Care Quality Commission

Great Western Hospitals NHS Foundation Trust

RN3

End of life care

Quality Report

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Date of inspection visit: 29 September – 2 October 2015
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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)
RN333	Chippenham Hospital	End of life care	SN15 2AJ
RN3C5	Warminster Hospital	End of life care	BA12 8QS
RN313	Savernake Hospital	End of life care	SN8 3HL

This report describes our judgement of the quality of care provided within this core service by Great Western Hospitals NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Great Western Hospitals NHS Foundation Trust and these are brought together to inform our overall judgement of Great Western Hospitals 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

Overall rating for this core service GOOD

We judged the overall service provision of end of life care as good. We found the service to be safe, effective, caring, responsive and well-led.

There were systems in place to keep patients safe. There was a good provision of equipment, including syringe drivers and mattresses for patient use in the community. We saw pre-emptive prescribing of anticipatory medications and availability of the 'just in case' medications.

End of life care was delivered through evidence based research and guidance. Education programmes had been developed and delivered, new documentation had been successfully introduced to the trust improving the pathway for patients

Patients and relatives spoke highly of the teams of nurses in the community; they were seen as very responsive to their needs. Out of hours there were good resources for staff to access including a 24 hour advice line managed by specialist palliative care nurses at a local hospice.

End of life care was seen as a priority for the trust. There was a clear overarching strategy for the service and plans to improve the delivery of care had already begun to take place with good results. The staff were able to collate evidence and influence change to improve services for patients.

Summary of findings

Background to the service

Information about the service

Palliative and end of life care encompasses all care given to patients who are approaching the end of their life and following death. It includes nursing care, specialist palliative care, bereavement support, and mortuary services. The definition of end of life includes patients who are approaching the end of life when they are likely to die within the next twelve months; patients whose death is imminent; those with advanced, progressive and incurable conditions, general frailty and co-existing conditions that mean a patient is expected to die within the next twelve months; existing conditions if they are at risk of dying from a sudden acute crisis in their condition; and life threatening acute conditions caused by sudden catastrophic events.

End of life care is delivered in the Great Western Hospital and within Wiltshire community by the Integrated Community Health Division (community wards and people's own homes). This report focuses on end of life care in the community, there is a separate report for end of life care in Great Western Hospital.

Outside the Great Western Hospital, the clinical teams delivered end of life care within community hospitals and in patients own homes by community nurses. They worked in collaboration with three hospices and a range of specialist community end of life care providers geographically spread to meet the needs of patients in Swindon and Wiltshire. During our inspection we went to three community hospitals and visited two patients in their own homes. We spoke with nine members of staff, one patient and three relatives.

Our inspection team

Our inspection team was led by:

Chair: Dr Nick Bishop, Professional Advisor, Care Quality Commission

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

The team included of 58 people included 17 CQC inspectors and a variety of specialists: A retired chief executive, a director of nursing, a safeguarding specialist,

a paramedic, a senior sister in emergency medicine, a consultant surgeon, a consultant in anaesthesia, a consultant neonatologist, a consultant in paediatric palliative care, a consultant haematologist, four community matrons, a health visitor, a speech and language therapist, two physiotherapists, an occupational therapist, specialist nurses in end of life care, medicine and maternity, a junior doctor, a student nurse and an expert by experience.

Why we carried out this inspection

We conducted this inspection as part of our in-depth hospital inspection programme. The trust was identified as a low risk trust according to our Intelligent Monitoring

model. This model looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations.

How we carried out this inspection

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

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

Summary of findings

- Is it well-led?

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about Great Western Hospital NHS Foundation trust and the Great Western Hospital. These included the local commissioning groups, Monitor, the local council, Healthwatch Swindon and Healthwatch Wiltshire, the General Medical Council, the Nursing and Midwifery Council and the royal colleges. We also talked to the provider of community services in Swindon, and the company who own, run and manage the hospital building, providing domestic and portering staff, meals and facilities management.

We held one listening event in Malborough on 24 September 2015, at which people shared their views and experiences. In addition we ran a 'share your experience' stall in a shopping centre in Swindon on 22 August 2015. In total more than 50 people attended the events. People who were unable to attend either shared their experiences by email and telephone as well as on our website.

