Derbyshire Community Health Services NHS Foundation Trust

RY8

Community end of life care

Quality Report

Derbyshire Community Health Services NHS
Foundation Trust
Trust Headquarters, Newholme Hospital
Baslow Road
Bakewell
Derbyshire
DE45 1AD
Tel: 01629 812 525
Website:http://www.dchs.nhs.uk/

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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)
RY8Y8	Cavendish Hospital	Fenton Ward	SK17 6TE
RY8Y7	Clay Cross Hospital	DNs Alton Ward	S45 9NZ
RY846	Ilkeston Hospital	Heanor Ward Hopewell Ward	DE7 8LN
RY8Y4	Ripley Hospital	Butterley Ward	DE5 3HE
RY8NT	Bolsover Hospital	Hudson Ward	S44 6DH
RY8Z2	Babington Hospital	Baron Ward	DE56 1WH

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

End of life care services at this trust was rated as good overall.

Safety was rated as good. Patients were protected from avoidable harm; staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses and, arrangements to minimise risks to patients were in place. Patients were protected from abuse; staff had an understanding of how to protect patients from abuse, could describe what safeguarding was, and the process to refer concerns.

We rated the effectiveness of this service as good. Patients received effective care and treatment that reflected current evidence-based guidance, standards and best practice. Patients had a comprehensive assessment of their needs, which included pain management, nutrition and hydration and physical and emotional aspects of their care.

Care from a range of different staff, teams and services was coordinated effectively; there was effective multidisciplinary working, with staff, teams and services at this trust and external organisations working in partnership to deliver effective care and treatment.

Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005; this was reflected in the 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders reviewed during our inspection.

The care provided to patients in end of life care services was good. Patients were truly respected and valued as individuals and were empowered partners in their care. Feedback from patient's, relatives and carers was consistently positive and there were many examples of staff going 'above and beyond' when delivering care.

We found the responsiveness of end of life care services to be good. Patients' needs were mostly met through the way end of life care was organised and delivered. However, the rapid discharge of those patients expressing a wish to die at home was not monitored. We could not therefore be assured this was happening in a timely way.

The leadership of end of life care services was good. This was an evolving service with a developing vision and a strong focus on patient centred care. There were robust mechanisms in place to share learning across end of life care services. However, not all incidents and complaints specific to end of life care had been identified and used to improve the quality and safety of end of life care services and, good practice was not always recognised and widely shared across end of life care services.

Summary of findings

Background to the service

Derbyshire Community Health Services NHS Foundation Trust cares for patients across a wide range of services, delivered from 133 sites. This included 13 community hospitals and 28 health centres across Derbyshire and in parts of Leicestershire, serving a patient population of more than one million.

Between April 2015 and March 2016, there were 146 inpatient deaths and, 739 deaths in the community.

Derbyshire Community Health Services NHS Foundation Trust provides end of life care services across the trust as part of the Integrated Community-Based Services Division. Palliative and end of life care services is provided by inpatient and community nurses and allied health professionals across the trust. Specialist palliative care services are provided by partner organisations for example, a local hospice or NHS trust.

During our inspection we spoke with seven patients, 11 relatives and 34 staff across inpatient and community settings, including staff nurses, health care assistants, ward sisters, housekeeping staff, student nurses, advanced nurse practitioners, a discharge co-ordinator, an occupational therapist, community matrons and, district nurses.

We observed interactions between patients, their relatives and staff, considered the environment in inpatient areas, looked at 51 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders, ten medical and nursing care records and, ten prescription charts. Before our inspection, we reviewed performance information from, and about, the trust.

Our inspection team

Our inspection team was led by: Carolyn Jenkinson, Head of Hospital Inspection

Chair: Elaine Jeffers

Team Leader: Carolyn Jenkinson, Care Quality Commission

The team included CQC inspectors, inspection managers, pharmacy inspectors, an inspection planner and a variety of specialists including:

Clinical Project Manager, Non-Executive Director, Community Children's Nurses, Community Health Visitors, Dentist, Dietitian, Occupational Therapists, Physiotherapists, Paramedic, Nurse Consultants, District Nurses, Palliative Care Director, GP, Learning Disability Nurses, Specialist Nurses and a Mental Health Act Reviewer.

The team also included other experts called Experts by Experience as members of the inspection team. These were people who had experience as patients or users of some of the types of services provided by 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 fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- visited four inpatient wards at the three hospital sites, looked at the quality of the ward environment, and observed how staff were caring for patients
- spoke with five patients who were using the service
- completed two short observational framework for inspection observations (SOFI)
- spoke with the ward managers for each of the wards
- spoke with 16 other staff members; including doctors, nurses and occupational therapists
- interviewed the divisional director with responsibility for these services
- attended and observed one hand-over meeting, one clinical meeting, two multi-disciplinary meetings and one peer supervision meeting
- collected feedback from five carers visiting the ward
- looked at 20 patient records and 30 prescription charts
- carried out a specific check of the medication management on two wards
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider say

Feedback from patients who used the service and those who were close to them was continually positive about the way staff treated people. Staff were described as, "warm, friendly and helpful" and, "amazing".

Good practice

- The Derbyshire Alliance End of Life Care (Eolc) Toolkit was a readily accessible online toolkit. This comprehensive toolkit provided both professionals and members of the public with access to a range of learning materials polices and Eolc documentation. The toolkit was designed collaboratively by professionals who worked across Derbyshire and had received national recognition. The toolkit provided national guidelines and local Derbyshire- wide guidelines for all agencies offering unified documentation bespoke for staff working in, primary and secondary care settings, including hospices, social care, ambulance services and the voluntarysector. A range of information leaflets were available on the website that staff were able to print and share with patients and carers. Training opportunities were also provided supported by notification of forthcoming events by personal emails and 'training flyers'.
- All staff throughout the trust were dedicated to providing compassionate end of life care.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should ensure the arrangements for managing complaints are operating effectively.
- The trust should ensure the strategic plan for end of life care services continues to be developed.
- The trust should ensure there are robust governance arrangements in place in order to continue to improve the quality and safety of end of life care services.
- The trust should ensure clinical supervision is available for all staff delivering palliative and end of life care.
- The trust should consider monitoring how rapidly patients are discharged from inpatient services if they wished to be cared for at home.
- The trust should consider monitoring the provision of out of hours services in order to assure themselves patients' needs are responded to in a timely way.

