CareQuality Commission

East Sussex Healthcare NHS Trust

RXC

End of life care

Quality Report

CQC Registered Location   **CQC Location ID**

Rye Winchelsea and District Memorial Hospital RXCX2

Bexhill Hospital   RXC03

Crowborough War Memorial Hospital RXCX1

Lewes Victoria Hospital   RXCLV

Uckfield Community Hospital   RXC18

St Anne's House   RXCX5   Date of inspection visit: 09 September to 12 September 2014

Tel: 01424 755255

Website: http://www.esht.nhs.uk   Date of publication: 27 March 2015

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

Summary of findings

Ratings

Overall rating for End of life care	Requires Improvement	🟠
Are End of life care services safe?	Requires Improvement	🟠
Are End of life care services effective?	Good	🟢
Are End of life care services caring?	Good	🟢
Are End of life care services responsive?	Requires Improvement	🟠
Are End of life care services well-led?	Requires Improvement	🟠

Summary of findings

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Summary of findings

Overall summary

Overall this core service was rated as requires improvement.

End of life care services in the community were caring and responsive and effective however improvements are required in the leadership and safety of service to patients in their care.

Direct end of life care to patients is provided by East Sussex Healthcare NHS by community nursing teams and within five community hospitals.

Our key findings were as follows:

- Staff felt well trained and supported by managers.

- Staff were passionate about the service and proud of the care they provided.

- People we spoke with were very positive about the care and knowledge staff demonstrated about their relatives.

We saw some good and practice including:

- We found evidence of exemplary multidisciplinary working that was embedded throughout the service provision.

However, there were also areas where the Trust needs to make improvements.

Importantly the trust must

- Ensure that proper and complete information about patients is available to all those involved in their end of life care by taking account of the different paper and electronic systems in use.
- Regularly assess and monitor the quality of the services provided in the community for end of life care as well as the resources required to sustain the service.
- Regularly seek the views and experiences of patients, their families and carers
- Improve direct access to community nurses and palliative care support out of hours.
- Improve the community teams ability to deliver a rapid response service to patients receiving end of life care.

The trust should

- Ensure that support for the new electronic patient record system recently introduced is readily accessible for all community staff so that staff feel confident and understand the benefits of the system.
- Ensure a continuous cycle of improvement embedded in the audit and monitoring systems for community staff, with leaders identifying areas for improvement and ensuring staff involvement in actions to be taken.
- Monitor community team meetings to ensure that corporate information and learning was disseminated to all staff.

Summary of findings

Background to the service

East Sussex Healthcare Trust provides end of life services in patients' homes and at five locations throughout the county of East Sussex. These are Bexhill Hospital, Crowborough War Memorial Hospital, Lewes Victoria Hospital, Rye, Winchelsea and District Memorial Hospital and Uckfield Community Hospital.

The ongoing medical care of patients admitted to the community hospitals is provided by a local GP and in some hospitals by a consultant geriatrician. Patients cared for in their own homes remain under their own GP.

Community hospitals and community nursing teams have access to Trust specialist palliative care nurses, Macmillan nurses, therapists as well as local hospice staff to support end of life care. Multidisciplinary working between all the specialties and the GPs is integral to high quality end of life care for patients and their families and carers. The voluntary hospice movement is strong in the

area and their services impact significantly on how end of life care needs are met. Hospices are inspected separately and therefore their services are not included in this report.

We visited all the community hospitals and a variety of community nursing bases that included Seaford, Peacehaven and Wheel Farm as well as a specialist palliative care base. We also visited two hospices. We spoke with over 40 staff that included managers, lead nurses, advance community nurse practitioners, district nurses, community staff nurses, health care assistant, phlebotomist, Macmillan nurses and district nurse trainees. We observed individual care on a ward and in a patient's home and spoke with three relatives. We looked at 16 patients records as well as other data and information provided by East Sussex Healthcare Trust.

Our inspection team

Our inspection team was led by:

Chair: Dr Mike Anderson, Chelsea and Westminster NHS Foundation Trust.

Head of Hospital Inspection: Tim Cooper, Care Quality Commission.

The team included CQC inspectors and a variety of specialists: The team of 52 that visited across the Trust on 10, 11, 12 September and the team of five who visited the

two district general hospitals on 23 September 2014 included senior CQC managers, inspectors, data analysts, inspection planners registered and student general nurses and a learning disability nurse, a consultant midwife, theatre specialist, consultants and junior doctors, a pharmacist, a dietician, therapists, community and district nursing specialists, experts by experience and senior NHS managers.

Why we carried out this inspection

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

East Sussex Healthcare Trust was rated as a band one risk in the July 2014 CQC intelligent monitoring data, (where band one is the highest risk and band six is the lowest risk).

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

Summary of findings

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit between 10-12 September 2014. During the visit, we held focus groups with a range of staff who worked within the service, such as nurses, doctors and therapists. We talked with people who use the services. We observed how people were being cared for and talked with carers and/or family members and reviewed the care or treatment records of people who use the services. We met with people who use the services and their carers, who shared their views and experiences of the core service with us.

Good practice

We saw some good and practice including:

- We found evidence of exemplary multidisciplinary working that was embedded throughout the service provision

Areas for improvement

Action the provider MUST or SHOULD take to improve
Importantly the trust must

- Ensure that proper and complete information about patients is available to all those involved in their end of life care by taking account of the different paper and electronic systems in use.
- Regularly assess and monitor the quality of the services provided in the community for end of life care as well as the resources required to sustain the service.

Regularly seek the views and experiences of patients, their families and carers

The trust should:

- Ensure that support for the new electronic patient record system recently introduced is readily accessible for all community staff so that staff feel confident and understand the benefits of the system.
- Ensure a continuous cycle of improvement embedded in the audit and monitoring systems for community staff, with leaders identifying areas for improvement and ensuring staff involvement in actions to be taken.
- Monitor community team meetings to ensure that corporate information and learning was disseminated to all staff.

Care Quality Commission

East Sussex Healthcare NHS Trust
End of life care
Detailed findings from this inspection

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

Requires Improvement ●

Are End of Life Care services safe?

By safe, we mean that people are protected from abuse

Summary

Safety for end of life care services in the community requires improvement.

Record keeping was inconsistent with lack of evidence that all patient risk assessments were undertaken promptly and regularly reviewed.

There was lack of governance in respect of safe transport of equipment and medicines to support care in patients' homes.

