This report describes our judgement of the quality of care provided within this core service by Wye Valley 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 Wye Valley NHS Trust and these are brought together to inform our overall judgement of Wye Valley NHS Trust.
## Summary of findings

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End of life care services Quality Report 14 October 2014
## Summary of findings

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Overall we found that community end of life services require improvement. Staff cared for people with kindness, dignity, respect and compassion. However, there were shortfalls in safety, effectiveness, being responsive to people’s needs and leadership.

We found assessments of patients’ mental capacity to make decisions were not consistently completed or documented before decisions about care that was in their best interests were made, in all of the community hospitals we visited. Further improvements were needed to make sure all patients' records in relation to ‘do not attempt to resuscitate’ decisions were completed and documented as per trust policy.

Care was not delivered in line with current best practice. Staff were not aware of any clear evidence-based guidance or pathway to support them to deliver effective end of life care. The trust had taken part in a national audit for families who had been recently beavered. From the evidence seen we did not know which results related to community services.

We found that not all staff were able to identify or assess patients who required end of life care. Therefore, some patients did not receive specialist advice, support and care in meeting their needs.

Staff in the community hospitals and community worked hard to provide a high standard of care to patients in the final days of their life.

All of the patients we spoke to told us that care was good and they described the community nurses as “marvellous”. They were treated with respect and dignity and felt involved in their care and treatment.

Wye Valley NHS Trust provided end of life care at three of their community hospitals: Leominster; Ross on Wye; and Bromyard. Care was also provided in people’s homes by community nurses.

We inspected the following regulated activity of treatment of disease, disorder and injury. We found the trust had not met three regulations from the Health and Social Care Act 2008, Regulation 9, 10 and 18. These relate to the care and welfare of the people who use services, assessing and monitoring the quality of service provision and consent to care and treatment.
Summary of findings

Background to the service

Wye Valley NHS Trust provided end of life care at three of their community hospitals: Leominster; Ross on Wye; and Bromyard. Care was also provided in people’s homes by community nurses. There was a specialist palliative care team to support patients who required complex symptom management both in the community hospitals and in their homes. This team consisted of nine specialist palliative care nurses and one consultant.

The specialist palliative care team provided advice and support for patients and their families between the hours of 9am to 5pm, seven-days-a-week. Out-of-hours specialist advice and support could be obtained from the local hospice.

Our judgements were made across all of the hospitals and adult community services visited, where differences occurred at particular hospitals or sites we have highlighted them in the report.

Our inspection team

Our inspection team was led by:

Chair: Andrea Gordon, Deputy Chief inspector Hospitals, Care Quality Commission

Team Leader: Tim Cooper, Head of Hospitals Inspections, Care Quality Commission

The team included CQC inspectors and a variety of specialists: practice nurse, specialist palliative care nurse and an expert by experience.

Why we carried out this inspection

We carried out this scheduled inspection because Wye Valley NHS Trust had been identified by CQC Intelligent Monitoring as a risk. Additionally, the trust was subject to a rapid response review by NHS England in autumn 2013 and so considered a high risk trust.

We inspected this core service as part of our comprehensive Wave 2 pilot community health services inspection programme.

How we carried out this inspection

During our inspection at the community hospitals we met one patient receiving end of life care. We spoke with staff based at the hospital, specialist nurses and community nurses. We visited people’s homes, with their permission while they were receiving care from the community nurses. During these visits we met three people receiving end of life care.

We spoke with one occupational therapist and one GP. We looked at care records for patients who had recently died and four records for patients receiving end of life care.

Before our inspection we reviewed performance information from and about the community services.

We visited community bases for the community nurses and the three community hospitals that provided end of life care. We spoke with three people who used services, three relatives and 16 staff.

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people’s needs?
- Is it well-led?
Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out announced visits on 4 and 5 June 2014. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/ or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

What people who use the provider say

One patient told us the community nurses were “marvellous” and they wouldn’t “know what to do without them”. They also said they could ring them at any time.