Derbyshire Community Health Services NHS Foundation Trust

Community end of life care

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

We rated safety of end of life care services as good because patients were protected from avoidable harm and abuse.

We found:

- Openness and transparency about safety was encouraged.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses and where incidents had been raised actions were taken to improve processes.
- 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.
- Arrangements to minimise risks to patients were in place with measures to prevent falls, malnutrition and pressure ulcers. We observed staff following good infection and prevention control practices.
- Staff recognised and responded to the changing needs of patients with anticipatory medications readily available and care needs assessed and reviewed appropriately.
- There was appropriate arrangements for out of hours cover with close partnership working between the trust and external providers.
- Specialist equipment needed to provide care and treatment to patients in their home was appropriate and fit for purpose so that patients were safe. Syringe drivers were maintained and used in accordance with professional recommendations.

However we also found:

- We could not be assured all incidents relating to end of life care were separately identified and acted upon in a timely way. The trust electronic incident reporting system did not filter incidents that directly related to end of life patients.

Safety performance

- End of life care was provided as part of the Integrated Community-Based Services Division of the trust. At the time of our inspection, the electronic incident reporting system did not 'filter' incidents that directly related to end of life patients. We could not be assured therefore that all safety information was being appropriately monitored in order to feed into service improvement.

Service leads told us this was something they were aware of and, there were plans currently underway to enable leads to identify safety information, including incidents, specific to end of life care services.

- Where incidents specific to end of life care had been identified these were discussed at the trust end of life care group meeting. We saw minutes from these meetings confirming incidents had been discussed and lessons learnt.

Incident reporting, learning and improvement

- 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. Whilst staff were unable to tell us of any incidents specifically related to end of life care they did report receiving feedback from incidents through team meetings, email and, their immediate line managers.
- Following our inspection we manually reviewed all incidents, reported by the trust, between 1 January 2015 and 31 December 2015. We found 193 incidents raised through the trust electronic reporting system that directly related to end of life care. Of these, 123 (64%) incidents related to pressure damage to skin of grade one or above.
- We reviewed eight incidents where there was a delay in a syringe driver being received in either a community or community hospital setting. It was unclear if these incidents related to the trust or an external organisation.
- Following our inspection we asked the trust for assurance that issues relating to syringe drivers had been fed back to relevant organisations. The trust responded that copies of all incident reports were forwarded to the relevant organisation in order that the incidents may be discussed in detail at their medication safety group. In addition to this, the trust had asked for feedback from the relevant organisation in order that trust incident reports could be appropriately updated.
- During the reporting period January 2015 to December 2015, the trust reported 231 serious incidents . Prior to our inspection we asked the trust if any related specifically to end of life care. We were told there had been no serious incidents relating to end of life care services. We reviewed this data and found four serious incidents specifically related to pressure damage on patients receiving end of life care at the trust. We received the root cause analysis investigation reports for all four incidents. Reports demonstrated that there were discussions with patient family/ carers, appropriate investigations had taken place and learning had been identified where required. With all four incidents the conclusion reached was the incidents did not meet the criteria for a serious Incident and as a result the severity of the incidents had been downgraded by the trust.
- The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology.
- Staff we spoke with had an understanding about duty of candour and gave examples of where duty of candour had been applied which included a recent serious incident currently under investigation.

Safeguarding

- All the staff we spoke with had an understanding of how to protect patients from avoidable harms. We spoke with staff who could describe what safeguarding was and the process to refer concerns. Staff gave examples of where they had raised a safeguarding concern as a result of finding pressure damage on a patient. One ward sister told us they were particularly mindful of safeguarding with those patients nearing the end of life who were unable to communicate with staff. The ward sister felt patients who were unable to verbalise may be more vulnerable.
- Staff told us it was easy to raise a safeguarding concern through the trust online incident reporting system. Staff said, when raising an incident, there was a prompt asking if the incident should be considered a safeguarding concern.
- Staff were aware of the safeguarding lead for the trust. We were also told of safeguarding 'champions' working within community inpatient areas.

Medicines

- A medicine code of practice was available to all staff. This provided guidance to all staff involved with medicines and included the procedure for the prescribing, storage, transportation and administration of medicines. We observed two 'home visits' during our inspection. On both occasions the nurse was observed to be following the trust medicine code of practice.

Good

Are services safe?

- All staff had access to procedures for the prescribing of anticipatory medicines, medicines prescribed for the key symptoms in the dying phase (i.e. pain, agitation, excessive respiratory secretions, nausea, vomiting and breathlessness).
- A team of Advanced Clinical Practitioners (ACP) were available across the trust, to prescribe medicines. ACPs are Independent Prescribers and are able to prescribe any medicine for any medical condition. This meant, where patients had increased needs they were identified and responded to quickly and appropriately. For example, the need for change to medication.
- We reviewed ten prescription charts of patients identified as being in the last hours or days of life. We saw where anticipatory medications were prescribed appropriately and administered in a timely way.
- Patients had anticipatory medicines available to them in their home.

Environment and equipment

- The trust used standard 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 and Healthcare Regulatory Agency (MHRA) and national guidance. 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.
- Specialist equipment needed to provide care and treatment to patients in their home was appropriate and fit for purpose so that 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 most said equipment could sometimes arrive in the patient's home within four hours of the request being made.

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.
- With the exception of Baron Ward at Babington Hospital, all inpatient areas had paper care records. Baron Ward were in the process of trialling an electronic system to record and access patient records.
- We reviewed the care records of 10 patients who were receiving end of life care. The notes were accurate, complete, legible and up to date.
- Care records were audited as part of the end of life care quarterly audit to provide assurance that individual person-centred care plans were planned and delivered in line with The Leadership Alliance for the Care of Dying People (LACDP) 'Five Priorities for Care'.
- Between April 2015 and March 2016, an individual, personalised care plan was completed in 91% of patients in inpatient areas and 78% of patients nursed in a community setting. Individual personalised care plans included; hydration and nutrition; symptom control and anticipatory medications; psychological care and; social and spiritual support. Gaps in care were escalated to the Senior Matron for clinical quality and professional standards for further action.