Whilst work towards developing a system to replace the Liverpool Care Pathway (LCP) was, "ongoing", there were areas of the Trust which had been working without access to appropriate documentation and tools to deliver end of life care in accordance with the Trust policy. Some staff were unfamiliar with the documentation despite a national recommendation that the LCP should be replaced with individual end of life care plans from July 2013.

We found inconsistencies in record keeping. Of the records we reviewed, 25% did not have end of life care documentation such as the Key Elements in End of Life

Care completed. There was a lack of recording of the wider, holistic needs of patients such as spiritual and emotional care needs but better records demonstrating that physical care needs had been assessed.

Staff were able to demonstrate a sound understanding on the use of Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) forms and we were assured that weekly spot checks were undertaken by the team leaders. The correct use of DNACPR was audited. However, we found several incomplete and missing DNACPR forms in the records we reviewed.

The Trust could not demonstrate best practice was being followed in relation to the purchase and provision of syringe drivers for continuous subcutaneous infusions.

Staff demonstrated a good understanding of the requirements of the Mental Capacity Act 2005 and the Trust Safeguarding Policy.

Detailed findings
Incidents

- The Trust operated an electronic incident reporting system. All community staff we spoke with were aware of the system and were able to report incidents.
- We were given an example of a recently reported incident where there was a medication concern when a patient was being transferred from a neighbouring acute hospital to a community hospital. We were told that the matron for the community hospital was currently investigating the incident and in discussion with the other trust.
- We saw examples of community staff team minutes where recent reported incidents were discussed together with action and learning. There was an agenda item for serious incidents, however none of the areas we visited had reported a serious incident involving end of life care.
- We saw an example of a full investigation undertaken, together with action taken and shared learning, for an incident in another part of the service. It was comprehensive and used as an example of good practice in future staff training. This demonstrated senior staff knowledge of managing incidents and sharing learning.
- All matrons and lead nurses we spoke with demonstrated good knowledge of their role in investigating incidents and the importance of shared learning. We were told that learning was also taken to the regular matrons' meetings.

Safety thermometer

- We saw two examples of community safety thermometers. There had been no reported incidents of concern during August 2014 for end of life care patients.

Medicines

- District nurse based staff told us that all patients referred for end of life care had their medicines reviewed as part of their initial assessment. The recently introduced Key Elements Nursing Care Plan included a medicines review and we saw evidence of this in patient records that we looked at.

- Guidance for symptom control was included in the Key Elements documentation. Medicine administration record sheets for individual patients receiving end of life care were clearly completed and provided evidence of compliance with the guidance.
- An audit was carried out in July 2014 regarding pharmacy led medicines reconciliations and review of allergy status for patients in community hospitals in line with National Patient Safety Agency and National Institute for Health and Clinical Excellence Technical patient safety solutions for medicines reconciliation on admission of adults to hospital (2007). The guidance did not specify a timeframe. The audit considered that medicines reconciliation should take place within 72 hours within the community, based on the current pharmacy staffing levels. The audit demonstrated that generally medicine reconciliations took place within 72 hours of admission. However, an accurate allergy status was not recorded at the time of the medicines reconciliation. Allergy recordings varied from 63% of patients to 88% between the six community hospitals. This meant that some patients were at risk of being administered an inappropriate drug. Audit recommendations were underway.
- All community staff we spoke with told us that, as part of the advanced planning for a person's death, 'Just in Case' boxes were placed in their home. These support anticipatory prescribing and access to palliative care medicines. Patients often experience new or worsening symptoms outside GP working hours so the boxes ensured access to the medicines at any time of the day. Staff described their continuous discussions with patients and their families/carers regarding these medicines.
- We observed 'Just in Case' medicines in a patient's home where they were entering the final phase of life. These were reviewed and it was found that there was not sufficient analgesia (pain relief) to last for the weekend so the community nurse ensured that these were replenished before the weekend.
- The 'Just in Case' medicines had been dispensed in a paper bag rather than in a sealed container which is best practice. We were told that containers did get lost and were not replaced so that this sometimes occurred. These medicines could be in homes for some weeks or months. We subsequently discussed this with a community nursing team leader in a different area. We were told that safe storage of medicines should form

part of the risk assessment carried out when planning for end of life care in a patient's own home. We were not able to visit further patients' homes on this inspection to review medicine storage and were not provided with audits on current practice.

- We observed that the syringe driver equipment being brought to a patient's home was in a plastic bag that was not sufficiently strong to contain the equipment. We were told that plastic "carry boxes" had been withdrawn. This meant there was potential that clinical equipment could be dropped during transport.

Records

- The Trust introduced an electronic system for patient records for community nursing staff. This had been introduced between May and July 2014 with training programmes in place together with support available once the system was in use.
- We received varied comments from staff regarding the new system. Some teams felt they had got, "up and running" with it well and were able to access support. Others felt less confident with it and told us that it made record keeping very slow.
- There were issues about duplication of electronic and paper records that staff told us impacted on their workloads.
- There were also some concerns in one team that there was no system in place to ensure that paper records were matched with the electronic ones. We were told of reduced administrative staff over the past nine months but that recruitment was now underway.
- In addition, if the electronic system failed in a patient's home then staff were unable to complete contemporaneous records and had to return to a district nursing base to remedy this. However, these issues were being fed back to those managing the project roll out with work underway to resolve them.
- Not all of those involved in the multi-disciplinary care of patients had access to the electronic system, such as specialist palliative care nurses, hospice staff and social workers. There was a copy of the patient assessment, care plans and record of visits as well as medicine administration records and prescriptions kept in each patient's home. We saw the records in the patient's home that we visited. However, palliative care nurses told us that not all information was always available to them and they were not clear when they may have access to the electronic system.

