Derby Hospitals NHS Foundation Trust

RTG

Community end of life care

Quality Report

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

Summary of findings

Ratings

Overall rating for Community end of life care services	Requires Improvement 
Are Community end of life care services safe?	**Requires Improvement** 
Are Community end of life care services effective?	**Good** 
Are Community end of life care services caring?	**Good** 
Are Community end of life care services responsive?	**Good** 
Are Community end of life care services well-led?	**Requires Improvement** 

Summary of findings

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Summary of findings

Overall summary

Derby Hospitals NHS Foundation Trust delivered community based services to people requiring palliative and end of life care throughout South Derbyshire. The community palliative care team was part of an integrated team, working alongside colleagues from the specialist palliative care team based at the Royal Derby Hospital. The community end of life care service provided palliative and end of life care in a range of environments such as people's own homes, London Road Community Hospital and the Nightingale Macmillan Day Unit. We visited these sites and went on home visits, the community palliative care team. We spoke with patients, carers and staff including community nurses, district nurses, community matrons, matrons, health care assistants, volunteers and doctors.

Community palliative care staff received good feedback about incident investigations, but there was little sharing and learning across the service in order to improve practice. Staff working in the community caring for people at home were not always able to access current information about their patients' care and treatment plans, which meant they might not be fully prepared to care for a patient.

District nursing teams and the specialist palliative care team were under-staffed and taking on increasing workloads. There were high levels of sickness absence. Recruitment was not successful in filling vacancies, and teams were delivering far more activity than they were contracted for. Staffing shortfalls meant that nurses did not attend mandatory and other training. We have included more detailed findings about the district nursing teams within our inspection report, "Community health services for adults."

Care and treatment were evidence based and staff followed current best practice recommendations. Community staff were appropriately qualified, skilled and competent to carry out their roles, and worked well to meet the needs of patients. Community teams worked in a multidisciplinary manner and there was good team working to ensure patients received effective care in the community. Patients received compassionate care and we witnessed positive interactions between patients and staff. Staff provided emotional support for patients and their carers.

All of the staff we observed demonstrated compassion and were passionate about providing good end of life care. Community end of life care services were responsive to people's needs. The trust had a number of initiatives to ensure patients received the care they needed in the most appropriate place.

Leadership at a local level was good and managers demonstrated a clear understanding of their services and were aware of the risks and challenges their service faced. Staff spoke positively about the contribution they made to patient care. There was some engagement with staff but this needed to improve.

Summary of findings

Background to the service

Derby Hospitals NHS Foundation Trust provided community based palliative and end of life care services to a population of over 600,000 people in and around South Derbyshire.

Palliative and end of life care was delivered on the Nightingale Macmillan Unit at the Royal Derby Hospital, London Road Community Hospital and in people's own homes. Care was provided by community and district nurses, the intermediate care team, healthcare assistants, allied healthcare professionals, community GPs who were not employed by the trust, a specialist palliative care consultant and the community palliative care team.

Our inspection team

Our inspection team was led by:

Chair: Jan Ditheridge, Chief Executive, Shropshire Community Health NHS Trust.

Team Leader: Carolyn Jenkinson, Head of Hospital Inspection, Care Quality Commission

The team included three CQC inspectors, two specialist nurses, an occupational therapist and an expert by experience who was a carer of someone using community services.

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 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 hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 9 and 10 December 2014. During our inspection we visited London Road Community Hospital, the Nightingale Macmillan Day Unit, and went out on home visits with community nurses and Macmillan nurses who formed part of the Community Palliative Care team. We spoke with two patients, two carers and 14 members of staff including community nurses, district nurses, community matrons, matrons, health care assistants, volunteers and doctors. We carried out an unannounced visit to the London Road Community Hospital on 22 December 2014.

What people who use the provider say

All of the people we spoke with were complementary about the service they received.

One person who was receiving a home visit from a community palliative care nurse said about the nurse, "There's no one kinder ." Another person told us "I never feel rushed, I am given enough time to talk about things."

Summary of findings

A relative of a patient receiving end of life care at London Road Community Hospital told us they were happy with the care their relative was receiving. They said the staff were attentive, kind and caring.