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 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'.

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 10 patients identified as being in the last hours or days of life. Risks to patients, for example dehydration, falls, malnutrition and pressure damage, were assessed, monitored and managed on a day-to-day basis using nationally recognised risk assessment tools. Risk assessments for patients were completed appropriately on admission, or first assessment, and reviewed at the required frequency to minimise risk.
- Pressure ulcer damage, which included skin damage acquired in the trust, was a significant challenge for the

trust. As a result, community staff were provided with 'smart' phones that enabled them to photograph pressure damage at the point of discovery. This allowed staff to 'upload' photographs immediately to the trust tissue viability team and through 'real time' advice commence immediate curative and preventative treatment.

Staffing levels and caseload

- The trust did not provide dedicated end of life care beds within the community inpatient wards. Nor was there a dedicated specialist palliative care team. The trust provided end of life care across a range of settings this was delivered by inpatient and community nursing and allied health professional staff. Specialist palliative care services were provided by partner organisations for example a local hospice and nearby acute NHS Trusts.
- Quality and safe care champions were part of the trust 'Quality Always' initiative. These were a network of advocates for high quality care, with particular focus on specific clinical concerns, i.e. end of life care (EOLC). EOLC champions were encouraged to champion their areas of interest and expertise, supporting quality improvements across end of life services. During our inspection we spoke with three EOLC champions.
- The EOLC champions we spoke with showed us the EOLC resource folders they were responsible for, which were available as a learning resource for all staff. The resource folders included current national guidelines to provide evidence based EOLC. The EOLC champions said they attended monthly meetings and provided feedback to colleagues.
- The trust employed a team of 31 Advanced Clinical practitioners (ACPs) who worked across inpatient and community services. Of these, 15 were currently in training and there were three vacancies. ACPs were available to support staff, in addition to seeing, treating and discharging patients.

Managing anticipated risks

- Potential risks were taken into account when planning services, for example seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing. Business continuity plans were in place and available to staff should there be any disruption to the day-to-day running of the service.
- Lone Working Guidance was available to those staff working in the community. Staff we spoke with were aware of the guidance. To minimise risks to staff, community staff would 'text in' to team leaders when they arrived at a patient's home. In addition to this team leaders were able to 'track' community nurses electronically through the use of the mobile computers.

Good

Are services effective?

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

The effectiveness of end of life care services was good.

We found:

- Patients care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. All staff involved in delivering end of life care had access to current guidance through the Derbyshire Alliance End of Life Care (EOLC) Toolkit.
- Care records were personalised and aligned to the Leadership Alliance for the Care of Dying People (LACDP) 'Five Priorities for Care' and included a comprehensive plan of care that reflected both patient and carer/ relative involvement and continuous monitoring of patient need to ensure changes in condition or symptoms were dealt with in a timely manner.
- We saw where patients symptoms of pain were suitably managed and staff were proactive in assessing the patient's nutrition and hydration needs. Patient outcomes were routinely monitored and comprehensive plans had been put in place to improve outcomes for patients.
- Whilst the trust did not have a specialist palliative care team, staff reported good access to external palliative care support and, care and treatment was planned and delivered by health care professionals appropriately trained in end of life care.
- We saw evidence of effective multidisciplinary working, with staff, teams and services at this trust and external organisations working in partnership to deliver effective care and treatment.
- Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms had been fully completed in 44 out of 51 cases with only two forms having no record of a mental capacity assessment where this had been required.

However, we also found:

- We did not see evidence of formal clinical supervision for those teams dealing with palliative end of life care on a regular basis.

Evidence based care and treatment

- End of life care was managed in accordance with the National Institute for Health and Care Excellence (NICE) guidelines. For example a review of 10 prescription charts showed symptom control for end of life patients had been managed in accordance with the relevant NICE Quality Standard. This defines clinical best practice for the safe and effective prescribing of strong opioids for pain in palliative care of adults.
- Health care professionals involved in delivering end of life care at the trust accessed the Derbyshire Alliance for End of Life Care Toolkit which contained evidence based guidelines (including NICE guidelines) to underpin the care provided and included for example guidance in; symptom management; recognising dying and last days of life; advance care planning and; care after death.
- All staff we spoke with were aware of the Derbyshire Alliance End of Life Care (EOLC) Toolkit, and readily accessed the toolkit online to share with us. This comprehensive toolkit provided professionals and members of the public with access to a range of learning materials, polices and EOLC documentation. The toolkit was designed collaboratively by professionals, including this trust, and had received national recognition. The toolkit provided national guidelines and local Derbyshire-wide guidelines for all staff working in, primary and secondary care settings, including hospices, social care, ambulance services and voluntary and community organisations.
- A range of information leaflets were available on the website that staff were able to print and share with patients and carers. Training opportunities were also provided, supported by notification of forthcoming events by personal emails and 'training flyers' that staff showed us during our visit.
- Medicine management, prescribing and guidance was available through the Derbyshire Medicines Management website. The Derbyshire Medicines

Management Guidelines were ratified by the Joint Area Prescribing Committee (JAPC) which reviewed and reflected the latest evidence (including NICE guidelines) in its published guidance.

- In response to the 2013 review of the Liverpool Care Pathway (LCP), patient care records included personalised care plans aligned to the Leadership Alliance for the Care of Dying People (LACDP) 'Five Priorities for Care'. In all of the 10 care records we reviewed we saw a robust assessment of the patient's needs, a plan of care that reflected both patient and care/relative involvement and continuous monitoring of patient need to ensure changes in condition or symptoms were dealt with in a timely manner.
- The trust did not employ a dedicated specialist palliative care team. Where there is no specialist palliative care support patients may receive poor end of life care. However, from our observations and review of the patient care records of 10 patients identified as being in the last days or hours of life we saw; care and treatment had been planned and delivered by health care professionals appropriately trained in end of life care. Where palliative care support and guidance had been required, records demonstrated where this had been sought externally, including out of hours.
- We saw consistent documented evidence of the advanced clinical practitioners (ACPs) having sensitive conversations with patients, and their families identified as being in last year of life. This included where appropriate discussion and completion of 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders with patient and family involvement and understanding.
- Patients approaching the end of life were identified appropriately. A 'recognising dying' form, accessed through the Derbyshire Alliance End of Life Care (EOLC) Toolkit, was completed by a senior doctor who assessed the patient may be in the last days of life. This was a collaborative decision made in discussion with the patient and/or family and relevant healthcare professionals.
- Our inspection took place during the national 'Dying Matters' week. Dying Matters is a national coalition which aims to raise both professional and public awareness about death and dying. None of the staff we spoke with spoke of dying matters or told us of any events that were taking place within the trust.