- All staff we spoke with felt that they ensured patient safety by the actions they were taking. Some staff were very positive about the benefits of an electronic system, they could make instant referrals to other services such as dietetics and speech and language therapists.
- The national review and withdrawal of the Liverpool Care Pathway (LCP) took place between July 2013 and July 2014. During this period the trust introduced Key Elements in End of Life Care documentation. These included a checklist to be completed and stored in patient records together with guidance that the key recommendations from the LCP review should be practiced. However, we were aware that these had not been introduced across all community areas at the same time with some areas we visited only having received their Key Elements complete documentation the week before inspection. We therefore found that there was inconsistency in their use in the records we reviewed. We were told by the trust lead for end of life care that the work for replacing the LCP was ongoing and that they proposed to follow national guidance when it has been published.
- Staff we spoke with were aware of the new documentation, in some areas it was clearly in use; in one area we visited it had not yet been fully discussed with staff.
- Records reviewed in a patient's home were seen to be complete. The Key Elements form had been discussed and completed. The preferred place of death was recorded as well as decisions regarding treatment and interventions.
- We reviewed 16 sets of records for patients, these included current records and for those who had died recently. We found record keeping inconsistent, particularly with recording the person's preferred place of death and very little information about emotional support or spiritual care. Risk assessments were not all completed for all patients, however those for skin integrity were generally well completed. Medication and syringe driver records were also generally well completed. Multidisciplinary team reporting was good. Four of the records did not have LCP or Key Elements documentation completed.
- When we visited a patient's home the clinical staff were aware that a Do not attempt cardiopulmonary resuscitation (DNACPR) form was in place and we saw the message in a bottle stickers on the front door and

fridge door. However the DNACPR form was not found on the premises. This was discussed at the time and the community nurse will follow up and ensure new documentation if necessary.

- Staff told us that generally DNACPR forms were in place when patients were referred to them from the acute hospitals. However, if the form was not clear then this would be discussed with the GP.
- Ten of the 16 records we looked at had fully completed DNACPR forms that clearly demonstrated discussions with patients, families and friends. We found one instance where there was no form and one was not applicable as the patient wanted to return to another country and this was facilitated and supported. The remainder were incomplete.
- Staff were very clear about the DNACPR status of their end of life care patients. However, where forms were incomplete or not held in the correct place, there was potential for inappropriate intervention at a time of crisis.
- The Trust had a DNACPR policy and training in place. The Trust ran six monthly audits of form completion in the acute settings that demonstrated continued failings. We were also provided with examples of weekly spot check audits carried out with the feedback provided to relevant doctors.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us they had received Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training and staff training records we looked at confirmed this.
- Staff demonstrated knowledge and understanding of the MCA and DoLS and described when these might be applied for health or care needs. Staff also understood when an advocate would be required and how to access this.
- The Key Elements for Care at the End of Life documents included guidance on the Mental Capacity Act.

Equipment

- The Trust used two different of syringe drivers with patients sometimes being discharged from the acute hospitals with the, "wrong sort" of syringe driver. This

was of concern because the service could not demonstrate that they had followed the requirements of the NPSA publication Rapid Response Report (RRR) Safer Ambulatory Syringe Drivers 16 December 2010.

Safeguarding

- Staff told us that they had Level 2 training in safeguarding. All staff we spoke with demonstrated a good understanding of safeguarding and knew how to refer a patient if required. Staff training records we looked at evidenced that staff received training in safeguarding.
- The Trust provided us with data that stated 84% of all clinical staff working with adults in the community had completed safeguarding adults training in the last two years.
- The training matrix for cancer services showed that five out of 11 community specialist palliative care nurses did not have current safeguarding adults training. This meant that they may not be aware of changes or initiatives in protecting vulnerable adults.
- One member of staff described a recent safeguarding referral that had been fully investigated. The outcome was that no further action was required.

Mandatory training

- The trust provided us with mandatory training data showing good levels of completion for topics such as Mental Capacity Act, Deprivation of Liberty Safeguards and Safeguarding Vulnerable Adults for staff working outside the acute hospitals. The completion percentages for topics such as health and safety were lower. We also saw evidence of the learning records for the Trust's specialist palliative care nurses that demonstrated completed mandatory training at September 2014. Training matrices monitored mandatory training for individual staff by department. These showed the date of the last training and alerted when training was due or overdue and we saw evidence of this.
- Community nursing staff held their mandatory training records and these were discussed at the monthly one-to-one meetings with their manager. We saw examples of mandatory training attended in staff records we looked at.
- Staff told us that generally they were able to take the time to attend mandatory training sessions.

Assessing and responding to patient risk

- All community staff we spoke with told us of the regular meetings with GPs which they referred to as the 'Gold Standard Framework' meetings. This was the process for coordinating end of life care in the community.
- The Trust Key Elements for Care at the End of Life and guidance supports staff in assessing and responding to patient risk. The Key Elements were in line with the Leadership Alliance "Priorities of Care for the Dying Person".
- We saw that skin integrity was well managed for end of life care patients.
- We observed good infection prevention and control practice in the community hospitals we visited as well as in a patient's home.

Nursing staffing

- The ability of the Trust to meet the service specification for district nursing services due to the number of vacancies remained on the high level trust risk register as an ongoing area of concern. Staffing levels had been established for all the teams and the numbers of staff approaching retirement age identified.
- Staff in particularly affected areas told us that staffing levels had improved over the last months. We were told that there were six members of staff currently undertaking the district nurse training with another six places available next year. We spoke with one nurse who felt well supported during their training. Other teams told us that staffing was sufficient and that they were now able to recruit where possible.

- Some teams raised concerns regarding lack of management time due to high staff sickness. We saw that the trust had implemented sickness management procedures and that these were being followed.
- Advanced Community Nurse Practitioners worked closely with the district nursing teams. We were told that the community phlebotomists assisted in reducing some of the workload.
- All staff told us that they prioritised end of life care patients and, where there were capacity issues, these patients would always be visited. There was a rating process in place and handover of care to the out of hours team.
- Staff told us that there had been no administrative support at the district nursing bases for 10 months. About one month ago administrative support was reinstated. All staff we spoke with emphasised the importance of the role.
- Most of the district nursing teams and community hospitals had end of life care champions in place. (End of Life Care – Last Days Meeting minutes in August 2014 stated there were 34 champions trust wide.)

Medical staffing

- There was access to medical staff at the community hospitals we visited.
- Community staff had access to GPs and 24 telephone advice from the hospices. Staff told us that they were always able to access medical advice and support when required.
- Out of hours cover was provided by the hospices. We were given examples were hospice medical staff attended patients in their own homes.

Good ●

Are End of Life Care services effective?

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

Summary

End of life care services in the community were effective.

We saw that staff provided evidence based care and treatment and had access to advice and support when necessary. Staff demonstrated knowledge of individual patients and a strong commitment to ensure patients experienced comfort and good symptom control. We saw strong evidence of the close partnership and multidisciplinary working within end of life care services. This was a high priority with all staff and others they worked with.