Good practice

Our inspection team highlighted the following areas of good practice:

- Staff were passionate and committed to providing a good standard of end of life care for patients.
- All staff we spoke with were positive about their role and the work they were doing despite the resource difficulties they were experiencing.
- Patients were always placed at the centre of their care and were given choices which were listened to and acted upon.
- The holistic therapy service in the Nightingale Macmillan Unit provided an excellent service to patients from the community.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The provider must ensure that there are sufficient suitably qualified, skilled and experienced staff in the district nursing and community palliative care teams to meet the needs of people using the end of life and palliative care service, and to respond to changing circumstances in the service.
- The provider must ensure that staff visiting patients in their homes to deliver end of life and palliative care are able to access the complete information they need before providing care and treatment.
- The provider should strengthen ways of learning from incidents and sharing good practice across the community end of life and palliative care services.
- The provider should improve the monitoring of patients' concerns, comments and complaints so that they can be used systematically as an opportunity to learn.
- The provider should strengthen the engagement with staff delivering community end of life and palliative care, and improve communication about service design and strategy.

Derby Hospitals NHS Foundation Trust

Community end of life care

Detailed findings from this inspection

The five questions we ask about core services and what we found

Requires Improvement

Are community end of life care services safe?

By safe, we mean that people are protected from abuse

Summary

The specialist palliative care team were familiar with the process for reporting incidents.

District nursing teams and the specialist palliative care team were under-staffed and taking on increasing workloads. During our inspection we saw no evidence that staff shortages were having a negative impact on care delivery. We attended three home visits to patients requiring end of life care during our inspection and at no time did we observe the visit to be rushed.

There were suitable arrangements for safeguarding adults and children, the prevention and control of infection, and ensuring safe equipment. The risks to patients health were assessed and responded to appropriately. Patient information was stored securely.

Community staff were required to complete electronic patient records using the trust's electronic care system. Some local GPs also used the same system and this enabled information about patients' current care and treatment plans to be shared with other health care professionals. Some community teams were unable to access the electronic recording system

Detailed findings

Incident reporting, learning and improvement

- The specialist palliative care team were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic reporting system.
- Lessons learnt following incident investigations were shared at team meetings, multidisciplinary team forums and monthly clinical governance meetings.

Duty of Candour

- Duty of Candour is concerned with openness and transparency and places a responsibility on NHS hospitals to inform patients when things have gone wrong and harm has been caused. Duty of Candour was being discussed at the district nursing sisters weekly

meetings prior to its implementation in November 2014. Minutes from their November meeting made reference to a leaflet that had been developed for patients explaining about the development of pressure ulcers.

Safeguarding

- The trust had policies and processes in place for the safeguarding of adults and children.
- Training in safeguarding adults and children was mandatory for all community staff. The staff we spoke with all said they were up-to-date with this training and were confident in reporting safeguarding concerns.
- All of the staff we spoke with were able to describe the procedures to follow if abuse was suspected or alleged.
- The trust provided three levels of safeguarding training to staff; awareness, standard and enhanced training. Ninety-seven per cent of community staff had completed safeguarding training.

Medicines management

- There were systems in place to ensure the safe administration of medication for patients receiving end of life care. The trust had an up-to-date medication policy for staff to follow and people had medication administration records within their home.
- Within the community hospital environment, we saw that anticipatory medicines (medicines that were prescribed in case they were required) had been prescribed in line with national guidance for patients who were receiving end of life care.
- Community nurses supported nursing homes to set up ambulatory syringe pumps when they were required. (These are small battery operated infusion pumps that deliver a continuous infusion of medication to control symptoms, such as pain, restlessness and nausea.)
- Syringes for the ambulatory pumps were prefilled and supplied by the trust's own pharmacy. Having the syringes pre-drawn up reduced the risk of medication errors. Once requested, the response rate from the pharmacy should have been four hours. The trust were auditing the response times to ensure this was happening. The results of the audit were requested, but were not available at the time of our inspection.

Safety of equipment

- The trust used ambulatory syringe drivers for patients who required a continuous infusion to control their symptoms and these met the current NHS Patient Safety guidance so as to protect patients from harm. The syringe drivers were tamperproof and had the recommended alarm features.
- None of the staff we spoke with raised any concerns about the safety of equipment in people's own homes.