We had no feedback on end of life services at our listening event.

Good practice

Our inspection team highlighted the following areas of good practice:

Staff treated people at the end of their life with kindness, dignity, respect, compassion and empathy while providing care and treatment. Nurses who worked in people’s homes spent time with them, visited relatives after someone died and consistently delivered high quality care to people, often working over their contracted hours to do so.

Staff on the wards in the community hospitals and the community nurses were able to access support from the specialist nurses seven days a week. Out of hours they could call the GP service or the hospice for further guidance and advice.

Areas for improvement

Action the provider MUST or SHOULD take to improve

MUST

- The trust must ensure that assessments of patients’ mental capacity to make decisions are consistently completed and documented before decisions about care that is in their best interests were made.
- The trust must ensure that care is delivered in line with current best practice.
- The trust must ensure that all staff are able to identify or assess patients who required end of life care so all patients receive appropriate specialist advice, support and care in meeting their needs.
- The trust must ensure end of life care in the community hospitals is delivered in line with national guidance. Following the removal of the Liverpool Care Pathway (LCP) for dying patients, there was no clear pathway for staff to follow when delivering end of life care.
- The trust must ensure that evaluation and monitoring of the effectiveness of the care delivered in the community takes place

SHOULD

- The trust must ensure there are plans in place to respond to the NPSA safety alert for the use of Graseby syringe drivers and that this is reflected on the trust risk register.
- The trust should take steps to ensure community nurses feel safe when responding to out-of-hours calls.
- The trust should ensure charts used to monitor patients general health and wellbeing are consistently completed.
Summary of findings

- The trust should develop a clear vision and strategy to deliver high quality care and promote good outcomes for people receiving end of life care in the community and the community hospitals.
The five questions we ask about core services and what we found

Are End of life care services safe?

By safe, we mean that people are protected from abuse

Summary
Safety requires improvement, in all of the community hospitals we visited. Assessments of patients’ mental capacity to make decisions were not consistently completed or documented before decisions about care that was in their best interests were made.

There were no plans in place to respond to the 2011 patient safety alert from the former National Patient Safety Agency (NPSA), now the National Patient Safety Alerting System, on the use of Graseby syringe drivers, and this was not reflected on the trust risk register.

Community nurses felt vulnerable and unsafe when responding to out-of-hours calls.

Charts used, in the community hospitals, to monitor patients general health and wellbeing were not consistently completed, which could lead to an inaccurate assessment of the patient’s condition.

Staff and GPs were able to access support and guidance from the palliative care team.

Infection control procedures were in place and well monitored across all of the community settings.

Box

Incidents, reporting and learning
- Across all three of the community hospitals, a new system had been implemented to aid staff to record incidents. Staff understood their responsibilities with regard to incident reporting, although not all staff had access to the system such as domestic and portering staff. We were told they would inform nurses on the ward who completed the incident form. Staff told us they did not always receive feedback about the incidents they had reported such as concerns around staffing levels. Senior staff told us they were able to access the system and feedback the outcomes to staff of investigations into specific incidents. Senior members of staff at two of the hospitals told us they discussed incidents relating to patients at their ward meetings and these meetings were minuted.
- There had been no recent never events (a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers) with end of life care or the specialist palliative care service.
Are End of life care services safe?

Cleanliness, infection control and hygiene

- The ward areas at all the community hospitals were visibly clean. Equipment had been clearly labelled to identify when it had been cleaned. We saw that staff regularly washed their hands and used hand gel between patients.
- Community nurses maintained good infection control procedures.
- Staff followed the trust policy on infection control, for example, the ‘bare below the elbows’ policy. Personal protective equipment was available in the form of gloves and aprons and staff were observed wearing these when delivering personal care.
- Infection control policies were available to staff on the trust intranet. Staff applied protective isolation principles to protect at risk patients from infection.
- All three community hospitals had an area specially designed to keep deceased patients prior to collection by the funeral directors. Members of staff told us a chapel of rest was available if needed and we saw this at Bromyard Hospital.