Staff were trained in end of life care and this was being further developed with training needs analysis completed. We saw that training was discussed during staff appraisals and heard that staff felt well trained. However, the figures taken from the training records were Trust wide rather than community specific; we were not given a breakdown of number of community staff completing training.

Whilst the full service was not available outside working hours there were processes in place to reduce the impact on end of life care patients. The Trust and county wide End of Life Care Board were working towards extending services. Community nursing staff used workaround solutions, where necessary, to optimise patient care. This included, for example, ensuring they brought a syringe drive with them on a first visit to ensure it was available, should the patient need a continuous infusion of analgesia.

There was limited auditing of end of life care within community settings. Anecdotally, the care delivered was good and people largely died in the place they wanted to but this could not be evidenced.

Detailed findings

Evidence-based care and treatment

- The process used to coordinate end of life care in the community was the Gold Standards Framework. This is in line with Department of Health End of Life Care Strategy 2008.

- The Trust responded to the National Recommendations of the Liverpool Care Pathway Review by developing the Key Elements for Care at the End of Life documents. This led to the decision to withdraw the LCP with the remaining references removed during July 2014.
- The Key Elements were based on the "Priorities of Care for the Dying Person" published in June 2014 by the Leadership Alliance for the Care of Dying People.
- We saw evidence at all community hospitals and community nursing bases that staff were supported and provided with evidence-based advice when caring for patients reaching the end of life, for example on complex symptom control.
- The Trust has undertaken some audit of adherence to the Key Elements in the acute hospitals. As this change is relatively new there was not yet sufficient evidence to demonstrate good use. However there was limited evidence of audit of end of life care in the community settings.
- In July 2013 the Trust carried out a baseline audit of end of life care using a national assessment tool based on National Institute for Clinical Excellence (NICE) standards for end of life care. This was undertaken in the acute hospitals, however the actions and learning from the audit were reflected in the End of Life Care Action Plan that the Trust were currently working to with the Clinical Commissioning Groups (CCGs). The action plan was for the whole Trust, including community services. Actions were monitored by the Trust End of Life Steering Group chaired by the executive end of life care lead.
- We saw examples of other evidence based audits undertaken in the community, such as the reconciliation of medicines and allergy status carried out by pharmacy.

Pain relief

- Effective pain control was an integral part of delivering an effective end of life care service. Community hospital and community nursing teams were supported in this by Macmillan nurses and hospice staff. This was observed when we attended a hospice daily triage meeting with a district nurse.

Are End of Life Care services effective?

- The Trust guidance for symptom control for adults included pain management and prescription of anticipatory pain relief for patients at the end of life.
- An issue was highlighted when patients were sometimes discharged from the acute hospitals with either no syringe driver or a different one from that used in the community. The Trust lead nurse for end of life care was aware of this and changes were planned for the acute areas but we were not provided with a time frame. Community staff we spoke with were also aware and ensured that they took a syringe driver with them on their first visit to a patient's home when required.
- Community staff we spoke with demonstrated a good knowledge of managing the transfer of patients from, for example, pain relief patches to the use of a syringe driver following discharge from hospital.
- Staff in the community felt that pain relief was good but were not aware whether this had been audited.

Nutrition and hydration

- The Trust Last Hours/Days of Life guidance highlighted the focus on comfort, dignity and support for the patient. This included supporting the patient with oral hydration and food as they were able.
- Staff demonstrated good knowledge and understanding of nutrition and hydration. This was not only in respect of the patient's comfort but also in managing relative and carer concerns. They described how they would support families when a patient could no longer tolerate food or fluids and what this meant.
- Catering was retained on site in three of the five community hospitals. The two hospitals where this was contracted out were rated highest for food in the patient led assessments of the care environment with 91% the top score. The lowest rate was 85% which meant that all were rated satisfactory.

Patient outcomes

- The community services were notified of patients needing end of life care prior to discharge from hospital. GP practices held lists of patients requiring end of life care. Patients' treatment and care was discussed at the monthly multi-disciplinary GP meetings.
- We saw evidence where community staff worked to facilitate discharge to patients' own homes, for example by ensuring appropriate equipment was ordered and in

place. We were told that where patients were discharged at short notice on a Friday afternoon it was difficult to ensure everything required was in place over the weekend.
- End of life care patients were entered on the database used by the ambulance trust so that ambulance staff were aware if called to a patient's home. They would contact the community nursing team and ascertain whether a DNACPR form was in place. This meant that a patient's preference to die at home could be facilitated where possible with symptom control measures in place.
- We found that community staff worked hard to ensure patients were cared for and died in accordance with their stated preferences. Staff demonstrated knowledge of the end of life patients they were currently caring for and their wishes. Anecdotally staff felt that, except in rare cases when it was not possible for clinical reasons, patients died in their preferred place of death. However, there was no audit or quality assurance in place to evidence this.
- Community staff were trained in verification of death and the Trust monitored when this took place. Trust data stated that 70% of deaths were verified within four hours. A multi-agency group were meeting to ensure robust data collection and improvements in timely verification of death to reduce suffering for families and carers at this time.
- The end of life care action plan that the Trust worked to highlighted the need to develop ways of collecting the experience of patients and carers and we were told this was underway. We saw that most district nursing teams had received no complaints in respect of end of life care with very few overall. We also saw examples where families had written to thank staff for their care and their knowledge of what their relative wanted to happen.

Competent staff

- The Trust provided us with their End of Life Care Training Data March 2012 – March 2014. This demonstrated the provision of courses such as Advance Care Planning, End of Life Care, Verification of Death and Breaking Bad News throughout this period. We saw that community staff had attended relevant courses. We were not provided with the percentage of community staff who had completed the training, however all community staff we spoke with told us that they felt trained and qualified for their role in end of life care.

Are End of Life Care services effective?