We talked with patients and staff from across most of the trust. We observed how people were being cared for, talked with carers and family members, and reviewed patients' records of their care and treatment.

What people who use the provider say

We spoke with four relatives during our visit.

They were complimentary about the care and professionalism of the staff that provided the services. We were told that staff were respectful, caring and compassionate

- One relative we spoke with described the district nurses as 'brilliant, very efficient and deliver care with empathy and love. Another told us 'I'm respected and treated as an individual.'
- We saw thank you cards from families comments included 'passed away with peace and dignity' 'wonderful care', 'a truly caring team'

Good practice

The community services participated in 'IWantGreatCare', this was a continuous, real-time collection, monitoring and analysing quantitative and qualitative patient and relative feedback and could act as an early warning system.

People's individual needs and preferences were central to the planning and delivery of services. The service was flexible, provided choice and ensured continuity of care

in the wider community. The involvement of other organisations and the local community was seen to be integral to how patient care was planned and ensured the service met people's needs.

End of life care had become part of the induction and mandatory training programme, these programmes of learning had been devised by the palliative consultant and end of life nurse.

Great Western Hospitals NHS Foundation Trust
End of life care
Detailed findings from this inspection

Good 🟢

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We judged the safety of end of life care as good. There were systems in place to makes sure that all reported incidents were investigated, staff were clear on the process for reporting and felt able to report appropriately. Staff were trained to recognise and act upon suspicions of abuse in vulnerable people.

Medication was prescribed appropriately and was easily available both in patients own homes and community hospitals although obtaining medication out of hours was problematic but was being looked into.

Treatment Escalation Plans for patients had been successfully introduced trust wide. Patients' risks were assessed and identified appropriately. Plans were in place to identify care to end of life patients as a priority during times of poor weather.

Specialist equipment was easy to order for patients in their own homes and delivered quickly if required. Community nurses had good access to equipment at their local bases.

However we found not all staff were up to date with mandatory training.

Incident reporting, learning and improvement

- Staff were open, transparent and honest about incidents. Systems were in place to make sure that incidents were reported and investigated appropriately. All staff told us that they would have no hesitation in reporting incidents and were clear on how they would report them.
- Staff we talked with across the trust, community hospitals and community nurses had good knowledge of how to report incidences using the electronic reporting system. The senior nurses were able to describe how they used incident reporting as a learning tool for their staff. Incidences had an agenda at staff meetings they were discussed and ways to improve were looked at.
- A senior nurse described how an incident report had led to her team now receiving group supervision led by a professional from one of the local hospices.

Duty of Candour

- New fundamental standards and regulation for the provider came into force in November 2014 regarding Duty of Candour. The duty of candour explains what providers should do to make sure they are open and honest with patients when something goes wrong with their care and treatment. The trust had a comprehensive duty of candour policy in place. Staff

Are services safe?

were able to demonstrate an understanding of this and senior nurses were able to describe how the duty of candour was part of their working practices. The process they followed was firstly a verbal apology followed up with a written one.

Safeguarding

- Staff were trained to recognise and act upon suspicions of abuse of vulnerable people. The staff we spoke with had received safeguarding training. We saw evidence in one community hospital of 94% of staff had completed safeguarding training. The community teams had good links with the safeguarding teams and were able to seek guidance on issues if required. The staff had access to a resource folder which held useful information and contact telephone numbers.
- We were told of an example whereby the escalation of a safeguarding issue had been dealt with appropriately and action had been taken.

