Leicestershire Partnership NHS Trust

RT5

Community end of life care

Quality Report

Trust Headquarters,
Riverside House,
Bridge Park Plaza,
Bridge Park Road,
Thurmaston,
Leicester
LE4 8PQ
Tel: 0116 225 2525
Website: www.leicspart.nhs.uk

Date of inspection visit: 14 - 18 November 2016
Date of publication: 08/02/2017

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RT5YJ	Rutland Memorial Hospital	End of life care	LE15 6NT
RT5YG	Loughborough Hospital	End of life care	LE11 5JY
RT5YF	Hinkley and Bosworth Community Hospital	End of life care	LE10 3DA
RT5YD	Coaleville Hospital	End of life care	LE67 4DE
RT5KT	Evington Centre	End of life care	LE5 4QG
RT5	Trust Headquarters (Community Services, Diana, Hospice @ Home and Macmillian CNS Team)	End of life care	LE4 8PQ

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

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of this inspection

Detailed findings from this inspection

Summary of findings

Overall summary

We rated end of life care services as good overall because:

- The trust had worked collaboratively with local partners to develop an end of life care strategy for the region as a whole which had incorporated a health needs analysis.
- Patients were protected from avoidable harm by sufficient staffing and safeguarding processes.
- Staff recognised and responded to the changing needs of patients with anticipatory medications readily available and care needs assessed and reviewed appropriately.
- Staff followed infection and prevention control practices and the community inpatient wards were visibly clean. Specialist equipment needed to provide care and treatment to patients in their home was appropriate and fit for purpose so patients were safe.
- Staff demonstrated commitment to delivering high quality end of life care for their patients. There was a strong, person-centred culture. Staff treated patients with compassion, dignity and respect. Patients and their relatives felt involved in the care provided. Patients' social, emotional and religious needs were met and relatives valued the emotional support they received.
- Services were planned and delivered in a way that met the current and changing needs of the local population. The needs and preferences of patients and their relatives were central to the planning and delivery of care with most people achieving their preferred place of care. Care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- We saw evidence of multidisciplinary working, with staff, teams and services at this trust and external organisations working in partnership to deliver effective care and treatment.
- There was strong local leadership on the community inpatient wards and in the community. Staff told us they felt supported by their line managers, ward managers and matrons.

However:

- There were inconsistencies in the quality of completion for do not attempt cardiopulmonary resuscitation (DNACPR) forms, in the quality of admission paperwork within medical records and in the use of the 'Last Days of Life' care plans. This had been raised as a concern in the March 2015 inspection and had not been sufficiently addressed.
- There was an unstructured, non-mandatory approach to formal end of life training for community hospital staff.
- Concerns were raised regarding the fast-track process and appropriateness of admissions to hospital by the out of hours GP service.
- We did not have assurance service leads had good oversight of the risks relating to this service as staff were not always recording incidents, the service was unable to identify incidents specific to patients at the end of life and concerns relating to the out of hours GP service were not formally recorded.

Summary of findings

Background to the service

Leicestershire Partnership NHS Trust cares for patients across a wide range of services, delivered from 154 sites. This includes community hospitals and health centres across Leicester, Leicestershire and Rutland, serving a patient population of one million.

Leicestershire Partnership NHS Trust provides end of life care services across the trust as part of the community health services division. Palliative and end of life care services for adults and children and young people are provided by inpatient, community and specialist palliative care nurses and allied health professionals across the trust. Patients at the end of life are cared for across 12 wards in eight community hospitals. Specialist palliative care services are also provided by partner organisations for example, local hospices or NHS trusts.

During our inspection we visited five community hospitals and accompanied specialist nurses making visits to patients in their own homes. We spoke with six patients, ten relatives and 18 staff across inpatient and community settings, including staff nurses, specialist palliative care nurses, health care assistants, ward sisters, student nurses, advanced nurse practitioners, community matrons and district nurses.

We observed interactions between patients, their relatives and staff, considered the environment in inpatient areas, looked at 15 ‘Do Not Attempt Cardio Pulmonary Resuscitation’ (DNACPR) orders, 15 medical and nursing care records and two prescription charts. Before our inspection, we reviewed performance information from, and about, the trust.

The trust was last inspected in March 2015 and end of life care received a rating of requires improvement. Concerns were identified about staffing, mandatory training, lack of alternative to the Liverpool care pathway, lack of audits, DNACPR forms, data collection, lack of an end of life strategy and lack of specialist support for staff. We checked these areas on this inspection to see if improvements had been made and have included later in the report.

Following on from the last Care Quality Commission inspection of End of Life Care provision at Leicestershire Partnership NHS in March 2015, two requirement notices were issued relating to the end of life strategy and implementation of the alternative care pathway following the withdrawal of the Liverpool Care pathway. We saw that both of these issues had been addressed.

Our inspection team

Chair: Dr Peter Jarrett

Team Leader: Julie Meikle, head of hospital Inspection (mental health), CQC

Inspection Managers: Sarah Duncanson (Mental Health) and Helen Vine, (Community Health Services)

The team that inspected the end of life services consisted of two inspectors, two specialist advisors experienced in end of life care.

The team would like to thank all those who met and spoke with the team during the inspection and were open and balanced in sharing their experiences and perceptions of the quality of care and treatment at the trust.

Why we carried out this inspection

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

Summary of findings

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.

During our inspection we visited five community hospitals and accompanied specialist nurses making visits to patients in their own homes. We spoke with six patients, ten relatives and 18 staff across inpatient and community settings, including staff nurses, specialist palliative care nurses, health care assistants, ward sisters, student nurses, advanced nurse practitioners, community matrons and district nurses.

We observed interactions between patients, their relatives and staff, considered the environment in inpatient areas, looked at 15 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders, 15 medical and nursing care records and two prescription charts. Before our inspection, we reviewed performance information from, and about, the trust.

What people who use the provider say

Feedback from patients who used the service and those who were close to them was entirely positive about the staff working within end of life care. Staff were described as, "warm, friendly and helpful" and, "so lovely".

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust must ensure that staff follow trust policy and the legal framework of the Mental Capacity Act when completing Do Not Attempt Cardio-Respiratory Resuscitation forms.

Action the provider COULD take to improve

- The provider should ensure staff report all incidents and concerns relating to end of life care according to trust policy.
- The provider should ensure medical records are completed fully and accurately by all staff and by out of hours GPs.
- The provider should ensure staff understand their responsibilities and follow trust policy when completing the 'Last Days of Life' care plans.

Leicestershire Partnership NHS Trust

Community end of life care

Detailed findings from this inspection

Good ●

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as good because:

- Specialist equipment needed to provide care and treatment to patients in their home was appropriate and fit for purpose so patients were safe. Syringe drivers were maintained and their use was monitored.
- Safeguarding was given sufficient priority. Staff had an understanding of how to protect patients from abuse, could describe what safeguarding was and the process to refer concerns.
- Staff recognised and responded to the changing needs of patients with anticipatory medications readily available and care needs assessed and reviewed appropriately.
- Staff followed infection and prevention control practices and the community inpatient wards were visibly clean.
- Effective business contingency arrangements were in place to ensure patients continued to receive essential care during periods of adverse weather.
- Staffing levels were sufficient to provide care for patients.