Pain relief

- Guidelines for the assessment of pain were accessed through the Derbyshire Alliance End of Life Care (EOLC) Toolkit. These included guidelines for the use of a pain scale for the measurement of pain in patients who could not verbalise and/or may have a cognitive (memory) disorder.
- Patients and relatives we spoke with had been asked about pain management and all spoke positively about being given pain relief when they needed it. All staff were pro-active in managing patient's pain. We reviewed 10 nursing records for patients in the last days of life and saw where pain assessments were included in their plans of care.
- We spoke with seven patients and 11 relatives about how their /their relative's pain had been managed. All were consistently positive in their comments describing pain that had been well managed, good access to pain medicines and pain medicines given in a timely way.
- Anticipatory medications (just in case medicines) were prescribed in all ten patients identified as requiring EOLC. Symptom control and anticipatory medication individualised plans of care, were audited as part of the end of life care quarterly audit. Results for April 2015 to March 2016 demonstrated average compliance rates of 95% in inpatients and 99% in community nursing.
- Nursing staff told us specialist palliative care advice in relation to symptom control was available 24 hours a day, seven days a week. This was provided by a local hospice who worked closely with the inpatient wards and community nurses to provide telephone advice. Care records we reviewed demonstrated patients had been made aware of contact details for support and, we saw evidence where support had been obtained out of hours.

Nutrition and hydration

- We reviewed 10 care records for patients in the last days of their life. We saw patients were screened for malnutrition and the risk of malnutrition on admission to hospital or at their first assessment (in the community) using the malnutrition universal screening tool (MUST).
- Patients were screened for dehydration and the risk of dehydration using the 'GULP Dehydration Risk Screening Tool'.

Good

Are services effective?

- Where interventions were required we saw these documented in the patient's individual plan of care.

Patient outcomes

- The trust were committed to delivering a programme of comprehensive end of life training in support of a local Commissioning for Quality and Innovation (CQUIN), this 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 summarised a number of key indicators which had enabled the trust to meet this CQUIN target for 2015/16. Indicators of improvement included; the number of trust staff who had attended a variety of training events to support best practice in end of life care; a plan of all current and future training based on the Core Competency Framework that had been adopted for use by the East Midlands Clinical Strategic Network and; the continuous monitoring of the end of life care audit standards amongst inpatient and community based services.
- A trust wide end of life care audit was completed within 72 hours of all patient deaths; this was collated by the clinical lead for advanced practice. The end of life care audit provided a measure of the implementation of the Leadership Alliance for the Care of Dying People (LACDP) 'Five Priorities for Care' among inpatient and community based services within Derbyshire. Data captured also included Advance Care Planning (ACP), Preferred Place of Care (PPC) and, 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) status.
- The audit also contributed to the trust mortality surveillance governance processes within inpatient services, through the classification of deaths according to the likelihood of death. An analysis of unexpected deaths and details of cause of death were included in the report.
- The trust were unable to contribute to the National Care of the Dying Audit. The trust had enquired about participation in this audit but were declined due to not having sufficient numbers of deaths within their services.
- The 'recognising dying form' was audited as part of the trust wide end of life care audit. Between April 2015 and March 2016 the recognising dying form had been completed in 78% of cases in inpatient areas and, 28% of cases in community nursing settings. The trust recognised that the use of this form in community nursing settings may have been low because patients might have already been included on the GPs palliative care register. A palliative care register is a complete register, held by a GP, of all patients in need of palliative care or support.

Competent staff

- Education and training to support registered nurses deliver care in the last days and hours of life was based upon the Strategic Clinical Network 'recommended core education standards for care and support for the dying person in the last days and hours of life'. Training content included; symptom management in the final days of life; principles of pain management; introduction to communication; introduction to advance care planning and do not attempt cardio pulmonary resuscitation; embedding end of life care in practice; dying well with dementia; bereavement care and confirmation of adult death.
- Without exception all staff told us they had received appropriate training to meet their learning needs and were encouraged and given opportunities to develop within end of life care. Staff said there were excellent training opportunities they could access. These included sessions provided by the end of life care (EOLC) facilitators, the EOLC specialist lead and a nearby hospice.
- Staff had also accessed EOLC training through learning beyond registration (LBR) funding, completing accredited modules. Staff said they were encouraged to share EOLC learning opportunities with their colleagues.
- The team of Advanced Clinical Practitioners (ACPs) supported staff in the inpatient units and community settings, providing informal learning and 'shadowing opportunities' to facilitate learning in practice.
- Staff said they received training for use of the syringe driver; this was provided in-house and was competency based. Ward sisters in the inpatient ward areas reported 100% compliance with syringe driver training. However, data provided by the trust prior to our inspection showed, over the last two years, only 5% of registered nurses had completed syringe driver training.

Good

Are services effective?