Maintenance of environment and equipment

- In 2011, the former National Patient Safety Agency (NPSA) recommended that all Graseby syringe drivers should be removed by the end of 2015. We were told that these syringe drivers were still available for use if required. During our inspection we reviewed the records of a patient who had used a syringe driver in their home. We saw regular monitoring records for the use of this equipment. Staff at the community hospitals were not aware of the recommendation. The community nurses we spoke with were aware of the NPSA recommendation and had implemented extra checks on the machines to ensure they remained safe to use. In our discussions with senior managers a business plan had not been produced to replace these syringe drivers. The NPSA recommendations were not documented on the trust risk register.
- Equipment had been regularly maintained and checked in the community hospitals to ensure it was safe to use.
- The community nurses we spoke to told us that a new company had recently been employed to service equipment used in the community. We were told that some of this equipment was out of date for maintenance. A senior member of staff told us the trust was working with the company to address this issue.

Medicines

- Medicines at the community hospitals were stored safely.
- One member of staff told us about how they ordered medication for their resuscitation trolley because it was about to expire. They said they always ordered it a week in advance to make sure it arrived in time.
- Staff at the community hospitals clearly described the process of ordering medicines and ensuring there was sufficient to meet patient needs.

Safeguarding

- Staff were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults.
- Staff told us they had attended safeguarding training. We saw training records at Leominster Hospital, which confirmed staff had attend the training.
- The trust’s safeguarding adult training records demonstrated that 89% of the staff working in community inpatient areas had completed their training.
- Assessments of a patient’s mental capacity to make decisions were not consistently completed or documented before a ‘best interest’ decision was made. For example, we read in one patients notes at Leominster hospital that a ‘do not attempt cardio-pulmonary resuscitation’ (DNACPR) form had been marked that the patient lacked capacity, but no written assessment of their capacity had been undertaken. One member of staff confirmed an assessment had not taken place. We saw a similar example at Ross on Wye hospital where it was stated a patient lacked capacity on their DNACPR form but no assessment had taken place. A member of staff confirmed no assessment had taken place.
- At Leominster hospital we examined two sets of records that contained a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order. One order had been discussed with the patient and at a multidisciplinary meeting. However, there was no record of these discussions in the patient’s notes, or explanation of why the patient’s family had not been involved. The other order had been discussed with the family and patient
Are End of life care services safe?

involved. There was documentation in the notes detailing who the discussions had been with. Nursing documentation had not been updated to reflect that the DNACPR was in place.
• At Ross on Wye hospital we examined the records of three patients. We found one patient had a completed DNACPR form that had not been discussed with them or their family. It was documented that the discussion would be too distressing for the patient, but the notes clearly indicated their family were actively involved in their care.
• Another patient’s DNACPR had also been discussed with their family and not them. A member of staff told us that both patients had varying degrees of capacity in relation to certain decisions and involvement in discussing their DNACPR. However, a mental capacity assessment had not taken place for either patient.
• For one of the other patients we found records that DNACPR had been discussed with them and their family and documented in their notes.

Records
• In Leominster and Bromyard hospitals, records were stored securely in lockable trolleys to ensure they could not be accessed by any unauthorised people. At Ross on Wye Hospital some nursing notes were stored at the nurses’ station, but they were not kept secure.
• A DNACPR audit had been completed in 2013 that included the three community hospitals providing end of life care. The audit identified areas for improvement in completion of the documentation relating to recording of discussions in patient notes and documentation not completed in line with trust guidance. Recommendations were made for the trust to consider including DNACPR audits as part of their regular audit programme. None of the staff we spoke with were aware of any regular monitoring of the completion of DNACPR documentation.
• Some staff told us the DNACPR forms were transferable between trust hospitals. However, part of the policy, which was written on the back of the DNACPR forms stated they should be reviewed when a patient was transferred from one healthcare institution to another. A GP at Bromyard Hospital confirmed they reviewed the order when a patient was transferred to them. We also saw evidence of this in patients’ notes we reviewed at Bromyard Hospital.
• At all community hospitals, charts were used to monitor patients’ general health and wellbeing such as fluid intake and pressure area care. Not all charts were consistently completed, which could lead to an inaccurate assessment of a patient’s condition. There was no information to guide staff to ensure they met a patient’s specific needs for end of life care.