However:

- The trust was unable to supply data relating to the number of incidents for patients at the end of life. We found staff did not report all incidents using the electronic reporting system therefore we could not be assured all incidents relating to end of life care were identified and reported.
- Staff had limited understanding of the duty of candour.
- The quality of admission paperwork in medical records was variable, with omissions in the completion of ceilings of care, advance care decisions and preferred place of death.

Safety performance

- Community hospitals within the trust took part in the national safety thermometer scheme. Data was collected on an identified day each month to indicate performance in key safety issues. However, this data was for all community inpatients and was not specific to end of life care. This included four key areas, pressure ulcers, falls, urinary catheter related infections and blood clots. Safety thermometer data between August 2015 and July 2016 showed the most harms recorded were for pressure ulcers although this did not differentiate between new harms and harms that were inherited from other providers.

Good 🟢

Are services safe?

Incident reporting, learning and improvement

- Trusts are required to report serious incidents to the Strategic Executive Information System (STEIS). These include never events which are defined as serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Trust wide there were 78 serious incidents reported between 1 October 2015 and 30 September 2016. None of these were categorised as never events and data provided by the trust showed none related specifically to end of life care.
- Between July 2015 and June 2016 the trust reported 69 serious incidents through its serious incident requiring investigation (SIRI) reporting system. Prior to our inspection we asked the trust if any related specifically to end of life care. The trust told us there had been no serious incidents relating to end of life care services. During our inspection, we learnt of a serious incident which related to a patient at the end of life who had a fall whilst an inpatient in one of the community hospitals. The serious investigation report had not yet been completed for this incident, however, we were able to review the initial review completed 72 hours after the incident had occurred. We saw there was a detailed action plan to review the incident including consideration of duty of candour.
- As part of our pre-inspection data requests, we asked the trust to submit incident data relating to end of life care. The trust advised the incident reporting system was not able to produce a report for the number of incidents relating specifically to adults or children at the end of life as the system did not identify patients at the end of life. However, data received from the trust relating to the Diana Service stated there had not been any incidents related to children at the end of life care within the previous year.
- Incidents were reported through the trust's electronic reporting system. All staff we spoke with were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic reporting system. Staff told us of an incident investigation relating to end of life medication which had led to a change of practice in the labelling of medication. Staff told us they received feedback from incidents through team meetings, email and their immediate line managers.
- Staff told us of their concerns about the out of hours GP service relating to admissions and transfers, however data provided by the trust showed no incidents had been reported regarding out of hours GPs. During our inspection we identified an incident relating to the service provided by an out of hours GP on one of the community inpatient wards, which had not been reported. We highlighted this to the ward manager, who agreed the incident should have been reported and gave an assurance the incident would be correctly reported.
- In view of the lack of data for the number of incidents and our concerns relating to staff not reporting all incidents, we were not assured service leads had good oversight of incident reporting for end of life care.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with had limited understanding of duty of candour but understood and could describe the need to be open and honest with patients. Service leads gave an example of where duty of candour had been applied following an incident investigation.

Safeguarding

- There were up-to-date trust wide safeguarding policies and procedures in place, which were accessible to staff via the trust's intranet site.
- All the staff we spoke with were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults and children and of the referral process to the safeguarding team. None of the staff we spoke with could recall a recent safeguarding incident regarding patients receiving end of life care.

Good ●

Are services safe?

- Staff who provided end of life care told us they had received mandatory training in safeguarding children and vulnerable adults. Data provided by the trust for the Macmillan CNS team and Hospice at Home nurses showed 86% had completed the adults safeguarding level two training and 83% had completed the level two children's training.
- The Macmillan CNS team and Hospice at Home nurses did not provide end of life care for patients below the age of 18 years. Registered children's nurses from the Diana Community Children's Service provided this. Data provided by the trust showed there was 100% compliance with safeguarding level three training within this team.

Medicines

- Data provided by the trust showed 43 community nursing staff across the trust had additional qualifications as non-medical prescribers and had prescribed palliative care drugs for adults within the past 12 months. Non-medical prescribing is undertaken by a health professional who is not a doctor and who has undergone additional training. These nurses were able to prescribe medicines in addition to those prescribed by GPs such as anticipatory medicines. Prescribing medicines, 'just in case', before the patient actually had any symptoms, allowed patients to receive effective symptom control in a timely way.
- There were non-medical prescribers within the children and young people's service at the trust. However, service leads told us they did not prescribe palliative care medication which was the responsibility of the lead consultant or a GP.
- Advanced nurse practitioners (ANP) were available at community hospitals from Monday to Friday to prescribe medicines. ANPs are registered nurses who have acquired expert knowledge and developed skills and clinical competencies for extended practice. They are able to admit patients, be available for nursing staff to refer to and are non-medical prescribers reviewing medication for symptom control. This meant, where patients had increased needs, they were identified and responded to quickly and appropriately. For example, the need for change to medication. Staff contacted the on-call GP service outside of the ANP working hours.
- The community hospital staff used an electronic prescribing system for medications. We were unable to access the system for patients who had recently died because of a technical difficulty which we escalated to an ANP and ward manager at one of the community hospitals who agreed to investigate. We looked at the nursing records for three of these patients in relation to medication and reviewed a further two prescription charts of patients identified as being in the last hours or days of life and we saw anticipatory medications were prescribed appropriately and administered in a timely way.
- We accompanied nursing staff during visits to patient's homes during our inspection. We observed nursing staff were observed to be following trust policy with regard to the checking and administration of controlled drugs. Nursing staff working within the Hospice at Home and Macmillan CNS team services did not routinely carry any medication, however, they were able to collect or return medication for their patients in exceptional circumstances, in line with the medicines policy.
- We observed prescription (FP10) forms in community settings were managed and stored in accordance with NHS Protect guidance 2013.

Environment and equipment

- The trust used syringe driver pumps for end of life patients who required a continuous infusion to control their pain. A continuous infusion is a controlled method of administering intravenous medicines without interruption. Syringe driver equipment met the requirements of the Medicines & Healthcare Regulatory Agency (MHRA). Patients were protected from avoidable harm when a syringe driver was used to administer a continuous infusion of medication; as the syringe drivers used were tamperproof and had the recommended alarm features.
- Syringe driver pumps were available in both the inpatients and community settings. We looked at 35 syringe drivers across all settings. All of the pumps were clean and had been safety tested. The Hospice at Home team had 22 pumps and we saw there was a robust system in place to ensure staff could account for all of the equipment.
- Specialist equipment needed to provide care and treatment to patients in their home was appropriate

and fit for purpose so patients were safe. Equipment was accessed through a local community equipment service. None of the staff we spoke with raised any concerns with accessing equipment and told us equipment could arrive in the patient's home within the same day.

- The Hospice at Home service had rapid discharge bags for patients being discharged home. These included a slide sheet, dressings, continence pads, gloves and aprons and a bottle of liquid soap for personal care.

