

# Sandwell and West Birmingham Hospitals NHS Trust

RXK21|RXK27

## End of life care

### Quality Report

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This report describes our judgement of the quality of care provided within this core service by Sandwell and West Birmingham Hospitals 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 Sandwell and West Birmingham Hospitals NHS Trust and these are brought together to inform our overall judgement of Sandwell and West Birmingham Hospitals NHS Trust

# Summary of findings

## Ratings

Overall rating for Community Health Core Service End of Life Care

Good



Are Community Health Core Service End of Life Care safe?

Requires Improvement



Are Community Health Core Service End of Life Care effective?

Good



Are Community Health Core Service End of Life Care caring?

Good



Are Community Health Core Service End of Life Care responsive?

Good



Are Community Health Core Service End of Life Care well-led?

Good



# Summary of findings

## Contents

### Summary of this inspection

	Page
Overall summary	4
Background to the service	5
Our inspection team	5
Why we carried out this inspection	5
How we carried out this inspection	5
What people who use the provider say	5
Good practice	6
Areas for improvement	6

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### Detailed findings from this inspection

Findings by our five questions	7
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# Summary of findings

## Overall summary

The inspection team visited four end of life community services. In total, we spoke with 10 patients and 25 staff members, including palliative medicine consultants, specialist palliative care nurses, district nurses, community nurses, healthcare assistants, an inpatient manager and volunteers.

The hospice at home team, based at Bradbury House Day Hospice, is a specialist palliative care service providing care and support for patients and families in Sandwell.

Bradbury House Day Hospice is run by a palliative care nurse specialist, healthcare assistant and volunteers, offering day care, support and advice for patients with a life-limiting illness in Sandwell. The hospice operates Monday to Friday 8.30am to 3.30pm, and is closed on Thursdays.

District nurse services provide 24-hour nursing care to people at home with a life-limiting illness in Sandwell.

The Leasowes Intermediate Care Centre provides two beds for people with a life-limiting illness.

End of life services were rated good within the trust. We identified areas where staff provided excellent care and showed a willingness to 'go the extra mile' for patients and their families. We heard numerous examples of staff working together and overcoming challenges to ensure the best possible outcomes for patients receiving end of life care.

Staff ensured that patients were safe by assessing and responding to risks appropriately, learning from incidents and having access to clean and well-maintained equipment. Records reflected patients' individual needs and followed the end of life pathway as a continuous journey until patients reached the end of their lives.

Services delivering end of life care were effective in meeting patients' needs. This was reflected with individualised care plans and robust risk assessments throughout a patient's journey. Staff across all end of life services were competent and knowledgeable, and we saw evidence of multidisciplinary working at its best in achieving optimum outcomes for patients and their families.

Teams worked hard to ensure that care was delivered with compassion, dignity and respect. Patients and their families were included in the decision-making process from individual likes and dislikes to preferred place of care and, eventually, where a patient would prefer to die.

End of life services responded well to patients' cultural and spiritual needs, and the end of life integrated care pathway supported patients' and families' wishes from time of diagnosis to time of death. Staff worked proactively, breaking down barriers to ensure that patients received care at the right time and in their preferred place.

The trust's vision for end of life services was clear, with proposed clinical developments planned for community services that were currently in a transitional phase of redevelopment. Teams were well managed both locally and strategically, and staff felt supported; in most areas, staff also felt listened to. Teams and managers collected data and conducted clinical audits to measure the quality of care they delivered and how teams performed in line with the national End of Life Care Strategy (Department of Health, 2008) for ongoing service improvement.

# Summary of findings

## Background to the service

Sandwell and West Birmingham Hospitals NHS Trust serves a population size of 530,000 from across West Birmingham and covers six towns within Sandwell. The trust employs approximately 7,500 staff who work across acute and community services.

## Our inspection team

Our inspection team was led by:

Chair: Karen Proctor, Director of Nursing & Quality, Kent Community Health NHS Trust.

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

The team included CQC inspectors and a variety of specialists: a community matron, a district nurse, a therapist and 'experts by experience'. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

## Why we carried out this inspection

We inspected this core service as part of our Comprehensive wave 3 Combined Acute and Community health services inspection programme.

## How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out

announced visits on 15, 16 and 17 October 2014. During the visit we held focus groups and interviews with a range of staff who worked within the service, such as palliative care nurse specialists, district nurses, nurses, healthcare assistants and senior clinicians. 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

People who used the service were very complimentary about the care they received.