- Between April 2014 and March 2016, 74% of registered nurses, in the trust, had attended one or more training events to support best practice in end of life care. Prior to our inspection we asked the trust for training compliance data for all staff who had received some form of training in end of life care. Training compliance figures for unregistered and allied health professional staff was not provided.
- Verification of death training, although not mandatory, was identified as a priority for all registered staff and included completion of an objective structured clinical examination (OSCE) in the clinical skills suite that was available. Over the last two years, 13.6% of registered nurses had completed this training.
- Heath Education East Midlands (HEEM) had provided funding to support training in end of life care. This funding was for the whole health community across Derbyshire and included this trust. From April 2016 two 'Training Hubs' had been formed at two locations external to the trust in the North and South of the county. Trust staff would have access to a core curriculum of end of life care training delivered by the 'Workforce Development Team' at HEEM. In addition to this 15 hours of specialist end of life care facilitator support was to be provided by the trust to the end of December 2016, to provide some internal resource for trust staff.
- Senior leaders told us about a three-hour communication skills workshop had been developed, in partnership with a local university. Workshops were designed to help clinicians feel more confident about holding difficult conversations with patients and take away some 'top tips' to help them in practice.
- National Institute for Health and Care Excellence (NICE) guidance states that clinical supervision and reflective practice should be available for staff delivering palliative / end of life care. Advanced clinical practitioners accessed clinical supervision sessions of two hours, four times a year through the trust clinical psychology service. Staff described this as a minimum standard with some staff accessing more supervision depending on their circumstances. Clinical supervision is an activity that brings skilled supervisors and practitioners together in order to reflect upon their practice.
- Clinical supervision was available and was accessed by some of the clinical staff we spoke to in the hospital and community nursing teams. There was some evidence of multidisciplinary debriefs taking place after more challenging deaths experienced by the community teams. However, we did not see evidence of formal clinical supervision for those teams dealing with palliative end of life care on a regular basis. Nursing staff told us of informal peer group supervision but said this did not follow a formal reflective model or provide written records for staff to capture learning.

Multi-disciplinary working and coordinated care pathways

- We saw a multi-disciplinary team approach to the 'Fast Track' patient discharge process (a fast track process is where a patient has a rapidly deteriorating condition, and who may be entering the final stages of their life). This approach included input from; specialist palliative care; Erewash Care Team; continuing healthcare; occupational therapy; district nurses; the voluntary sector; a discharge co-ordinator and local commissioners of the service.
- District nurses (DNs) reported attending regular meetings at their allocated GP practice. These were multidisciplinary meetings with attendance from a range of professionals which could include: DNs, a care coordinator, a social worker, practice nurse, community matron, mental health community psychiatric nurse and, a Macmillan nurse practitioner from a nearby hospice.
- Meetings adopted the principles of Gold Standards Framework (GSF). 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.
- Each inpatient unit we visited had access to an Advanced Clinical Practitioner (ACP) who provided clinical support in close partnership with local GP practices. This included twice-weekly joint ward rounds with the GP.

Referral, transfer, discharge and transition

- The trust provided generalist end of life care across a range of settings. Specialist palliative care services were provided by partner organisations for example, a nearby hospice and, local acute NHS trusts.
- We saw partnership working between this trust and external organisations when assessing and planning ongoing care and treatment. In the 10 care records we

Good

Are services effective?

reviewed we saw evidence of communication with social services, providers of out of hour's services and the specialist palliative care team from a nearby hospice. A number of voluntary organisations were also involved to ensure a seamless pathway of care from the inpatient setting to the patients preferred place of care.

Access to information

- Information needed to deliver effective care and treatment was available to all staff in a timely and accessible way. For example, inpatient wards had access to an end of life resource folder, there was good access to external specialist palliative care support and relevant guidance was available through the Derbyshire Alliance End of Life Care (EOLC) Toolkit.
- Community nursing staff used an electronic system to access patient records this included access to GP records.
- Patients care preferences and key details about their care at the end of life were recorded through the GP palliative care registers, the recognising dying form and through individualised patient-centred care planning.
- To ensure that community teams were fully informed of end of life care planning, including 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) status district nurses were encouraged to attend regular practice-based palliative care meetings with the GP and document relevant information in the patient's record.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Consent to treatment, capacity and Deprivation of Liberty Safeguards were included in end of life training. Staff were able to demonstrate their understanding of the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- We reviewed 10 sets of care records of patients in the last days of life. We saw consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005 and patients were supported to make decisions.
- During our inspection we reviewed 51 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms. Our review showed 44 (86%) DNACPR forms had been fully completed. Seven forms had not been completed fully; three forms had either no date or the date had been entered incorrectly; two forms had no corresponding discussion recorded in the patient's records and; two forms had no record of a mental capacity assessment where this had been required. Where one patient had lacked capacity relatives had been consulted. We saw no evidence to suggest the relative had lasting power of attorney for health and welfare. Additionally, one of the seven incomplete forms had no signature of the person completing the form.

Good

Are services caring?

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

We rated caring as 'good'. Patients were supported, treated with dignity and respect, and were involved as partners in their care.

We found:

- We observed a strong, person-centred culture. Staff treated people with compassion, kindness, dignity and respect.
- Feedback from patients and their families was positive and included many examples of where staff had gone "above and beyond".
- We saw where patients' emotional, social and religious needs had been taken into account and were reflected in how their care was delivered.
- All staff were committed to providing compassionate care not only to patients but also to their families including post bereavement.
- Patients and their families were truly respected and valued as individuals and were empowered as partners in their care.
- Emotionally, relatives were well supported by the nursing staff and were appropriately signposted to external sources where required.
- Staff provided a caring service and people told us that they felt safe and happy with the care and support both they and their families received.
- Interactions between staff and patients demonstrated a respectful, kind and compassionate approach.

Compassionate care

- Throughout our inspection we observed patients being treated with compassion, dignity and respect. Staff we spoke with showed an awareness of the importance of treating patients and their families in a sensitive manner.
- On a home visit to a patient in a care home, we saw excellent holistic care undertaken by a community nurse. The patient had difficulty communicating; the nurse demonstrated a good awareness of this patient's needs. The nurse provided good support showing kindness and gave the patient the time they needed.
- We spoke with seven patients and 11 relatives during the inspection. Patients and relatives were consistently complementary about staff attitude and engagement. The comments received from patients and relatives demonstrated that staff cared about meeting patients' individual needs and that they had been extremely caring and attentive to their needs as relatives.
- A patient at Cavendish Hospital described the care they had received as "first class, an excellent caring service". Another person whose relative received care at Babington Hospital described staff on the ward as creating an atmosphere of "we are here for you, be it patient or relative".
- We saw a number of thank you cards from relatives of patients who were deceased thanking staff for the care provided. One card stated that the care had been "above and beyond".
- During our inspection we were told of many examples where staff had gone 'the extra mile' for patients and their carers / relatives. These included, fulfilling a patients dying wish to eat a meal at the table with their family one last time and installing satellite television to enable a patient to watch their favourite sport.
- Nursing staff at Ilkeston Hospital told us of a patient, who they were caring for, and their spouse who had significant health issues that required daily nursing input. The nurses made sure the relative's health issues were addressed whilst they were visiting the patient. This allowed the relative to spend as much time as possible with their spouse of over 60 years in the last days of their life.
- Staff described to us of the positive relationships they formed with the patient and their relatives and where staff would remain on duty to support these relatives if a patient death was imminent.

