

The Rotherham NHS Foundation Trust

RFR

Community end of life care

Quality Report

The Rotherham NHS Foundation Trust
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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RFRPA	Rotherham General Hospital	Community nursing teams	various
RFR30	Breathing Space	Unit	S65 2QL
RFRPA	Rotherham General Hospital	The Oakwood Community Unit	S60 2UD




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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

The Rotherham NHS Foundation Trust did not provide specialist community palliative or end of life care. This was commissioned by the Rotherham Clinical Commissioning Group from the Rotherham Hospice. The trust provided general end of life care in the community. Care was predominantly given by community nurses in patients own homes. End of life care could also be provided in the trusts community inpatient units, BreathingSpace and the Oakwood Community Unit. We visited these sites and went on home visits with district nurses from the community nursing team. We spoke with patients, carers and staff including community nurses, district nurses, matrons, health care assistants and doctors.

Staff did not always report patient safety incidents and did not always receive feedback about incident investigations and there was little sharing and learning across the service in order to improve practice. Staff working in the community providing palliative and end of life care for people at home reported difficulties in connecting to their remote working devices. This meant they could not always access current information about their patients' care and treatment plans.

We found that staff had received very little or no training in relation to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), and assessments had not always been appropriately

undertaken when a patient was said to lack capacity as a reason for not discussing Do Not Attempt CardioPulmonary Resuscitation (DNA CPR) decisions with them.

Arrangements to minimise risks to patients were in place with appropriate measures taken to prevent falls and pressure ulcers. We saw elements of good practice including good infection prevention and control practice and, the use of independent and community nurse prescribers.

There had been an investment in the staffing of community nurses and it had seen an increase in nurses. Despite this, community nursing staff were working under significant pressure because of their workloads. All staff we observed demonstrated calm compassion and were passionate about ensuring patients received good end of life care. Community nurses were not always able to fulfil supportive visits to patients requiring palliative and end of life care because of their workload.

District nurses told us they would be the first point of call for patients on their caseload who required end of life care. We saw evidence that some patients found it difficult to get through to the district nurses via the telephone number they had been given.

Community staff delivering end of life care felt they were not always listened to and many staff expressed community services were the poor relation compared to acute services and that the two had not been integrated.

Summary of findings

Background to the service

Community health services were transferred from the Primary Care Trust to the Rotherham NHS Foundation Trust on 1 April 2011. The Rotherham NHS Foundation Trust did not provide specialist community palliative or end of life care. This was commissioned by the Rotherham Clinical Commissioning Group from the Rotherham Hospice. The trust, however, provided general end of life care and worked in partnership with the Rotherham Hospice to provide community-based palliative and end of life care services to a population of 257,600 people in and around Rotherham.

Community palliative and end of life care was delivered by staff at BreathingSpace (a unique, nurse-led service

that provided care for people with chronic lung disease including treatment with non-invasive ventilation), the Oakwood Community Unit and in people's own homes. Care was provided by community and district nurses, healthcare assistants, allied healthcare professionals and the trust's chaplain. Care was also provided by community GPs, a specialist palliative care consultant, clinical nurse specialists and the hospice at home rapid response team who were not employed by, but had been commissioned to provide this service in partnership with the trust.

Our inspection team

Our inspection team was led by:

Chair: Dr Jane Barrett, Chair Thames Valley Clinical Senate

Head of Hospital Inspections: Carolyn Jenkinson, Head of Hospital Inspection, Care Quality Commission

The team included two CQC inspection managers, 12 CQC inspectors and a variety of specialists including: consultant surgeon, consultant in respiratory medicine, a consultant paediatrician, consultant intensivist, a GP, a

student nurse, two midwives, two executive director nurses, a governance expert, an occupational therapist, a speech and language therapist, a matron, two community adult specialist nurses, one health visitor, one school nurse, a physiotherapist, a head of children's nursing and a dentist. We were also supported by two experts by experience who had personal experience of using or caring for someone who used the type of services we were inspecting.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

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

Before 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 from 23 to 27 February 2015. During our inspection we visited the BreathingSpace centre, Oakwood Community Unit and went out on home visits with district nurses who delivered palliative and end of life care in people's own homes. We held focus groups with a range of staff who worked within the service, such as nurses, doctors and therapists. We spoke with six patients, four carers and 26 members of staff including community nurses, district nurses, matrons, healthcare assistants, doctors and chaplaincy staff.

Summary of findings

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment delivered by the trust.

What people who use the provider say

We spoke with over 40 people who attended our listening event. Some people were very positive about the care they had received at the trust. Other people were less positive about their care.

The NHS Family and Friends (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.

The trusts performance in all of the NHS Friends and Family tests in January 2015 was largely positive.