Examples of comments included:

"Staff are like angels. I have been well looked after."

"Nothing is too much trouble. I can tell the nurses anything."

"We needed loads of support at the start and they were there when we needed them."

# Summary of findings

## Good practice

Excellent service provision from the hospice at home team to include redesign of the SCP (supportive care pathway), provision of training programmes for end of life care services and introduction of the quarterly SCP newsletter.

## Areas for improvement

### **Action the provider MUST or SHOULD take to improve**

#### **Action the provider MUST or SHOULD take to improve**

To carry out a review of Bradbury House Day Hospice to include:

- The trust should ensure safe staffing levels, particularly at pick-up and drop-off times and times of absenteeism, such as training, annual leave and sickness.

- The trust should ensure adequate registered nurse staffing levels on night shifts at the Leasowes Intermediate Care Centre.
- The trust should ensure a variety of activities provided on a daily basis.
- The trust should ensure reliability of ambulance transport.

# Sandwell and West Birmingham Hospitals NHS Trust

## End of life care

### Detailed findings from this inspection

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

Requires Improvement 

## Are Community Health Core Service End of Life Care safe?

By safe, we mean that people are protected from abuse

### Summary

The end of life community services for safety required improvement. Bradbury House Day Hospice, had not received an infection control audit for 12 months, the trust ambulance for this service was unreliable and there was insufficient staff members present at all times during service delivery.

Staff were confident to report incidents, and lessons learned were shared within local and wider teams to reduce the risk of a repeat incident.

Staff identified risks quickly, responded appropriately and showed a good understanding of when safeguarding alerts should be raised.

Arrangements for end of life medications were well planned. The prescription of anticipatory medication, the involvement of an advanced nurse practitioner and the use of 'comfort boxes' in patients' homes meant that patients received their medication safely.

We reviewed 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) records and found that patients and family members were part of the decision-making process. However, we saw audits to indicate that not all forms were completed appropriately.

Generally, equipment and facilities were well maintained and safe for patient and staff use.

### Incidents, reporting and learning

- 'Never events' are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. We saw end of life community services reported zero never events within the past 12-month period.
- All staff we spoke with said that they were encouraged to report incidents and able to access incident-reporting systems. They understood that a 'no blame' culture was promoted.
- Staff told us they were made aware of incidents from other services within the trust in various forms (for

example, weekly team meetings, quarterly governance meetings, quarterly newsletters and emails disseminated from line managers to share lessons learned).

## **Cleanliness, infection control and hygiene**

- Staff across all end of life community services followed the infection control policy and demonstrated appropriate infection control practices, such as the use of personal protective equipment and regular hand washing pre- and post-patient care. However, staff at the Leasowes Intermediate Care Centre told us gloves and wipes were not always available, which made infection control practices a challenge to uphold.
- Information provided by the trust indicated that the Leasowes Intermediate Care Centre scored 100% in their past 12-month infection control audit, which did not highlight any shortages of gloves or wipes.
- We were told Bradbury House Day Hospice did not have an infection control audit this year, but we were given no specific reasons why.
- Staff at Bradbury House Day Hospice and the Leasowes Intermediate Care Centre complied with the trust's policy to be 'bare below the elbows' during work time. Each room had hand gel, soap and sinks within them. Hand gel and information about how to prevent the spread of infection was readily available throughout both units.

## **Maintenance of environment and equipment**

- Across all community end of life services, patients and staff had access to well-maintained, clean equipment, and items such as syringe drivers, pressure-relieving mattresses and cushions, and electric profiling beds were in good supply.
- The district nurses and palliative care nurse specialists were supported by a home loan equipment service that provided equipment 7 days a week for patients who were discharged home and needed equipment at short notice.
- The ambulance used to collect and drop patients to and from Bradbury House Day Hospice was considered by staff to be unreliable. They told us it was more than 20 years old and regularly broke down. This had been escalated to management. However staff were told

there were no plans to replace the vehicle. However the ambulance had passed its latest MOT with minor repairs required. With a replacement vehicle supplied whilst that work was undertaken.