Understanding and involvement of patients and those close to them

- Patients and their relatives were overwhelmingly positive about their care and the way staff communicated with them and they told us they felt involved in decision making.
- We spoke with seven patients and 11 relatives about the care they were receiving and information that they were provided with. All were highly complementary about the information that they had been provided with, and felt that staff were always there to support.

Good

Are services caring?

- Advance Care Plans we saw were individualised to reflect the choices and preferences of the patient. 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 observed the assessment process used by the nursing team, and how this was used to inform discussions and plan person centred care. Patients' records showed detailed discussions had been held with patients and their families.
- We saw where a member of staff had been nominated for the trust 'extra mile' award for care and compassion by the relative of a patient who had remained on the ward over Christmas.
- In July 2015 four inpatient wards at Ilkeston, Ripley and Whitworth commenced a six-month pilot to assess the views of bereaved relatives through a short postal questionnaire based on the five priorities of care. During this six month period a total of 39 deaths occurred at these sites and 26 questionnaires were sent to relatives three to four weeks after the bereavement. Eleven questionnaires were returned, indicating a response rate of 42%. All respondents agreed that communication was sensitively conducted, that they were involved in their loved one's care, that their own needs were both identified and met, and that the care was delivered with dignity and respect.

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 wards providing emotional support. Relatives also confirmed that staff provided them with emotional support. One relative told us, "The emotional support is very much there".
- We saw that patient records included psychological or spiritual goals in their care plans. One patient explained to us the importance of their faith and how nursing staff asked regularly whether they (the patient) wanted to see a member of their church.
- We saw where a carer's diary was in use. This was accessed through the Derbyshire Alliance End of Life Care (EOLC) Toolkit. The diary for carers was completed when their loved one was believed to be in the last days of life and used to improve communication between carers and professionals.

Good

Are services responsive to people's needs?

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

Responsiveness of end of life care at this trust was good. People's needs were mostly met through the way end of life care was organised and delivered.

We found:

- 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.
- Care plans were holistic and included an assessment of the patient's spiritual and emotional needs.
- 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.

However we also found:

- We could not be assured the arrangements for identifying complaints specific to end of life care services were operating effectively. Only two out of 13 complaints had been raised through the trust end of life care group.
- The service did not monitor how rapidly patients were discharged from inpatient services if they wished to be cared for at home.
- The trust did not monitor the provision of out of hours services in order to assure themselves patient's needs were responded to in a timely way.

Planning and delivering services which meet people's needs

- 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. There were no dedicated end of life beds at this trust. Nursing staff we spoke with told us those patients recognised as being in the last hours or days of life were, where possible, nursed in a side room to protect their privacy and dignity.
- The day to day management of those patients at end of life was provided by advanced clinical practitioners (ACPs) and local general practitioners (GP) in the community inpatient settings and ACPs, district nursing services and GPs in the patient's place of residence. Out of hours support, including urgent medical attention was provided by a local social enterprise organisation in collaboration with local voluntary services. The trust did not monitor the provision of out of hour's services in order to assure themselves patient's needs were responded to in a timely way.
- There were facilities and arrangements in place for families and other loved ones to stay overnight if the patient was in a community hospital. Relatives were offered the use of a dedicated room or were able to stay in the room with their relative.
- The trust had a 'home from hospital service' delivered by a network of volunteers who supported patients in their own home. The service had been designed to reduce the anxiety that a patient or relative might feel following their discharge from hospital and provided support with day-to-day activities.
- The trust provided community services to some diverse populations such as Derby City. To respond to the challenges of a diverse community, psychological, spiritual and pastoral services were currently under review by the Patient Engagement Team in collaboration with a nearby university.
- RightCare Management Plans were in place for patients nursed in the community setting, with for example, complex health problems and long term conditions such as Chronic Obstructive Pulmonary Disease (COPD) and those requiring palliative care. RightCare is a scheme which was designed by local clinicians to ensure that seamless patient care takes place out of hours, when GP practices are closed. The scheme helps to prevent unnecessary admissions to hospital and attendance at A&E, lower patient anxiety, provides reassurance and allows patients to access the most appropriate healthcare and advice quickly.
- Normal visiting times were waived for relatives of patients who were at the end of their lives.
- Patients at end of life were provided with a side room where possible; staff told us this was normal practice and we observed this during the inspection.

Equality and diversity

Good

Are services responsive to people's needs?

- 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.
- End of life care (EOLC) resource folders were available in the ward areas and contained information about different faiths and local places of worship.
- Chaplaincy services at this trust were limited with only one chapel and a part-time chaplain available across the community hospitals. Senior trust staff told us the chaplain would only be available for patients at the hospital where the chapel was based. Nursing staff told us they would refer to the end of life resource folder, available in the ward area, to identify individuals from external places of worship who would be available to attend the ward if requested by the patient or their relative.
- A newly approved bereavement support booklet had been developed and was being distributed throughout the trust.
- Services provided met the needs of the local population. During our inspection we observed services that had been planned to take account of the needs of different people, for example on the grounds of age, disability and sexual orientation. On one of the inpatient wards we observed end of life care being delivered to a patient who had been identified as being homeless.