Records and management

- Community staff were required to complete electronic patient records using the trust's electronic care system. Some local GPs also used the same system and this enabled information about patients' current care and treatment plans to be shared with other health care professionals. Some community teams, however, were unable to access the electronic recording system, for example the rapid response team who visited patients in the evening.
- The community specialist palliative care team were unable to access the electronic system. This meant that staff were not always able to read the most current information about the people they were supporting. One community nurse told us about an incident when a new community nurse had visited a patient to find they had complex palliative care needs. The nurse had not been given enough information, was not familiar with the patient and did not have the right experience or skills. This compromised the care the nurse was able to give to the patient.
- Patient identifiable information was stored securely and electronic records were protected by password access.
- There were systems and protocols in place for sharing information with other professionals, such as with GPs. Staff were aware of the requirements for ensuring people's confidentiality was maintained and protected.
- Information governance training was mandatory and community staff told us they were up to date with this training. Ninety-two percent of community staff had completed information governance training against the trust target of 95%.

Cleanliness, infection control and hygiene

- The trust had an up-to-date infection control policy relating to the care of people after death.
- The ward areas we visited were clean, well ordered and uncluttered. Staff working on the wards and in the

community demonstrated appropriate practice to reduce the risk of spreading infection. This included appropriate hand washing and use of personal protective equipment such as gloves and aprons.
- We observed staff during home visits. Staff demonstrated they had a good understanding of infection prevention and control. We observed staff cleaning their hands prior to and following the provision of care. We saw that staff used gloves and aprons where this was appropriate.
- All the staff we spoke with told us they had received infection control training. Hand hygiene audits undertaken between April and June 2014 showed that all staff demonstrated good hand hygiene.
- Clinical staff wore clean uniforms with arms bare below the elbow and community nurses were provided with hand sanitising gel to use when providing care in the community.

Mandatory training

- End of life care training was not mandatory but the specialist palliative care team told us that all community nurses had received end of life care training. All of the community nurses we spoke with told us they had received end of life care training.

Assessing and responding to patient risk

- Community palliative and end of life care took place in a patient's own home or in the community hospital. All of the nursing teams completed risk assessments for patients receiving end of life care. These included risk assessments for falls, pressure ulcers and nutrition. These risk assessments had been documented in all the records we reviewed. We also saw that care plans were regularly evaluated and revised as appropriate.
- The Nightingale Macmillan Unit (NMU) within the trust operated a 24 hour advice line for patients at home, their carers and health professionals. The NMU nurses were responsible for the advice line, answering queries and signposting people to the most appropriate resources to meet their needs.

Staffing levels and caseload

- Throughout community palliative and end of life care services we were told of issues around shortages of staff and increased caseloads.
- We were told about staff shortages in the community palliative care team due to four members of staff being off sick. This had led to increased pressure for the rest of the team. In response the community palliative care team had sent letters out to GPs and district nurses to ask them to only refer patients who required their specialist input.
- As reported in the community health services for adults report, district nursing teams had high levels of vacancies, absence and maternity leave, and increasing workloads. The trust was actively recruiting staff but was finding it difficult to fill vacancies.
- During our inspection we saw no evidence that staff shortages were having a negative impact on care delivery. We attended three home visits to patients requiring end of life care during our inspection and at no time did we observe the visit to be rushed.

Managing anticipated risks

- Risk assessments were undertaken across all end of life community services to identify and reduce potential and actual risks to patients. This included pressure damage, falls, nutrition, moving and handling and pain risk assessments.

Major incident awareness and training

- Community staff reported that major incident planning had not taken place and they had not received any specific training relating to major incidents. There were however, arrangements in place for staff to follow in severe weather conditions. If weather was severe, staff would work from home and walk to the patients who urgently required a visit and who lived nearest to them.

Good

Are community end of life care 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

Care and treatment were evidence based and staff followed current best practice recommendations.

Community staff were appropriately qualified, skilled and competent to carry out their roles, and worked well to meet the needs of patients. The community palliative care team supported patients in their own homes, care homes and the community hospital, in collaboration with the patient's primary care team.

Community teams worked in a multidisciplinary manner and there was good team working to ensure patients received effective care in the community. Community staff were required to complete electronic patient records using the trust's electronic care system. Some community teams, including the community specialist palliative care team, were unable to access the electronic recording system. This meant that staff did not always have the complete information they needed before providing care and treatment.