Quality of records

- Community nursing staff used an electronic system to access patient records, this included access to GP records. Electronic records were updated contemporaneously. This meant an accurate record of the patient visit was recorded at the time of the visit. All community hospital inpatient areas had paper care records.
- We reviewed the care records of 15 adult patients who had recently died or were receiving end of life care. The nursing records were accurate, complete, legible and up to date. However, the quality of the admission paperwork was variable. These records were either completed by ANPs or GPs from the out of hours service and the majority of incomplete records were those completed by the GPs. We found there to be limited documentation about ceilings of care, advance care planning and preferred place of death.
- Staff told us that they were concerned that GPs were not completing Venous Thromboembolism (VTE) (blood clots) assessments for the patients they admitted to the community inpatient hospitals. Two of the records we looked at did not have an initial VTE assessment recorded in the admission paperwork.
- We reviewed a copy of a record keeping audit provided by the trust. The audit was for the Hospice at Home team from April 2016 and covered both paper and electronic records. The results of the audit showed more than 90% compliance against every standard audited. The action plan included with the results would be presented at clinical supervision meetings.

Cleanliness, infection control and hygiene

- Throughout end of life care services we observed staff to be complying with best practice with regard to infection prevention and control policies. Staff were observed to wash their hands or use hand sanitising gel between seeing patients. There was access to hand washing facilities on the inpatient wards and, a supply of personal protective equipment, which included gloves and aprons, was available both on wards and during home visits. All staff were observed to be adhering to the dress code, which was to be 'bare below elbows'.
- PLACE assessments are self-assessments undertaken by teams of NHS and private/independent health care providers, and at least 50% of the team are members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services such as cleanliness. These assessments included community hospitals where some patients at the end of life were cared for. In relation to cleanliness, the trust scored 94.7%, which was below the national average of 97.6%. Loughborough and Rutland exceeded the national average score.
- Data provided by the trust showed the Diana nurses had a checklist for equipment used by children and young people at the end of life. The checklist had been used for all children who died within the last year. The checklist included instructions of how to clean the equipment and dispose of single patient use items.
- Hand hygiene audit data provided by the trust for the Hospice at Home service between April and November 2016 showed 100% for every month apart from one. The service also audited the top ten infection prevention and control markers. Data provided by the trust from April to October 2016 showed average compliance rates of 85% and included action points to rectify non-compliance points.

Mandatory training

- Mandatory training was mostly completed using an on-line electronic system, although some modules were provided as face to face sessions.
- Mandatory training included information governance, infection prevention and control, safeguarding adults and children, fire training, basic life support for adults and children, medicines management and record keeping and care planning.

Are services safe?

- The trust provided training data prior to our inspection. The training data provided did not have a target for each training course. Compliance rates for all mandatory training for the Macmillan CNS team was above 79% and Hospice at Home nurses was 100%.

Assessing and responding to patient risk

- Comprehensive risk assessments were carried out for patients and risk management plans developed in line with national guidance. We reviewed the care records of 19 patients identified as being at the end of life. Risks to patients, for example moving and handling, continence, nutrition and hydration and pressure ulcers were assessed, monitored and managed on a regular basis.
- Community nursing staff were issued with cameras to enable them to photograph pressure ulcers and areas of skin damage in order to monitor damage and healing. However, the Hospice at home staff did not photograph patients in the last days or hours of life as this was considered inappropriate and more emphasis was placed on comfort rather than healing.
- Occupational therapists (OTs) used a WOMBAT (Windsor outcome measure before and after therapy) tool to assess patients at risk of falls, with limited mobility and who needed assistance with personal care. We saw that OTs documented their assessments in the nursing records and recorded “goals” for patients to attain.
- ANPs were available from Monday to Friday at the community hospitals for review of patients requiring urgent medical attention. Out of these hours, staff were able to contact the on-call GP service.
- Staff were able to contact the local hospice 24 hours a day for advice and support. We observed a member of staff using this service to obtain advice about a patient at the end of life.

Staffing levels and caseload

- The trust did not provide dedicated adult end of life care beds within the community hospital inpatient wards. Beds for end of life patients were the same beds as those provided for other inpatient provision and were allocated as required. Staffing for these beds was included as part of the inpatient provision.
- There were dedicated specialist palliative care teams which included the Macmillan CNS team and Hospice at Home team for patients over 18 years of age. Data provided by the trust for the Macmillan CNS team for August 2016 showed they were 10.6 whole time equivalent (WTE) qualified nurses and no vacancies. Data for the same period for the Hospice at Home team showed an establishment of 9.3 WTE qualified nurses and 2.8 nursing assistants, with one WTE vacancy for a qualified nurse and a 0.6 WTE vacancy for a nursing assistant.
- Staff within the Hospice at Home team told us their caseloads were variable depending on the number of referrals received. Staff felt they were able to spend time with their patients and their families to meet their needs. Staff within the Macmillan CNS team told us their caseloads were higher and were set at a level that kept patients safe. However, Macmillan CNS team staff told us caseload levels left insufficient time for non-essential duties such as training of other staff.
- Children and young people were cared for by registered children’s nurses from the Diana Service. However, staffing numbers were not specific to end of life care as nurses looked after a range of children with long term, complex and acute nursing needs.

Managing anticipated risks

- The trust had provided business continuity plans for each of the community teams. We reviewed the Hospice at Home service business continuity plan together with the winter contingency arrangements. These plans gave clear direction for staff in the event of loss of services such as telephones and IT, and also in the event of adverse weather.
- Staff told us, in the event of severe weather, they would contact patients by phone to assess their needs. The service had access to local volunteer drivers with “four by four” vehicles, who were willing to assist with the transportation of staff to essential visits during episodes of severe weather.
- Lone working guidance was available to those staff working in the community. Staff we spoke with were aware of the guidance and we saw systems were in place to keep staff safe.

Requires improvement ●

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

We rated effective as requires improvement because:

- There were inconsistences in the completion of the 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms. These included lack of mental capacity assessments for those deemed to lack capacity, lack of information regarding the discussions held with patients and/or their families and not discussing the DNACPR with the patient, even though it stated they had capacity. DNACPR decisions and discussions were not always clearly recorded in the patient's medical records.
- The 'Last Days of Life' individualised care plans used for adults at the end of life were not fully embedded across the trust.
- There was an unstructured, non-mandatory approach to formal end of life training for community hospital staff.

However:

- Patients' care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- We saw evidence of multidisciplinary working, with staff, teams and services at this trust and external organisations working in partnership to deliver effective care and treatment.
- Patients and relatives we spoke with told us their pain had been well managed by staff.
- Paperwork developed within the Diana Service, specifically for referrals for children and young people requiring on-call support in the last days/weeks of life, was used in all instances.