Lone and remote working
• Staff told us an on-call system was in place. This involved a community nurse being on call seven-days-a-week from 10pm until 8am for the whole of Herefordshire.
• Staff reported phone signals were poor and there were black spots across the county where staff could not make or receive calls, which left them feeling vulnerable.
• The trust’s Out of Hours/Lone Worker policy was in operation, but staff were not always able to adhere to it because they were too busy. For example, if a member of staff was called out at night and worked two hours they should come in two hours later the next day. However, staff said they were aware of the team’s heavy caseload and due to lack of capacity they inevitably started at their normal time to prevent visits being missed or delayed until the next day.
• Lone worker devices had been issued to some community teams in the past, but the facility had been withdrawn as the evidence did not substantiate it improved staff safety or provided any benefits.

Adaptation of safety systems for care in different settings
• Safety thermometer information was clearly displayed at the entrance to all three community hospitals. This included information about falls, pressure areas and infection rates.

Assessing and responding to patient risk
• Risk assessments were completed appropriately on admission and care plans put in place to address any risk.
• Staff at Leominster community hospital told us that over the previous year they had had an increase in patient falls. They conducted a full investigation and root cause analysis. As a result they had a system to alert staff if people at risk of falls were found walking around. They also ensured people were checked regularly and had a
member of staff in the area at all times. At Bromyard community hospital staff told us they had also seen an increase in the amount of falls and they too were in the process of completing an investigation.

- Staff said that the Liverpool Care Pathway for the management of people who required end of life care was no longer being used in the community hospitals. Senior managers told us an end of life care pathway had been developed, but had not yet been agreed by the board.
- Staff told us if a patient’s condition worsened they would contact the specialist palliative care nurses or the hospice for further advice.

**Staffing levels and caseload**

- All of the community hospitals we visited reported they did not have the full staffing establishment. Bromyard was staffed by two-thirds qualified agency staff. Leominster had the full complement of staff on the day we visited. However, we were told they had vacancies for 4.4 (whole time equivalent) registered nurses. At Ross on Wye hospital staff told us they had issues recruiting qualified staff.
- Patient’s records showed that specialist palliative care nurses had been involved in supporting the ward and community nurses with advice regarding treatment and assessment.
- Each community hospital had specialist palliative care nurses assigned to them.
- There had been a recent recruitment drive. However, the community hospitals were not able to fill all of their vacancies.
- We spoke with some community nurses who told us that practice nurses at a GP surgery in Ross on Wye did not undertake wound care for patients. This meant they spent a lot of time visiting patients who were actually able to get their local surgery for wound care. They felt this impacted on the time they could have spent with patients who were receiving end of life care
- One palliative care consultant was employed to work across all areas of the trust.
- Patients were supported by their GPs and an out-of-hours GP service. A GP we spoke to told us they were able to access further help and advice from the trust or the local hospice if required.

**Deprivation of Liberty safeguards**

- Staff at Bromyard Hospital were able to show us their policy and procedure for Deprivation of Liberty Safeguards. One patient was subject to a safeguard and we saw that staff had completed the required documentation and obtained authorisation for its use.

**Major incident awareness and training**

- Some staff knew what the expectations of them were in the event of a major incident, but most did not.
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
The community services requires improvement. The specialist palliative care team coordinated multidisciplinary care in the community. However, end of life care in the community hospitals was not delivered in line with national guidance. Following the removal of the Liverpool Care Pathway (LCP), there was no clear pathway for staff to follow when delivering end of life care. Some ward staff across all three hospitals we spoke with were not clear about which patients were receiving end of life care and were not appropriately trained to meet patients’ needs.