- When the vehicle was being repaired, patients had to use private taxis funded by the trust. However, these were unsuitable because taxi drivers were often impatient and would not escort patients to their front doors.
- The Leasowes Intermediate Care Centre was in a good state of repair and fit for purpose. We saw Bradbury House Day Hospice was considered by staff as not fit for purpose to deliver end of life care. Staff told us the building was old and there was insufficient room to offer a programme of activities for patients, however Bradbury House Day Hospice had refurbishments in the summer of 2014, including new flooring, redecorated and had new windows.
- We found the hospice social activities to be underfunded, and staff purchased items themselves (such as knitting and board games) to increase activities for patients. Staff told us management was aware of this. Staff said they would like to offer alternative therapy to patients, and day trips; however, this had not been supported by the trust. Following the inspection the trust said they had not received a proposal from staff for the extra funding.
- We saw the hospice could cater for up to 14 patients per day, but the attendance register indicated that between two and eight people regularly attended.

## **Medicines management**

- Staff at both inpatient units and within community bases had access to the trust's medicines management policy.
- The hospice at home team employed qualified advanced nurse prescribers, who were able to conduct medication assessments, prescribe new medication for symptom management and check medication prescriptions. This provided additional safety mechanisms and also reduced the delay in patients receiving medication to ease suffering.
- The Leasowes Intermediate Care Centre had one night nurse on night duty 7 days a week. This meant that, when a controlled drug was needed, such as morphine or midazolam, which legally require two nurses to check and sign, a district nurse was required to attend from the community.

- Staff told us this system was unsuitable because patients had to wait for their controlled drugs to manage their symptoms.
- Trust managers told us plans were in place to employ a second night nurse and in the meantime the district nurse out-of-hours service would be based at the Leasowes Intermediate Care Centre by the end of October 2014 to ensure they were on hand throughout the night to avoid delay in patients receiving their medication.

### **Safeguarding**

- There was a clear safeguarding policy in place. Staff we spoke with across all end of life community services were able to say who their local safeguarding lead person was in their respective areas.
- Staff provided examples of when and how they had raised alerts. They told us they felt supported by their immediate line manager on safeguarding issues and found the safeguarding team easily accessible and helpful.

### **Records systems and management**

- All end of life community services used the supportive care pathway (SCP). This was a document designed for any patient within the trust who had an advanced life-limiting illness. It ensured they had access to, and were supported with, care tailored to their individual needs.
- We found that all SCP documents in both inpatient units and in patients' homes were completed appropriately.
- The SCP contained multidisciplinary team contact details, risk assessments, care plans, anticipatory drug information, current condition and details relevant to a person's death. It was divided into two phases, phase 1 and phase 2, which reflected the condition of the patient; phase 2 was concerned with the more advanced stage of their illness.
- Staff told us the SCP was an excellent tool and provided all the information for the patients, their families and their multidisciplinary colleagues to refer to, to ensure that care was delivered to reflect patients' unique needs and wishes.
- We looked at 'do not attempt cardio-pulmonary resuscitation' (DNACPR) arrangements across the community services. The DNACPR policy was in place but out of date by 5 months. We were told the trust was in the process of reviewing it.

- Both an advanced nurse practitioner and a physician signed the DNACPR paperwork we reviewed. The decision-making process was clear. We saw where patients did not have capacity; the decision was discussed with relatives.
- We saw an example of where a patient was attending Bradbury House Day Hospice and staff were keen to put the DNACPR in place as soon as possible to ensure that appropriate action was taken should the patient suddenly deteriorate.

### **Lone and remote working**

- There was a clear lone worker policy in place.
- District nurses and the hospice at home team demonstrated that they knew the principles of safe practice when working and travelling alone.
- Staff told us they supported their colleagues and kept in contact with each other via mobile phone to ensure safety out of hours.
- We saw the nurse in charge of Bradbury Day Hospice was left alone for 3 hours a day while another staff member collected and dropped off patients. We were told that, although there was always another staff member in the building, such as a volunteer or an administrator, they could not be called upon to assist her with patient care if and when necessary.

### **Assessing and responding to patient risk**

- We found that staff from most of the end of life community teams were proactively responding to risks.
- However, the Leasowes Intermediate Care Centre had one night nurse on duty and two healthcare assistants. Nurses told us they were unable to respond to patient risks quickly because their time was shared among 18 other patients who were receiving rehabilitation care.
- Staff told us it was difficult to prioritise care between patients with rehabilitation needs and those with end of life care needs when they were the only registered nurse on night duty.
- Similarly at Bradbury House Day Hospice, we saw for 3 hours each day the staffing numbers reduced to one person, when the second staff member accompanied the driver in the ambulance to collect and drop off patients at the start and end of the day.
- On the day of the inspection, we saw two out of three people assessed as being at high risk of falls and breathing problems.