Evidence based care and treatment

- In response to the 2013 review of the Liverpool Care Pathway (LCP) the trust had introduced individualised care plans for patients in their last days of life, which we reviewed. We found the use of the care plans was not fully embedded across the trust, particularly on the community inpatient wards. When completing symptom assessments for patients in the last days of life, staff were required to complete care plans for each symptom. We looked at five 'Last days of Life' care plans and found four were not completed in line with the trust's guidance, as there were no additional care plans completed when symptoms were present. Staff we spoke with working within the community inpatient wards told us there was a degree of confusion about when and how to use the care plans. Service leads told us the embedding of the last days of life care pathway was on the service risk register.
- We reviewed a draft audit "Care of patients in the last days of life" provided by the trust covering the period September to October 2016. The audit covered the pathways for both adults and children and young people (CYP); against 32 standards for adults and 23 standards for CYP. The audit results were RAG rated (a coloured representation of results with red, amber and green) with green representing full compliance, amber representing partial compliance and red showing minimal compliance (below 80%) although some results did not have RAG rating applied for reasons not specified in the audit report. The report showed the pathways for CYP were 100% green against all criteria except documentation showing a clearly designated 'senior responsible clinician' responsible for the patient's care.
- The audit report for the pathways for adults showed eight standards were green including assessment of patients' symptoms every four hours (inpatient) and at each visit (community) and wellbeing of relatives/carers assessed. Three standards were amber and 15 were red which included patients records had care plans in place for all symptoms requiring action (50%) and 'last days of life' documentation has been utilised within patient record (40%). As this audit was in draft form, no action plan or dissemination of learning was available.
- End of life care Care for adults at the end of life was managed in accordance with the National Institute for Health and Care Excellence (NICE) guidelines. Data

Are services effective?

provided by the trust showed compliance with NICE guidance was monitored and a review of NG31 'care in the last days of life' had been completed in December 2015 and showed full compliance.

- A review of three medical records and two prescription charts showed symptom control for end of life patients had been managed in accordance with the NICE Quality Standard CG140 Opioids in palliative care. This defines clinical best practice for the safe and effective prescribing of strong opioids for pain in palliative care of adults. Data provided by the trust showed this standard was being included in an audit of inpatient controlled drugs (CD) currently in progress and a similar audit for the community would be conducted in December 2016.
- The end of life service provided for children and young people followed the guidance issued by Together for Short Lives; "A Core Care Pathway for Children with Life Limiting and Life Threatening Conditions", 2013. A holistic approach to care involved the patient, where possible, and the whole family in care planning directed at providing the individualised care and support required.
- The trust was contributing palliative care data to the National Minimum Data Set (MDS). The National Council for Palliative Care collects the MDS for specialist palliative care services for palliative care on a yearly basis, with the aim of providing an accurate picture of specialist palliative care service activity. It is the only annual data collection to cover patient activity in specialist services in the voluntary sector and the NHS in England.
- The trust submitted data to the NHS Benchmarking network for end of life care.
- The trust was part of the East Midlands Palliative Care Network which meant they had strong links to other care providers and were able to share learning and resources.
- The trust was a contributor to the East Midlands Strategic Clinical Networks 'Audit of children's palliative care services in the East Midlands and identification of the gaps in service provision' 2015.

Pain relief

- We spoke with three patients and four relatives about how their or their relative's pain had been managed. All were positive in their comments describing the management of their pain, good access to pain medicines and pain medicines given in a timely way.
- Pain and discomfort was assessed as part of the last days of life care planning and on admission into the community inpatient wards. However, we saw two records where pain had been identified as a symptom but a care plan had not been completed. This meant other staff may not be aware of the plan to manage pain.
- We reviewed nursing records and prescription charts and saw that anticipatory medications (just in case medicines) were prescribed for patients identified as being at the end of life. Nursing staff in the community hospitals told us the ANPs or out of hours GP service were always available to review patients if there were concerns about pain or symptom management. Specialist palliative care nurses working within the community were available to advise on symptom management together with staff from local hospices who provided a 24 hour helpline to the consultants at the hospice.
- Staff used syringe driver pumps for adult and children end of life patients who required a continuous infusion to control their pain. Parents or carers of children at the end of life could also be trained if they wished on the administration of sub-buccal (under tongue) pain relief which gave them some element of control over the management of their child's pain. Staff told us parents had reported they were happier with this arrangement.

Nutrition and hydration

- Staff screened for malnutrition and the risk of malnutrition on admission to hospital or at their first assessment in the community. Where patients were transferred to the community inpatient wards from the local acute NHS trust, we saw nutritional assessment information was included as part of the handover of care.
- Protected meals times were in place on all the community inpatient wards we visited. We observed all patients which included those at the end of life had access to drinks, which were within their reach.

Are services effective?

- The care records we reviewed showed staff supported and advised patients who were identified as being at nutritional risk. Dieticians had been involved in the management of end of life patients who had additional needs. Where interventions were required we saw these documented in the patient's individual plan of care.
- There was a red tray system in place on the wards we inspected. The red tray system identified those patients who required assistance with their nutrition and hydration. For example, we saw one patient who was at the end of life receiving assistance with their lunch due to a difficulty in managing.
- Families were encouraged to assist their loved one at mealtimes as required.
- We looked at the menu on each ward we visited. The menu had a main section, which included special diets, and a vegetarian section. Patients at the end of life were also able to order from the children's menu.

Patient outcomes

- The National Gold Standards Framework (GSF) Centre in End of Life Care is the national training and coordinating centre for all GSF programmes, enabling generalist frontline staff to provide a gold standard of care for people nearing the end of life.
- The trust were committed to participation in the Gold Standards Framework (GSF) Community Hospitals training programme in support of a local Commissioning for Quality and Innovation (CQUIN), which had been developed by commissioners in response to the recognised priorities across the healthcare community. The Commissioning for Quality and Innovation (CQUINs) framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. For patients this can mean better experience, involvement and outcomes. We saw a copy of the trust progress report which showed the trust was on track to meet this CQUIN target for 2016/17 and we saw work in progress toward this during our inspection.
- The trust provided data which showed between August 2015 and July 2016 there were 12 children and young people referred to the Diana nurses for palliative end of life care.
- Data provided by the trust from May 2016 to October 2016 showed there were 1828 referrals to the community specialist palliative care teams, of which 1287 were to the Macmillan CNS team, and 541 to the Hospice at Home service.
- The trust did not contribute to the National Care of the Dying Audit.

Competent staff

- Some staff working within the end of life care service had received additional training to be able to verify death. This included advanced nurse practitioners (ANP), senior Hospice at Home nurses and some community inpatient nursing staff in post for more than two years.
- The trust provided data which showed the staff appraisal rate as of September 2016 but did not provide a target figure. Of the 14 staff in the Macmillan CNS team nursing team, 11 (78.6%) had received an appraisal within the previous 12 months. For the Hospice at Home nursing team, 14 out of 15 staff (93.3%) had received an appraisal. Staff explained the reason for the 15th member of staff not having an appraisal within the previous 12 months was due to the staff recently joining the team, therefore an appraisal would be carried out in due course following a period of induction and orientation. The overall trust appraisal rate was 83%.
- Staff we spoke with told us they received clinical supervision. Specialist nurses within the Macmillan CNS team and Hospice at Home service told us they had planned clinical supervision once a month. Nursing staff working within the community hospital told us they had clinical supervision at least four times a year. Staff from the Macmillan CNS team told us they had attended reflection groups every six weeks which allowed them to discuss and reflect on their practice. Data provided by the trust from September 2016 showed the recorded rate of clinical supervision was 93.3% for the Hospice at Home team and 57.1% for the Macmillan CNS team. The trust target for clinical supervision was 85%.
- Nursing staff working with children within the Diana service received annual training supported by professionals from the East Midlands Palliative Care Network. Service leads told us seven nursing staff had

attended the Palliative care Module and Cancer Care Module at a local university and local hospices coordinated additional training which was available to staff.