- The trust scored higher than the England average of 96% for the inpatient FFT, with 98% of patients recommending the inpatient services provided by the trust. a total of 361 patients responded to this question.
- The trust scored slightly lower (worse) than the England average of 87% for the A&E FFT, with 73% of patients recommending the service. A total of 997 patients responded to this question.
- The trust scored higher (better) than the England average of 96% for the antenatal question in the maternity NHS FFT, with 100% of women recommending this service.
- The trust scored higher (better) than the England average of 97% for the birth question in the maternity NHS FFT, with 99% of women recommending this service.
- The trust scored higher (better) than the England average of 93% for the post natal ward question in the maternity NHS FFT, with 100% of women recommending this service.
- The trust scored higher (better) than the England average of 97% for the post natal care in the community question in the maternity NHS FFT, with 100% of women recommending this service.

From April 2014, the staff NHS Friends and Family Test (SFFT) was introduced to allow staff feedback on NHS services based on recent experiences to be captured.

Staff were asked to respond to two questions. The “care” question asks how likely staff are to recommend the NHS service they work in to friends and family. The “work” question, asks how likely staff would be to recommend the NHS service they work in as a place to work.

The trusts scores in this test were lower (worse) than the England average. Fifty seven per-cent of staff would recommend the trust for care and 43% would recommend as a place to work. The England averages were 77% for the care question and 61% for the work question.

The trust had a total of 29 reviews during 2013-14 on the NHS Choices web site. Fifty nine per cent of these were positive and 41% negative. On the Patient Opinion website there were 133 reviews, of which 70% were positive and 30% negative. In February 2015, the Patient Choices website gave the trust an overall rating of 3.5 stars out of a possible five which meant patients had rated this hospital as they would be “likely to recommend” it.

The CQC Adult Inpatient Survey was carried out between September 2013 and January 2014. A total of 367 patients responded to the survey. The overall score for the trust was about the same as other trusts. There were ten areas of questioning in this survey and nine out of the two areas were about the same as other trusts, but the questions relating to the hospital and wards scored worse than other hospitals. This was due to the response to the questions relating to food quality, food choice and single sex accommodation.

In the Survey of Women’s Experience of Maternity Care (CQC 2013), the trust performed about the same as other trusts in all of the four areas. The survey asked women a number of questions relating to their labour and birth, the staff who cared for them and the care they received in hospital following the birth.

The National Cancer Patient Experience Survey 2012/2013 was designed to monitor national process on cancer

Summary of findings

care. The trust was performing within the top 20% of trusts for 16 of the 34 areas, the middle 60% of trusts for 13 areas and in the bottom 20% of trusts for five areas. The areas where it was performing well better were:

- Patients not been given conflicting information
- Privacy when discussing condition/treatment
- Being able to discuss fear
- Treated with respect and dignity
- Given clear information
- Feeling they were given enough care
- Health got better or remained about the same while waiting for treatment
- Seen as soon as necessary
- Given a choice about the types of treatment
- Given the name of the nurse in charge of their care, given information of who to contact post discharge
- GP was given enough information
- Had confidence in the doctors treating them
- Did not feel doctors talked in front of them as if they were not there
- Had confidence in ward nurses
- Saw GP once or twice before being told they had to go to hospital.

The areas they scored in the bottom 20% were:

- Hospital staff told patient they could get free prescriptions
- All staff asked patient what name they preferred to be called
- Staff definitely did everything to control side effects of chemotherapy
- Hospital staff gave information about support groups
- Staff gave complete explanation of what would be done.

The patient-led assessment of the care environment (PLACE) programme are self-assessments undertaken by teams of NHS and private/independent healthcare providers and include at least 50% members of the public. They focus on the environment in which care is provided, as well as supporting non-clinical services, such as cleanliness, food, hydration, and the extent to which the provision of care with privacy and dignity is supported. The outcomes of the patient led assessments of the care environment for 2014 showed that the trust was rated worse than the England average for all areas.

Areas for improvement

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

The provider **MUST**:

- The provider must ensure that all 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms are completed appropriately.
- The provider must ensure that all staff delivering community end of life and palliative care are able to attend mandatory training and other essential training as required by the needs of the service.

The provider **SHOULD**:

- The provider should ensure they support staff delivering community end of life and palliative care to report patient safety incidents appropriately and ensure they are able to access training in incident reporting on a regular basis.

- 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 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 ensure that all staff delivering community end of life and palliative care are able to access appropriate one to one supervision on a regular basis.
- The provider should strengthen the engagement with staff delivering community end of life and palliative care, and improve communication about service design and strategy.

The Rotherham 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 services safe?

By safe, we mean that people are protected from abuse

Summary

We judged that safety in community end of life care services required improvement.