Detailed findings

Evidence based care and treatment

- All staff providing end of life care in the community delivered evidence based practice and followed recognised and approved national guidance such as the National Institute for Health and Care Excellence (NICE) quality standards for end of life care and the Gold Standard Framework for end of life care. For example, standards were being met with the provision of a specialist palliative care team who provided seven day working and could be contacted in person or by telephone out of hours.
- The trust had a 'Derbyshire Gold Record about my future care' booklet which enabled patients to record their preferences for their care in the future. This was in line with the recommendations published by the Department of Health document 'End of Life Care Strategy: promoting high quality care for all adults at the end of life' (2008). The service was meeting the locally set target (or CQUIN) based upon its use.
- The hospital palliative care team was part of the Derbyshire Alliance for End of Life Care, which had produced an end of life toolkit for staff. The toolkit was available online and provided information about the end of life care plan, medication and care after death. Staff told us the information was useful when supporting patients at the end of their life.
- The 'Trust policy and procedures relating to the death of an adult patient' had a review date of February 2014 and was therefore due for review. All other related end of life policies and procedures we looked at were up to date, and staff were using appropriate documentation.
- Relevant end of life care policies, guidance and support were available to all community staff via the trust's intranet.
- Care and treatment were planned in a personalised and holistic way and care plans took into account people's health and social care needs.

Pain relief

- Effective pain relief was considered a priority for patients receiving care across all end of life care services. We saw pain control being discussed with patients throughout visits and within multidisciplinary team meetings.
- Anticipatory prescribing took place within end of life care services which helped to reduce the risks associated with delays in receiving pain relief medication.

Nutrition and hydration

- Each patient had been nutritionally assessed using a Malnutrition Universal Screening Tool (MUST). This identified patients at risk of malnutrition and a nutritional care plan was commenced when risks were identified.
- Recommendations regarding artificial nutrition and hydration for patients requiring end of life care were available for staff on the trust's intranet.
- Appropriate care was put in place to ensure that, where relevant, patients who had lost the ability to take food and fluids orally were reviewed and alternative methods of hydration and nutrition were administered. One

Good

Are community end of life care services effective?

patient we visited was receiving nutrition via a percutaneous endoscopic gastrostomy (PEG) tube. This is a tube directly inserted into the stomach to enable fluid and nutrition to be delivered. We saw this was discussed and reviewed.

Approach to monitoring quality and outcomes of care and treatment

- The National Bereavement Survey (VOICES) was conducted by the Office for National Statistics on behalf of the Department of Health. The aims of the survey were to assess the quality of care delivered in the last three months of life for adults who died in England and to assess variations in the quality of care delivered in different parts of the country to different groups of patients. The National Care of the Dying Audit 2013/2014 showed that the trust performed better than the England average against clinical key performance indicators (KPIs), such as multidisciplinary recognition that the patient is dying, a review of the patient's nutritional requirements and a review of the care after death.

Competent staff

- The training coordinator told us that they had implemented a programme for community nurses to visit the hospital to understand the role of staff within the acute team. This had provided two way learning about end of life care between the acute and community service. This meant that there was improved staff understanding of the trust's end of life care pathway.
- Staff who attended training courses facilitated by the specialist palliative care team were asked their opinions of both content of the training and style of presentations. The majority of this feedback was positive, with community nurses reporting feeling more confident to listen and discuss issues around death with patients.
- Staff received an induction on starting employment with the trust.
- Staff were appropriately qualified, skilled and competent to carry out their roles in a safe and effective manner. All of the patients we spoke with were complementary about the ability of community staff.
- Some of the community specialist palliative care team were able to prescribe, but due to sickness, not all staff had completed the course.
- Nurses working in the community palliative care team told us they regularly received supervision.

Multi-disciplinary working and coordination of care pathways

- A multidisciplinary team approach was evident across all end of life care services. Patients receiving palliative and end of life care received coordinated support from many healthcare professionals, including Macmillan nurses, consultants, GPs, community and district nurses, hospital nurses and healthcare assistants, dieticians, occupational therapists, physiotherapists and speech and language therapists. In line with the principles of the Gold Standard Framework for end of life care, multidisciplinary team meetings took place weekly within GP surgeries to ensure any changes to patient needs could be addressed promptly.
- Staff reported good team working between all disciplines and grades of staff and we saw good evidence of multidisciplinary team working.
- We attended a community specialist palliative care team meeting where each member of the team had the opportunity to speak and contribute to patient treatment plans.