Medicines

- The community hospitals had a stock supply of anticipatory medications, prescribing of these medicines was undertaken by the GPs. We were told the GPs were very good at prescribing anticipatory medications. If medicines were unavailable prescriptions could be faxed to a local pharmacy for next day delivery. Guidance on prescribing of palliative medicines had been produced and was available on the trust intranet. Pocket cards for staff had also been developed advising on palliative care prescribing, these cards gave direction to the intranet for more in-depth guidance on prescribing, including opioid conversions and renal failure.
- Just in Case (JIC) boxes were used in people's own homes, these contained anticipatory drugs for patients use. Anticipatory drugs were used to control patient's symptoms such as pain or sickness, they were kept in patients home in order to be given as and when required. These were prescribed by GPs and dispensed by the local pharmacy. The boxes were blue in colour and were clearly identifiable. The patient and carers were given information leaflets clearly explaining the use of the drugs inside the box. The information gave instructions of how to store the box and to keep out of

reach from children. A community nurse explained how they advised patients and carers to store the medications especially if children were present in the home.
- The JIC boxes were sealed with a tamper proof seal. Inside the box contained guidance and information on drug doses for symptom control and contact numbers to seek further advice.
- We were told of the difficulties in obtaining medications out of hours. Across the county there were only a very few number of pharmacies open and this meant some families were travelling long distances to collect medications. Discussions were taking place with the local commissioning groups to rectify this problem.

Environment and equipment

- The provider was using appropriate equipment. The NHS National Patient Safety Agency (an agency established to improve patient safety in hospitals) recommended in 2011 that all Graseby syringe drivers (a device for delivering medicines continuously under the skin) should be withdrawn by the end 2015. A replacement syringe driver had been introduced into the trust. A comprehensive policy and guidelines on the use of syringe drivers were in place for staff to access. We saw evidence of the syringe drivers annual service to be up to date.
- The homes we visited had sharps containers to allow for the safe disposal of objects such as needles, syringes and glass ampoules. It was the responsibility of the local council to dispose of the sharps containers. An information leaflet was being developed to give to patients on the safe storage of the container.
- The staff had timely access to equipment they required to look after patients in the community. They had a good supply of syringe drivers and community nurse bases held a fully stocked equipment store. Larger items of equipment were able to be delivered to patients' homes seven days per week. Unfortunately equipment could not be collected on the same day following a patients' death and this had caused some concern for relatives at times.

Quality of records

- In June 2015 the Specialist Palliative Care Team (SPCT), based at Great Western Hospital, rolled out a document titled 'Personalised Care Plan' in response to the phasing out of the Liverpool Care Pathway. Funding had

Are services safe?

been sought and awarded from Health Education South West for the delivery of the document. During our visit the document had been in the early stages of implementation and only a few staff had used the document fully. The response we received about that document was all very positive, staff told us they thought it was very good and allowed them to address psychological concerns and enabled them to help focus the care.

- Treatment Escalation Plans (TEP) and Resuscitation Decision Record were introduced into the trust in August 2015. These plans of care replaced the Do Not Attempt Cardio Pulmonary Resuscitation forms. The TEP document engaged the patient at an early stage in their care, to support and help identify the patients' ongoing health needs and clinical treatments and wishes. The TEP was transferable and was adopted both within the primary and secondary care services both within Swindon and Wiltshire. It was only necessary to complete the plan once and was formally recognised across the healthcare organisations.

- We saw nine TEP documents within the community and 100% of them had been completed fully and appropriately.

- A few staff talked about the Advanced Care Plan this was new to the trust and being rolled out along with a training programme called "circle of life". The Advanced Care Plan was used to direct a discussion with the patient and a recording tool to document the future care of an individual and their care providers, with family and friends being involved if the patient wished. Nursing documentation of care given to patients was consistent and regularly updated.

Cleanliness, infection control and hygiene

- Staff were witnessed washing their hands prior to attending to patients in their own homes and within the community hospitals. We saw good use of appropriate personal protective equipment such as gloves and aprons.

- On a patients' death we were told by staff they had a contract with a local undertaker who they were able to use if the patient or relatives had not stated a preference. There was a 'care after death policy' in place, advising staff to inform undertakers of any relevant infection control risk.

Mandatory training

- End of life mandatory training commenced July 2015 for all patient facing staff, this was a three yearly requirement.

- The mandatory training target of 80% had not been met in most areas such as advanced basic life support, infection prevention and control including hand hygiene for staff working in both the community and community hospitals.

Assessing and responding to patient risk

- Patients were risk assessed as appropriate, for example, we saw completed risk assessments for pressure ulcer care and mobility in patients' homes.