Staff did not always report patient safety incidents and did not always receive feedback about incident investigations. There was little sharing and learning across the service to improve practice.

Some staff working in the community providing palliative and end of life care for people at home reported difficulties in connecting to their remote working devices. This meant they could not always access current information about their patients' care and treatment plans.

There had been an investment in the staffing for the community nursing service and it had seen an increase in the number of nurses. Despite this, teams were still understaffed and were working under increasing pressure.

Although a significant number of community staff were not up-to-date with safeguarding training, they had a good understanding of safeguarding procedures and were able to explain situations where safeguarding concerns had been acted on appropriately.

We found that some staff had received very little or no training in relation to the Mental Capacity Act 2005 and its associated deprivation of liberty safeguards even though there were training sessions available. Assessments had not always been appropriately undertaken when a patient was said to lack capacity as a reason for not discussing DNA CPR decisions with them.

Arrangements to minimise risks to patients were in place, with appropriate measures taken to prevent falls and pressure ulcers. We saw elements of good practice, including good infection prevention and control and the use of independent and community nurse prescribers.

Incident reporting, learning and improvement

- Incidents were reported through the trust's electronic reporting system.

- All community staff we spoke with were familiar with the process for reporting incidents, near misses and accidents using the system. However, staff did not always report incidents when they should have done. For example, staff did not consider it necessary to report as incidents issues such as a high workload or lack of capacity to provide supportive visits to patients requiring end of life care.
- Community nursing staff did not always receive feedback about incidents they had reported, and some staff told us they were unaware of any actions or interventions to prevent incidents from recurring. During our inspection, we found little evidence of staff being involved in learning from incidents or sharing good practice across teams and departments.
- The head of nursing for the medicine directorate told us there had been no reported incidents relating to community end of life care by trust staff.

Duty of Candour

- Managers were aware of the Duty of Candour regulation introduced in November 2014, The intention of this regulation is to ensure that providers are open and transparent with people who use services. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology.
- A head of nursing told us that the Duty of Candour had been incorporated into the incident reporting system and would not allow an incident to be closed until a meeting had taken place with the patient or their representative.

Safeguarding

- The trust had policies and processes for the safeguarding of adults and children.
- All nursing staff we spoke with had an understanding of how to protect people from abuse. Staff were able to explain and give examples of times when they would make a safeguarding referral.
- Training in safeguarding adults and children was mandatory for all community staff. However, information provided by the trust demonstrated that a significant number of community nursing staff were not up-to-date or had not completed safeguarding training as of 31 January 2015.

Medicines management

- There were systems to ensure the safe administration of medication for patients receiving end of life care in the community. When community nurses did not have the capacity to set up or change syringe drivers they relied on the hospice at home rapid response team for support.
- 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.)
- We saw that anticipatory medicines (those prescribed in case they are required) had been prescribed in line with national guidance for patients who were receiving end of life care.
- Throughout community services there were 38 independent nurse prescribers and 31 community nurse prescribers. Independent nurse prescribers are specially trained nurses who are allowed to prescribe any licensed and unlicensed drugs within their clinical competence. Nurse prescribers have full access to the British National Formulary and work on a par with doctors in relation to their prescribing capabilities. Community nurse prescribers are a distinct group under independent prescribers. They are allowed to independently prescribe from a limited formulary called the Nurse Prescribers' Formulary for Community Practitioners, which includes over-the-counter medicines, wound dressings and applications. Nurse prescribers worked to enable faster access to medicines for people who were receiving end of life care.

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 National Patient Safety Agency guidance to protect patients from harm. The syringe drivers were tamperproof and had the recommended alarm features.
- Community nursing staff told us they could access some of the equipment they needed, such as syringe drivers, but there was often a delay when equipment such as mattresses were required.
- None of the staff we spoke with raised any concerns about the safety of equipment in the community.

Records and management

- Community staff completed electronic records using the trust's electronic care system. The Rotherham Hospice and some local GPs also used the same system and this enabled the sharing of information about patients' current care and treatment plans with other healthcare professionals.
- Throughout community end of life care services, we found that patient-identifiable information was stored securely and electronic records were password protected.
- Information governance training was mandatory for all staff within the trust. However, only 62% of community nursing staff had completed information governance training against the trust target of 95%.
- We looked at DNA CPR arrangements across community services – a policy was in place but out of date by two months. We were told the trust was in the process of reviewing it.
- We reviewed five DNA CPR forms. Two at BreathingSpace and three at the Oakwood Community Unit. The forms we reviewed at BreathingSpace were appropriately completed. However, the three forms we reviewed at the Oakwood Community Unit indicated that the patients did not have the capacity to make decisions. The decision had been discussed with relatives; however, we found that mental capacity assessments had not been completed.
- End of life and palliative care training was not included as part of the trust's mandatory training programme. Mandatory training included topics such as dementia awareness, information governance, moving and handling, resuscitation and safeguarding adults and children.
- Community nursing staff told us they were not up to date and said they often found it difficult to attend training due to their caseloads.
- Information received by the trust indicated that, for community nurses the overall target rate for mandatory training was 95%. However, we saw that compliance was significantly below the trust target as of January 2015. For example, just 22% of community nurses had received mandatory training in moving and handling and 33% had attended level three safeguarding adults training.

