliative care home had improved since the previous inspection.
- Staff we spoke with felt they were engaged with in a meaningful way through discussion with their line managers, divisional leaders and at governance meetings.
- End of life care was delivered as part of the governance framework within the integrated service division, education and training was integral to the delivery of the strategy. Staff had access to a wide range of end of life care training.
- Risks in the provision of community services which impacted on end of life care were recorded and monitored in the divisional risk registers.
- We observed effective multidisciplinary working and staff attended Gold Standards Framework meetings at GP practices to plan the care for end of life patients.
- On the wards we visited and in patients' homes we observed compassionate and caring staff who provided dignified care to patients who were at the end of their lives.
- Staff followed guidelines on prescribing and administration of anticipatory medication including pain relief to patients at the end of life.

Summary of findings

Background to the service

The trust provides end of life care to patients in their own homes and on the inpatient wards at the trust's community hospitals. End of life care is a core service provided by Southern Health community teams and community hospitals within Hampshire, with over 95% of the end of life care delivered in this way.

Specialist palliative care services are commissioned from the trust solely in the South East Hampshire geography.

End of life care for children's services was not provided by Southern Health NHS Foundation Trust, this was commissioned from another provider, and does not form part of this inspection report.

Community services in the trust operate within the integrated service division (ISD) of the trust. There are four business units within the division; business units 1, 2 and 3 are aligned with the local acute trusts in the area, business unit 4 covers children and families across the whole trust. During the inspection of end of life care we visited community and inpatient services in three business units: business unit 1 (South East Hampshire) business unit 2 (South West Hampshire) and business unit 3 (North and Mid Hampshire).

From June 2016 to January 2017 the total number of adult deaths in the community hospitals was 96. The trust received 3678 referrals for initial EOLC assessments between April 2015 and March 2017.

During the inspection we visited 10 community nursing teams and wards in seven community hospitals. We spoke with approximately 10 patients and relatives, 30 staff including service leads, community nursing staff, palliative care specialist nurses, consultants, medical staff, administrative staff, porters and chaplains.

We observed interactions between staff and patients, and their relatives. We looked at 25 'do not attempt cardio pulmonary resuscitation' (DNACPR) forms and 15 care records. Before and after the inspection, we reviewed service performance information provided by the trust.

Our inspection team

Our inspection team was led by:

Chair: Karen Bennett- Wilson Care Quality Commission

Team Leader: Caroline Bishop Care Quality Commission

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

Why we carried out this inspection

We carried out this short notice inspection of Southern Health Foundation NHS Trust to follow up on some areas that we had previously identified as requiring improvement or where we had questions and concerns that we had identified from our ongoing monitoring of the service.

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

Summary of findings

share what they knew. During the visit we observed the end of life care provided by staff in the community hospitals and in people's homes. We spoke with 10 patients and relatives receiving end of life care. We spoke with 30 staff including nursing staff, doctors and managers about how they provided end of life care. their work information received from members of the public who contacted us separately to tell us about their experiences.

We spoke with 30 members of staff and how they were supported. We also checked 15 records of patients and 25 do not attempt cardiopulmonary resuscitation orders. We reviewed the service performance information, such as notes of meetings, staff training and audits.

What people who use the provider say

Patients and their relatives told us they were satisfied with the service they had received. Relatives said staff were kind and compassionate. They provided appropriate advice and support and took account of the patients' and families' wishes.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the service MUST take to improve

- The trust must ensure that do not attempt cardio-pulmonary resuscitation (DNACPR) forms are completed in line with national guidance.
- The trust must improve appraisal rates for community nursing staff.
- The trust must ensure that individualised care for patients at end of life is planned and delivered for patients cared for at home.
- The trust must ensure that community staff have access to up to date information in the record of patients at end of life who are cared for at home.
- The trust must ensure appropriate support is available to community hospital staff to respond to end of life care patients who deteriorate.

Action the service SHOULD take to improve

- The trust should consider analysing themes of incidents in relation to the provision of end of life care for all patients cared for in the community and in patient settings to ensure lessons are learnt.The trust should work to improve the provision of beds to end of life patients.
- The trust should monitor the uptake of staff training on end of life care and syringe driver competency assessment.
- The trust should evaluate the provision of end of life care.

Southern Health NHS Foundation Trust

Community end of life care

Detailed findings from this inspection

Are services safe?

By safe, we mean that people are protected from abuse

We found:

- Staff were familiar with the incident reporting process, however, all staff we spoke with could not confirm if incidents relating to care of end of life patients had been reported. The trust undertook a thematic review of inpatient deaths at Lymington New Forest Hospital which identified actions and recommendations with regards to end of life care.We observed the appropriate prescribing of medicines for patients who were on the end of life care plan.
- Staff said they had undertaken syringe driver training and competency assessments but this data was not monitored trust wide.
- There were delays in the provision of beds for end of life patients, the trust had identified equipment issues on the divisional risk register and was addressing the situation.
- In the community teams we visited individualised end of life care plans were not in use.
- There was a delay in updating records and inconsistency in paper and electronic records. This meant an accurate and contemporaneous record of the patient visit was not always available for staff to access. We saw care plans and risk assessments were not always up to date.
- Inpatient and community staff had good access to support from the local hospice. However, at Romsey hospital, staff raised concerns that in cases where a patient deteriorated, if they could not obtain timely support from medical staff, the patient may be transferred to an acute hospital.

However

- There were systems and processes to ensure standards of infection prevention and control were maintained.
- There was a mandatory training programme for all staff.
- Individualised end of life care plans were used in the community hospitals.
- Staffing levels had improved since the previous inspection.

Safety performance

- Data provided by the trust showed staff reported 9307 incidents between April 2016 and March 2017. Approximately 15% of incidents related to slips, trips and falls and 11% to pressure ulcers. Ninety per cent of all incidents resulted in no or low harm or were categorised as a near miss. End of life care was not a specific incident category, however we identified 172 incidents which included a description of end of life care (EOLC) and the majority of these related to an incident

categorised as a pressure ulcer. The majority of pressure ulcers reported caused low or no harm to the patient, 20 (2%) were categorised as major harm and 167 (18%) as moderate harm.