Staff did not assess patient’s nutrition and hydration needs and deliver care in line with current legislation, standards and internationally recognised evidence-based guidance. We were told since the changes to the palliative care team in 2012 regular evaluation of the effectiveness of care delivered by the palliative care team in the community had not taken place.

Evidence based care and treatment
- There was no end of life care policy in use at the time of the inspection. There was a plan to develop a county-wide policy by the End of Life Forum hosted by the Clinical Commissioning Group (CCG).
- Staff at the three community hospitals told us there was no clear pathway to follow when providing end of life care. Some staff told us they were still using the principles of the Liverpool Care Pathway in the absence of guidelines produced by the trust. We had been told by the manager of the palliative care team a specific Herefordshire care pathway had been implemented as an interim measure. However, no staff we spoke to were aware of this. There was no clear evidence-based guidance to support staff to deliver effective end of life care.
- We were told that the GP practices had regular Gold Standards Framework meetings.
- Staff told us that they were able to contact palliative care specialists based at the local hospice for advice. The clinical nurse specialists for the palliative care team told us care was based on the National Institute for Health and Care Excellence (NICE) Quality Standard QS13. This quality standard defines clinical best practice for end of life care for adults. The community palliative care nurses were working toward this, but the community and hospital nurses were not because they had no clear pathway to follow.

Pain relief
- Staff at Leominster Hospital told us that when a patient had been identified for end of life care all medication, including anticipatory pain relief, would be ordered in advance. This was to ensure that patients did not have to wait to receive medication. Staff told us if someone was in pain, they could contact their GP or the out-of-hours service for further medication.
- We observed community nurses visiting patients in their own homes. We saw in the records of one patient and observed the details of checks carried out on their pain relief medication. This was to make sure the medication was working and that they were comfortable. We saw records that pumps used to deliver continual doses of pain relief, were checked regularly and the patient’s level of pain assessed.

Nutrition and hydration
- All community hospitals were screening patients using the Malnutrition Universal Screening Tool (MUST) to identify people who were nutritionally at risk.
- Generic plans to monitor their nutrition and hydration were in place. These had not been consistently completed. There were no specific plans to support people with these needs at the end of their life.
- At Ross on Wye Hospital we found detailed records about the use of subcutaneous fluids and specialist feeding regime for one patient. However, there was no care plan for this specific aspect of care.

Patient outcomes
- Staff we spoke with were not always clear about identifying when a patient was receiving end of life care, or needed to be referred to the specialist palliative care team.
Are End of life care services effective?

- The palliative care team contributed information towards the minimum data set for Specialist Palliative Care Services collected by National Council for Palliative Care.

**Performance information**

- The palliative care team senior manager told us there had been significant changes in the service since 2012. Prior to that time regular audit and performance information about the community service had been gathered. They acknowledged since that time the community service had not been audited. There was little information about patients and their families’ views of the service.

**Competent staff**

- The specialist palliative care nurses were highly skilled and regularly updated to ensure their knowledge reflected current best practice.
- Training at the community hospitals was variable. Some members of staff told us they had received training from the local hospice. One member of staff told us “they are brilliant there, the training is really good”. Most members of staff told us that had not received any training from the specialist nurse team, although some bereavement training had recently been delivered at Bromyard Hospital.
- The senior manager of the palliative care team acknowledged that training for staff in the community and community hospitals had not been regularly delivered since 2012. Training was offered at the main hospital site. Staff we spoke with told us it was not always possible to travel to the main hospital.

**Use of equipment and facilities**

- Leominster hospital staff told us that if someone was nearing the end of their life they would always try to ensure they had a single room to allow privacy for patients and their relatives.

- Staff told us they had enough equipment to support people with their range of needs.
- Most of the staff across all three hospitals were not aware of the 2011 NPSA safety alert on the use of Graseby syringes drivers. They were also not aware of any plans to change them.