- Staff told us risk assessments were carried out, but it was not appropriate to leave only one staff member in charge when patients were escorted home individually due to living in different areas. This had been escalated to the manager who was aware of the situation but unable to remedy it because the hospice was under review and part of the wider end of life community transformation strategy.
- We looked at the attendance register and saw that on several days there had been between two and eight patients attending the hospice, several of whom had been assessed as high risk.
- We looked at risk assessments completed by district nurses and the hospice at home team and they were comprehensive and individualised, and provided the basis for care and treatment.

### **Staffing levels and caseload**

- Staff absences within district nurse teams had the potential to increase patient risk. However, staff prioritised patients' visits and managed their caseloads with minimum disruption to end of life care. Staff and managers told us absences such as long-term sickness and maternity leave were covered by bank and agency staff when they were available.
- Hospice at home staff were busy. However, staff told us they managed their caseloads appropriately and supported each other during busy periods.
- We saw hospice at home staff were called upon to backfill the hospice registered nurse during annual leave, training and sickness. We were told this had a negative impact on their own caseload and on some occasions the hospice was forced to close because of staff shortages. This meant that vulnerable patients who looked forward to attending the hospice had to be told it was not available.

### **Managing anticipated risks**

- Risk assessments were undertaken across all end of life community services to identify and reduce potential and actual risks to patients. These included pressure areas, falls, nutrition, manual handling and pain risk assessments.
- The trust undertook patient and family awareness initiatives (such as on infection control), and we saw leaflets displayed in Bradbury House Day Hospice and Leasowes Intermediate Care Centre with detailed information on how to minimise cross-infection.
- Across patients' homes, the trust promoted 'comfort boxes', which contained items that may be required at short notice (for example, catheters, dressings and anticipatory medication).
- Advanced care planning was promoted as part of the SCP across all services. This enabled patients to map out their individual wishes and pre-planned arrangements for their end of life.
- The hospice at home risk register showed that previous sickness within the team affected its ability to undertake fast-track continuing health care assessments. The service supported the avoidance of admission and rapid discharge of end of life patients. The trust had taken remedial action to ensure this risk was addressed by directing any patients with end of life care needs to a district nurse to fast-track the assessment and ensure that patient care was not adversely affected.

### **Major incident awareness and training**

- Policies were in place, and staff were aware of emergency planning procedures and systems of escalation for immediate and long-term management.
- Staff at the Leasowes Intermediate Care Centre had encountered a major incident when a lorry had crashed into their building in January 2014; 13 staff and 20 patients were evacuated from the damaged part of the unit with no injuries.
- Staff told us the incident provided good experience of how to manage a major, unplanned incident with the least disruption to patient care.

# Are Community Health Core Service End of Life Care 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

Services were meeting the needs of patients through evidence-based practice, using integrated care pathways to optimise the best possible outcomes for patients and families. There was good evidence of multidisciplinary working and excellent examples of multi-agency working, breaking down barriers to ensure that patients' care and treatment was effective and patient focused.

## Evidence based care and treatment

- We found all end of life community teams delivered evidence based-practice and followed recognised and approved national guidance such as the National Gold Standards Framework in End of Life Care and the national End of Life Care Strategy (Department of Health, 2008).
- Staff understood their roles, and clinicians worked within their scope of practice in accordance with their professional governing bodies. We saw that teams made timely internal and external referrals to health professionals to ensure that patients were seen by the right person at the right time.

## Pain relief

- Effective pain relief was considered a priority for patients receiving care across all community end of life services, and it was discussed with the patient at each nursing intervention and in regular team meetings.
- Anticipatory prescribing took place within end of life services. This helped to avoid delay in patients receiving medication to reduce pain associated with their illness.
- The hospice at home team provided an in-reach service to the Leasowes Intermediate Care Centre and Bradbury House Day Hospice, and also visited people at home. This allowed them to assess patients' pain levels and prescribe new pain relief quickly to avoid unnecessary suffering.

## Nutrition and hydration

- Across all end of life services, staff used the supportive care pathway (SCP) to assess patients' nutrition and hydration levels.