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.
- Ward managers reported good links with the trust's learning disability team and told us they would approach the team for advice and support if they had an end of life patient who had a learning disability.
- The Derbyshire Alliance for End of Life Care Toolkit included guidance for staff, patients and carers / relatives in caring for vulnerable patients who may be in the last year of their life. For example, motor neurone disease and patients living with dementia.
- We saw use of the 'This is me' document within one of the care records we looked at. 'This is me' is a tool for people living with dementia, or their carers to complete that informs health and social care professionals know about their needs, interests, preferences, likes and dislikes.
- In one community hospital we saw the use of 'pet therapy'. A volunteer who had previously been a patient in the trust visited with their dog and would often sit with end of life care patients and/or their relatives. Animal-assisted therapy can significantly reduce pain, anxiety, depression and fatigue in people with a range of health problems.

Access to the right care at the right time

- Between April 2015 and March 2016, there were 146 inpatient deaths and, 739 deaths in a community nursing setting. For the same reporting period patient's preferred place for end of life care was discussed in 75% of cases in inpatient areas and, 92% of cases in community nursing settings. The percentage of patients who died in their preferred place for end of life care was 65% in inpatient areas and, 90% in community nursing settings (an average of 78%). 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.
- The Erewash care team provided individualised and flexible care packages for patients in their own homes. The service supported primary care teams to care for patients during the last few weeks of their life. The team worked with the patient and carers to allow patients wishes to be considered.
- A 'Rapid Response Care Team (RRCT)' was available to support those patients who required end of life care support at home. End of life care patients were referred direct to RRCT by the District Nurse, Macmillan Nurse or GP. They had already assessed the patient as appropriate for Continuing Care funding, and would refer at the same time as referring to Continuing Care. NHS Continuing Healthcare is a package of care arranged and funded solely by the NHS. It is awarded depending on whether a person's primary need is a health need.
- Patients who required end of life care support were usually referred on for a care package by Continuing Care, but approximately 95% remained with RRCT till

the end, as other agencies could not always be found. If a patient was referred to RRCT for care and their life expectancy was only a couple of days they may not be referred for agency care.

- Continuing care assessments for a fast track discharge were completed electronically and sent through to a nearby NHS trust. Nursing staff told us fast track discharges could usually be arranged within 24 hours. Where staff had experienced delays they told us it was usually due to awaiting a package of care. The trust did not monitor the fast tracking of patients in the last days of their lives that chose to die at home.
- We looked at the care records of three patients who had been identified as requiring a fast track discharge. Two of the patients had recently passed away. In both care records we saw evidence of a fast track discharge being completed within 24 hours of the referral being made. For both patients we could see they had been complicated discharges that required multi-disciplinary and multi-agency support to ensure the discharge could take place. However, the third care record for a patient showed a delay of one month between the decision for a fast track discharge and referral for continuing healthcare. We could not be assured therefore; patients were achieving their preferred place of care in a timely way.
- Prior to our inspection we asked the trust for a copy of their fast track discharge policy or similar. The trust told us staff used the continuing care assessments which incorporated fast-track documentation. A policy was not provided.

Learning from complaints and concerns

- Before our inspection we identified13 complaints relating to end of life care for the reporting period August 2015 to January 2016. Issues around communication accounted for six of the complaints, care provided for three of the complaints and, pain management and patient / family involvement two complaints each. Service leads told us all complaints would be reported through the end of life care audit. Audit data for April 2015 to March 2016, had only identified two complaints specific to end of life care. We could not be assured therefore; the arrangements for identifying complaints specific to end of life care services were operating effectively.
- Following two complaints the trust had commissioned a programme of training working with a nearby university. Training provided included 'breaking bad news', difficult conversations, advance care planning and, preferred place of care.
- Staff would speak to anyone raising a complaint at the time they raised it. Senior managers were also available to talk to anyone with a concern or complaint. The aim was to resolve the concern or complaint at the time it was raised.
- Information on how to raise a concern or make a complaint was available around the community hospital wards we visited. Patients and relatives told us they would raise a concern or complaint with ward sisters or their district nurse if required.

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.

The leadership of end of life care was good. The leadership, governance and culture mostly promoted the delivery of high quality person-centred care.

We found:

- Staff were engaged and demonstrated commitment to delivering high quality end of life care for the trust.
- End of life care services had been considered at board level with representation from the deputy medical director.
- Leadership was strong with good public engagement.
- There were robust mechanisms in place to share learning across end of life care services.

However we also found:

- There was limited recognition of the services strategic direction and as such a strategic plan was only in its infancy.
- The arrangements for governance were not always operating effectively. There was limited assurance that all incidents and complaints specific to end of life care had been identified and used to improve the quality and safety of end of life care services.
- Good practice was not always captured, learned from or celebrated by the trust wide end of life group.

Service vision and strategy

- End of Life Care was included in the trust operational plan for 2016/17 with pathway development, enhanced training and, the end of life care audit remaining the priorities for this operational year.
- The trust vision for end of life care was to inform and support all health care professionals involved in providing high quality end of life care to patients and their families. Their aim was to provide individual patient focused care to support patients, relatives and carers within their home environments to prevent hospital admission and allow patient choice where possible.
- To support future developments a task and finish group had been developed to take forward and develop a trust end of life care strategic plan. Senior leads told us this plan would link to local commissioning priorities and the strategic plans of the wider healthcare community. The strategy was to be based on the 'Ambitions for Palliative and End of Life Care' national framework. During our inspection we saw where this group had met for the first time and plans, whilst in their infancy, had started to be developed but had not yet been shared across the trust.
- Representatives from the trust end of life care senior team were part of the '21st Century Joined Up Care five year plan' in North Derbyshire. Health and care commissioners, and providers in North Derbyshire were working together to develop a five year plan for the future of care in order to better meet the changing needs of the local population.

Governance, risk management and quality measurement

- The 'Quality Always' programme was a trust-wide initiative focused on improving the quality of care provided. Part of this programme was the clinical assessment and accreditation scheme (CAAS). This was a process of assessment, review and accreditation of services, linked to care quality commission standards. An initial assessment was carried out by the quality always team in the form of a one-day visit; the team leader received verbal and written feedback post-visit. A quality improvement plan was put in place within two weeks of the visit to address any areas for improvement highlighted by the visit.
- Within community inpatients, eight wards had achieved a green rating (the highest accreditation possible) in the end of life care standard whilst the remaining four achieved amber. However, staff were directly observed delivering end of life care to patients on six wards only during the assessments. The remaining six wards were not caring for anyone recognised as approaching end of life at the time of the assessment.
- The 'End of Life Care Group' managed all work concerning end of life practices and processes. The group was responsible for providing an informed view, and making recommendations in response to national and local end of life care drivers. The outcomes from the end of life care audit also fed into this group to give

feedback on the quality of care standards and identify future training needs. The terms of reference for this group had recently been reviewed and updated; and taken to the April meeting of the Clinical Effectiveness group (CEG) for ratification.