Incident reporting, learning and improvement

- Staff we spoke with were familiar with the trust's electronic incident reporting system.
- There were no never events reported between April 2016 to March 2017. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Staff we spoke with on the wards and in community teams described incidents which had occurred, however, staff could not confirm if all the incidents had been reported. For example, at Romsey hospital, staff said there had been two occasions when a patient had died a few hours after being admitted to the ward and this was distressing for staff. Another incident where a community team could not confirm if the incident had been reported involved a patient with a mental health condition who refused end of life care and the Gosport community nursing team felt other primary care services (GP) were unresponsive. In our review of incidents we found two incidents regarding deaths of patients occurring rapidly after admission. However, staff we spoke with were not aware of learning from these incidents. The trust undertook a thematic review of inpatient deaths at Lymington New Forest Hospital (2016) which identified actions and recommendations with regards to end of life care.
- Staff at Alton Community hospital said an incident involving a syringe driver flow had been reported and learning shared. Community nursing staff we spoke with based at Lymington New Forest hospital described learning from an incident where a particular brand of battery had not been secure in a syringe driver and led to malfunction. Mortuary staff described an incident related to the fridge temperatures which led to immediate actions being taken. At Petersfield community team we observed staff were informed about learning from an incident, which involved security of confidential personal information.
- Staff were aware of the trust procedure to report all inpatient deaths and all unexpected community deaths on the incident reporting system within 48 hours. We saw records of a patient who had died unexpectedly in the community and a note that an incident form had been completed. Staff at all levels we spoke with said quarterly mortality meetings and 48 hour death panel meetings were held to enable a timely discussion of the immediate events around the death including the quality of end of life care provided.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. The trust monitored duty of candour through their online incident reporting system.
- The trust monitored their performance against the duty of candour process. This showed between April 2016 and March 2017 compliance with the process had steadily improved. Most teams achieved 100% compliance with patients receiving the outcome from investigation of the incident. Information collected by the trust identified themes that resulted in them following the duty of candour process. This included development of pressure ulcers, accidents or injuries to patients, infection, prevention and control incidents and medicine management incidents.

Safeguarding

- Safeguarding training was mandatory for all trust staff. For community nurses safeguarding adults training and safeguarding children training level 2 was required.
- Data provided by the trust showed 97% of community staff had received safeguarding adults and 93% had received safeguarding children level 2 training.
- Staff we spoke with and our observations of handover meetings demonstrated staff were knowledgeable about their roles and responsibilities regarding the safeguarding of vulnerable adults and children.
- Community nursing staff we spoke with were aware of their safeguarding responsibilities. For example, they described how they would raise a safeguarding if grades 3 or 4 pressure ulcers were identified.

Medicines

- Medicines management policies were in date and included procedures regarding anticipatory medicines.

These are medicines prescribed for the key symptoms in the dying phase. For example, to manage pain, agitation, excessive respiratory secretions, nausea, vomiting and breathlessness.

- Community nursing staff told us controlled drugs including anticipatory medicines were prescribed by GPs and supplied by the community pharmacist.
- We reviewed 15 care records of patients identified as being in the last days of life and saw anticipatory medicines were prescribed appropriately.
- The trust had a palliative care (end of life) medicines administration chart for use in patient's own homes, this contained the prescription and administration record. There was a standard operating procedure for GP medication requests.
- We saw doctors had access to the 'Wessex Green Book – good practice guide for prescribing at end of life' and also sought advice from the local palliative care team when needed. We saw there were clear guidelines for medical staff to follow when prescribing anticipatory medicines for patients.

Environment and equipment

- At the previous inspection in 2014 we found there had been delays in provision of mattresses and beds for patients at end of life. Staff informed us equipment needed to provide care and treatment to patients in their homes was ordered through a central equipment store. Community staff in the Gosport community teams told us there were sometimes delays in equipment supply particularly issuing of beds, however incident forms were not always completed. During the inspection we observed a request for a bed for an end of life care patient had been rejected. The request was escalated to a senior manager to resolve. Community teams said although there were often delays to supply of equipment at weekends, such as frames and beds this was not particularly an issue for requests which related to end of life patients. Staff told us beds were normally obtained within 48 hours to five days of the request. In our review of incidents we saw a small number of incidents related to equipment issues.
- The trust end of life care lead informed us delays to equipment supply was recorded as a risk on the divisional risk register and the trust was in discussion with the commissioners to address the issues. The integrated service division (ISD) West risk register identified the risk of delays to provision of equipment to community patients and the measures and monitoring of the risk to mitigate the impact on patients and staff.
- The trust had consolidated to one model of syringe pump device, used to administer continuous medicine. This met the requirement the Medicines & Healthcare Regulatory Agency (MHRA). Patients were protected from avoidable harm when a syringe driver was used to administer a continuous infusion of medication; as the syringe drivers used were tamperproof and had the recommended alarm features. A policy and protocol for the use of the device in order to reduce the risk of medicine administration error was in place. The trust provided data to indicate they had a maintenance record of all the syringe drivers in use and monitored when the service dates were to ensure they were maintained appropriately.
- We visited the rooms which contained the holding fridges for deceased patients at Alton Community Hospital, Gosport War Memorial Hospital, Lymington New Forest Hospital and Petersfield Hospital. These rooms were all secure with controlled entry. At Gosport War Memorial Hospital we observed some extraneous equipment for example, wheelchairs which was promptly removed. We saw temperature records which demonstrated staff monitored the fridges to ensure a safe environment for storage of deceased patients.

Quality of records

- Community nursing staff used an electronic system to access patients' records. Staff had laptops but tended to update records in their base office rather than the patients' homes which resulted in delays to updating records. Staff said this was due to time constraints and sometimes due to connectivity issues. This meant an accurate and contemporaneous record of the patient visit was not always available for staff to access. We observed a record for an EOLC patient who was referred to one of the Basingstoke community teams in February 2017, the record of the visit was recorded on the electronic system seven days after the visit. Matron said this was longer than the standard of 48 hours but at the time there had been a period of severe short staffing. However, staff would have been updated daily of all priority (including end of life care) patients at the handover meeting.

Are services safe?

- Patients receiving end of life care in hospital had a paper version of an individualised end of life care plan. In the community, staff did not use an individualised end of life care plan to support the care of patients at end of life. The individualised care plans replaced the Liverpool Care Pathway documentation, which was phased out in July 2015.
- The end of life care lead for the trust said the individualised EOLC plan was due to be introduced with the end of life care strategy shortly after the inspection in April 2017.
- The lack of individualised end of life care plans was identified as an area for improvement at the previous inspection in 2014.The trust EOLC lead told us an individualised EOLC plan was used for inpatients, however it had not been implemented in the community setting and we observed this during the inspection. Although requested the trust could not provide us data on the number of patients on an individualised EOLC plan.
- Our review of records in eight community teams we visited showed priorities of care documentation was completed on the electronic record system.
- We observed there was a variation the way staff maintained records. For example, community teams at Gosport said that records were primarily updated and maintained electronically. Only medication forms were kept in the patient's home, other paper records at home were out of date. Whereas staff in one of the Basingstoke community teams said the paper records including risk assessments were also stored in the patient's home. The information governance risk associated with community teams transporting paper records was on the ISD risk register.
- We reviewed the care records of 15 patients who were receiving end of life care. On the inpatient records we saw individualised EOLC plans were in use. In 10 community records we saw care plans were not always up to date, we found priorities of care was not completed in three records and holistic assessment not complete in two records. Not all care plans and risk assessments were up to date.
- Do not attempt cardiopulmonary resuscitation (DNACPR) forms were kept at the front of a patient's notes, which allowed easy access in an emergency.
- At Lymington New Forest Hospital staff said they were aware a particular patient's advance care plan was stored securely in the controlled drugs cupboard to avoid undue distress by discussing it each time the patient was admitted.