Referral, transfer, discharge and transition

- Staff worked hard to ensure patients were safely transferred and discharged from hospital into the community.
- Patients we spoke with told us about their experience of discharge and transfer and no problems were highlighted.
- Most people who were referred to the intermediate care team were seen within 24 hours.

Availability of information

- Community staff were unable to access the trust's electronic record system while on visits. The specialist palliative care team and evening district and community nurses were unable to access the system at all. This meant that staff were unable to access the most up-to-date information about service users while they undertook their visits. This sometimes caused problems for staff.as it impacted on patient care.

Good

Are community end of life care services effective?

- All patients receiving end of life care in the community had care plans available in their homes.
- Staff told us they could access patient information leaflets in a variety of accessible formats.

Consent

- Staff demonstrated confidence in seeking valid consent to treatment from patients. They explained things to patients in a way that they could understand and helped them make informed decisions.
- Staff were aware of their responsibilities in relation to patients who lacked the capacity to make decisions about care or treatment, in line with the Mental Capacity Act (2005). Staff knew the procedures to follow to involve other professionals and relatives in reaching decisions in patients' best interests.

Good

Are community end of life care services caring?

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

Summary

Staff providing community end of life care were caring. Patients received compassionate care and we witnessed positive interactions between patients and staff. Community staff discussed planned care and treatment with patients and they provided information to reinforce patient understanding. Patients told us they felt involved in making choices and decisions about their care and treatment. Staff provided emotional support for patients and their carers.

Community staff were working under significant pressure because of their workloads but all staff we observed demonstrated calm compassion and were passionate about providing good end of life care.

Detailed findings

Dignity, respect and compassionate care

- We found the care and treatment of patients and support for their families, within the hospital, and throughout Macmillan and community nursing services to be empathetic and compassionate.
- Staff always made sure people's confidentiality was maintained. Patients and their families had confidence in the care delivered. It was clear that patients were at the centre of decision making.
- People who used the service were treated with compassion, dignity and respect. All of the people we spoke with were positive about the care they received. One person who was receiving a home visit from a community palliative care nurse said about the nurse, "There's no one kinder ."
- Staff tried to see the same patients to establish continuity of care and we witnessed good rapport between staff, patients and their carers.
- Patients were always asked for consent and spoken to in a respectful way prior to any care or treatment being given. All staff asked permission to enter patient's homes prior to walking through the door.

Patient understanding and involvement

- Patients and those close to them told us they had been fully involved in the care provided and had a clear understanding of what was happening at all times.
- During a home visit, we observed staff discussing patient wishes, and saw that they discussed advance care plans, planned care and treatment with patients.
- Information leaflets were available about a range of end of life care subjects, such as pain control and bereavement support. The leaflets could be obtained in other formats and languages, if required.

Emotional support

- The chaplaincy had three full time and two part time chaplains working within the trust hospital, providing a service seven days a week. One of the chaplains provided support for community patients coming to the Nightingale Macmillan Day Unit. One chaplain told us that they had good working relationships with other faiths to ensure the religious and spiritual needs of patients were met.
- Community staff considered emotional support as part of their assessment and could refer patients to appropriate support services where appropriate.
- All staff we spoke with told us that part of their job was to provide emotional support for patients and also their families and carers. Staff completing home visits demonstrated knowledge of patients and their unique situations. We saw that appropriate emotional support was provided.

Promotion of self-care

- People were supported to maintain their independence. During the home visits we saw that nurses took an active interest in the patient's and their relative's social activities and provided opportunities to discuss how they could continue to engage in social activities even when the symptoms of their illness may have restricted them.

Good

Are community end of life care services responsive to people's needs?

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

Summary

Community end of life care services were responsive to people's needs. All of the patients we spoke with confirmed their needs were being met and were full of praise for the service they received. The trust had a number of initiatives to ensure patients received the care they needed in the most appropriate place. Across the service, staff worked to ensure patient's received care in a place of their choice. Patients' concerns, comments and complaints were not used systematically as an opportunity to learn.