- An early warning scoring system was used to identify patients whose condition was deteriorating.

- The staff had access to a 24 hour telephone line for palliative care advice; this advice was provided by a local hospice.

- In the community hospital environment verbal handovers about patients were completed at the beginning of each shift. Bedside handover was encouraged and staff were reminded of 'highlights', for example, areas of most importance such as infection control.

- Patients were given an out of hour's telephone number but a patient described how difficult it was to get through to the relevant person and they were asked a lot of questions. This frustration was acknowledged by the community nurse.

Staffing levels and caseload

- End of life care was provided by community nurses who worked across the county providing a seven day service working from 8am until 10pm. A smaller team covered outside of these hours which provided a responsive service.

- Medical cover for each hospital was provided consistently by allocated GPs. In the community hospitals, staff described how they were able to contact GPs for any out of hours concerns and confirmed that GP's were always quick to respond and patients were not kept waiting for long periods of time.

- Managers and staff we spoke with told us that caseloads were fairly and effectively distributed. Managers reviewed and discussed caseloads in team meetings

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and with staff individually. Staff we spoke with said they could discuss any issues they had with their capacity and workload with their manager and they would be supported to address any problems.

- A new staffing tool, a capacity management tool was implemented in the community in August 2015. Numbers of visits and staffing workload were reviewed on a daily basis, by looking at staffing levels and workload diaries. In one of the largest teams, work load was above capacity at the time of inspection, but was being achieved by nurses working extra hours or staff being borrowed from neighbouring teams where possible. Therapists accessed a similar tool but worked to waiting lists.

- In one team where staff turnover was high, we were informed how the recruitment and advertising teams responded rapidly to vacancies and how nearly all vacancies were quickly filled.

Managing anticipated risks

- Plans were in place to ensure that patients receiving end of life care continued to receive care at a safe and appropriate level during periods of bad weather. Community nurses told us how they were transported to patients' homes via 4x4 vehicles during bad weather. Patients were prioritised according to their need, but end of life patients are always a top priority.

Are services effective?

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

Summary

We judged the effectiveness of end of life care as good. End of life care was being delivered through evidence based research and guidance. Education was delivered for clinical staff to update their skills and knowledge in caring for end of life patients. Resources were easily available for staff to access.

Medications were prescribed timely and patients received effective pain relief in their own homes and in the community hospitals. There were high numbers of patients being cared for in their preferred place. Community staff attended multi-disciplinary team meetings at GP centres to discuss the end of life patients; this was attended by a varied group of staff including representatives from other organisations.

Evidence based care and treatment

- Evidenced based care had been implemented for patients in their last year of life. In response to and in line with NICE guidance (QS13 End of Life Care for adults) for the phasing out of the Liverpool Care pathway new documentation had been introduced by the trust, this included the treatment escalation plan and personalised care plan. The personalised care plan was developed using guidance from the Leadership Alliance for the Care of Dying People, it was focussed around the five Priorities of Care. The personalised care plan was very new (introduced August 2015) and some staff had yet to become familiar with it. Although staff we spoke with were pleased to have this document in place and recognised the importance of it. This document was being slightly altered to accommodate the differences in the community environment compared with the acute trust.

- Some staff were aware of the Advanced Care Plan but we did not see any evidence of its use as it was a fairly new document to the trust, a rolling teaching programme had been commenced to assist staff in using it. Advanced Care Plan was a key part of the Gold Standards Framework Programme. It should be included consistently andsystematically so that every appropriate person was offered the chance to have an advanced care planning discussion with the most suitable person caring for them. Advance care planning was a key means of improving care for people nearing the end of life and of enabling better planning and provision of care, to help them live and die in the place and the manner of their choosing.The main goal in delivering good end of life care was to be able to clarify peoples' wishes, needs and preferences and deliver care to meet them.

Pain relief

- Patients' pain relief was well managed. Numeric pain scores were being used to assess patients' level of pain. For those patients who were unable to communicate a specially devised pain scale, called the Abbey Pain Scale, was used in assessment. If pain relief was required the assessment tool prompted a reassessment of pain.