Cleanliness, infection control and hygiene

- The provider had an up-to-date infection control policy, which provided guidance for staff on the prevention and control of infection. Risks associated with the prevention and control of infection following the death of a patient was contained in the provider's infection prevention guidelines.
- We viewed the rooms containing holding fridges, they were visibly clean. The trust had an up-to-date policy on care of the deceased patient in relation to infection control procedure
- We observed inpatient and community staff adhered to the trust dress code policy which was 'bare below the elbow' in clinical areas and on home visits. The staff had access to personal protective equipment and we saw that they used it appropriately. Staff undertaking community visits had adequate supplies of gel hand sanitiser and personal protective equipment (PPE).
- Throughout end of life care, we observed staff complied with best practice with regard to infection prevention and control policies. We observed staff washed their hands or use hand-sanitising gel between patient contacts. There was access to hand washing facilities on the inpatient wards.
- The meticillin resistant staphylococcus aureus screening audit (June 2016) showed 100% patients were screened within 48 hours in all inpatient areas.

Mandatory training

- The trust's mandatory training programme included moving and handling, infection prevention, fire safety and information governance. Data provided by the trust showed that the compliance rate in March 2017 was between 94% and 98%, this met the trust target of 95%.
- End of life care was not part of the trust's mandatory training programme. However staff we spoke with on wards and in the community said they had undertaken EOLC training either by e-learning accessible on the trust learning, education and development (LEaD) portal and/or via the local hospice. Many staff we spoke with said they had completed the EOLC e-learning training. However, the trust did not monitor uptake of

this training centrally, as it was not mandatory, and could not provide data on the proportion of staff who had completed training.Team managers we spoke with were able to monitor uptake of mandatory training uptake for their teams on the trust's electronic governance and monitoring system and we saw this for some of the teams, for example, Lymington New Forest integrated community team achievement was 94.8% and Basingstoke ICT team was 98.4%

Assessing and responding to patient risk

- Community end of life care and palliative care took place in patients' own homes or on the community hospital wards.
- Comprehensive risk assessments were carried out for patients and risk management plans developed in line with national guidance. We saw that risk assessments and care plans were in place for patients at the end of life in the community hospitals. Patients were cared for using relevant plans of care to meet their individual needs.
- We reviewed the care records of 15 patients identified as being at the end of life. We identified the following risk assessments being used; a Waterlow assessment for pressure ulcers, malnutrition universal screening tool (MUST) and falls assessment. We noted that risk assessments had not all been reviewed.
- The organisation worked collaboratively with other providers who operated hospice at home services. As patient's needs increased, or where community nurses felt they were unable to meet the needs of patients at the end of their life, they could refer patients to this service if it was available.
- Staff in community hospitals demonstrated a good awareness of the AMBER care bundle approach to manage the care of patients who were at risk of dying in the next few months (AMBER- Assessment, Management, Best practice, Engagement, Recovery uncertain). Staff spoke of identifying deteriorating patient over weekend and action taken in response.
- The specialist palliative care team operated a triage process to offer advice and prioritise referrals based on appropriate information. Our review of records showed examples where patients referred to the SPCT had been triaged and then prioritised depending on patient circumstances, for example if the patient was not coping at home.
- Some of the community teams had a triage nurse who allocated new referrals to ensure patients' needs were prioritised appropriately.
- Ward staff we spoke with were aware of how to escalate changes in a patient's condition to relevant clinical staff. In such instances, their first step would be to contact the specialist palliative care teams based at the local hospice, for advice and guidance.
- At the community hospitals we visited, staff had access to a palliative care/ EOLC resource folder and described good support from the local hospice.
- Community nursing teams told us specialist palliative care support was provided via the local hospice. At the time of the inspection there was only one area which had a trust provisioned specialist palliative care team, based at the local hospice; this was in South East Hampshire. Plans were in place to transfer this service to the local hospice.
- Staff we spoke with said they generally had good access to support from the local specialist palliative care team, except at Romsey Hospital, where staff said they obtained advice from the GPs and out of hours service when needed. Staff at Romsey hospital raised concerns that in cases when a patient deteriorated and there was no 'ceilings of care' agreed (prior agreed limitations to treatment) the patient may be transferred to an acute hospital. They also said there were occasions when a patient deteriorated and there was no doctor available to stop medicines which were not needed in the final stages of life. However, we did not identify incidents of this type in our review of the incidents information the trust provided.
- The community nursing team scheduled patients into the twilight nursing service planner for calls or visits if necessary and we saw examples of this during our inspection. For example, at Basingstoke ICT and Romsey ICT. Patients on syringe drivers were scheduled for at least daily visits to provide support, assess the patient and refill the syringe driver.
- We observed in the community notes we reviewed referral to hospice at home services was discussed and recorded.
- We saw patients and their families were provided written information on who to contact in and out of hours.
- Lymington New Forest community nursing staff said they had good support from the tissue viability nurse for advice about pressure ulcers and wound care.

Are services safe?

Staffing levels and caseload

- The majority of end of life care and palliative care was provided by community nurses to patients resident in their own homes.
- There was a trust provisioned specialist palliative care team (SPCT) located in the local hospice in South East Hampshire. Since the previous inspection in 2014, the team structure had changed and the establishment had increased by two additional band 6 nurses. At the time of the inspection there were no vacancies in the SPCT.
- Staff within the community nursing teams told us their caseloads were variable depending on the number of referrals received, for example, at the time of the inspection, data showed EOLC active caseloads varied from 2 to 26 per community team.
- Community staff were deployed across a wider area to ensure patients were seen in a timely manner and provide support to teams which were more understaffed.
- Although staff said some teams, for example, Basingstoke integrated care team (ICT) and Romsey in patient teams had been short staffed and under considerable pressure to meet patients' needs. Staff felt there had not been an impact on EOLC patients as these patients' needs were always prioritised.
- Some staff said they regularly worked overtime and either were paid or took time off in lieu.
- The trust had implemented a community acuity and dependency tool which had been used by community teams since November 2016. This involved allocating a specified number of units to a particular task, one unit was 15 minutes. An EOLC assessment was allocated four units (1 hour).The team coordinator, usually a band 6 nurse, would allocate planned units and workload for each member of staff into the weekly planner taking account of staff skills and patients' needs. We saw the tool in use in all the teams we visited. For example, the Basingstoke planner showed for the month of February 2017 the team had been consistently working substantially over capacity. One of the matrons informed us incident forms for staffing had been completed in January and February 2017.
- Basingstoke ICT staff had been under considerable pressure due to lack of staff. Staffing demand was on the ISD West risk register as a moderate risk and reviewed at least monthly. However, new staff had been recruited and staff were optimistic the situation was improving. EOLC patients' needs were managed by the skill mix of staff and ensuring experienced band 5 or band 6 nurses were available to support new staff, especially in the use of the syringe driver. The team matron said staffing had improved and time had been factored in to ensure new and inexperienced staff were provided support.
- We saw a daily review and handover meeting to manage workload and reprioritise patients took place.
- We requested data on the number and spread of EOLC link nurses. The trust told us that each community hospital had an EOLC lead and most community teams had an EOLC champion.