Detailed findings

Planning and delivering services which meet people's needs

- Staff were able to access equipment for patients if their risk assessment indicated it was required. For example, if a patient was assessed as being at high risk of developing pressure ulcers a pressure relieving mattress was provided. The community nurses assured us they were able to order this equipment 24 hours a day, seven days a week.
- End of life care took place in different settings such as the community hospital and people's own homes. Patients had a choice about where they wanted to die and community staff worked to support their wishes. For example, one patient had expressed a wish to die on one of the wards at London Road Community Hospital. Staff on the ward told us they would respect the patient's wishes and when we visited the hospital nine days later, we saw the patient was still on the ward.
- At Royal Derby Hospital the Nightingale Macmillan Day Unit provided activities for 12 community patients three days per week. Activities included making decorations, painting and reading. We saw patients chatting to one another and engaging in the activities of the day.
- The trust ran a scheme which provided eight beds in nursing homes for people requiring end of life care across Southern Derbyshire. Each nursing home had a Derbyshire End of Life Quality Award and was selected due to their good track record. Between 24 June and 1 October 2014 there had been 26 admissions to these beds, with an average length of stay of 13 days. This helped to prevent unnecessary hospital admissions for people requiring end of life care.
- One bed on the Nightingale Macmillan Unit was for respite care. This was available for patients with advanced, progressive neurological conditions and complex care needs that could not be managed by a care home. Patients were admitted for one week at a time every eight weeks. Staff told us that the service was often fully booked.
- Managers we spoke with were aware of the risks in their areas such as staffing levels and skill mix and were working to alleviate the pressures staff were facing. For example, a new nurse had been recruited to the community palliative care team and letters had been sent out to GPs and community nursing teams to ask them to assess the appropriateness of their referrals.
- The Macmillan nurses told us they had developed links with specialist nurses across community services. This helped to ensure appropriate management of patients with non-malignant conditions such as those with respiratory, cardiac or neurological conditions who required end of life care.
- Staff told us they were able to access interpreters for patients who required them. Some staff were not always accessing interpretation services when they should have done and relied on family members or staff who spoke the same language as the patient.

Equality and diversity

- All of the patients we spoke with confirmed their needs were being met and were full of praise for the service they received.
- Community teams told us they could access interpreters and that information was available in different languages but they often relied on members of staff or relatives who spoke the same language as people who used the service.
- We found no evidence to suggest that patients would be denied access to services on the grounds of their age, ability, gender, gender reassignment, pregnancy or marital status, race, religion or belief and sexual orientation.

Good

Are community end of life care services responsive to people's needs?

Meeting the needs of people in vulnerable services

- We saw the service responded to the needs of people with complex physical and learning disabilities.
- All of the staff we spoke with demonstrated a good knowledge of their patients and particularly those people who were vulnerable.

Access to the right care at the right time

- A system was being developed to facilitate rapid discharge for people requiring end of life care from the hospital into the community, across Derby City and Derbyshire Community Health Services. A district nurse would be allocated to a patient to create a single point of access to improve communication about discharge planning, resulting in accelerated discharge. The hospital palliative care team told us that they hoped to achieve this in 2015.
- The trust used a form called 'Recognising dying' to identify patients who may be in the last hours or days of life. We saw three patients who had been recognised as dying on two wards at London Road Community Hospital. Staff had completed the form for all three patients.
- Community nurses took part in a scheme called the RightCare plan. This scheme was designed to ensure joined up patient care when GP practices were closed, and help prevent unnecessary hospital admissions. Patients could contact RightCare when their own GP surgery was closed and they felt unwell. A clinician would be able to view the patient's care plan and organise relevant care and support, such as a home visit.
- There were two complementary therapists based in the Nightingale Macmillan Unit who provided therapies for community patients attending the day unit. The complementary therapists delivered treatments such as reflexology, aromatherapy and massages. They were passionate about providing their service to patients and would individualise treatments to ensure patients gained optimum benefit from their sessions. One patient told us that they always felt more relaxed after the treatment.
- The intermediate care team, who were able to assess most patients within 24 hours of referral, could support the discharge of people requiring end of life care until a package of care had been established.