Lone and remote working

- The trust had a policy for managing the security of lone workers. All community nursing staff we spoke with were aware of the lone worker policy and the procedures that should be followed.
- Staff told us that, where the level of risk indicated it was necessary, community staff worked in pairs. An alert was placed on the person's electronic care record and staff would have contact details for a named individual in the event of an emergency. All staff had access to mobile telephones.

Cleanliness, infection control and hygiene

- The community units we visited were clean, well-ordered and uncluttered. Staff working on the units 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 nursing staff during home visits. They demonstrated a good understanding of infection prevention and control. We saw staff cleaning their hands prior to and following the provision of care and they used gloves and aprons where appropriate. Staff were provided with hand-sanitising gel to use when providing care in the community.
- Community nursing staff wore clean uniforms and were 'bare below the elbows' in line with recommended hygiene practice.

Assessing and responding to patient risk

- Community palliative and end of life care took place in a patient's own home or in the BreathingSpace centre. Occasionally end of life care took place in the Oakwood Community Unit, although staff told us that the purpose of this unit was not to support end of life care. All of the nursing teams completed risk assessments for patients receiving end of life care. These included assessments for falls, pressure ulcers and nutrition. These assessments were comprehensive, individualised and provided the basis for care and treatment.
- Where a patient required specialist palliative care, referral was made to the Rotherham Hospice.
- In the first instance, patients and their families would try to contact their community or district nurse, however, we observed that patients sometimes found it difficult to get through to staff on the contact numbers provided.

Mandatory training

Staffing levels and caseload

- Information provided by the trust suggested that, between November 2014 and January 2015, people receiving end of life care accounted for 13% of the community caseload.
- Most staff we spoke with in the district nursing teams experienced difficulty in managing their caseloads on a daily basis. There had been an investment in the staffing for the community nursing service and it had seen an increase in the number of nurses. Despite this, community teams were still understaffed and taking on increasing workloads. Staff told us they regularly worked over their contracted hours and often without taking breaks.
- Staff shortages were not filled with bank or agency staff and staff felt this had resulted in a crisis, especially in the trust's central locality.
- Staff shortages and increasing workloads in the district nursing teams had the potential to increase risk for patients receiving end of life care. We were told of times when district nursing staff had been unable to fulfil visits to support patients receiving end of life care. There was an awareness that this could lead to a crisis for patients and their families.

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.
- The trust encouraged patients in their homes to use 'just in case boxes' which contained items that could be needed at short notice, such as anticipatory medication and syringe drivers.

Major incident awareness and training

- The trust had a major incident plan and business continuity plans for community services.
- There had been no major incidents or emergencies within the past year within community end of life care services. Community services would respond to an emergency situation using its business plans and would respond to a major incident in line with the trust's major incident policy.
- Community staff could not recall undertaking any specific training relating to major incident planning. Information provided by the trust indicated that practices had not taken place within the last 12 months.
- Community services had identified and assessed potential risks that could negatively impact on community services.
- The head nurse for the medicines directorate told us that, in severe weather conditions, community staff would go to their nearest office and would prioritise patients who needed a home visit.

Are Community end of life 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

The effectiveness of the community end of life care services required improvement.

The trust had been slow to respond to the withdrawal of the Liverpool Care Pathway for end of life care and, at the time of our inspection, there was no individualised end of life care pathway in place. An end of life care operational group had been set up and had produced a draft individualised care plan, but this had not yet been implemented. The group had also run a one-day event for staff to raise awareness of the guidance available in One Chance to Get it Right: Improving people's experience of care in the last few days and hours of life, published by the Leadership Alliance for the Care of Dying People.

The trust did not monitor the quality and outcomes of care and treatment for patients who had received, or were receiving, end of life care. Not all staff who were responsible for delivering end of life care had received training to enable them to undertake this role.

Examples of a multidisciplinary teamwork approach were evident throughout end of life care services and the trust had a good working relationship with the Rotherham Hospice. Patients receiving palliative and end of life care received coordinated support from many healthcare professionals, including clinical nurse specialists, consultants, GPs, community and district nurses, hospital nurses and healthcare assistants, dieticians, occupational therapists, physiotherapists and speech and language therapists.