Managing anticipated risks

- The trust had business continuity plans for each of the community teams. This identified risks to business continuity including loss of utilities such as gas, electricity and vehicle fuel, IT failures, lack of staff and loss of premises. The plans detailed actions staff and the trust needed to take to ensure continuity of the service in these instances.
- Patients with end of life care needs were prioritised for visits and staff could describe what actions they would take and the support available to them to ensure their own and patients' safety.
- Conflict resolution training was mandatory and community nurses told us they were up to date with this training. Data showed 17 community teams out of 33 were below the trust target of 90%.

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.

We found:

- On inpatient wards 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 had taken account of the Alliance's Five Priorities for the Care of the Dying Person. Although, the trust used individualised end of life care plans these had not yet been implemented in the community.
- Staff had access to guidelines on prescribing anticipatory medicines including pain relief to manage symptoms at the end of life.
- Appraisal rates for community nurses was lower than the trust target, 65% against 90%.
- There was no single patient record to enable all community staff to access patient information in one record, for example, specialist nurses and GPs used their own record, this meant staff did not always have access to up to date information.
- 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.

However,

- Data showed that between February 2017 and April 2017, 93% of patients who died, achieved death in their preferred place of care this exceeded the trust target of 80%.
- Patients' pain, nutrition and hydration needs were monitored in accordance with national guidelines.
- We observed effective multidisciplinary working and staff attended Gold Standards Framework meetings at GP practices to plan the care for end of life patients.
- Staff had access to a wide range of end of life care training via e-learning and more specialist subjects provided by the specialist palliative care and the local hospices.
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Evidence based care and treatment

- End of life care policies and procedures were based on, for example, national guidance such as the National Institute for Health and Care Excellence (NICE) NG31, which defines clinical best practice in care of dying adults in the last days of life. The individualised end of life care planning document took account of the NICE guidance and prompted staff to consider all the domains.
- The trust followed recognised and approved national guidance, for example the trust used individualised care plans for patients in their last days of life on inpatient wards. However, at the time of inspection the trust confirmed end of life care plans were not used in the community. The trust end of life care lead reported the EOLC plan for use in the community was due to be formally introduced in the week following the inspection.
- Staff worked with GPs to follow the Gold Standards Framework for patients on their case load.
- Staff were aware of the five priorities for care of the dying person (Leadership Alliance).
- At the time of our inspection, the trust had recently developed a new end of life care strategy and plan. The care plan was formulated around national guidance and written in line with 'Ambitions for palliative and end of life care', a national framework for local action 2015 to 2020.
- Policies and procedures including prescribing protocols for patients at end of life care were in place for staff to follow. Medical staff had access to the palliative care handbook, a good practice guide by Wessex Palliative care physicians.
- The trust wide 2016/17 audit programme included the following audit subjects applicable to community services: discharge summaries, wound audit, holistic assessment and safeguarding. No EOLC audits had been undertaken. The trust EOLC lead said an audit of the use of the individualised end of life care plan was planned for later in 2017.

Are services effective?

- On inpatient wards nursing staff said the consultant would make the decision to initiate the EOLC plan if appropriate.
- Staff would initiate a continuing health care assessment and consult with the family on the transfer to home, nursing home or hospice, depending on the patient's preferred place of care and death.
- Staff on inpatient wards said there were small numbers of patients' deaths on the wards. Data showed there were 96 inpatient deaths in the period June 2016 to January 2017.

Pain relief

- We saw where patient's symptoms of pain were suitably managed. Staff said they underwent training at the local hospice and by the specialist palliative care team on how to identify patients who were at the end of their life.
- We saw that care followed the National Institute for Health and Care Excellence (NICE) Quality Standard CG140. This quality standard defines clinical best practice in the safe and effective prescribing of strong opioids for pain in palliative care of adults and children.
- The individualised EOLC plan for inpatient settings included an initial review of pain and prompts to review pain regularly on daily reviews.
- Patient's symptoms were managed and anticipatory medicines were prescribed (medication that patients may need to take to make them more comfortable in the end of life stage).
- Advice concerning symptom and pain management was available to staff from specialist palliative care staff at the local hospice on a 24 hour seven day basis.
- Patients within end of life care had their pain control reviewed daily or more often as was needed. Regular analgesia was prescribed in addition to 'when required medication' (PRN), which was prescribed to manage any breakthrough pain. This pain occurs in between regular, planned pain relief. Pain relief was reviewed for effectiveness and changes were made as appropriate to meet the needs of individual patients. We also observed staff ask patients whether they were experiencing any pain as well as exploring the type of pain.
- Patients told us staff had discussed pain relief with them and they understood what they were taking and the effect the medicine would have. Staff confirmed that syringe drivers were accessible if a patient receiving end of life care required subcutaneous medication for pain relief.

Nutrition and hydration

- Staff used a screening tool, the malnutrition universal screening tool (MUST) to identify those patients who were nutritionally at risk. When patients were identified as at risk, fluid and food charts were put in place and referral made to a dietitian if necessary.
- Protected meals times were in place on all the wards we visited. We observed end of life care patients had access to drinks. All of the care records we reviewed showed staff supported and advised patients who were identified as being at nutritional risk.
- Staff were proactive in assessing the patient's nutrition and hydration needs. We observed nutritional assessments were completed and nursing records, such as nutrition and fluid charts were completed accurately.

Patient outcomes

- The service collected data on the number of patients who achieved death in their preferred place. Data showed that between February 2017 and April 2017, 93% of patients who died, achieved death in their preferred place of care. The trust target was for 80% of patient dying in their preferred location.
- The trust used the Gold Standard Framework to plan the right care for people as they neared the end of their life. The National Gold Standards Framework (GSF) Centre in End of Life Care is the national training and coordinating centre for all GSF programmes, enabling generalist frontline staff to provide a gold standard of care for people nearing the end of life.
- We saw the end of life care teams also liaised closely with the nurses, who provided evening and night-time care in the community. At the time of our inspection, end of life care services had not participated in any national audits or benchmarking exercises.
- On our visits with community teams we observed staff carried out a holistic assessment visit to document the patients' wishes including their preferred place of care and death. Compliance with completion of holistic assessments was on the ISD East risk register as it had been recognised that this had not been implemented across all teams.
- We reviewed the holistic assessment report (January 2017) this identified some areas that had improved

since the previous audit in 2015 and also areas which required further improvement such as involvement of the patient in defining goals and the variation in use of paper and electronic records in different teams.
- Ward sisters were trained to verify the patient death, this expedited the process for obtaining the death certificate and funeral arrangements.
- There was a system to monitor visits were 'outcomed'. Staff said they aimed to outcome notes within 24 to 48 hours of the visit. An outcome appointment is where a visit was achieved and recorded by the health care professional.