- A relative told us his wife's pain was well controlled when she was at home in the dying phase. The staff were able to use non-verbal clues to assess her pain.

- Patients identified as requiring end of life care were prescribed anticipatory medicines. These 'when required' medicines were prescribed in advance to be given to allow prompt management of any changes in patients' pain or other symptoms. Palliative medicines (which could alleviate pain and symptoms associated with end of life) were available at all times. Wards and community nurses had adequate supplies of syringe drivers (devices for delivering pain medicines continuously under the skin) and the medicines to be used with them. Staff were trained to set up this equipment.

Nutrition and hydration

- Screening tools were used to determine how best to support patients. A patient in receipt of palliative care, for example, had been assessed using the Malnutrition Universal Screening Tool (MUST). Referral to a dietician would depend on the outcome of the score. Food and fluid charts were completed for the first three days of admission to assess intake further. We saw evidence of daily fluid charts in use and recorded appropriately

Are services effective?

Patient outcomes

- Outcomes were measured to ensure that the needs of patients were being met in the service.
- We were shown audit results of patients preferred place of death for the community. The monthly results were in between 88% and 100% dying in their preferred place. However, this was for patients who had been asked and their wishes recorded, there were no figures for how many had been asked.
- Feedback on the service was through the National Care of the Dying Audit and Care of the Dying
- Evaluation (CODE Bereavement survey). This was an online bereavement survey validated for relatives to complete when they felt ready, the service was also offered via a telephone through the Chaplaincy service. The first results of the first audit were due to have been presented at the patient quality committee in September. The results were used to improve the services.

Competent staff

- Syringe driver training was robust; staff were encouraged to have the syringe driver with them when they did the training. One to one training was available with the end of life trainers. The nurses were competency assessed; this could be completed as many times as necessary to achieve the competency and confidence of the staff member.
- Staff including GPs were able to access a wide range of courses in relation to end of life care, for example pain control, having difficult conversations. Many of these courses were at the local hospices supporting the community hospitals, training also included online e-learning. Staff had attended advanced communication courses and symptom control modules.
- We identified end of life care champions within the community and on the wards in community hospitals. The leads included registered and non-registered nurses. Staff had been able to attend training days and to participate in end of life champions' meetings.

- There were two end of life lead trainers within the community setting. Their role was to assist staff in developing the correct skills to be able to care for people in their own homes and within the community hospitals. They had implemented the 'conversation project', this assisted staff with having difficult conversations with patients and relatives. The project

was delivered in the form of a board game (the circle of life). This board game was designed as a training resource to support learning for best interest decisions. It included topics relating to advanced care planning, communication and the Mental Capacity Act. The game encouraged discussions and debates in a supported environment. An audit was undertaken prior to the project and again afterwards which showed a marked improvement of staff confidence. Staff had commented on how useful it had been in discussing such emotive subjects.

- End of life care had become part of the induction and mandatory training programme, these programmes of learning had been devised by the palliative consultant and end of life nurse.
- Staff we spoke with in the community felt proud of the way end of life care was delivered and were pleased to have increased knowledge and confidence in the delivery of care.

Multi-disciplinary working and coordinated care pathways

- Community nurses attended monthly Gold Standards Framework meetings held at the GP practices to discuss end of life patients and their care plans. These meetings were also attended by specialist palliative care nurses from the local hospice. The integrated community teams held weekly end of life meetings, these were attended by the occupational therapist, physiotherapist and representatives from the local hospice, which gave a full overview of the patient. The clinical teams worked closely with social services' colleagues to ensure continuity of care.
- We were told about clinical co-ordinators who were based at GP practices and provided liaison between GPs and the community teams. They were able to visit patients who were of a particular concern or were deteriorating and assist in their care planning.

Referral, transfer, discharge and transition

- Patients who were known to the community service, and required additional support for end of life care, could seek direct admission to a local community hospital. A comprehensive medical handover between the referring GP and ward was expected to take place. All the community hospitals provided end of life care.

Are services effective?