- End of life care services including results from the end of life care audit, and the bereavement pilot, reported directly to the clinical effectiveness group, quality services committee and ultimately the board. Feedback from all groups was shared with the end of life care group who disseminated information down through the matron meetings. Community Matron meetings were held monthly. We saw where end of life care had been discussed at these meetings for example; the end of life care toolkit had been included in the minutes for March 2016.
- Prior to our inspection we reviewed incident and complaint data provided by the trust. Data was not sorted in order to easily identify incidents or complaints directly related to end of life care services. We discussed this with service leads who told us a review of the incident reporting system was underway to enable the easy identification of service specific incidents. We were not provided with of a timeline for completion.
- With the exception of pressure damage, service leads were not able to tell us of any other themes around their incident and complaint data. We could not be assured therefore; the arrangements for governance were operating effectively. For example, the number of reported complaints to the end of life care group did not correlate to the number of complaints received relating to end of life care therefore not all complaints were being considered to improve the quality of the service.
- Senior leads told us incidents and complaints were reported quarterly through the end of life care group but recognised until recently this had not been a consistent process. As a result, the focus of the end of life care group meetings had been reviewed and with revised terms of reference was to have a more structured approach to governance arrangements within end of life care.
- Nursing staff told us any incidents; risks or complaints specific to end of life care would be communicated to them through their immediate line manager. Ward sisters received information through their meetings with the matrons.
- From July 2015, deaths classified as 'unexpected' or 'unlikely' were reviewed within 14 days of reporting by the clinical lead for advanced practice, using the 'community Hospital Trigger Tool' to identify potential adverse events. Findings were discussed directly with the medical director, deputy chief nurse and head of patient safety as appropriate. There had been seven deaths identified as 'unexpected' between July 2015 and March 2016. We saw where a robust review of each death had taken place with six deaths concluded as 'unavoidable' and one death misclassified as 'death unlikely'.
- Deaths reported through the end of life care audit were also discussed alternate months at the 'Critically Ill Patient Prevention Group'.
- The trust was represented at the East Midlands Clinical Strategic network in relation to end of life care. Key work streams discussed at the meeting were; 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR); Deprivation of Liberty and; the new education programme relating to the core standards. Progress on the rollout of electronic registers of palliative care patients across the East Midlands was to be discussed within the 2016 meetings.
- Senior leads told us currently there were no risks specific to end of life care on the trust risk register. We did not identify any risks specific to end of life care services during our inspection.

Leadership of this service

- Leadership of end of life care services at this hospital was provided by the Deputy Medical Director, a specialist lead nurse and a clinical lead for advanced practice.
- With the exception of two staff all other staff knew, and had met the leadership team for end of life care services.
- Leaders of the service were clearly committed to developing end of life care services at this trust and demonstrated this through their desire to create a strategy unique to end of life care. However, we were not assured they had an awareness of some of the current good practice within this service. During our inspection we were told of, and observed many examples of outstanding and innovative practice however these practices were not always recognised by the senior team, nor were they consistently replicated across the trust.
- Examples included the Erewash Care team who worked in partnership with patients and their relatives to enable the patient to be discharged to their preferred place of

Good

Are services well-led?

care; the 'comfort box' pilot in the Derby City locality. Comfort boxes were to be provided in patient's homes and would include items such as mouth swabs and cleansing wipes.

- Senior leads told us they were also unaware of reflections gathered from clinical supervision, where end of life care may have been particularly upsetting, or had gone well.

Culture within this service

- 'Caring Always' was the name the trust had given to their commitment to patients and families about the quality of care they could expect from the trust. It included eight promises about how staff want their patients to feel when receiving care. Promises were developed with staff and were at the heart of the trust patient experience strategy, launched in 2014.
- Staff were clearly committed to providing good end of life care at this trust. Having no specialist palliative care team at the trust was not seen by staff as a barrier to good end of life care. Each individual member of staff we spoke with saw end of life care as their responsibility. Comments from staff included, "I love this part of my job, I know where to go to get support, I can get the care in, it is really good", "support for the family and patients is what we do best" and, "everyone pulls together".
- Staff felt well supported by the team lead and their colleagues and could describe examples of when they had received emotional support following the death of a patient.
- Staff worked collaboratively with external stakeholders, primary and secondary care providers and the voluntary sector to deliver good quality end of life care.

Public engagement

- The families of deceased patients were invited to contribute to service evaluation and improvement through the completion of a questionnaire and/or telephone interviews regarding the care received by their relative during their last weeks of life, as part of a pilot bereavement project. Actions from this pilot had not been agreed at the time of our inspection.
- Three public governors with a specialist interest in end of life care formed part of the trust council of governors. They worked with the executive board to ensure services were developed to meet the needs of patients. These governors were direct representatives of the local community.
- A dedicated patient experience team was available to the public and encouraged and welcomed all forms of feedback.
- Patient stories involving individuals' experiences of end of life care at this trust were presented to the trust board of directors. Patient stories provide an opportunity for learning from patient / relative experience.

Staff engagement

- The trust recognised the hard work and contribution of their staff and publicly said thank you through their 'Extra Mile' awards. Nominations were received either from staff working at the trust or, from the public. We saw where individual staff had received nominations for the end of life care they had provided.

Innovation, improvement and sustainability

- A new initiative on Baron Ward at Babington hospital had commenced where a card would be sent to relatives 10 to 12 weeks after a patient had died. This highlighted services the relatives may wish to access and let relatives know they were still being thought about by the ward staff.
- The week after our inspection district nurses in the Derby City locality were due to start a pilot of issuing 'comfort boxes' in the patients home. Comfort boxes would contain items of toiletries for those patients in the last days / hours of life. Contents included lip balm and soft cleansing wipes.