Staff providing end of life care in the community could not always readily access information about the patients they were visiting. This was due to online connectivity issues associated with the trust's electronic record system. Patients did not have paper copies of records in their homes.

Not all staff were aware of their responsibilities in line with the Mental Capacity Act 2005 for people who lacked the capacity to make decisions about care or treatment. Staff were unclear about the procedures to follow when reaching decisions in people's best interests.

Detailed findings

Evidence-based care and treatment

- Following the withdrawal of the Liverpool Care Pathway, the trust had not yet established individualised end of life care pathways. The end of life operational group had been working on a replacement but, at the time of our inspection, this had not been implemented.
- We spoke with staff about what trust guidance was being used for caring for patients at the end of their life. Staff were unable to tell us about current trust guidance relating to end of life care. However, all staff we spoke with were aware of the One Chance to Get it Right information day that had been provided by the trust.
- Community palliative and end of life care services had not audited themselves against any national end of life care guidance. This meant they did not know whether they were meeting national end of life care guidance or where they needed to improve.
- The Gold Standard Framework for end of life care aims to help doctors, nurses and care staff to provide the highest possible standard of care for all patients who may be in the last years of their life. We saw that the standard had been adopted by some local GP surgeries. Some community nurses attended the Gold Standard meetings to develop a coordinated approach to good-quality end of life care based on the wishes and preferences of the individual.

Pain relief

- There was no tool used to assess pain levels for people receiving end of life and palliative care in the community. We did, however, see that nurses discussed levels of pain with patients.
- Syringe-driver training was variable throughout community end of life care services. Community nurses and nurses providing end of life care at BreathingSpace were competent and trained to use syringe drivers. Anticipatory prescribing took place which helped to reduce the risks associated with delays in receiving pain relief medication. However, nursing staff working at the Oakwood Community Unit had not received up-to-date syringe-driver training. Staff told us they would contact

Are Community end of life services effective?

the trust's specialist palliative care team (SPCT) if they needed support with a syringe driver. This meant there could be delays in accessing and setting up a syringe driver if a member of the SPCT was not available.

- A number of nurses in community end of life care services were able to prescribe medication for the treatment of pain and other symptoms, such as restlessness and nausea. This enabled a timely response to control distressing symptoms and meant that patients did not have to wait for a doctor to write a prescription.

Nutrition and hydration

- Throughout community services, a national assessment tool was used to assess patient's nutritional status and identify when interventions were required. Staff told us they could access the support of a dietician if needed.

Approach to monitoring quality and outcomes of care and treatment

- The trust did not monitor the quality or outcomes of care for patients receiving end of life care in the community.
- The trust did not seek feedback from the relatives of patients who had received palliative or end of life care in the community.

Competent staff

- The trust employed a palliative care consultant who was based at Rotherham Hospice and gave advice to community staff.
- New staff undertook mandatory training as part of their induction programme, but this did not involve training in end of life care.
- The trust had invited staff to an information day to discuss the new five-year strategy and the principles behind One Chance to Get it Right: Improving people's experience of care in the last few days and hours of life, by the Leadership Alliance for the Care of Dying People. However, not all staff had been able to attend and there were no plans for further sessions.
- Not all staff who were responsible for providing end of life care had received formal training to enable them to do this. Training was variable. Staff in BreathingSpace had been well-supported in received training in end of life care, while staff at the Oakwood Community Unit had not received any training in this area. Most of the

community nurses told us they had received some training in providing end of life care and they could access specialist support from the community SPCT at the Rotherham Hospice when they needed it.

- We received mixed feedback from staff about their appraisals. Not all community staff had received an appraisal in the last year. Information received from the trust following our inspection indicated that the overall percentage of staff appraised since April 2014 was around 84%. Consultants told us they received an annual appraisal.
- Community staff at all levels told us that one-to-one supervision did not take place in the community.

Multidisciplinary 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 clinical nurse specialists, consultants, GPs, community and district nurses, hospital nurses and healthcare assistants, dietitians, occupational therapists, physiotherapists and speech and language therapists.
- We saw evidence of effective multidisciplinary team working throughout our inspection. For example, staff at BreathingSpace worked closely with physiotherapists and occupational therapists. We also saw evidence that other clinicians, such as tissue viability nurses, dietitians and speech and language therapists were involved in patient care where their input was required.
- Within the community we saw evidence that district nurses worked closely with GPs as they attended Gold Standard Framework meetings to discuss patients on their caseload to ensure that any changes to patient needs could be addressed.
- We saw how community nursing staff worked with staff in care homes to undertake nursing assessments and provide advice and guidance to staff regarding end of life care. Community staff also provided advice, guidance and links to other community-based services for the provision of specialist equipment to enable patients to remain in the care home if this was their preferred place of care and death.