- Patients were admitted to the community hospitals if it was their wish to die in hospital. The use of the treatment escalation plan had assisted patients to die in their preferred place. The target for patients preferred place of death was 75% but they had been achieving 88-100%.

- The community teams achieved a rapid discharge of patients from hospital. However they were concerned about patients being discharged who required a syringe driver. The acute hospital used different syringe pumps, which had to be discontinued during transfer home and a nurse would be required to meet the patient at their own home to set up a new syringe driver. Patients would have to have extra doses of pain relief given to ensure they were pain free during their transfer home. This was a risk highlighted on the risk register but there were no plans to replace the pumps at the acute hospital. At the time of the inspection, this was due to be discussed with the divisional directorate

Access to information

- Staff had access to the end of life care information page on the trust intranet. This held information such as symptom control and prescribing guidance. A palliative care resource folder was also available on each ward; this meant information was readily available for staff to access to aid symptom control for patients. Staff were also able to access specialist palliative care advice from the team based at Great Western Hospital and out of hours they were able to use the 24 hour advice line managed by the local hospices. Community nurses were provided with 'Palliative care symptom management guidelines', version 2014. This gave the community nursing staff instant access to guidance on symptom control for patients whilst they were out visiting.

- Care records were available for external care staff, such as care agencies and hospice nurses, visiting patients at home. A new electronic record system was due to be introduced across the community with access for GPs and community staff allowing improved access of information sharing.

- A new computerised system was soon to have been implemented across Wiltshire which had an end of life component; this would allow information to be shared among health professionals across the county.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were able to explain how important it was to obtain patients consent prior to delivering any care. Staff told us of a two stage process to assess a patient's capacity if required and were aware of the process to make a referral for deprivation of liberty safeguarding.

- We spoke about the Mental Capacity Act with community nurse who had been asked to become a 'practice influencer', this role was to build on up competencies and to be able to feedback to the team and act as a resource. We also spoke with nurses working within the community hospitals who were able to discuss the Mental Capacity Act and Deprivation of Liberty Safeguards with us.

Are services caring?

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

Summary

End of life care was judged as good for caring. Staff were caring and compassionate. Staff interacted with patients with kindness, dignity and respect. Families were actively involved in care when they wished to be and were included in all conversations.

Compassionate care

- Patients were treated with compassion. We spoke with three patients and four relatives; they were aware of how busy the nurses were and at times short staffed but overwhelmingly all felt as though their needs had been met in a caring and compassionate way. Patients we spoke with described 'how brilliant' the nurses were and they were kind and considerate.

- Staff were aware of people's different cultural needs and requirements. Patients were asked about the specific times they wished to get up, meal times and their normal routines these would be accommodated as far as possible.

- Patients nearing the end of their life were moved into a side room wherever possible; this allowed families to remain with them for as long as they wished. Single beds were available for relatives to use in the side room if they wished.

- Staff were observed interacting with patients with kindness and encouragement. Call bells were answered promptly and drinks were within easy reach.

Understanding and involvement of patients and those close to them

- Patients and relatives were involved in discussions about care and treatment. Communication between the ward staff, the GP and the patient and their family was seen as being important at all times but in particular with a patient nearing the end of life. A document called 'all about me' was completed on admission and along with the advanced plan (if completed) gave information to staff about the person they were caring for. Information leaflets were given to carers to back up the verbal information given to them.

- End of life patients were moved into a side room if they wished, relatives were able to stay with them and staff worked hard to make them as comfortable as possible. There were not any separate rooms for relatives to use, however, this had been identified as a need. Relatives were able to assist in delivering care if they wished. There was open visiting.

- Along with a community nurse we visited a patients home, the family was very involved in the delivery of care and were actively included in conversation and discussion surrounding the patients future care needs.

Emotional support

- We observed communication between community nurses and patients, the discussions were very patient focussed and demonstrated sensitivity. The nurse discussed flexibility of their visits depending on the patients' activities. The community nurse also checked with the patients' partner coping strategies and how they were feeling.

- Staff had conversations with families and carers during the last phase of the patient's life, and to support this conversation, leaflets were given, which included 'coping with dying', and explanation about the changes which occurred before death.