**Multi-disciplinary working and working with others**

- A weekly multidisciplinary team meeting was held at the hospice to discuss all patients receiving end of life care. This meeting included doctors, nurses, occupational therapists, physiotherapists and members of the specialist palliative care team.
- The out-of-hours GP service worked closely with the specialist palliative care nurses, community nurses and the local hospice to ensure patients had continuity of care out of hours. However, community staff told us that because they covered the whole of the county when they worked out of hours, a patient could be visited by a nurse they were unfamiliar with.
- The senior clinical nurse specialist and the palliative care consultant attended the new CCG End of Life Forum was to discuss plans for end of life care at a strategic level.
- Staff at all of the community hospitals told us that the palliative care nurses were supportive. They could contact them by phone for advice, and they usually responded to referrals within 24-hours during the week.

**Co-ordinated integrated care pathways**

- The specialist palliative care nurses worked closely with all the community hospitals and community nurses. However, there was no clear end of life care pathway to enable continuity of care.
- There was no trust wide strategy for integrated service development or delivery.
By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary
Services for end of life care in the community are caring. Staff treated people at the end of their life with kindness, dignity, respect, compassion and empathy while providing care and treatment. Nurses who worked in people’s homes spent time with people, visited relatives after someone died and consistently delivered high quality care to people often working over their contracted hours to do so.

Compassionate care
- We observed staff interacting with patients in a kind and caring manner.
- Staff we spoke with talked passionately about caring for someone at the end of their life.
- One patient told us the community nurses were “marvellous” and they “didn’t know what to do without them”. They also said they could ring the community nurses at any time.
- During our inspection some of the community teams were not caring for any patients who were receiving end of life care. Staff told us how they worked with other agencies to make sure patients were receiving the correct physical and psychological support.

Dignity and respect
- In all of the community hospitals we saw that staff protected the privacy and dignity of patients, ensuring bathroom doors were closed and curtains were drawn around people when they were receiving personal care.
- Staff at the community hospitals described to us how they would care for a patient after they had died and the process of transferring them from the ward to their mortuary. They told us they had a chapel of rest if relatives wanted to visit. We saw the mortuary facilities and chapel of rest at Bromyard Hospital, which was organised to maintain a private and dignified environment. Staff also said they would stay with the relatives if necessary.

Emotional support
- Spiritual support could be found either through the chaplains at the hospice or visiting chaplains at the community hospitals.
- Community nurses offered bereavement visits to family members after their relative had died.
- Patients had access to a specialist palliative care psychologist if required.
- A psychologist told us they attended the multidisciplinary meetings.
- Staff offered each other support regarding potentially emotionally upsetting events.
- The specialist palliative care nurses had access to the clinical psychologist for support on a regular basis in either groups or on an individual basis.
- The specialist palliative care team had received training to enable them to support patients and families.
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**
Services were not always responsive to people’s needs and required improvement in all of the community hospitals we visited. Staff on the wards in the community hospitals and the community nurses were able to access support from the specialist nurses seven days a week. Out of hours they could call the GP service or the hospice for further guidance and advice.

There was no specific care plans for end of life care to provide staff with guidance or a pathway to follow. Care was planned to meet the needs of people on an individual basis by the nurses delivering their care. However some records lacked information to deliver personalised care.

One patient from outside the area, who required palliative care, had been offered a bed at a community hospital to enable them to be closer to their relatives. Due to bed pressures from the main hospital site, they were unable to be admitted.

Another patient who wished to receive end of life care at home was unable to be discharged home in a timely manner because of funding concerns in other agencies.