- The report was part of the preparation of the Trust's five year end of life care training programme developed as part of a local improvement programme with commissioners. We were also provided with Trust wide data that 419 staff had received end of life care training since March 2014. This showed that training was being offered but did not demonstrate specifically for community staff.
- The Trust provided us with their draft training needs analysis for the provision of end of life care. This identified the additional training requirements for staff and will be reviewed annually.
- The Trust had put in place two posts for End of Life Care Facilitators to develop training and education for staff across the acute and community services. Staff told us that these posts were valued and provided good support for end of life care. One facilitator had recently retired and their role was being reviewed.
- We were told that "The End of Life Care 5 Year Training Programme" would provide evidence based training for all staff groups in the Trust. The programme follows the recommendations from the Department of Health End of Life Care recommendations. As this programme is in early stages it was not yet embedded for community staff providing end of life care services and therefore not possible to evaluate.
- We also saw evidence of the training on symptom control commissioned to be provided by local hospices. These were planned from May 2014 to March 2015 and would accommodate 240 staff.
- We were provided with the Trust's syringe driver training programme which demonstrated that training needs analysis had been undertaken and training programmes were in place for the types of equipment used in the organisation. The training was in line with national guidance and recommendations, including the Medicines and Healthcare products Regulatory Agency (MHRA) and NICE Quality Standards.
- The Trust told us that 94 staff had been trained in the syringe driver specifically used in the community.
- We saw examples of monthly one-to-one meetings with managers where training needs were discussed. Annual appraisal was in place and we saw examples that demonstrated that training undertaken was monitored and discussed. Staff were able to access clinical supervision groups.

Multidisciplinary working

- Multidisciplinary working was integral to the delivery of effective end of life care in the community. All the community staff we spoke with described their role in multidisciplinary working and how essential this was for end of life care. The staff were proud that this applied throughout the whole service of care provided to patients.
- Multi-disciplinary meetings were held monthly with the GPs. Attendance included district nurses, the hospice medical adviser and hospice matron. In addition to reviewing the care for current end of life patients, all deaths were also reviewed for quality of care and any learning.
- Community hospitals held twice weekly multidisciplinary meetings.
- Staff described good partnership working with the local hospices where doctors and nurses came out to see patients in community hospitals and in their homes. The hospices provided advice and support for community nursing staff and GPs. We saw evidence of good partnership working across the different services at a daily meeting attended at one of the hospices.
- In one area we were told that the Hospice at Home clinicians and community nursing teams were virtually, "As one team" in that they worked so closely and effectively for the patients and their families.
- We were given an example of where there may be difficulty with a patient's symptom control and community staff would telephone the hospice doctor for advice and support.
- Staff working at the west end of the geographical area said that some of the hospices were not able to provide all the services, for example Hospice at Home. This meant that more use was made of continuing care funding and agencies for night sitting services.
- The main reason for delayed discharge for patients on the end of life pathway was cited as waiting for social care funding and this was reflected in the Trust action plan.
- Staff told us they had good access to therapy services such as speech and language and dieticians. We saw evidence of this in the patient records we looked at. Community hospitals felt well supported by therapy services.

Are End of Life Care services effective?

Seven-day services

- There was a full end of life care service from 9am to 5pm Monday to Friday that included community nurses and specialist palliative care nurses.
- Outside those hours referrals were diverted through the hospices and discussed at the multi-disciplinary meetings held the following morning Monday to Friday. Those that came in over the weekend were discussed on Monday.
- We were told that the out of hours support from the hospices was very good with community nursing staff able to access advice when required. However, access to face to face specialist palliative care was restricted to Monday to Friday working hours and this was reflected in the Trust action plan with work towards extending hours in place.

- There was a district nursing out of hours service for nights and weekends. They worked with the Hospice at Home teams (where available), night sitters and agency staff to support patients at these times.
- All community staff we spoke with told us that they could access all necessary equipment from Monday to Friday. They could also have equipment delivered to patient's homes on a Saturday morning if it had been requested by midday on Friday. The district nursing bases held low to medium support mattresses, pressure cushions and commodes to cover needs at the weekends. However, if a large, very specialist piece of equipment was required, such as a hospital bed, this would not be available at the weekend.

Are End of Life Care services caring?

Good 🟢

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

Summary

Staff in the community settings provided very compassionate care to end of life patients. We saw evidence of their strong commitment to each patient and their wider needs. We saw how they worked to ensure patient wishes were supported.

Staff demonstrated the importance of family and friends as life ended. Feedback from relatives was entirely positive about the service. Information and support was available for patients and their carers from the service, hospices and voluntary services.

Detailed findings
Compassionate care

- Staff demonstrated a strong commitment to giving high quality care to patients and their relatives. This was apparent in both the community hospital settings and the community nursing teams that we spoke with.
- Many staff told us of the importance of care at the end of a person's life. One member of staff told us, "We only have one chance to get it right. It is at the forefront of everything we do."
- Staff described where they had facilitated a wedding in the community hospital for a patient in the last days of their life. Staff at community hospitals provided accommodation and food for relatives so that they could be with their loved ones at the end.
- We spoke with one patient's relative who described the care and support for herself and her son throughout the last few weeks. In the last days she was able to stay in a room next to her father. She described the difference such care and compassion had made to her at such a difficult time, and how it had helped her son to cope.
- We observed a nurse speaking with a relative in a caring and sensitive manner that demonstrated empathy and understanding of that person's needs.
- We observed professional and caring communication in a patient's home between staff and the patient and their relative.
- Another person told us of the high quality of care seen demonstrated by the community staff involved in their relative's care in the last weeks of their life. They said staff, "went over and above to ensure the quality of care."

- The Trust Key Elements documents included guidance for staff on the individual care requirements for the last hours or days of life. Staff we spoke with demonstrated a good knowledge of these and a huge commitment to understanding each patient's needs and wishes and ensuring that these were respected and accommodated.
- We saw several examples of letters from relatives thanking staff for their care. More than one emphasised that the staff had really understood their relative.

Patient understanding and involvement

- We observed care in a patient's home and saw that good information was provided, including the benefits and disadvantages of treatments. The patient asked questions and was listened to. The decision for pain relief was then agreed with the relative also involved.
- All staff we spoke with described the discussions they had with each patient as part of their advance planning. The discussions included the patient's preferred place of care and death, interventional care and funeral arrangements. We saw evidence of discussion in some, but not all, of the patient records we looked at.
- We found a variety of patient information available in the community hospitals and district nurse bases pertinent to end of life care. Examples included "Coping with Dying" and "An explanation of the plan of care in the last hour or days of life" as well as local charity information on therapy treatments and counselling services. There were also various leaflets from the hospices as well as a booklet on living through bereavement.
- We observed examples of excellent communication skills with patients and colleagues.

Emotional support

- Some of the hospices provided a counselling service for end of life patients in the community hospitals and in their own homes. However, this did vary across the geographical area.
- The community hospitals we visited worked with local religious communities in the area. We were told that local priests visited regularly and were available to people of all faiths.

Good 🟢

Are End of Life Care services caring?