- Community staff contacted relatives of the deceased on the day to offer support and advice; they then followed this up with either visits or telephone contact. The staff were able to signpost relatives for further bereavement support to, for example, charitable organisations or local GP surgeries who had their own counsellors.

- The community teams encouraged patients and relatives to seek spiritual and pastoral support if this was important to them. The staff told us the chaplain based at Great Western Hospital would always visit a patient in their own home if required.

Are services responsive to people's needs?

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

Summary

We found that the service was responsive to patients' needs. Community nursing teams were very responsive to the needs of patients and relatives. Community hospital staff had access to out of hours support from GPs and all staff had good access to an out of hours end of life advice line.

The trust had involvement from other local services and organisations in the planning of meeting the needs for end of life care across the community and were continually looking at ways to work together to provide a co-ordinated service.

Planning and delivering services which meet people's needs

- People's individual needs and preferences were central to the planning and delivery of services. The service was flexible, provided choice and ensured continuity of care in the wider community. The involvement of other organisations and the local community was seen to be integral to how patient care was planned and ensured the service met people's needs. We were informed by the medical director, who was the trust board lead for end of life care, that the commissioners, providers and relevant stakeholders were invited to end of life committee meetings in order to plan the service for future needs of their local people. There was at the time ongoing work involving social services to improve timely discharge planning.
- In recent months the community mortuaries had been closed down due to the cost of upgrading them to be fully complaint with the HTA regulations (Human Tissue Act 2004). Contracts were negotiated with local funeral directors to provide a 24 hour, seven day collection service for deceased patients at the community hospitals. Funeral directors were able to collect the deceased patient within three hours of the request. Relatives were also able to use their own choice of funeral directors if they wished. Carers were able to stay with their deceased relative for as long as they wished.
- We found there to be guidance on Implantable Cardioverter Defibrillator (ICD) deactivation and flow charts for staff to follow. The cardiac team provided a

responsive service to these requests; patients could be visited at home if required. The cardiac team generally had discussed with patients this sensitive issue of deactivating the device when the time was appropriate.

Equality and diversity

- We observed, from visiting community hospitals, good access for disabled people with slopes in and out of buildings.
- Translation of the personalised care plan into different languages had been investigated; however this was a costly service. It was felt many non-English speaking families generally had some members of the family who would be able to speak English and translate the document for use; this was not considered a risk by the trust. For those who did not a translator would be found.

Meeting the needs of people in vulnerable circumstances

- A community nurse explained about a 72 hour emergency care service. This was accessible for patients who were vulnerable at home and in a deteriorating condition and were waiting for fast track funding from continuing health care. The care was provided by another care provider and supported by hospice at home.
- One of the community hospitals was caring for a patient with learning difficulties, the ward staff liaised with the carers in order to maintain the patients normal routine and to have an understanding of how new things distressed her.

Access to the right care at the right time

- Patients and staff were able to access appropriate care and assistance. Staff had access to GPs out of hours if required and a staff nurse told us she had not had to wait long for the GP to visit. Staff were able to access specialist palliative care advice via the out of hour's advice line managed by the local hospices. Relatives were given a telephone number to ring for out of hour's assistance.

Are services responsive to people's needs?

- Community staff were able to accommodate patient's rapid discharge from hospital by prioritising their workload. Overnight support for the newly discharged patient was available from the local hospice if required.

Learning from complaints and concerns

- There were very few reported complaints in regards to end of life care. A nurse we spoke with recalled there being complaints about families having to travel quite a distance to collect prescriptions if they were required out of hours. This was being looked at and negotiations were underway with the local clinical commissioning group to rectify this problem.

Are services well-led?

Good 🟢

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

Summary

We judged the end of life care as good for being well led. End of life care services were well led and had been seen as a priority within the trust. The trust had developed a three year end of life strategy, this had been supported by a service review and a commitment to improve the service and care provided to patients and families. Not all of the documentation recently introduced to support the implementation of the strategy was fully embedded yet.

There was a clear governance structure in place. The end of life committee was held monthly, from this meeting information was fed through to the governance meetings and at trust board level. Risks were identified and actions plans were in being put into place.