Referral, transfer, discharge and transition

Are Community end of life services effective?

- The local Hospice had been commissioned to ensure that community specialist palliative and end of life care support was available 24 hours a day. However, general end of life care was provided by community nurses who were employed by the trust.
- District nurses could refer patients to the hospice at home rapid response team who were employed by the Rotherham Hospice and aimed to see referred patients within two hours. This helped to prevent patients from being inappropriately admitted to hospital.

Availability of information

- The electronic patient record system was used by all staff, including those at the Rotherham Hospice, which meant that individual clinicians could see the input from other colleagues. Staff could access the electronic system at their bases or remotely using laptops.
- Some community staff reported problems connecting to the electronic system while in people's homes. This meant staff could not always access the most up-to-date information relating to the care of some patients as paper records were not kept in people's homes. We went on home visits with some of the district nurses and observed the difficulties that some nurses were experiencing. It took one nurse 10 minutes to access the electronic records at two different locations.
- We also heard of concerns about DNA CPR forms – if community staff were unable to access the electronic record system, they may not know whether a patient was meant to be resuscitated in the event of a cardiac arrest. A member of community staff told us that this had been the reason for an incident where a patient had been resuscitated when they had requested a DNA CPR order.

Consent

- Staff told us that they were aware of, and had access to, the trust policy and procedures for consent.
- Staff undertaking home visits asked for patients' permission before entering their homes.
- Community staff sought informed consent prior to undertaking any patient care or treatment. They communicated in a way that patients would understand and helped them make informed decisions. Patients we spoke with told us they felt involved in decisions about their care.
- However, not all staff were aware of their responsibilities in line with the Mental Capacity Act 2005 for people who lacked the capacity to make decisions about care or treatment. Staff were unclear about the procedures to follow when reaching decisions in persons' best interests. Most staff told us they would not be involved in completing a mental capacity assessment but would approach the person's GP or next of kin to gain consent.
- We found that staff had received very little or no training in relation to the Mental Capacity Act and its associated deprivation of liberty safeguards, and assessments had not always been appropriately undertaken.

Are community end of life services caring?

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

Summary

We judged community end of life services as ‘good’ because patients received compassionate care. We saw positive interactions between patients, their families or carers and staff. Throughout our inspection, staff spoke with compassion, dignity and respect about the patients they cared for.

Community nursing staff were working under significant pressure because of their workloads, but all staff we observed demonstrated calm compassion and were passionate about ensuring that patients received 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 throughout community nursing services to be empathetic and compassionate.
- At BreathingSpace and the Oakwood Community Unit, all patients were allocated single rooms which afforded them privacy and dignity.
- Staff spoke with patients in a discrete manner when discussing their care, and doors were closed when delivering personal care.
- People who used the service were treated with dignity, respect and compassion. All of the people we spoke with were positive about the care they received. One person who was receiving a home visit from a district nurse said, “They [the nurses] are worth their weight in gold. I don’t know what we would do without them”.
- On our home visits we saw that staff treated patients with dignity and respect. Nurses were sensitive towards the needs of patients and supported them in a professional manner.
- Where possible, district and community nurses tried to see the same patients to ensure continuity of care. Patients knew the nurses by name and confirmed that they regularly saw the same team of nurses. We witnessed good rapport between nursing staff, patients and their carers.

Patient understanding and involvement

- We saw that staff discussed planned care and treatment with patients and, where necessary, provided information to reinforce understanding. We also observed that community staff explained treatment to patients. For example, one patient was receiving end of life care in a care home. The district nurse was required to assess the patient and to change a wound dressing. The patient was unable to communicate with the nurse but the nurse explained everything to the patient and spoke to them in a quiet, calm, reassuring and unhurried manner.
- Patients, and those close to them, told us they felt involved in their care and had a clear understanding of what was happening at all times.
- Community nursing staff delivered patient-centred care. They were calm and took account of patients' individual preferences.

Emotional support

- Community staff considered emotional support as part of their role. Staff completing home visits demonstrated knowledge of patients and their unique situations. We saw that appropriate emotional support was provided.
- The Rotherham Hospice had a service level agreement with the trust for chaplaincy services in the community. The chaplain could be called on to support people requiring palliative and end of life care.
- Staff at BreathingSpace provided on-going bereavement support for relatives following a death. There was a book for relatives to place a memorable photograph in following the death of a patient. There was also a tree on which people could place messages. We saw numerous messages had been placed on the tree. Staff at BreathingSpace held an annual memorial for people who had died throughout the year and those who had been bereaved were invited to attend the service.