- In some areas, such as Hastings and Rother and Uckfield, local charities provided counselling and complementary therapies to patients as well as support for their families and carers.
- We observed spiritual care being discussed with a patient who was known to have a deep faith. A member of the family was involved and able to provide support.
- The specialist palliative care nurses were able to offer support to patients, their families and carers.
- Community staff told us that they provide emotional support for patients. If further support was required they would seek help from others such as the Macmillan nurses, local religions or counselling services. We were told they provided support for the families as well.

- We saw that referrals to the Macmillan nursing service were predominately from GPs and clinical nurse specialists (acute hospitals). One Macmillan Community Palliative Care Team annual report stated that the majority of patients were referred for psychological support.
- The Trust Key Elements documentation contained guidance for spiritual, religious and pastoral support in end of life care.

Are End of Life Care services responsive to people's needs?

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

Summary

End of life care in the community was not responsive to the need of patients and their families outside of usual working hours.

There was no direct access to the community nursing teams during the evenings, at night and at weekends. Patients or their relatives had to make contact via the 111 telephone triage service who would not be aware of their needs. The staff at the 111 service then decided whether to contact the community nursing service/ There was 24 hour advice available from the local hospice but this was accessed via the community nurses.

A lack of a dedicated rapid response team reduce the capacity of the Trust staff to react very quickly during crisis points. Community staff prioritised end of life care patients but the rapid response element of care was incorporated into their usual caseload.

There was a lack of assurance that patients were transferred to their preferred place of care as they approached the end of their life. A report from the Macmillan Community Palliative Care team showed that of 375 patient records reviewed only 25% had a discussion about preferred place of care and death recorded. There were no Trust audits of this aspect of end of life care available.

Where there were constraints, either due to staffing levels or late referral to their service, staff worked within these to respond to patient needs.

Staff in the community hospitals and in the district nurse teams demonstrated a commitment that individual needs were met and worked with others in the local community to ensure this happened. Staff demonstrated understanding of their end of life care patients and facilitated discharge from hospital wherever possible.

The Trust participated and worked with the county wide end of life service planning board. The Trust had plans in place to manage staff shortages and these had shown improvement.

Detailed findings

Service planning and delivery to meet the needs of local people

- The Trust participated in the local authority led End of Life Care Board responsible for planning end of life care across the county. This included the development of an electronic system to identify patients in the last 12 months of their life. This work was being led by the commissioners.
- Current difficulties in identifying patients in the last 12 months of their life, or those in the last few days or hours, had been identified by the Trust and reflected on the action plan. This was constrained by not having appropriate IT systems currently in place, either county wide or within the trust. However, once patients were in the community setting staff were aware of those requiring end of life care.
- One of the medical directors was Trust lead for end of life care and chaired the End of Life Care Steering Group. We saw that the End of Life Care Board requirements were fed into this steering group in the minutes we looked at. This was also clear in the discussions we had with the medical and nursing leads for end of life care. This meant the Trust were working in line with the county wide service planning.
- The Irvine Unit at Bexhill Hospital had a small mortuary that we were told was used as a holding area whilst awaiting the undertakers. We saw evidence of temperature checks and porters and nurses oversaw the area. Protocols were in place and the facility was used on only a few occasions over a year. Other community hospitals and in the community there were 24 hour contracts in place with local undertakers.

Access and flow

- There was a clear commitment to ensure that patients could be cared for as close to home as possible. This included the network of community hospitals, support from the hospices and the efforts of the community staff.
- Contact numbers available for staff included palliative care teams, local counselling services and hospices for 24 hour telephone advice.

Are End of Life Care services responsive to people's needs?

- Staff involved with end of life care felt that patients in some rural parts of the area were not able to access the services so easily due to the distances involved. In addition, the smaller hospices do not offer the same range of services so these were accessed elsewhere.
- Referrals came in every day. We were told that all urgent and non-urgent referrals received a telephone call either the same day or the next day. We saw evidence in the patient records we looked at.
- We were told that referrals out of hours were diverted to the various hospices for triage and discussed the next morning. We attended a morning meeting and observed the partnership working that ensured patients had access to the services relevant to their needs.
- There was no out of hours direct access to the district nursing service or palliative care nurses. Relatives and carers called the 111 service in the first instance. This meant that there was no rapid response for end of life care patients at that time. This had been identified and the Trust was working to improve access to community nursing out of hours for families and carers.
- We found that rapid response had been integrated into the district nursing team case load. This meant there was no bespoke rapid response team in place to ensure response within two hours at all times.
- Hospice at Home services were provided by some of the hospices and worked closely with community nurses.
- The Trust Patient Admissions, Transfer, Clinical Handover of Care and Discharge Policy included procedures and guidance for rapid discharge of patients who do not want to die in hospital. The Key Elements were also included. Concerns regarding rapid discharge had been highlighted with ongoing work towards improvement and equity across the whole service.

Meeting people's individual needs

- Personalised care plans encouraged tailored care for patients at the end of life. Where we saw these in place they were personalised, included appropriate risk assessments and symptom management. However, there was variable practice and some staff found the new Key Elements documentation less conducive to individual care planning. As this documentation was not fully embedded it was not possible to evaluate whether this was a documentation or training issue for staff.

- We looked at 16 patient records and found well completed personalised care plans in 12 of them. However, staff we spoke with demonstrated a good knowledge of individual patient needs.
- We saw several examples of care meeting individual needs. One example was where a patient had deteriorated and was transferred to the acute hospital where they were put on the end of life care pathway. The patient returned to the community hospital, improved and were therefore taken off the end of life care pathway and subsequently mobilised.
- The community hospitals facilitated families staying with their relatives for the last days of their life.
- We observed care in a patient's home where their wishes for treatment and place of death had already been listened to and recorded. These were being supported by multidisciplinary team working that included the community nurses and a hospice doctor.
- The community hospitals had medicines written up to anticipate any deterioration in the patient's condition.
- All staff we spoke with told us they could access other services when required. These included speech and language therapists, occupational therapists and dieticians. They also met with other services at the monthly Gold Standards Framework meetings at the GP surgeries.
- Night sitters were arranged for patients who wished to die at home.
- The Trust used the language line to provide interpreting services where required.
- We were provided with annual reports from two Macmillan Community Palliative Care Teams and whilst they reported where patients died, there was no indication as to what the percentage was of those who would like to have died at home, or whether this was the patient's preferred place of death. In the Eastbourne area the report stated that, "the 'Home' deaths have reduced by 5% and the 'Hospital' deaths have increased by 1%." In the Uckfield and Heathfield area it was reported that 107 patients died during the period with the majority (36%) dying at home which was an increase from the previous year. The report stated, "It is especially noted that only 8% of patients died in the acute sector, a 50% reduction from last year."
- The reports either did not record patients' preferred place of care or provided partial information. One report showed that for 95 patients out of 376 this was not discussed which was an increase from 56 patients the

Are End of Life Care services responsive to people's needs?

previous year. It was felt that this was because it was inappropriate at the stage of referral to the team however no evidence was included. We were not provided with specific audits on patients' preferences on care, treatment or place of death. This meant there was a lack of assurance that patient preferences were being met. However, individual staff demonstrated very good knowledge of individual patients and felt strongly that, where possible, patient preferences were managed and supported.