**Service planning and delivery to meet the needs of different people**

- The specialist palliative care service had formed an alliance with St Michael’s Hospice in Hereford to ensure support was available 24-hours-a-day.
- Patients who required end of life care were referred to the specialist palliative care team by individual consultants, ward staff or GPs.
- At Bromyard Hospital they had two link nurses from the ward who had been identified and trained to support staff on the wards.
- At Leominster Hospital we were told they had a ‘Link’ nurse, but they had not attended any meetings. Link nurses also ensured that staff end of life standards of care.
- Senior staff in the community hospitals told us they were often short staffed. If they had a patient who was at the end of their life, they prioritised their work to ensure they were able to spend time with that patient.
- Community nurses told us they were very busy but end of life care was a priority. They coordinated the care of patients with other agencies. They offered a 24-hour service with on-call from 10pm until 8am. There were strict criteria for the on-call community nurse that included end of life care.

**Access to care as close to home as possible**

- The community hospitals were located around the county. On the whole people were admitted to the hospital closest to where they lived. This enabled family and friends to visit.
- At Bromyard Hospital staff told us that patients could request where they wanted to spend their last few days of life. If a patient asked to stay at the hospital they would “do their very best” to facilitate this.
- Community nurses told us they would do all they could to enable people to end their life in their own home if that was their wish. They would coordinate with other services such as Marie Currie nurses and carers to ensure care would be provided to meet the patient’s needs. The Commissioning for Quality and Innovation (CQUINs) audit into preferred place of death for October to December 2013 showed that overall 70.6% of patients died in their preferred place. Fourteen people asked to die at home and were unable to do so. The trust investigated the cases and reviewed the possible factors that contributed to the patients’ requests not being met. The trust has implemented the lessons learnt from the review to ensure more people are able to die in their chosen place.

**Access to the right care at the right time**

- Patients were referred to the specialist palliative care service if the community hospital ward staff and community nurses identified they may require end of life care. Staff we spoke with did not always identify when people required end of life care. At Ross on Wye hospital we reviewed the notes for two patients and one who had recently died. One patient did not have a terminal diagnosis, but their condition had deteriorated. The other patient was very unwell and required intensive care and support from hospital staff. The staff had accessed the specialist palliative care nurses in
Are End of life care services responsive to people’s needs?

relation to one specific area but did not ask for support or advice in relation to the other aspects of their care. This meant patients did not always have access to specialist advice and support from staff that were skilled and experienced in this area.

- At Leominster hospital we saw that the specialist palliative care nurse had been contacted to assess whether a patient required input from the service. We were told by the specialist nurse that although the patient did not currently require specialist input they were able to advise staff about symptom control, and would review the patient at a later date.
- There was no specialist team for children requiring end of life care. The community children’s nurses supported children in their homes and worked with the community adult nurses on the use of syringe drivers if they were required.
- There was no recognised out-of-hours children’s community nursing team. Therefore, if a child required a visit because they were receiving end of life care this would be undertaken by one of the children’s nurses in their own time.

Flexible community services

- Staff worked flexibly across the community to ensure they responded to changes in need for patients receiving end of life care.
- The manager of the palliative care team told us if someone’s situation had changed at home they would coordinate a meeting between the district nurse, GP and specialist palliative care nurse at the person’s home to ensure care was planned and delivered effectively.

Meeting the needs of individuals

- Staff at all of the community hospitals told us they endeavoured to discharge people quickly if they wished to die at home.
- At Bromyard Hospital we saw multidisciplinary team ward rounds were undertaken each morning where plans relating to appropriate discharge were discussed. A community nurse also attended these meetings.
- Some community staff clearly described to us how they met the individual requirements and complex needs of a patient who recently died in their own home.

Moving between services

- The trust offered a rapid discharge service if people wished to be discharged home. This service involved the occupational therapist, GP, community nurses and specialist palliative care nurses. Senior staff told us they would normally be able to discharge patients home with 24-48 hours of the initial request.
- We heard at Leominster hospital that one person had requested to go home. The occupational therapist told us all the equipment was in place and the nurses had completed planning to enable the patient to be supported. The person was still in the community hospital over 48 hours from the original request because of commissioning arrangements with agencies outside of the county.
- During our inspection at Leominster community hospital we were told about a patient who had requested to be admitted to the hospital because it was located close to their relatives. The community hospital had agreed they could be admitted, but the community hospital remained full and the patient could not be admitted. Staff explained that this was due to the impact of the lack of beds at Hereford County Hospital,
- Staff we spoke with told us that people living in their homes had priority for admission to the hospice over patients in the community hospitals.