Competent staff

- There was one specialist end of life care community team for adults end of life care which covered South East Hampshire. The majority of patients requiring palliative and end of life care were cared for by community nursing in their own homes. Patients were included within the caseload of the community nurses. Staff received training through e-learning as well as face to face teaching. Staff were positive about the training they received. They understood how to support people to make decisions for themselves and how to achieve this. Nurses said they had access to electronic learning. Community nurses received specialist clinical support from the clinical nurse specialists at the local hospice.
- EOLC training was not mandatory for staff, however EOLC training was available through the trust's learning, education and development (LEAD) framework launched in January 2016. Individual training needs were identified at local level through supervision and appraisal to ensure staff had the skills to perform their role.
- Staff said they received training sessions from the local hospice. These sessions were delivered to all grades of staff and included advance care planning.
- Appraisal rates for community nurses were 65% against the trust target of 90%. Staff said appraisals were undertaken regularly and were positive about the appraisal system. Team matrons were able to monitor their team appraisal rates on the electronic governance system. We saw appraisal compliance for the Basingstoke team was 91.7% and for Lymington ICT was 97.7%.
- Basingstoke community staff said they participated in band 7 development days and there was excellent support for band 6 nurses.
- All staff we spoke with on inpatient wards and community teams said they had good access to training. A number of courses for staff on EOLC subjects were available on LEaD ranging from 30 minutes e-learning to one and two days courses delivered at the hospice on priorities of care and counselling. Staff said were invited to training provided by the local hospice in the area they worked.
- We spoke with EOLC link nurses in a number of the teams we visited. They said they had all undertaking EOLC training. The EOLC link nurse in Petersfield ICT said there was a plan for staff to spend time at the local hospice to gain more experience of end of life care.
- We requested information related to the number of staff who had completed competency assessment training to use the syringe drivers. The trust informed that syringe driver training was not mandatory for staff and syringe driver training needs were identified locally through appraisal . There were no trust targets for syringe driver training. New staff said they were not allocated EOLC patients until they had gained more experience and had completed their syringe driver competency assessment.

Multi-disciplinary working and coordinated care pathways

- Patients receiving end of life care received co-ordinated support from a multi-disciplinary end of life care team, which included a specialist palliative care team, consultants, GP's and community nurses.
- As part of our inspection, we attended three handover meetings and a multidisciplinary meeting, which included discussions about palliative patients and those requiring end of life care. Staff were knowledgeable about patients' needs. Since January 2017 the reorganisation of the community teams into integrated service teams had brought together community nurses, therapists and mental health staff into a single team, this facilitated closer working relationships and exchange of information and expertise.
- Community nursing teams attended daily handover meetings where patients' needs were discussed. Weekly multidisciplinary virtual ward meetings took place which also involved for example, the community geriatrician, therapists and Macmillan nurses. This resulted in actions taken, for example, at Lymington New Forest hospital, an urgent care plan was identified for a patient who had deteriorated and anticipatory medicines ordered for the patient at home.

Are services effective?

- Community nurses confirmed they attended multidisciplinary Gold Standards Framework (GSF) meetings at GP practices, to discuss care plans and changing needs of patients with palliative care and EOLC needs. The specialist palliative care nurses said they attended weekly handover meetings with Gosport integrated care teams to discuss escalation plans for individual patients and monitor patients on the Gold Standards Framework.
- Community nursing teams described effective working relationships with the specialist palliative care teams at the local hospices. For example, at Petersfield ICT community nurses said they would coordinate visits with Macmillan nurses to ensure, for example, syringe drivers were replenished without disturbing the patient with too many visits.
- We observed the clinical nurse specialist palliative care meeting. Staff demonstrated constructive exchange of information, which included up date to policies and procedures.

Referral, transfer, discharge and transition

- Staff identified patients' wishes for their preferred place of care and preferred place of death. These were documented in their notes and we saw this in the records we reviewed.
- There was a process for patients' end of life to be transferred home with continuing health care funding, into a nursing home or a hospice depending on the patient's wishes. Staff fedback there were often delays in arranging care packages to support patients at home, however data showed 93% patients died in their preferred place of death between February 2017 and April 2017. The delays in achieving continuing health care funding was identified on the divisional risk register.
- Community staff also referred patients to the hospice at home service if there was one in the local area and if the criteria were met.
- Staff at Lymington New Forest hospital said transfer to the local hospice at weekends was not usually possible and they proactively managed this to ensure actions were taken during the weekdays.

Access to information

- Patients and relatives told us they were provided with all the necessary information required to make decisions about their care and treatment.
- During our visit with Petersfield community team, staff said specialist palliative care nurses gave verbal handover to community nurses when they visited patients but this was not recorded in a single patient record as the specialist nurses had their own notes. At Lymington ICT community nurses said they did not have access to the GP records and this meant they were not apprised of all information unless they called the surgery.
- On discharge from the hospital, staff sent a discharge letter either electronically or by fax to the end of life care patient's GP and to the community services.
- Paper based medical notes and nursing notes were easily accessible within the community hospitals when required.
- We observed that ward based nursing staff had access to a ward resource file on end of life care. For example, at Lymington New Forest Hospital we saw the resource box contained information on EOLC, opiate prescribing, achieving priorities of care in last days, what to do after death, local hospice details, bereavement leaflets, DNACPR and NICE guidance on EOLC.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- At the previous inspection we found 'do not attempt cardiopulmonary resuscitation (DNACPR) forms were not always fully completed in accordance with national guidance, including mental capacity assessments not always undertaken. We reviewed 25 DNACPR forms during our inspection of community inpatient wards. We found variable completion of the forms: At Fordingbridge hospital, all the forms we viewed were fully completed, out of 13 forms reviewed at Lymington New Forest hospital we found three were not fully completed due to a lack of mental capacity assessment recorded or no evidence of discussion with patient or family.
- A biannual audit of DNACPR completion was undertaken at Lymington New Forest hospital. We reviewed the latest DNACPR audit report (March 2017). It showed compliance in the areas which had not scored 100% in the previous audit in September 2016 had not much improved. For example, mental capacity assessment of the patient had dropped from 94% to 83% and discussion with the relative had dropped from 67% to 35%.

Are services effective?

- Patients and relatives told us that staff did not provide any care without first asking their permission. During a home visit, we observed staff asking for verbal consent before undertaking personal care.
- Mental Capacity Act (MCA) 2005 training was delivered as part of the Safeguarding adults level 2 training, 97% of community nursing staff had received this training. Nursing staff were knowledgeable about the processes to follow if a patient was unable to give informed consent to care and treatment.
- Inpatient staff we spoke with at Lymington New Forest hospital demonstrated an understanding of the MCA. Community staff we spoke with understood the MCA and described how they would liaise with older people's mental health services as well as the patient's GP to facilitate completion of the DNACPR form. Training including competency assessment was available for nursing staff to be authorised to complete the DNACPR form.
- During our visit to Lymington New Forest hospital we heard how staff cared for a patient with palliative needs who was regularly admitted to the hospital and to reduce the patient's distress the DNACPR was kept at the hospital and staff did not request it at every admission.