- The Trust's return for the 2013/2014 CQUIN stated that the new electronic patient record includes a code for recording the preferred place of death. We saw an example of this completed and staff felt that recording this preference was improving as they became more confident on the system.
- Audits by the palliative care team at one of the acute hospitals looked at reasons that patients had been readmitted to hospital during 2013-2014. This showed that the majority of readmissions were appropriate and in line with patient wishes but did not include end of life care patients not under their care.

- The Key Elements documentation included staff guidance on all elements of advance care planning should patients wish to put these in place prior to reaching end of life care.

Learning from complaints and concerns

- There were very few complaints regarding end of life care in the community. We saw evidence of two completed complaints in the period May 2013 to June 2014. Both had been investigated and demonstrated actions and learning.
- We were told that the community nursing teams were proactive in responding to and taking action where concerns were raised by patients or their families/carers. Staff we spoke with told us of the importance of good communication and relationships with end of life patients so that they could ensure preferences had been taken account of and care was provided in line with these.
- Some teams we spoke with told us that they had never received complaints about end of life care. Other teams had received a few which were mostly concerning communication.

Are End of Life Care services well-led?

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

Summary

Leadership for end of life care services requires improvement.

There was a perception amongst community staff that the felt disengaged from the wider Trust. Staff reported feeling well supported by local team leaders but less so from higher up the management structure. We found local leadership open and accessible with staff confident in raising issues and seeking advice and support.

There was lack of clarity on the direction of the service; there was no service specific or Trust vision or strategy. Resources and support across the geographical area were variable for patients and staff.

Many staff using workaround tactics to ensure patients had good quality care. There had been many changes of management, the introduction of a new electronic record system and withdrawal and replacement of end of life care pathways. We found that not all staff were aware of changes and found difficulty managing such things such as new documentation when it, "just arrived".

We found that there was a lack of monitoring and audit in areas such as DNACPR policy compliance, preferred place of care and preferred place of death or the provision of 'Just in Case' medicine boxes. Where the Trust was aware of concerns and areas that prevented high quality care it was not always clear how these would be improved or mitigated, by when and how the community staff were involved in the actions.

Detailed findings

Vision and strategy for this service

- The executive lead for end of life care is the Medical Director – Governance. The work is supported by one of the Associate Directors of Nursing. We met with both during the visit. However, we noted that the Trust End of Life Care Policy (August 2014) stated that the Director of Nursing was the lead director.
- During 2013/2014 end of life care was part of a Commissioning for Quality and Innovation (CQUIN)

payment with an action plan developed. The action plan was monitored by the Clinical Commissioning Groups and we saw evidence that this had been completed.
- We were told by the executive lead that whilst there was no Trust strategy for end of life care, they had been working to the Department of Health End of Life Care Strategy 2008. Their current action plan has been developed from the National Recommendations of the Liverpool Care Pathway Review.
- The action plan identified areas for improvement such as delayed discharges and the need to collect patient and carer experience. However, it was not clear how assurance of quality of care would be measured.
- The Trust continued to participate in the county wide End of Life Care Board that is a working group for improving end of life care.

Governance, risk management and quality measurement

- We saw that the action plan was reviewed at the Trust End of Life Care Steering Group meetings with evidence that work was progressing. The minutes highlighted where there were resource issues that impacted on the quality of care, such as the delays in discharging patients who wanted to die in their own homes.
- We were provided with several examples of the monthly End of Life Care – Last Days Meeting minutes. These demonstrated that the End of Life Care Steering Group minutes were reviewed and more detailed work undertaken. For example, the specific issues delaying rapid discharge of patients was being collected for action by a multi-disciplinary team to be developed. We also saw where an individual case of delayed discharge was discussed and reflected on. The learning from this would be incorporated in the training programme.
- End of life care was not mentioned in the Trust's Quality Improvement Plan 2014/15.
- As part of the CQUIN an End of Life Care Quality Assessment audit was initiated in August 2013 that reviewed expected deaths for patients who died in their own homes or in a care home. The End of Life Care Quality Assessment Tool (ELCQuA) based on the NICE

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standards for End of Life Care was used. As only the specialist palliative care and community nursing notes were audited the limitations of the audit were noted. Results varied, being generally good for identifying patients approaching end of life care and receiving holistic assessments. The results were less good in recording patients' preferred place of care and place of death, with very low recording whether spiritual or religious needs had been explored. We found that these elements were not recorded in all the patient records we looked at on this inspection.

- The Trust's Key Elements for Care at the End of Life had replaced the Liverpool Care Pathway. There was a check list that included a prompt in respect of a patient's preferred place of death. We were also shown a Nursing Care Plan that had been developed regarding key elements of good care in the last few hours to days of life and this did not specifically record preferred place of care, preferred place of death or emotional support.

- We were provided with several examples of community hospital team meetings. These demonstrated that information was shared and disseminated. We saw that incidents were discussed. Some teams were using the Trust template for meetings that ensured local incidents were collated, as well as any complaints. Discussion and learning from incidents and complaints was less clear where the teams were not using the Trust template. There was variable attendance at the meetings but, where poorly attended, this was being addressed. Trust updates, alerts and feedback from events such as Listen in Action were included. For two community hospitals we saw reference to the phasing out of the LCP to be replaced by the Key Elements documentation.

- We were provided with evidence that the Trust collated community nursing incident reporting and these were sent out monthly to team leaders.

- We understood that the Key Elements for Care at the End of Life had been put in place whilst awaiting further national guidance following the withdrawal of the Liverpool Care Pathway, we found that this had not been fully understood by all staff and there was lack of clarity how the quality of the service would be monitored.