Complaints handling (for this service) and learning from feedback

- The manager of the palliative care team told us they were not aware of any complaints in relation to end of life care. We were told of one complaint that was raised before the manager was in post. The complaint had been fully investigated and responded to by the trust.
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**

The trust did not have a clear vision and strategy to deliver high quality care and promote good outcomes for people receiving end of life care in the community and the community hospitals.

Staff in the community hospitals told us they were unsure what the trust vision was and at times felt like they were “left to get on with it”.

The manager of the specialist palliative care team was relatively new in post. They acknowledged that there had not been a clear focus on end of life care in the community, which had been due to changes in staffing.

**Vision and strategy for this service**

- An action plan for end of life care (EOL) had been developed in response to the publication of the National EOL strategy in 2008. The action plan had not been formally recognised by the trust. The content of the action plan has recently been fed into the work plans of the joint palliative care team. The trust EOL Strategy group has not been re-established while it develops an understanding its role in the trust and its working relationship with the CCG. There was no clear vision or strategy for this service.

**Guidance, risk management and quality measurement**

- There had not been any audits since 2012 into the quality of care received by patients in the community hospitals. The manager of the specialist palliative care team acknowledged that this had not happened due to changes in staffing and the focus had been on the main hospital.
- There had been no recent patient satisfaction audit.
- A bereavement audit was conducted in 2013. We were given only a few of the responses related to patients receiving care in the community.

**Leadership of this service**

- The medical director had previously had the responsibility as executive lead for end of life care, but had recently left this post although this responsibility would stay with the post staff were not aware of this.
- We were told there had been difficulty obtaining a board member to support end of life and palliative care.
- Staff told us there was a supportive unit manager, who was able to represent end of life and palliative care at a senior management level in the trust.
- A senior manager acknowledged that since 2012 the “support for community hospitals is not as good as it should have been” and there was “confusion about how to deliver end of life care” in the community due to staff changes and shortages and lack of a clear pathway.

**Culture within this service**

- Staff at Leominster hospital thought end of life care needed to be improved from a trust perspective. They felt there was no clear guidance to follow to enable them to support people’s needs in community settings. However, they felt patients received a high standard of care due to the experience and commitment of the staff working there.
- A member of medical staff at Bromyard hospital told us they felt patients received a high standard of end of life care both in the community hospital and their own homes. They said they were well supported by the trust palliative care service and the local hospice.
- Staff working at Ross on Wye hospital in the community said they also provided a high standard of care to patients in the final days of their life. There were no audits or feedback so we were unable to substantiate this.
- Community nurses told us they provided a high standard of end of life care. They got to know the patient over time and increased their input as required towards the final weeks/days of their life. They also told us they coordinated all the care for the patients with other agencies. For example, they maintained open communication with all providers concerned to ensure patients received continuity of care.
Public and staff engagement

- The trust had participated in recent public events, for example, Public Death Awareness week and at the trusts annual AGM which was open to the public.
- The trust attends the Herefordshire Bereavement Forum which included representatives from the main hospital and community.
- A member of staff at Bromyard hospital told us they were one of two link nurses for end of life care. This involved attending meetings with the palliative care service about every two months and disseminating this information to the other staff on the ward. They also told us two of the palliative care specialist nurses were assigned to their ward to provide them with ongoing advice and support when required.
- All staff described good, supportive working relationships with the specialist palliative care team.

Innovation, improvement and sustainability

- We were told during our inspection that the palliative care team had secured funding for another specialist nurse to help with training of community nurses.
- Care delivered by the goodwill of staff in their own time was not sustainable.