Complaints handling (for this service) and learning from feedback

- Information for patients about making complaints, raising concerns or giving compliments was displayed in public areas and clinics at London Road Community Hospital. However the information about how to make a complaint directed people to contact the Patient Advice and Liaison Services at the Royal Derby Hospital, rather than providing a local contact. None of the patients we spoke with had experience of raising concerns with the trust.
- Patients receiving care in their own homes told us they did not know how to make a formal complaint, but told us they felt comfortable raising any concerns with their community nurse.
- Staff understood the complaints process and who to refer people to if they wished to complain or if they could not resolve their complaint locally.
- Clinical team leads were responsible for managing complaints. Informal complaints were addressed and verbal comments were stored in a computer database. These comments were fed back to matrons at weekly matrons meetings. The records were not reviewed for themes or trends in order to establish wider learning from feedback. The clinical director of the business unit said that complaints monitoring and management was not robust and was an area for development.

Requires Improvement

Are community end of life care 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

There was no strategic plan documented regarding the future vision of the end of care at the trust. Leadership of community end of life care services at a local level was good and managers demonstrated a clear understanding of their services and were aware of the risks and challenges their service faced.

Staff spoke positively about the contribution they made to patient care.

Detailed findings

Service vision and strategy

- There was no strategic plan documented regarding the future vision of the end of care at the trust.
- Members of the community palliative care team attended regional groups which worked to enhance end of life care across the local area. For example new guidance, current care and innovative plans for the future across Derbyshire were discussed with the community and external bodies such as the Clinical Commissioning Group, local authority and local hospices.
- We saw a business case for staff education in end of life care for 2015-16, based on NHS England's Leadership Alliance for the Care of Dying People guidance (2014). The palliative care team aimed to develop a competency based education and training programme that would enable staff involved in end of life care to have the essential skills and knowledge required to deliver high quality care.
- Palliative care provision across Southern Derbyshire was a joint transformation scheme work stream, focused on reviewing the specialist palliative care service across Southern Derbyshire and the scope of the current seven-day service to ensure a co-ordinated, integrated, efficient service for the local population.

Governance, risk management and quality measurement

- Since the organisational re-structure in April 2014, the quality, risks and performance issues within community health services were monitored through the Division of Integrated Care governance framework. Those relating to the community palliative care team and end of life care facilitators were monitored through the cancer business unit in the Division of Medicine and Cancer.
- There were regular governance meetings and senior managers told us they were aware of the main risks and challenges for community end of life services.
- We looked at the risk registers for both divisions and saw there were no risks identified in relation to the community palliative care team or end of life care in the community.
- Most community end of life care staff we spoke with demonstrated an awareness of governance arrangements. They understood the actions taken to monitor risk and patient safety. This included incident reporting, maintaining a risk register and undertaking audits. Staff we spoke with were generally clear about their roles and accountabilities
- The chair of the end of life group was a member of the patient experience committee to help provide governance and accountability of patient and public feedback regarding end of life care.

Leadership of this service

- The chief nurse represented end of life care at board level to ensure end of life care was highlighted at trust board level. In October 2014 the end of life team presented to the trust wide quality committee which is a sub committee of the trust board.
- Not all staff knew who the Chief Executive Officer (CEO) for the trust was. However, those that did, expressed that she was very approachable.

Culture within this service

- Senior managers spoke highly of their staff and recognised the difficulties and challenges staff within community end of life care services faced.
- Staff were committed to providing good quality care and told us they were proud of their work.

Innovation, improvement and sustainability

Requires Improvement

Are community end of life care services well-led?

- We saw evidence of the palliative care team working with information technology to implement an email alert system where details of patients identified as being at the end of life on the palliative care electronic system could be flagged to the team. This would allow them to be notified when patients from the community had been admitted to hospital and prevent unnecessary home community visits. It was hoped that this could be implemented in 2016 when information technology systems were being updated to make it more user friendly.
- The palliative care team had produced and developed a training DVD for staff, with examples of end of life discussions between patients, relatives and healthcare professionals, to emphasise the importance of good communication. They had created an associated facilitators handbook to help the trainer use the resources effectively.
- The palliative care team had published a trust palliative medicine newsletter, designed to promote best practice, training and education opportunities. The first newsletter was issued in October 2014 with the second due in March 2015. Readers were asked for ideas of topics to be included, to ensure the newsletter targeted the concerns of the staff.

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **The provider did not ensure that electronic patient records could be located promptly by staff visiting patients at home, before providing care and treatment .** [Regulation 20 (1)(a) & (2)(a)]

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The provider did not take appropriate steps to ensure that at all times there were sufficient numbers of suitably qualified, skilled and experienced staff employed for the purposes of carrying out end of life care in the community.** [Regulation 22]