Promotion of self-care

- People were supported to maintain their independence. Staff told us that, where possible, they promoted self-care, self-management and independence. One patient in the BreathingSpace centre told us they were actively encouraged to maintain their independence.

Are community end of life services caring?

- During home visits, we saw that nurses discussed patients' social interests and provided opportunities to

discuss how they could plan for their future and continue to engage in social activities with them, even when the symptoms of their illness may have restricted them.

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

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

Summary

We judged that the responsiveness of the end of life care services required improvement. The needs of patients were not always met because of the way the service was organised and delivered. Community nurses were not always able to fulfil visits to support patients requiring palliative and end of life care because of their workload.

There was a lack of recognition that patients with progressive conditions could also benefit from palliative or end of life care. No audits were undertaken to provide evidence of whether patients received the right care at the right time. This meant the trust could not be certain of the care that was being provided met their needs.

District nurses told us they would be the first point of call for patients on their caseload who required end of life care. However, we saw evidence that some patients found it difficult to get through to the district nurses using the telephone number they had been given.

Patients were referred to the SPCT based at the Rotherham Hospice if they needed specialist symptom control or had specialist palliative care needs.

Detailed findings

Planning and delivering services which meet people's needs

- The trust relied on the Rotherham Hospice to ensure that community specialist palliative and end of life care support was available 24 hours a day.
- Patients had a choice about where they wanted to die. All the community staff we spoke to were aware of the importance of this choice and worked to support their wishes.
- We looked at data the trust collated in relation to the number of community patients who died in their preferred place of death. This showed 82 out of 86 patients between October 2014 and February 2015 died in their preferred place.
- Patients who received end of life care at BreathingSpace were not offered a choice of where they wished to rest following their death. All patients who died at

BreathingSpace were taken to the trust's mortuary following their death. Staff explained that this was so doctors could easily access deceased patients in order to write their death certificates.

- Community staff told us that staffing levels and increasing workloads had impacted on their ability to provide supportive care for people who had palliative or end of life care needs.
- The chaplain told us about facilitating the marriage of a patient receiving end of life care in the community.

Equality and diversity

- All of the patients we spoke with confirmed that their needs were being met and were full of praise for the service they received.
- Community staff told us they were able to access The Big Word – a national organisation that uses interpreters to translate information from different languages – if they were supporting people from different cultures whose first language was not English. Staff also told us they would use other family members to ensure that patients' cultural needs were met. This meant there was a risk that patients confidentiality could be breached and patients may not have the opportunity to express themselves to the staff caring for them.
- The chaplain told us they could access leaders from different faiths to support patients in the community if needed.

Meeting the needs of people in vulnerable circumstances

- District nurses told us they would be the first point of call for patients on their caseload who required end of life care. However, we saw evidence that patients may find it difficult to get through to the district nurses using the telephone number they had been given. One patient's relative had contacted the Rotherham Hospice because they had been unable to get through to the district nurse. Staff at the hospice told us that calls for district nurses went through ambulance control and call handlers in the control room were not given any

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

information about which staff were on duty. This meant that, unless patients had individual district nurse's telephone numbers, they may be unable to get through to the district nursing services.

Access to the right care at the right time

- Patients who should have been identified as requiring end of life care were not always identified in a timely manner. Some community staff told us they thought end of life care applied to people who were in the last days or hours of their life. There was a lack of recognition that patients with progressive conditions could also benefit from palliative or end of life care.
- Patients were referred to the SPCT based at the Rotherham Hospice if they required specialist symptom control or had specialist palliative care needs.
- Staff working in the community told us they had to prioritise visits on a daily basis and it was not

uncommon to reschedule visits. This included the rescheduling of supportive visits to palliative and end of life care patients. The community nurses we spoke explained this could lead to crisis situations.

- No audits were undertaken to provide evidence of whether patients received the right care at the right time. This meant the trust could not be certain of the care that was being provided met their needs.

Complaints-handling and learning from feedback

- Staff told us there had been no complaints relating to community end of life care services.
- Patients we spoke with had not been given any information to tell them how to make a complaint. However, they told us they would speak to their community nurse if they felt they needed to complain about the service they were receiving.

Are community end of life services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We judged that the leadership in the community end of life care services was inadequate. There was little evidence of effective leadership for the service. The main focus on end of life care within the trust was mostly centred on acute end of life care services. We saw that there were lines of reporting between the end of life care operational group and the trust board, but the main focus was on acute end of life care issues. Risk factors, such as low staffing levels, poor access to patient information and the inability to fulfil supportive palliative and end of life care visits, were not being addressed. This meant it was not a well planned service that focused on the needs of patients at the end of their life.