- Training for end of life care was available as an e-learning package but was not mandatory. The majority of staff we spoke with in the community hospitals had not accessed this training. Ward managers we spoke with in the community hospitals told us the approach to end of life training was not structured, however we did see that some workshops were being held in the community hospitals to cascade the gold standard framework learning. We asked two members of staff to show us the training which was available on-line but they were unable to locate it. We asked the trust to provide data on the uptake of the training and were told the data was considered to be poor and did not reflect the uptake of the training. However, service leads told us the trust was working with partners within the Leicester, Leicestershire and Rutland group to develop a training strategy to establish an educational package for all staff working within end of life care.
- End of life care training was included as part of the preceptorship package for newly qualified nursing staff. A newly qualified nurse we spoke with confirmed they had received this training.
- Data provided by the trust showed 100% of ANPs and staff working within the Macmillan CNS team and Hospice at Home teams had completed an advanced communication course. This meant they would have received additional training in communication which would help them have sensitive discussions with relatives and patients at the end of life.

Multidisciplinary working and coordinated care pathways

- Patients at the end of life received support from an end of life care multidisciplinary team. This included the specialist palliative care nurses, consultants, nursing staff, occupational therapists, physiotherapists, oncologists and other relevant professionals.
- Staff worked collaboratively with the local hospice, which was regarded as a local centre of excellence for end of life care and care in the last days of life. Example of collaborative working included a 24 hour helpline to the consultants at the hospice for clinical staff for symptom management, joint home visits with trust and hospice staff, clinical supervision for ANPs and specialist palliative care nurses, access to study days and joint working with the clinical education teams.
- Staff within the Macmillan CNS team confirmed they participated in bi weekly, multidisciplinary meetings with staff from the local hospice.
- Consultant geriatricians and stroke specialists from a local acute trust visited most community hospital inpatient wards twice a week. ANPs had a close working relationship with the consultant who covered the wards and contacted them outside of their visits if they had concerns.
- We saw the use of multidisciplinary team stickers within nursing records which highlighted which multidisciplinary team professionals were to be involved in the patient's care and gave an indication of the goals for the professional's involvement.
- Multidisciplinary team meetings were undertaken to help identify and coordinate care for patients approaching the end of their life or requiring supportive care in the community.
- The Hospice at Home team worked closely with the community nursing at Night team. We saw there was effective communication and systems for handover of care.

Referral, transfer, discharge and transition

- The Hospice at Home service was available to all patients who met the referral criteria, which was to be registered with a GP within Leicester, Leicestershire and Rutland and for patients aged 18 years and over approaching the end of life or in an acute palliative care crisis.
- Referrals into the Hospice at Home service were received from community nurses, GPs or through the single point of access system. Referrals to the Macmillan CNS team were through the SPA system. However, staff we spoke with within these teams thought the SPA system led to avoidable delays in some cases as referrals were sent to the wrong teams. For example we heard of a referral to the district nursing team instead of

specialist nursing which meant the patient had to wait for specialist input. An item on the Community Health Services risk register related to the single point of access.

- Referrals into the Diana Community Children's Service for 24/7 on-call at the end of life are from acute settings, supported by the child/young person's lead consultant. The team supported discharge processes from hospital and provide families and carers with an emergency kit which included 24 hour contact numbers. However, an audit had identified there was a lack of referral for babies at the end of life from local neonatal units. This had been raised within the East Midlands CYP palliative care and neonatal networks and work had commenced to develop a pathway to raise awareness of services and the importance of offering families choices at end of life. Service leads told us a project group had been set up to look at the provision of bereavement care, for example, to consider how long specialist nurses should continue to support relatives following bereavement.

Access to information

- The trust used an electronic patient record system, which meant staff could access patient records flexibly within the community. However, staff within the community inpatient hospitals did not have access to this system.
- Staff could access information in the office or remotely using an electronic tablet in the families' homes.
- The trust was not using an electronic palliative care coordination system (EPaCCS). EPaCCS allows patient information to be shared with other agencies within the local area including acute NHS trusts and community inpatient hospitals, GPs and ambulance services. Service leads told us the use of an EPaCCS system was planned.
- Staff working within end of life care in both community and inpatient settings had access to a 24 hour advice line from specialists at the local hospice.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of the mandatory training programme across the trust, with compliance based on a three year cycle.
- Nursing staff we spoke with told us they had received training on the MCA. They had an awareness and understanding of DoLS, and MCA. Data provided by the trust showed s
- The service did not report any DoLs applications and we did not see anyone deprived of their liberty during our inspection.
- Patients and relatives told us staff did not provide any care without first asking their permission.
- Signed consent forms were evident in all the patient records we examined. This demonstrated staff obtained consent to treatment appropriately
- The 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms were kept at the front of the patients' medical notes, allowing easy access in an emergency and were recorded on a standard form with a red border. All of the DNACPR orders were easy to read and were transferable to hospital from the community. The DNACPR forms we looked at were completed by ANPs or GPs from the out of hours service.
- We looked at 15 DNACPR forms across the trust and of these five were accurately completed. We found there were inconsistencies in the completion of the remaining ten forms. These included lack of mental capacity assessments for those deemed to lack capacity, lack of information regarding the discussions held with patients and/or their families and not discussing the DNACPR with the patient, even though it stated they had capacity. DNACPR decisions and discussions were not always clearly recorded in the patient's medical records.
- We looked at the trusts the trust had a legal duty to consult with and inform patients if a DNACPR order is placed in their notes (and relevant others if the person lacks capacity to be involved in the process)'. It further stated 'Non discussion has been deemed as an infringement of a patient's human rights and in particular denies them the ability to seek a second opinion if they disagree with a DNACPR.'
- One ANP we spoke with told us additional training on completion of DNACPR forms was planned.
- The service conducted an audit of the DNACPRs for community hospital inpatients between August and October 2014, although this audit did not specifically include patients who were 'last days of life'. The audit

measured compliance against 12 standards and the results were allocated a RAG (red, amber, green) rating which is a clear visual aid of the results of the audit. Of the 12 audited standards two were green (full compliance) three were amber (partial compliance) and the remaining seven were red (minimal compliance). Following this audit the trust produced an action plan and introduced a new resuscitation policy. Staff told us of plans to repeat the audit in March 2017, extending it to include the community teams.

Good ●

Are services caring?

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

Summary

We rated caring as good because:

- There was a strong, person-centred culture. Staff treated patients with compassion, dignity and respect.
- Patients and their relatives felt involved in the care provided. Patients' social, emotional and religious needs were met and relatives valued the emotional support they received.

However:

- Documentation of advance care planning in some records was poor, which meant some staff might not fully understand patients' preferences.