- The hospice at home team held weekly multi-disciplinary team meetings, chaired by a palliative medicine consultant, to discuss patients' condition, including their hydration and nutritional status.
- We saw that staff acted quickly to provide advice and support to patients whose status was compromised. They prescribing high-nutritional value drinks and monitored hydration levels by linking in with care givers who provided the day-to-day care.

## Approach to monitoring quality and people's outcomes & patient outcomes performance

- End of life services used the SCP document to guide healthcare professionals on the planning and delivery of care.
- The SCP was comprehensive and took into account best practice in end of life care by being personalised to the patient and taking into account their current emotional and mental status and family expectations.
- There was an area for the medical plan of care, and this prompted staff to ask about care planning. A policy document was in place to support and guide staff further in the use of the SCP.
- Staff told us the SCP used in the community was unique because it had been designed as a nurse-directed document and not a medically directed one. Nursing staff had contributed to its design, which promoted a sense of team ownership.
- Staff told us this improved patient outcomes because the SCP followed a nursing model of care and so they were more likely to understand the principles and complete each section.
- The hospice at home team conducted monthly record audits that analysed quality of documentation. A September 2014 audit revealed that 85% of patients achieved their preferred place of care, and 84% of patients were supported with a SCP document. Staff told us they were on a continuous journey of improvement to increase these figures.

## Competent staff

- Staff across all end of life services were competent and knowledgeable in end of life care.

# Are Community Health Core Service End of Life Care effective?

- We observed team meetings where staff demonstrated excellent knowledge about specific health problems, and a good understanding of clinical expertise in managing a variety of end of life conditions (for example, congestive obstructive pulmonary disease (COPD), cancers, heart failure and Alzheimer's disease).
- We observed excellent clinical competence from district nurse staff, providing care and support to patients in crisis. They also demonstrated a wider team knowledge, which enabled them to refer patients in a timely manner.
- Staff we spoke to told us they received appraisals from their line manager and attendance at mandatory training was encouraged across all end of life services.
- Competencies were in place to show staff had been assessed and were competent to deliver care using syringe drivers, catheter care and verification of death at the Leasowes Intermediate Care Centre. We saw that most staff across end of life services had attended the end of life competency training programme, which focused on diagnosing dying, end of life care plan, communication, comfort care at end of life, modifying care, symptom management, spiritual care and care after death.
- Staff also told us they felt supported and cared for by their immediate line manager and engaged in informal

peer support; however, because of capacity and staff shortages, especially within the district nursing teams, this was not a structured process. We noted that 50% of healthcare assistants at the Leasowes Intermediate Care Centre had attended the end of life competency training programme.

## Multi-disciplinary working and coordination of care pathways

- We saw multidisciplinary working at its best across end of life community services. One example was the hospice at home team's coordinated care with district nurses, child hospice staff, GPs and community paediatric nurses to ensure that a patient could be supported 24 hours a day, 7 days a week at home. The patient had not yet reached adulthood and we saw staff breaking down barriers to fulfil wishes and needs.
- We were told that, by collaborative working, previous gaps in care had been filled, and staff considered patient choice to be the optimum factor regardless of shift patterns and service level agreements.
- We saw patients being discharged home and within hours the district nurses had organised delivery of equipment, a GP visit and had supported the patient and family with seamless end of life care.

# Are Community Health Core Service End of Life Care caring?

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

## Summary

Care delivered across all end of life community services was kind and compassionate. We saw that staff treated patients with dignity and respect. Patients told us they were involved in planning their care and we saw that staff responded to patients' changing needs with speed and sensitivity, despite some services experiencing staff shortages. We found staff from all services were committed to providing good-quality care and many staff went 'the extra mile' to ensure that patients received the right care at the right time. This was reflected in the positive comments made by patients and their relatives.

## Compassionate care

- We found the care and treatment of patients across all end of life services was empathetic and compassionate. Staff promoted and maintained the dignity of all patients when delivering care.
- Patients told us they received excellent care and we read 'thank you' cards to support this.
- We saw patients' culture, beliefs and values had been taken into account in the planning and delivery of end of life care.
- We found that staff had developed trusting relationships with patients and families, and knew their care needs well.