Patients and their relatives were engaged and involved through number of mechanisms which included involvement in the recent development to the personalised care plan.

Service vision and strategy

- The trust had developed a three year end of life care strategy in 2015, within the plan they had recognised the weaknesses of the service and developed action plans to improve upon. These areas included development of the Advanced Care Plan, the Treatment Escalation Plan and the Personalised Care Plan. The principle objective behind the strategy was 'the patient and family receive the care and support that meets their identified needs and preferences through the delivery of high quality, timely, effective individualised services, ensuring respect and dignity is preserved both during and after the patient's life.'
- Some staff within the community hospitals and community teams was aware of the strategy for end of life care.

Governance, risk management and quality measurement

- There was a clear structure for governance reporting and risks were identified and understood by members of the community teams**.**

- The end of life committee meeting was a monthly operational meeting monitoring the trust end of life service provision and overseeing the development, implementation and progress of the strategic plans. This committee reported into the trust patient quality committee on a quarterly basis which reported to the trust board. We saw actions from the strategic service review and end of life strategy reviewed from the minutes of these meetings
- There was a risk register specifically for the end of life service, there were three risks identified, with plans in place to rectify these areas:
  - End of life care mandatory training (the training had commenced in July 2015)
  - Seven day working for the specialist palliative care team
  - Use of different syringe drivers in the acute trust compared to the community. At the time of the inspection, this was due to be discussed with the divisional directorate.
- The trust had identified a representative from the board of governors to be on the end of life committee, their role was to provide public involvement and linked the work back through to the governors. Minutes from these meetings showed the governor had attended.
- An end of life quality indicator report was submitted quarterly to commissioners demonstrating their progress against the measures of the quality schedule and the Commissioning for Quality and Innovation. This included the key performance indicators, such as number of hours and attendees at end of life education sessions, percentage of patients, known to the SPCT, achieving their preferred place of care.

Leadership of this service

- Staff felt they were well led by their managers, they were aware of who to approach and felt comfortable doing so if necessary. They also said they received good support from the specialist palliative care team (SPCT) at Great Western Hospital and thought the SPCT were a well led team.

Are services well-led?

- One community nurse told us how the managers were creative and supportive; the nurse felt valued and listened to.

Culture within this service

- Staff told us that end of life care was very important as it took place across the trust. Staff training and involvement was essential. The provision of end of life care appeared to be high on the agenda for the whole trust.
- Staff we spoke with felt the trust had an open and honest culture. Junior staff we spoke with explained that the culture was one where staff felt confident to 'speak up' and that confidentiality was respected, they were able to approach any manager if they felt the need to.

Public engagement

- Systems were in place to engage with the public, for example, relatives were actively encouraged, when ready, to complete an evaluation form called care of the dying evaluation (CODE) which was accessible on the trust website. Information about this survey was given to relatives in the bereavement packs. This service was also offered via the telephone through the chaplaincy service. Carers were also encouraged to complete the carer experience evaluation form which was also available on the trust website. The feedback from CODE was monitored through the end of life committee and was being used to educate and train staff.

- During the planning phase of the personalised care plan, feedback was sought from two patient involvement groups. Since implementation feedback was sought via patient surveys, no results of this were available due the newness of the document.
- The community services participated in 'IWantGreatCare', this was a continuous, real-time collection, monitoring and analysing quantitative and qualitative patient and relative feedback and could act as an early warning system. It was similar to the NHS Friends and Family Test, collecting, monitoring and reporting feedback from thousands of patients every week.

Staff engagement

- Staff working in the community felt able to influence service change by collating evidence and presenting it to the trust, the staff felt they had a voice and were listened to. When the mortuaries were closed down there was a contract put in place with a local funeral director, staff felt relatives needed to have more choice and were able to influence this change in practice and a list of funeral directors was made available for relatives.

Innovation, improvement and sustainability

- We were told by the medical director, no savings were attached to end of life care, and the team had been working more efficiently with the aid of the ACP, PCP and TEP and would continue to aid efficiency within the service. Training and upskilling ward staff was important to aid the progress.