Compassionate care

- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care which was kind and promoted people's dignity. Without exception, the patients and relatives we spoke with told us staff were extremely kind and caring.
- We observed throughout our inspection and in accordance with the National End of Life Care Strategy (Department of Health 2008), staff speaking about the patients they cared for with compassion, dignity and respect.
- Throughout our inspection, we observed patients being treated with compassion, dignity and respect. All the patients we spoke with told us staff treated them respectfully and their privacy was respected.
- On a home visit to a patient, we saw excellent holistic care undertaken by two specialist nurses. The nurses demonstrated a good awareness of the patient's needs and wishes. The nurses provided good support showing kindness and gave the patient and relatives the time they needed.
- We spoke with the relatives of four patients who were at the end of life. The relatives described the care and support as excellent and said they felt well informed by the staff. One relative told us "I can't believe how caring and compassionate they all are, not just for the patient but also for me".
- All of the staff we spoke with showed an awareness of the importance of treating patients and their representatives in a sensitive manner.
- Chaplaincy services were available on request. Staff told us the trust did not have a Church of England or Lead Chaplain; however, there were chaplains from the Sikh, Muslim, Hindu and Roman Catholic faiths within the chaplaincy service who were available for referrals. In addition, informal arrangements were in place for chaplaincy support from a local NHS trust for Anglican referrals. Staff were able to phone or email a central number to ring to request a chaplain or a representative from a different faith. Staff within the Hospice at Home service told us they worked with the Muslim Burial Council to ensure funerals were conducted within 24 hours.
- Nursing staff were also able to contact local priests or spiritual leaders from the patient's own church or faith group. We saw a nurse on a community inpatient ward making arrangements for spiritual support for the relatives of a patient who had recently died.

Understanding and involvement of patients and those close to them

- Patients and family members we spoke with told us they felt involved in the care delivered. We saw staff discussed care issues with patients and relatives where possible and these were generally clearly documented in patient's notes.
- We observed specialist palliative nurses gave leaflets to patients and their relatives and explained their content. These included a booklet about the end of life and what they might expect to happen and information about syringe drivers. We spoke with six patients and ten relatives about the care they were receiving and information that they were provided with. All were complementary about the information that they had been provided with, and told us they felt supported by staff.

Good ●

Are services caring?

- Advance care planning is a process of discussing and/or formally documenting wishes for future care. It enables health and care professionals to understand how a patient wants to be cared for if they become too ill to make decisions or speak for themselves.
- We saw the quality of documentation of advance care plans in the community inpatient wards was variable as this was omitted in some of the records we looked at which meant staff may not understand patients' preferences.

Emotional support

- Staff offered emotional support for patients and their families. Emotional support was provided to patients and their families through a variety of services, including the voluntary sector. Community nurses and ward staff were able to refer bereaved relatives for support through these services if required.
- We witnessed nursing staff in the hospitals and in the community providing emotional support. Relatives also confirmed staff provided them with emotional support. One relative told us, "I feel so much calmer knowing I can just pick the phone up and talk to one of the nurses".
- The Hospice at Home team sent a card to the recently bereaved relatives of patients within their care, which were appropriately personalised by the nurse who knew the patient best.
- We saw patient records included psychological and spiritual needs within the "care in the last days of life" plans.

Good ●

Are services responsive to people's needs?

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

Summary

We rated responsive as good because:

- The needs and preferences of patients and their relatives were central to the planning and delivery of care with most people achieving their preferred place of care.
- Services were planned and delivered in a way that met the current and changing needs of the local population and included access to end of life services by people in vulnerable circumstances and the differing needs of individual patients and relatives.
- Care planning included assessments of the patient's emotional and spiritual needs.
- The end of life care service had not received any complaints within the past year.

However:

- Staff were concerned about the fast track process and inappropriate admissions by the out of hours GP service. The trust has not recorded these concerns appropriately nor raised them with those responsible for the out of hours GP service.

Planning and delivering services which meet people's needs

- The trust was working collaboratively with other local providers and commissioners of services within the Leicester, Leicestershire and Rutland area to formulate an end of life care strategy. As part of this, a health needs assessment covering the whole Leicester, Leicestershire and Rutland area had been completed which detailed both the current services available and the service gaps.
- The trust provided adult end of life care services in community in-patient ward and community nursing services seven days a week. These services were delivered by specialist palliative care nurses, advanced nurse practitioners (ANP), inpatient and community nurses and allied health professional staff. Specialist palliative care services were also provided by partner organisations for example local hospices for both adults and children and nearby acute NHS Trusts.
- There were no dedicated end of life beds in the community hospitals at this trust. Patients identified as being in the last days or hours of life were nursed in community inpatient wards or in their usual place of residence.
- The Hospice at Home service was nurse led and specialised in end of life care (particularly the last 72 hours), irrespective of diagnosis, in the patient's usual place of residence. The referral criteria for the service were; the patient will have a life limiting illness requiring specialist palliative care and be over the age of 18; or the patient will have one or more of the following needs which are unmet, uncontrolled or complicated symptoms, specialised nursing requirements, complex social/family issues requiring extra support, or psychological/emotional issue requiring extra support. The service was available from 7.00am to 10.00pm seven days per week including bank holidays. At other times the Nursing at Night team covered any unscheduled visits to patients at the end of life including for support and symptom control.
- The Macmillan CNS team was available between the hours of 8.30am and 5.00pm and worked within the city area with two staff based at Beaumont Leys health centre. Patients from the Leicester City area were cared for by specialist palliative care nurses from the local hospice, an historical commissioning arrangement. The criteria for referral to the Macmillan CNS team was; the patient has a diagnosis of advanced life limiting illness and; symptom control or other complex problems which are escalating or are unable to be managed by the current clinical team (symptoms may be physical, psychological, spiritual, social) or complex social needs resulting from their illness or whose carers show exceptional emotional distress.

Good ●

Are services responsive to people's needs?

- The community inpatient wards were nurse-led settings without any resident medical staff. ANPs were available at the community hospitals where end of life patients were nursed from Monday to Friday from 9.00am to 5.30pm.
- Within the Leicester, Leicestershire and Rutland area, support for children aged under 18 and at the end of life was provided by the Diana children's community service. There was a multidisciplinary approach with input from other services within the Diana service, for example Macmillan support, child and family support, cultural link specialist and transition team for those transferring into adult services.
- Some of the community hospitals we visited had dedicated palliative care suites. For example the suite at Rutland hospital included a kitchen area and en-suite wet room with a pull out bed for relatives to sleep on if they wished to stay overnight. The suite had a separate entrance so visitors could come and go as they wished and overlooked the garden. Staff told us these rooms were available for other patients to use if there were no patients in the last days of life.
- Staff in the community hospitals with no dedicated palliative care suites told us patients at the end of life would be nursed in side rooms wherever possible.