Are services caring?

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

- Staff provided sensitive and dignified 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 patients' homes we observed compassionate interactions between staff and patients and family members.
- 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.
- Staff provided reassurance and emotional support to patients and their families.
- Staff referred family members for bereavement support if needed.

Compassionate care

- During our visits with a number of community teams we observed examples of excellent care delivered by staff to patients and their families. One relative said the nurses were very thorough and reassuring. We observed difficult discussions between staff and a spouse of a patient conducted sensitively and compassionately.
- We observed nursing staff provided holistic person-centred care. We found the care and treatment of patients and support for their families delivered with dignity and respect.
- Nurses were sensitive towards the needs of patients and supported them in a professional manner.
- Patients knew the nurses by name and confirmed that they regularly saw the same team of nurses. Staff took time to listen to patients, give reassurance and took time to ensure patients understood what was happening. The community nursing staff at Petersfield told us they were usually able to arrange for the same staff to attend to the end of life care patients so staff were able to nurture a positive relationship and reduce the anxiety of patients and families by avoiding new contacts at the end of life.
- We observed staff discussed patients sensitively and compassionately during handovers.
- The nurses demonstrated a good awareness of the patient's needs and wishes. The nurses provided good support showing kindness and gave the patient and relatives the time they needed to ask questions or disclose their hopes and fears.
- We spoke with a small number of patients and relatives. The feedback we received was all positive. Relatives described examples of compassionate and sensitive care. They made comments such as "Staff are fantastic."

Understanding and involvement of patients and those close to them

- We saw that staff discussed planned care and treatment with patients and relatives. We also observed staff explain treatments with patients, family members and care givers.
- Patients and family members we spoke with told us they felt involved in the care delivered. We saw staff discuss care issues with patients and relatives and these were clearly documented in patient's notes.
- Staff took into account the patients' and care givers individual preferences.
- We saw staff offered verbal and written information to patients and their relatives. For example, this included a booklet about the end of life and what they might expect to happen.
- In our review of notes we saw examples of regular, daily documented discussions with patients' relatives since the patient had been admitted.
- At Lymington New Forest hospital medical staff said that staff manage expectations at the point of admission and throughout treatment so that the expectation is of "Care rather than cure."
- Porters at Lymington New Forest hospital told us that deceased patients were conveyed appropriately and securely, in body bags and with an identifiable tag. They said they had not identified any concerns when transporting deceased patients.
- The trust allowed open access visiting to relatives of end of life patients and they were accommodated overnight if appropriate. For example, if the patient was in a side room, a relative could stay in a reclining chair in the same room.

Are services caring?

Emotional support

- Nurses paid attention to the needs of family members who were caring for a dying person. This included signposting to counselling, chaplaincy and bereavement services.
- During home visits, we saw nurses discussed patients' personal and social interests as part of the holistic assessment process.
- All staff considered emotional support as part of their role. Staff completing home visits demonstrated knowledge of patients' individual and family circumstances.
- Community staff had access to training on counselling and were able to support patients directly. Staff said they would refer relatives for bereavement support through the hospices or local voluntary organisations.
- We spoke with the trust lead chaplain who told us the chaplain service had access to volunteers and chaplains of other faiths. Community staff said they would refer patients or contact the local faith group on the patient's behalf if appropriate.

Are services responsive to people's needs?

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

We found:

- The community teams provided a service that reflected the needs of the local population and ensured flexibility, choice and continuity of care.
- The inpatient wards we visited accommodated patients in single rooms if available and made arrangements to meet the needs of patients at the end of life.
- In the year April 2016 to March 2017, 92 patients required an end of life assessment in the same period and 100% had these completed. Ninety six per cent of patients at end of life were seen within the trust target of two hours where a rapid response was needed.
- Services were planned, delivered and coordinated to take account of people with complex needs and engage with people who were in vulnerable circumstances.
- The service received few complaints relating to end of life care. Lessons were learnt and action was taken to improve the quality of care.

Planning and delivering services which meet people's needs

- The trust worked with other organisations and the local community to plan services that met patient's needs. For example, the trust had working relationships with local hospices to arrange hospice care for patients, hospice at home service and bereavement services. However, there was variability in provision depending on which area the patient was resident. During our inspection, we spoke with community nursing staff and inpatient staff who confirmed they had good partnership working with the local hospices in their areas to provide palliative and end of life care.
- All business units provided a twilight nursing service until 11pm.
- We observed care delivered in the community. We saw staff prioritised patients' end of life and to ensure the needs of patients and families were met.
- Side rooms and facilities for relatives included open access for relatives to visit patients who were at the end of life on the community wards.
- Community hospitals provided 'step up' and 'step down' care closer to patients' homes; to prevent admission to the acute hospital and facilitate discharge from the acute hospital. Staff in the community hospitals provided palliative care for patients, at Lymington New Forest hospital, Romsey and Alton hospitals more end of life patients were cared for than at Gosport War Memorial hospital.
- Services were in place to support patients with care at home to be rapidly discharged from hospital to allow time for the care package to be organised.
- At the time of inspection there was a 'single point of access' referral system in place for business units 1 and 2 and had not yet been implemented for business unit 3.
- The inpatient wards had side rooms which could be used to accommodate end of life patients. For example, at Lymington New Forest hospital relatives could stay overnight with the patient if they were in a side room. At Romsey hospital there were three side rooms but none were ensuite.
- Senior staff at Lymington New Forest hospital said admissions from nursing homes for EOLC were often avoided as the consultants worked with the local GPs to ensure appropriate care was provided at home or transfer to the local hospice was enabled.
- Staff informed us the hospice at home service provision in North Hampshire had recently changed with no prior notice and this had impacted on the integrated service team's workload as well as on patient care. The ICT was working with the twilight nursing service to support patients and families.
- The trust worked with the local undertakers to arrange for deceased patients to be transferred directly to the undertaker in accordance with the families' wishes.

Equality and diversity

- All staff received awareness training in equality and diversity as part of their induction to the organisation and on an ongoing basis as part of their mandatory training. Data showed 100% of the community nursing team had undergone respect and values training compared to trust target of 95%.
- Throughout our inspection, we observed staff were non-judgemental in their approach to the care of patients and families. Staff were able to access interpreters for people whose first language was not English, however, they said this was rarely needed.

Are services responsive to people's needs?