## Dignity and respect

- Staff treated patients with dignity and respect during one-to-one care across end of life services.
- We saw documented entries made in a patient's supportive care pathway (SCP) record that supported a dignified and respectful approach to patient care.
- We observed staff providing one-to-one care in a crisis situation and the patient was looked after having had their hygiene, medication and emotional needs met before the nurse left.

## Patient understanding and involvement

- Patients and families were involved in their care throughout end of life community services.
- Following an audit of patients' preferred place of care, we saw 84% achieved their choice.

- We observed staff providing people with options and choices about care and treatment. For example, we saw one patient was given the choice to remain at home with support, be transferred to a hospice for symptom management and respite, or attend the day hospice.
- The patient decided to remain at home but thanked the nurse for offering them options.
- We saw the SCP was used as a joint assessment and care planning document and a patient's description of how they felt was used instead of clinical terms.
- We heard how another patient had decided to die at home, but changed their mind towards the late stages of their illness and wanted to die in hospital to reduce the strain on their young family. Their choice was respected and honoured.

## Emotional support

- End of life community services delivered good emotional support to patients and families, particularly from the district nurses and hospice at home team.
- Patients told us there was effective communication from staff, and that any concerns were addressed quickly and appropriately.
- Guidance was available for patients about a range of support services. These included Bridges Support Service, an organisation supporting people with life-limiting illness with bereavement, spiritual, advocacy and counselling help.
- Staff attended bereavement training programmes directed at all healthcare professionals across the end of life community pathway.
- The trust offered staff a well-being system, whereby individual staff could self-refer for formalised support in their health and well-being.

## Promotion of self-care

- The SCP and general attitude and approach of staff promoted patient independence.
- During a weekly team meeting, we heard how patients were offered personal care only when they were unable to self-care and agreed to have assistance.

## Are Community Health Core Service End of Life Care caring?

- We saw district nurses and the hospice at home team provided support visits for patients during the early stages of a patient's illness, respecting their right to independent living and allowing the patient the space and freedom to self-care when possible.

# Are Community Health Core Service End of Life Care responsive to people's needs?

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

## Summary

End of life community services provided a good response to patients' needs. Generally, patients achieved their preferred place of care and death through a well-organised and integrated multidisciplinary approach.

The lack of hospice overnight inpatient beds within Sandwell was raised as a concern by staff and managers. However, patients provided positive feedback about their care from all end of life services with no complaints registered within the past 12 months.

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

- End of life community staff were aware of people's needs, and services were well coordinated to meet those needs through robust multidisciplinary working.
- We found interagency working was well planned and patient focused. For example, district nurses had strong relationships with local authority continuing care coordinators. Planned care meant packages of care were arranged and equipment was delivered to meet the diverse needs of patients.

## Access to the right care at the right time

- Generally, patients' preferred place of care and death was at home, and a recent end of life audit showed that 85% of patients achieved this. However, there were no inpatient hospice facilities within Sandwell and West Birmingham and this meant that patients needing short-term respite care or symptom management, or those who wanted to die in a hospice environment, would need a referral to a hospice outside the area, such as St Mary's Hospice in Selly Oak, Birmingham, or John Taylor Hospice, Erdington, Birmingham.
- Staff explained this was a problem because patients preferred to stay within their local communities, and loved ones were unable to travel a significant distance every day to visit.
- The Leasowes Intermediate Care Centre offered two end of life beds; both were unoccupied during our inspection.

- The district nurse day service, district nurse out-of-hours service and hospice at home team provided excellent care and support to people at home 24 hours a day, 7 days a week.

## Discharge, referral and transition arrangements

- The end of life service followed an integrated care pathway, covering primary, secondary and tertiary care services.
- Referrals through the pathway were timely and patient focused, and end of life community services planned these transitions in advance whenever possible.
- In one case, referrals between services were made urgently because of the rapid deterioration of the patient's condition and the desire for them to return home. We saw services conduct rapid assessments and arrange care packages and delivery of equipment smoothly, with the least amount of disruption to the patient or their family.

## Complaints handling (for this service) and learning from feedback

- Across all end of life community services, patients and their families were very satisfied with the quality of service they had received and told us they felt supported and cared for.
- Staff followed the trust's complaints policy and provided examples of when they would resolve concerns locally and how to escalate them when required.
- There had been no complaints made to the end of life community services within the past 12 months.
- We saw patient feedback questionnaires were not available across end of life community services and managers told us they relied on 'thank you' cards and verbal feedback from patients and families. Senior clinicians told us a new patient feedback survey had been designed and was about to be rolled out across all end of life services.