Equality and diversity

- Staff had access to interpreter and translation services through an external company. Staff demonstrated a good awareness of the language needs of the local community and told us the process they would follow should they require an interpreter. We saw a large poster on the wall of one of the community hospitals printed with different languages and flags to help staff identify the language needs of patients.
- Purple resource folders for end of life care were available in ward areas and contained information about meeting the spiritual needs of patients. Chaplaincy services at this trust were available and we saw staff were able to access spiritual support for patients and relatives at the end of life. A chaplaincy leaflet was available to give to patients although the majority of staff we spoke with were not aware of its existence.
- Staff told us alternative spiritual needs were accommodated and we learnt of a Reiki healer that had visited one of the inpatient wards to support a patient.

Meeting the needs of people in vulnerable circumstances

- Care plans we looked at for inpatients and patients being cared for in the community included an assessment of emotional and spiritual needs
- In one community hospital we saw the use of 'pet therapy'. A volunteer visited with their dog and would often sit with patients including those at the end of life and/or their relatives. Animal-assisted therapy can significantly reduce pain, anxiety, depression and fatigue in people with a range of health problems.
- Staff told us they would liaise closely with the trust learning disabilities team and the carers of any patient with learning disabilities who was at the end of life. However, there was no pathway specific to end of life care for patients with learning disabilities or living with dementia.

Access to the right care at the right time

- Data provided by the trust showed the number of patients who had died with an active referral to one of the end of life services at the point they died. Between November 2015 and October 2016 the data showed 992 adults and 13 children and young people had died in the care of the service. The data for adults did not specify the place of death. Children and Young People data did specify place of death.
- The trust carried out an audit of whether patients had died in their preferred place of death. The audit data showed a total of 470 patients had died in the care of specialist palliative care services between April 2015 and March 2016. Of these, 410 (87%) patients had a preference for their place of death recorded in their handheld and electronic record. The average cited by The National Survey of Bereaved People 2015 (VOICES – Views of Informal Carers – Evaluation of Services) was that 69% of patients were cared for in the place they wanted to be.
- Data provided by the trust following our inspection showed 100% of children and young people referred for end of life care were seen by registered children's nurses working within the Diana team within 24 hours Monday

to Friday. 24/7 on-call (nursing support) was arranged for children and young people based on their individual needs. It could take up to 48 hours to set up a package of care, however, the family would have seen a nurse and the process started on the day of referral.The coordinator on-call would give advice if required and sign post to the local children's hospices if urgent care was needed for any referrals received at a weekend.

- The trust provided data for average speed of response to referrals for the Hospice at Home team for the period November 2015 to December 2016. The service had three timescale targets for response to referral, dependant on the urgency of the referral; 'planned appointment', 'attend within two hours' and 'attend within 48 hours'. Visits were monitored and recorded as to whether the referral was responded to within 24 hours or 48 hours. The data showed 83% of 'planned appointments', 98.8% of 'within two hours' and 92.7% of 'within 48 hours' were made within the 24 hour period. The response to referral rate within 48 hours was over 96% for all categories.
- Service leads told us every referral was responded to within two hours and if a face to face visit was needed the response time was agreed with the referrer. If a face to face visit could not be made due to capacity by the team telephone contact was made and further plans made dependant on urgency. The service monitored the capacity to respond to referrals for the Hospice at Home service. Data provided by the trust for November 2016 showed there were four referrals where telephone advice only was given because of capacity and referrals made to the wider community service teams to support the patient.
- The trust provided response to referrals data for the same period for the Macmillan CNS team. The data showed 11.6% of 'planned appointments', 26.2% of 'within 48 hours' and 9.6% of 'within five days' had been made within the 24 hour period. The rate of response within 48 hours was 18.2%, 45.4% and 20.1% respectively. The trust did not provide a target response time.
- The Hospice at Home team worked collaboratively with other staff in the trust to facilitate rapid discharge. The criteria for rapid discharge referral was a multidisciplinary team agreement that death was likely to occur within the next 48 hours, the option of continued hospital or hospice care had been discussed, the patient's preferred place of death was home and the relatives and carers of the patient supported the decision. Staff we spoke with within the Hospice at Home team told us patients would be discharged the same day if referrals were received for the rapid discharge service before 12.00 midday. For referrals received after 12.00 midday the patient would be discharged either that day or early the next day.
- Data provided by the trust showed from 31 October 2015 until 1 November 2016 the service received 107 referrals for rapid discharge home to the patients preferred place of death.
- Staff working across the trust in all care settings told us of concerns regarding the fast track process and inappropriate admissions by the out of hours GP service. (A fast track process is where a patient has a rapidly deteriorating condition, and may be entering the final stages of their life and where additional arrangements need to be put in place to facilitate a discharge home). Staff on the community inpatient wards told us of concerns some patients were admitted to hospital that could have been managed at home with an appropriate package of care. In addition staff told us some patients were transferred to acute NHS trusts by GPs who could have been managed by the community hospitals, for example for administration of intra-venous antibiotics. We also learned of concerns patients fast tracked for discharge home were not discharged in a timely way due to delays with the fast track system.
- We looked at the care records of a patient who was at the end of life who had been identified as requiring a fast track discharge. The original discussion within the multi professional team was documented on 7 November 2016. The fast track application was made on 11 November and the patient was still on the ward on 16 November 2016.
- Service leads acknowledged the fast track system was not always efficient. They told us they were currently in a tendering process for the fast track service with a new provider from April 2017. A new system was to be piloted in January which would focus on the patient, rather than the process.
- Staff called the out of hours GP service when ANPs were unavailable for example in relation to concerns about deterioration of patients or symptom management. Staff told us of concerns that GPs were not willing to attend the wards to review patients, particularly on

Sundays. We reviewed the medical records of one patient who had recently died and saw there had been an incident where a GP would not attend a ward in order to alter the electronic prescription for a patient in the last hours of life. This had not been reported using the trust electronic incident reporting system. Staff within the community inpatient wards told us ANPs monitored problems with out of hours GP services.

- Data provided by the trust showed there had been no concerns raised in relation to out of hours GP service either by the community or community hospital inpatients since January 2016. However, service leads told us the out of hours GP service was not contracted by the trust but by local commissioners. They told us they had a proactive approach to working with the out of hours GP Service for community hospitals to address issues and make improvements. We were told the service was looking at the possibility of extending the working hours of ANPs to include weekends. Therefore we were not assured all concerns relating to the out of hours GP service were being appropriately logged.
- Specialist nurses from the Hospice at Home team told us they were not commissioned to provide care for patients in nursing homes. However, although they would not go into the homes to provide personal care, they would respond to requests for assistance with symptom control as they did not wish patients to suffer unnecessarily, and would also try to train nursing home staff on the use of syringe drivers where possible.
- Staff at the community inpatient hospitals told us they gave relatives a support bag, which contained practical essentials for an unexpected overnight stay.
- Pre and post death bereavement support was provided by the Diana children's nurses. The patient's siblings were offered up to 12 sessions which might focus on key anniversaries for example birthdays and Christmas and families were supported to create memory boxes.

Learning from complaints and concerns

- Data provided by the trust showed the end of life care service did not receive any complaints between August 2015 and July 2016.
- Information on how to raise a concern or make a complaint was available in the community hospital wards we visited. Patients and relatives told us they would feel comfortable raising a complaint with ward or community nursing staff if necessary.