- We were provided with Macmillan Community Palliative Care Team annual reports from two areas and informed that these were the only ones completed at the time of the inspection. The Eastbourne team report stated that they saw a total of 496 patients between 1 April 2013

and 31 March 2014 which was an increase of 176 on the previous year. Of these, 42 patients were referred for end of life care but there was no comment on whether this was an increase on the previous year.

- Some clinical audit into end of life care had been undertaken in the acute hospitals. An audit in December 2013 with a re-audit in March 2014 on prescribing controlled drugs for patients to be discharged home on end of life care showed that the development of a standardised dispensing chart had improved the quality of the prescriptions. This in turn meant that the time patients' waited for their medicines in order to be discharged was reduced and the organisation took action and learning from audit results.

- An audit was carried out in May – July 2014 on use of the acute hospitals' rapid discharge pathway for patients identified as being for end of life care who did not wish to die in hospital. This demonstrated that there were significant delays in discharge. The audit identified a need for better end of life care information on all the wards. We saw that these boxes with the end of life care information had been recently received in the community hospitals as well as in the district nurse bases that we visited. They were not yet embedded in practice.

- This was also demonstrated in a further audit in July 2014 regarding the use of the Key Elements of Good Care guidelines. Findings were that there was minimal use of the documentation in the acute sector but that staff demonstrated an understanding of end of life care. We were not provided with evidence of end of life care audit in the community.

- We saw that delayed discharges and late referrals to the service were reported through the electronic reporting system.

- Six monthly audits of DNACPR forms in the acute hospitals have been carried out that demonstrate a continued need for medical education to ensure better completion results. Staff in the community told us that these varied in completion and we saw this variation in the patient records we looked at.

Leadership of service

- There had been a recent restructure which meant that managers had only been in post for a few weeks. We were told that the structure fitted with the three Clinical

Are End of Life Care services well-led?

Commissioning Groups which was felt to be helpful. Staff were also pleased to be moving away from interim management as some had experienced several changes over a relatively short time.

- Teams reported that they were well managed locally. We saw positive team relationships and approachable managers. We were told that lead nurses were available and staff felt able to ask questions and seek advice.
- We were told of one example where staff felt that issues within the team had not been managed well and they had felt unsupported at the time. We did not find further examples of concerns in the other teams we spoke with.
- We found that the majority of managers demonstrated good knowledge of Trust priorities and disseminated these in their team meetings. However, there was some variation in practice with not all teams using the Trust team meeting template that ensured required information was collated and disseminated to all staff.
- Managers did not generally have any additional training in end of life care than that for all staff. The end of life care facilitators provided support in knowledge and skills that managers told us was very helpful.
- The Trust did not provide evidence of specific leadership training for staff in those roles. However, the trust stated that matrons had internal 'Awaydays' and were invited to the Trust 'Leadership conversations' as part of their ongoing development. Matrons we spoke with told us the regular matron meetings were very useful.
- Some staff expressed concerns that the community services did not have the same focus and attention as the acute services. It was felt that there was a lack of understanding of community services and that the new end of life care documentation was more acute focussed.

Culture within the service

- Within the teams we met, the culture was open, positive and committed to providing high quality care for their end of life patients. They were clearly proud of the work they did and expressed a clear shared commitment to patients.
- Staff told us they felt confident in raising concerns and making suggestions to their managers.
- Staff felt that the most effective support was from their immediate colleagues and local managers. They told us they could always access advice and support in caring for end of life care patients.

- We found that the staff were very patient centred and wanted to develop their skills and knowledge in this area.

Public and staff engagement

- We found varying reports from staff on their feelings of engagement as part of the whole organisation. Whilst some staff said that they felt part of the Trust and well informed, others felt more isolated. One member of staff said that they no longer read some Trust communications as they felt so disengaged.
- Since the low response rate and the staff survey results in 2013 the Trust have been developing ways of communicating better with staff, particularly in light of the many structure changes that have been implemented. We again found varying responses from staff regarding these changes with many demonstrating a weariness in respect of the number of changes in management they have had. However, there was also some positive feedback about the most recent restructure that fits in with the three Clinical Commissioning Group boundaries. It was felt that this would improve working relationships and communication.
- We saw evidence that the community hospitals and district nursing bases were included in the Trust quality walks programme. These were carried out by board members and senior managers with a report presented to each board meeting that included analysis of the key issues and discussion points. Matrons and lead nurses where visits had taken place felt positive about them. We saw that the new electronic patient record system was included in the focus of the visits.
- One of the developments has been Listening into Action sessions for staff. We were provided with the June 2014 newsletter reporting on two events that focussed on end of life care and were attended by a range of staff. Areas for improvement were identified such as communication and shared documentation between the acute and community settings.

Innovation, improvement and sustainability

- We heard from everyone we spoke with, both internally and externally, that end of life care in the community was prioritised. Staff were all very passionate and proud of the service they provided, whether in the community hospitals or in people's homes. We heard and observed the huge efforts staff put into ensuring clear and timely

Are End of Life Care services well-led?

communication with patients, families, palliative care nurses, the hospice, GPs and each other. This meant that the patient was at the centre of multidisciplinary team working.

- Staff told us that end of life care was a, "huge part of their work" and increasing annually. Patients also had increasingly complex health needs.

- Once the new electronic patient record system is fully embedded and all staff confident and competent, it should support effective working locally. For example, the system flags up if more than one home visit is planned by different parts of the service. The required care can then be passed to the most appropriate member of staff to complete all at one visit.

- Whilst we saw the action plan the Trust was working to, without a Trust strategy or county wide strategy it was not clear how the increase in workload was being monitored and planned for. For example, there was good practice in ensuring the 'Just in Case' medicines were in patients' homes. However, we could not find evidence of monitoring for either effectiveness or cost and resource implications for forward planning.

- We did not see evidence of a cycle of continuous improvement embedded in end of life care serviced. The limited auditing and analysis of the services did not encourage significant changes in practice.

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People who use services were not protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them that could be located promptly by all of those involved in their end of life care. Regulation 20 (2) (a).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People who use services were not protected against the risks of unsafe or inappropriate care and treatment by regularly assessing and monitoring the quality of the services provided in end of life care in the community. Regulation 10 (1) (a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The provider did not regularly seek the views (including the descriptions of their experiences of care and treatment) of service users, their families and carers. Regulation 10 (2) (e)