- Staff demonstrated an awareness of how to care for the deceased in accordance with different religious and cultural beliefs. However, they said they rarely had experience of meeting different needs due to the demographic profile of the area.
- There were no facilities to view deceased patients at community hospitals. Administrative staff would arrange the paperwork so that the deceased could be transferred to the funeral home as soon as possible so the family could arrange a viewing.
- At Petersfield hospital we saw a small multi-faith room available for patients and relatives to use which was appropriately furnished.
- The trust had assessed itself against the Accessible Information Standards. The trust's patient experience and engagement group monitored implementation of the action plan to address any gaps identified.

Meeting the needs of people in vulnerable circumstances

- Where appropriate, equipment such as profiling beds and pressure relieving mattresses were provided to support patients who wished to die at home. Staff reported there were sometimes delays in the acceptance of the referral which impacted on the speed of provision of equipment
- Care plans we looked at for inpatients and patients being cared for in the community included an assessment of emotional and spiritual needs as part of the holistic assessment completed
- There was no specific end of life care pathway for patients with learning disabilities or living with
- dementia. However, staff told us all end of life care was delivered on an individual and holistic manner so that individual needs were both recognised and assessed.
- At the community hospitals, staff said they were able to contact chaplains in and out of hours to meet with patients and relatives. Community staff said they contact the local church for chaplain support or use chaplain service via the local hospice.
- Arrangements were in place at Lymington New Forest hospital to provide death certificates and the deceased patients' belongings to relatives.
- The specialist palliative care team administrative team said they had received training to manage calls from distressed patients and relatives.
- Staff at Lymington New Forest hospital said they had completed e-learning on dementia and supported patients with dementia. Such as allowing enough time, providing a range of stimulation including music to relax them and providing a safe calm environment.
- Staff in Petersfield ICT said they had good links with the older peoples mental health nurses for support. At the time of inspection the trust reported they had no patients on their mental health wards with end of life care needs.

Access to the right care at the right time

- Southern Health NHS FoundationTrust did not provide specific rapid discharge services, however community teams had a rapid response element to the service they provided and their standard was to respond within two hours. In the north of Hampshire the trust had an 'enhanced recovery and support at home team' that supported discharge of palliative patients to be cared for at home.
- In the year April 2016 to March 2017, the total number of rapid response contacts by ICT nursing and enhanced recovery teams was 3636 contacts; 97.4% of patients were seen within two hours and 99.1% within four hours. Ninety two patients required an end of life assessment in the same period and 100% had these completed.
- Data provided by the trust showed community nursing teams received an average of 6925 referrals each month, of which 87% were seen within one week and 96.7% of patients at end of life were seen within the trust target of 2 hours where a rapid response was needed.
- All patients or relatives, including those at the end of life, could access community health services through the single point of access service (SPA) in business units 1 and 2. This was a call centre and was available from 8am to 11pm daily. This provided a single point of contact to enable a consistent approach to triage calls and respond to patients' needs.
- Inpatient and community nursing teams worked closely with the hospice services and were able to access advice 24 hours seven days a week. Staff told us that there were sometimes delays in arranging packages of care due to a shortage of carers. Difficulties in provision of care packages across the West ISD was on the trust risk register

Are services responsive to people's needs?

- We saw in our review of records community nursing teams worked closely with the twilight service to ensure end of life care patients' needs were responded to appropriately.
- Where staff from different services visited patients at home they would work jointly, for example, to ensure patient's needs were met, for example, changing the patient's syringe driver.
- Staff at Lymington New Forest hospital said there was a high number of patients whose preferred place of death was at the hospital. The hospital had a close working relationship with the local hospice which facilitated patient transfer arrangements.
- Data showed that between June 2016 and January 2017, the trust recorded 96 inpatient deaths.
- The service reported on patients' preferred place of death. Between May 2016 and April 2017 the majority of teams achieved above or near the trust target of 80% except for Rural East ICT in North Hampshire which was approximately 60%.
- The specialist palliative care team were available 8.30am to 5pm Monday to Friday and on-call at the weekend 10am to 2pm. Consultant cover was available on an on call basis out of hours seven days a week. Between April 2016 and March 2017 over 98% patients were seen within three days, there was a slight decline to 93.6% in December 2016. The team received on average 80 referrals a month and had 124 patients on their case load and saw the majority of patients at least once a week.

Learning from complaints and concerns

- We saw information on how to raise a concern or make a complaint was available in the community hospitals we visited..
- We requested data on complaints relating to end of life care. The trust provided data which showed the trust received a total of 407 complaints between April 2016 and March 2017. We reviewed the caring sub group report (February 2017) which demonstrated complaints themes were analysed and presented to the quality and safety committee. The top three complaint themes were clinical care, communication and attitude, end of life care was not identified as a theme. The complaints data we received did not identify if any complaints received related to end of life care. No specific issues relating to complaints and EOLC were identified. Staff we spoke with were aware of a complaint which related to an end of life care patient and the omission to record the patient's next of kin on the electronic record. Learning from this complaint and incident had been shared at governance meetings and we observed staff checked patients' next of kin contact details.
- We saw complaints and compliments were discussed at governance meetings and learning points shared, for example, the need for clear documentation regarding communication with family members.
- During the inspection we saw notice boards with thank you cards from relatives. At meetings, staff shared messages of appreciation from patients and relatives and we saw teams collated messages in a folder for safekeeping.
- Staff received cards and small gifts from relatives of patients who had died, expressing their gratitude for kindness and compassion shown by staff.

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.

We found:

- The end of life care strategy group had developed an end of life care strategy which was due to be launched in April 2017. We spoke with the trust end of life care lead and the chair of the end of life care strategy group, they demonstrated a vision and plan to ensure high quality end of life care was provided in a consistent manner across the trust.
- End of life care was delivered as part of the governance framework within the integrated service division. Education and training was integral to the delivery of the strategy
- Risks in the provision of community services which impacted on end of life care were recorded and monitored in the divisional risk registers.
- The trust encouraged a culture of openness and honesty. Staff we spoke with felt they were engaged with in a meaningful way through discussion with their line managers, divisional leaders and at governance meetings.

However,

- There was no patient or public involvement in the development of the end of life care strategy.
- No evaluation of the provision of end of life care had taken place

Leadership of this service

- There was effective local leadership on the community inpatient wards and in the community. Community staff said they were supported by their area matrons, for example, band 6 staff said that community matrons encouraged them to accompany experienced staff on visits with EOLC patients.
- Staff told us they felt supported by their line managers and ward managers. Staff had confidence in their managers to ensure training and expert knowledge was available to improve end of life care experiences for patients and those who were close to them.
- The chief nurse held the executive board responsibility for end of life care and an assistant director of nursing in the integrated service division was the trust lead for EOLC. Each business unit had an end of life care lead. The majority of staff we spoke with were not aware of who the named trust lead for end of life care was, although they were aware of the name of the community end of life care lead.
- There was a non-executive director (NED) for end of life care at board level. Non-executive directors work alongside other non-executives and executive directors as an equal member of the board. They share responsibility with the other directors for the decisions made by the board and for the success of the organisation in leading the local improvement of healthcare services. This meant the provider had a designated person at board level to champion the strategic direction of end of life care within the organisation.
- The end of life care steering group was chaired by the trust lead chaplain, The group had multidisciplinary representation from across the business units and reported to the trust quality and safety group.