Good ●

Are services well-led?

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

Summary

We rated well-led as good because:

- Staff demonstrated commitment to delivering high quality end of life care for their patients.
- The trust had worked collaboratively with local partners to develop an end of life care strategy for the region as a whole which had incorporated a health needs analysis.
- There was strong local leadership on the community inpatient wards and in the community. Staff told us they felt supported by their line managers, ward managers and matrons.
- The service had recruited end of life champions to promote the work of the service and cascade learning to staff across the trust.

However:

- We did not have assurance service leads had good oversight of the risks relating to this service as staff were not always recording incidents, the service was unable to identify incidents specific to patients at the end of life and concerns relating to the out of hours GP service were not formally recorded.

Service vision and strategy

- Following on from the last Care Quality Commission inspection of end of life care provision at the trust in March 2015, a number of improvement actions were identified which included the need to develop an end of life care strategy. Service leads told us the strategy had taken time to develop because the trust worked with all partners in the Leicester, Leicestershire and Rutland area in order to produce a co-badged strategy. The strategy was also following the Leicester, Leicestershire and Rutland Sustainability and Transformation Plan (STP) ‘Better Care Together’. (STPs are plans for people and organisations to work together to transform the way health and care is planned and delivered for their population.)
- Following the CQC inspection in 2015, the trust introduced an end of life steering group and developed a quality improvement plan (QIP) as an intermediate strategy. The clinical director for community health services (CHS) was chair of the steering group and also sat on the Leicester, Leicestershire and Rutland End of Life Board. We reviewed the QIP and saw a wide range of issues had been considered including the engagement and development of collaborative relationships across Leicester, Leicestershire and Rutland, the future strategic direction, implementation of new care pathways and education.
- We reviewed minutes of the End of Life Steering Group from October 2016. The meeting was multidisciplinary and included a wide range of staff from across the trust and other partners such as the local hospice. We also spoke to service leads, managers and team leaders who attended the steering group meetings.
- We saw the Hospice at Home team had held a development afternoon for the specialist nurses team to discuss the strategy and service leads held ‘Cafe Conversations’ at CHS sites across the trust in order to engage with staff in the process.
- However, we were not assured this strategic information was being effectively cascaded downwards, as some junior staff we spoke with had a limited understanding of the strategy or the process.
- The Leicester, Leicestershire and Rutland strategic case for change was approved by Leicester, Leicestershire and Rutland end of life care Board and approved at the trust’s quality assurance committee on 15 November 2016. Service leads told us there were further plans to implement a new end of life strategy by April 2017.
- The Leicester, Leicestershire and Rutland end of life care strategy was for adults and did not include end of life care for children but service leads told us the new trust’s strategy would incorporate both adult and children’s services, including transition. In the interim period the trust had adopted the East Midlands Strategic Clinical Network strategy which had been adapted to the local services provided.

Good ●

Are services well-led?

Governance, risk management and quality measurement

- The trust held multidisciplinary, quarterly, morbidity and mortality review meetings which reviewed all inpatient deaths in Community Health Services (CHS) and other significant cases where morbidity was a feature and clinical management was complex. We reviewed the draft minutes of a meeting from August 2016 and saw a through discussion of cases was recorded and learning highlighted. Service leads gave an example of learning from these reviews which related to recognition of urinary tract infections in patients at the end of life.
- We reviewed the notes from a multidisciplinary, reflective morbidity review meeting held by the Diana team from October 2016. The service had reflected on care provision for a child who had died and the challenges posed when sharing care with another provider out of area.
- The community health services maintained a risk register with items which were division wide. In addition risks were recorded specific to end of life care. At the time of our inspection there was one item which was the embedding of the 'Last Days of Life' care plans. We reviewed the risk register and saw it was reviewed regularly at the monthly senior meetings. Each risk had identified named responsibilities, actions and review dates.
- However, we were told the service was unable to identify incidents specific to patients at the end of life. We saw staff were not always recording incidents for patients at the end of life and concerns relating to the out of hours GP service were not formally recorded. Therefore we were not assured service leads had good oversight of the risks relating to this service.

Leadership of this service

- End of life care services for this trust were part of the Community Health Services (CHS) division and were led by the clinical director. The deputy clinical director, who was also the head of nursing, supported the clinical director.
- Services for children and young people were part of the Family, Young Person and Children's service which was also part of the CHS division. Palliative care was supported, led and developed by the Diana Palliative Care Nursing Leads, Child and Family Support Service Lead, and a Consultant Community Paediatrician who was named lead for end of life care for children and young people. Service leads told us of a bid made to local commissioners for consideration of additional money to fund additional consultant hours, specialist nursing, training provision and rapid response respite for children's end of life care.
- Staff we spoke with told us they had spent time with senior managers and executives during their 'Board Walks' which was an opportunity to spend time with junior staff, understand the services and listen to concerns.
- There was strong local leadership on the community inpatient wards and in the community. Staff told us they felt supported by their line managers and ward managers.

Culture within this service

- Without exception, staff we spoke with were proud of the service provided for end of life patients at this trust. One health care support worker told us 'the patient always comes first'.
- Service leads told us they had recruited 60 end of life care 'champions' across the trust who would cascade any learning or best practice to their colleagues. Staff we spoke with called them 'link' nurses but they knew who they were and their purpose.
- Nursing and support staff spoke positively about the care they provided for patients. Staff reported positive working relationships and we observed staff were respectful towards each other.
- Staff felt well supported by their team leaders and their colleagues and could describe examples of when they had received emotional support following the death of a patient.
- Lone working guidance was available to those staff working in the community. Staff we spoke with were aware of the guidance and we saw systems were in place to keep staff safe.

Public engagement

- Data provided by the trust showed the end of life care service received 78 compliments in the 12 month period between August 2015 and July 2016. Of these 49 (63%) were for the Hospice at Home service, 16 (20%) for the Macmillan CNS team and the remaining 13 (17%) for the Diana service for children and young people.

Staff engagement

- The trust recognised the hard work and contribution of their staff and publicly said thank you through their awards schemes. We saw where individual staff had received an Exceptional Care Award for the care they had provided.
- Service leads hosted ‘Cafe Conversations’ with nurses and support workers. One member of staff we spoke with confirmed they had an event hosted by the Director of Nursing. This meeting gave nursing staff and support workers an opportunity to discuss the provision of end of life care services with staff from the local hospices and other health professionals.

Innovation, improvement and sustainability

- The service had implemented the use of the ‘Salford Swan’ logo on the trust’s intranet and paperwork relating to end of life care. This is a nationally recognised logo and was used so people can easily identify information relating to end of life care.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care 'Do Not Attempt Cardio-Respiratory Resuscitation' (DNACPR) decisions were not always completed fully in accordance with the trust's own policy and the legal framework of the Mental Capacity Act 2005. There were inconsistencies in the completion forms which included lack of mental capacity assessments for those deemed to lack capacity, lack of information regarding the discussions held with patients and/or their families and not discussing the DNACPR with the patient, even though it stated they had capacity. DNACPR decisions and discussions were not always clearly recorded in the patient's medical records. This was a breach of regulation 9