# Are Community Health Core Service End of Life Care well-led?

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

## Summary

There was a vision and strategy for the future development of the end of life community service, which aimed to strengthen the pathway between acute and community services.

Clinical governance and risks management was a priority for end of life services, and performance was measured regularly and disseminated across all teams to improve practice.

Local and senior management leadership was strong. However, some end of life community teams felt ignored by the executive board members.

Culturally, all services were compassionate and individuals were self-driven to provide excellent care. However, there were underlying concerns of job insecurity based on the wider trust reconfiguration.

## Vision and strategy for this service

- The executive board was relatively new and shared a vision for the organisation with common values and corporate objectives. However, most staff across end of life community services told us they were uncertain of the future because of job cuts.
- Senior staff shared with us the proposed transformational 5-year plan for end of life services from 2013 to 2018. The plan was clear and involved key stakeholders such as commissioners, primary care teams, and acute and community clinicians.
- Front-line staff we spoke to were aware that the end of life service was undergoing a service redesign. They felt well informed because this information had been disseminated via team meetings, quarterly governance meetings and email updates from line managers.

## Governance, risk management and quality measurement

- Quarterly clinical governance meetings took place and were well attended. The minutes reflected discussions on performance, quality and risk.
- We read minutes from palliative care link nurse meetings and saw a good representation from front line

and senior staff. The agenda included the launch of a new end of life initiative called 'My life', the results of a recent 'comfort box' audit and details of forthcoming training.

- The end of life service maintained a risk register that then fed into the corporate risk register so that the board had oversight of the main areas of risk for the service. There were no current risks identified by the trust for end of life community services, even though transport, staffing and facilities at Bradbury House Day Hospice were concerns.

## Leadership of this service

- The trust had commissioned a leadership development programme that would support the development of the top leaders within the trust to include end of life services. We saw that staff in the district nurse and hospice at home teams had been supported with leadership courses.
- Staff told us their immediate line managers were visible, accessible and approachable, and described them as caring leaders with good support systems in place.
- Executive members of the board, with the exception of the chief executive officer, were not seen as visible to front line community staff, and staff told us they sometimes felt forgotten by senior managers.
- Generally, staff were supported to attend mandatory training and specialist training specific to their role. This was echoed by the NHS Staff Survey 2013, which revealed that the trust scored better than the national average in terms of personal development, access to appropriate training for jobs and line management support to enable staff to fulfil their potential.
- All staff we spoke with had received their annual appraisal; however, we saw that staff took a relaxed attitude to clinical supervision and it was not embedded across end of life services. Staff told us they would ask for if they felt they needed it.

## Culture within this service

- In general, we found the culture of care delivered by staff across all end of life community services was

# Are Community Health Core Service End of Life Care well-led?

dedicated and compassionate, despite the fact that staff were unsure about job security and some district nursing teams such as those at the Victoria Health Centre had a high number of absences.

- We found staff to be hard working, caring and committed.
- Staff spoke with passion about their work and conveyed how dedicated they were to providing the best care possible every time.

## Public and staff engagement

- The end of life community service received many ‘thank you’ cards and letters from patients and families expressing their gratitude.
- We were told by staff and senior clinicians that no patient survey had been undertaken within the past 12 months to measure patient feedback. However, a new end of life patient survey had been designed and was about to be rolled out across all community services.

## Innovation, improvement and sustainability

- Senior managers encouraged innovation and improvements in practice across most of the of end life community services. For example, the hospice at home

team had redesigned the supportive care pathway (SCP) to incorporate a community nursing-led model, where previously there had been a medically led document used in the acute services.

- The same team was proactive in providing rolling programmes of palliative care training across all community services in Sandwell to increase staff’s knowledge and skills and to improve care for patients.
- We saw training was well attended by a range of clinicians.
- Senior end of life clinicians had updated and rebranded the ‘My life’ document, which had been rolled out across the community and was a recognised valuable information and advice document for patients and families.
- However, because of the uncertainty surrounding the future of Bradbury House Day Hospice, we saw little innovative practice there due to underfunding and decreasing numbers of patients. Sustainability of the service was a concern.
- This was raised with managers and senior clinicians who told us Bradbury Day Hospice was under review and part of the wider redevelopment project for end of life services across the trust.