Service vision and strategy

- In November 2016, the provider had developed a new end of life care plan as part of the strategy. The strategy was based on national guidance and written in line with the latest national guidance issued by NICE and the End of Life Care Ambitions Partnership 'Ambitions for palliative and end of life care', a national framework for local action 2015-2020. The trust's end of life care strategy had been approved and was due to be launched shortly after the inspection on 13 April 2017. Most front line staff we spoke with were not aware of the EOLC strategy, however, community matrons we spoke with were aware the strategy launch was imminent along with the individualised end of life care plan for use in the community. The trust planned to undertake a review of end of life care at the end of December 2017.
- Although staff were not aware of the EOLC strategy they were clear of the values of the organisation to provide 'High quality, safe services'.
- The EOLC strategy group was chaired by the trust lead chaplain.. We reviewed the notes of the end of life care steering group meetings which had taken place since

January 2016. These meetings were scheduled as monthly but only eight meetings had taken place and notes of one meeting were not available. The notes we reviewed showed a large variation in attendance of participants from four members in September 2016 and January 2017, to a maximum of 11 out of 13 in January 2017. The terms of reference were not agreed by September 2016, there was no patient/ public involvement at the meeting, although this issue was discussed at two meetings. Actions or updates were not provided from the subgroups and not followed through.

- We saw 'boats plans' in team offices we visited; these depicted the service business plan in line with the trust wide strategy.

Governance, risk management and quality measurement

- Governance for end of life care was part of the integrated service division. There was clear accountability through the structure and staff knew whom they were accountable too.
- Arrangements were in place to ensure staff were communicated with at least monthly at team meetings and at monthly band 7 governance meetings which were across the business unit. Staff we spoke with said the meetings they attended were positive, an opportunity to share learning between different areas and aimed to improve service delivery through an ongoing action plan.
- New policies and procedures were communicated to staff through staff meetings, emails and the weekly updates. All the staff we spoke with were able to demonstrate they received regular communication from the board, head of service and team leaders. Matrons we spoke with had been briefed about the launch of the EOLC strategy and were due to cascade the message to their staff at team meetings.
- We reviewed notes of the 2016/17 monthly business unit governance meetings and divisional governance meetings. There was clear evidence of discussion of end of life care in a number of meeting minutes, at business unit level staffing, for example, use of the night nursing and twilight service was raised and these services were often for EOLC patients. The notes of the divisional governance meetings showed palliative and end of life care issues were discussed, through learning from serious incidents, death reviews and patient stories. For example, the need for staff to be confident to have difficult conversations with patients and families about end of life and the courses available to staff. Meetings highlighted actions taken and learning points for staff to disseminate. The end of life care steering group did not regularly review risks and incidents relating to end of life care.
- We saw team matrons used the trust electronic governance system to monitor service performance, including training and metrics such as preferred place of care and death.
- The end of life care metric reported to the board was percentage of patients who died in their preferred place of care, this measure was reported monthly in the integrated performance report.
- We reviewed the divisional risk registers. These showed risks were recorded, reviewed and mitigating actions in place. Risks which potentially impacted on care provided to EOLC patients included for example, staffing levels, equipment, completion of holistic assessments and delays to inputting patient records on the electronic record system due to problems with connectivity and/or sharing information between different IT systems. During the inspection we had observed or staff highlighted these same issues.
- All inpatient deaths were initially reviewed within 48 hours followed by a more detailed review of the care and quality of documentation. At Lymington New Forest Hospital, one of the trust's larger community hospitals where more deaths occurred due to the greater number of patients, there was a daily death panel meeting led by a consultant. Examples of learning shared regarding an EOLC patient included a case where a patient had struggled with secretions; learning was this could have been managed more effectively.

Culture within this service

- Staff we spoke with demonstrated a desire to provide holistic and responsive care for patients at the end of their life and take account of the needs of their relatives.
- Community staff said they were proud of the support they provided to patients and families to enable them to be cared for and die in their own homes in accordance with their wishes.
- We found an open, honest and supportive culture in end of life care services with staff being very engaged, open to new ideas and interested in sharing best practice in end of life care.

Are services well-led?

- Staff reported positive working relationships, and we observed that staff were respectful towards each other across all disciplines.
- All staff we spoke with said they felt confident to raise concerns with their managers.
- At the specialist palliative care team (SPCT) meeting, we observed a supportive cohesive team, although they displayed some anxieties about the planned changes to the team. The meeting was well-structured and encouraged team participation around the headings of safe, effective, caring, responsive and well-led agenda items.
- Staff we spoke with at Basingstoke ICT said they had seen improvements since the team had merged into one integrated services team and was collocated. This enabled close working with therapists, However, 'hot desking' and space to be a team had been recognised as an issue which was being addressed. The team matron said although staffing had improved the trust recognised that time was needed to develop the team and support new staff in their roles.
- Staff on an inpatient ward at Lymington New Forest hospital told us that the critical incident team had done a debrief with staff after a difficult death on the ward. Lymington community nurses were aware of trust workplace counselling services if they needed support after a difficult death

Public engagement

- The trust website was accessible to patients and members of the public.
- The end of life care information on the website had recently been updated to include the launch of the end of life care strategy and associated information.
- The end of life care steering group did not include a lay member, although notes highlighted that members of the group had discussed the need to have public representation on the group.
- We observed staff took care to actively involve patients and those close to them in their care in and planning of their care in the last stages of life in accordance with their wishes.

Staff engagement

- All the staff we spoke with were able to demonstrate they received regular communication from the board, head of service and team leaders. This meant that staff were able to keep up to date with current practice and national guidance.
- Staff told us they felt engaged and were encouraged to contribute to ideas to shape and improve the service.

Innovation, improvement and sustainability

- The trust said there have been a number of quality improvement projects in relation to EOLC including the development of the end of life medication prescription chart.
- The launch of the education framework in January 2016 included a wide range of topics relating to EOLC.

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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 11 HSCA (RA) Regulations 2014 Need for consent The trust did not always provide care and treatment of patients with the consent of the relevant person because: All of the do not attempt cardio-pulmonary resuscitation (DNACPR) forms we reviewed were not completed in line with national guidance. This is a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing All staff had not received appropriate training and appraisal to ensure compliance with the requirements of the regulation because: Appraisal rates for community nursing staff were low This is a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

Systems were not in place to assess the risks to the

health and safety of service users of receiving care and treatment because:

All community staff did not have access to up to date information in the record of patients at the end of life.

Staff at Romsey hospital did not have access to timely support to respond to end of life care patients who deteriorated.

This is a breach of Regulation 12 (2) a b of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care was not always provided person centred because: The trust did not use individualised end of life care plans for patients cared for at home. This is a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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.