Community staff delivering end of life care felt they were not always listened to. Morale amongst the nursing staff working in the community who were delivering end of life care was poor.

Detailed findings

Service vision and strategy

- An end of life care operational group, which was led by the assistant chief nurse, was set up in September 2014 to develop a five-year end of life care strategy. The aim of the strategy was to provide a consistent focus and standard for patients, their carers and families.
- At the time of our inspection, the group had developed and was rolling out the five-year strategy for end of life care services. This was based on the five priorities for care recommended by the Leadership Alliance for the Care of Dying People in One Chance to Get it Right. The priorities had been presented as a one-page document to make it clearer for staff who would be implementing it.
- In January 2015, the trust ran a one-day event to provide staff with an awareness of the importance of good end of life care and to promote the messages associated with One Chance to Get it Right.
- Staff we spoke with were aware of the five-year end of life care strategy.

Governance, risk management and quality measurement

- The lead for the end of life care operational group told us the group reported to the board of directors through the patient experience group, the operational quality safety and experience group and the quality assurance committee. We saw that community governance meetings took place, but we saw no evidence that community palliative or end of life care services were discussed at these meetings.
- There were no audits or quality measures to monitor the effectiveness of end of life care within the community.
- During our inspection, we found low staffing levels and increasing caseloads. Staff were not reporting incidents and community staff were not always able to access patients' medical records. Staff were telling us that they were not always able to provide supportive visits to patients requiring palliative and end of life care. However, when we reviewed the minutes of governance meetings for the medicines directorate, there were no records of risks associated with the delivery of community palliative or end of life care. In addition, there was no risk register for community end of life care.
- There was no evidence of a trust-wide audit programme to assess compliance with the National Institute for Health and Care Excellence (NICE) Quality Standard for End of Life Care for Adults (NICE, 2013) and other national guidance.

Leadership of this service

- The Chief Nurse represented community palliative and end of life care at board level. Following the inspection we saw a report to the Quality Assurance Committee (a sub committee of the trust board) on end of life care from February 2015. The main focus of this report was about the acute end of life provision, although there was some reference to community services.
- Community staff were aware of who the lead for community services was, but were not aware who the lead for community end of life care was. The assistant

Are community end of life services well-led?

chief nurse had undertaken some work to increase the profile of end of life care within the trust and had taken the lead on developing the five-year strategy for end of life care.

- Community palliative and end of life care services were managed as part of the wider community services.

Culture within this service

- Community staff told us that morale was low due to the pressures they were working under. However, staff displayed an enthusiastic, compassionate and caring manner to the care they delivered.
- Staff working in the community told us they felt their concerns were not listened to by senior staff within the trust.
- Staff at all levels reported feeling that community services were the “poor relation” to the acute services. It was felt that community and acute care had not been integrated successfully.

Public and staff engagement

- We saw examples where teams working in community end of life care services had received ‘thank you’ cards from patients’ families, expressing their gratitude.
- None of the patients we spoke with had raised any concerns with the trust. All were pleased with the service they received.
- The NHS Friends and Family Test was not being used for community end of life care services. There was no other consistent method in use to seek the views and feedback of families using the service.

- The views of relatives of patients who had received community palliative or end of life care were not routinely sought. However, there was good engagement with relatives at BreathingSpace, where relatives or those important to patients who had died were invited back to the unit for a memorial to remember their loved ones.
- The results of the NHS Staff Survey for 2013 showed that the overall score for staff engagement was in the lowest (worst) 20% when compared with trusts of a similar type. This had not changed since the survey in 2012.
- Many of the staff we spoke with felt that community services came second to the acute services. They felt that the value of their work was not always recognised or understood by the trust Board and senior managers. Community-based staff told us they felt disengaged from the trust and expressed that they did not feel that services were integrated successfully. The senior leaders in the trust were aware of this before our inspection and had a programme of work to address community staff engagement. this was still work in progress at the time of the inspection and they recognised there was more work to do on this. There was a transformation plan for community services in place and it was hoped this would address many of the concerns staff had.

Innovation, improvement and sustainability

- Staff providing palliative and end of life care acknowledged that there was a lot of work to be done to improve end of life care services throughout the community.

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

Treatment of disease, disorder or injury

Regulation

Regulation 23 HSCA 2008 (Regulated Activities)
Regulations 2010 Supporting staff

The registered person must ensure there are suitable arrangements in place to ensure staff working in the community end of life care service receive appropriate training. This must include safeguarding, resuscitation, and mental capacity awareness.

Regulated activity

Regulation

Regulation 18 HSCA 2008 (Regulated Activities)
Regulations 2010 Consent to care and treatment

The provider must ensure that all 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms are completed appropriately.