CareQuality Commission

Oxford Health NHS Foundation Trust

RNU

Community end of life care

Quality Report

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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)
RNUX2	Fulbrook Centre, Churchill Hospital	City Community Ward Central Oxfordshire team	OX3 7JU OX14 1AG
RNUCK	Didcot Community Hospital		OX11 0AG
RNUCE	Bicester Community Hospital	North East Oxfordshire team	OX26 6HT
RNUDJ	Wallingford Community Hospital		OX10 9DU
RNUX3	Abingdon Community Hospital	Wards 1 & 2 South west Oxfordshire team	OX14 1AG
RNUDM	Witney Community Hospital	West Oxfordshire End of life care team	OX29 7DX

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

Summary of findings

Ratings

Overall rating for the service	Good	🟢
Are services safe?	**Good**	🟢
Are services effective?	**Requires improvement**	🟠
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 O

The end of life care service is delivered along with other general care services, in community hospitals and patients' own homes.

Overall, we rated this core service as "good". We found community end of life care service at Oxford Health NHS Foundation Trust were, "good" for safe, caring, responsive and well-led services but "required improvement" to be effective. This was because improvements to awareness and education had not yet had an impact on patients'.

Our key findings were:

- Services for end of life care were safe and there was a good culture of reporting and learning from incidents.
- Staff did not have a consistent knowledge of the requirements of the duty of candour.
- There were systems in place for escalating concerns about potential safeguarding concerns.
- The community hospitals were clean and well maintained. Equipment was clean and fit for purpose.
- The trust used a single model of syringe driver for end of life care medicines and staff had received appropriate training on the use of these. The administration of medicines by syringe driver was monitored, but the same documentation to record this was not used across the areas we visited.
- Staff participation in mandatory training was below the trusts target.
- The trust had recently introduced a new end of life care plan to replace the Liverpool Care Pathway, that had stopped being used in England in 2013.
- There were sufficient staff to provide high quality care in community hospitals; however this was mainly due to a reduction in the numbers of available beds.
- Patients at end of life had risk assessments completed where indicated.
- The trust could not demonstrate that end of life care was delivered consistently against the 'five priorities of the dying person'.
- There was a combination of paper and electronic records that made getting key information difficult for staff.

- Information about a patient's preferred place of care was not always communicated. Outcome data about patient's preferred place of care and actual place of death was not routinely collected.
- Decisions about resuscitation were not always discussed with the patient or relatives. Do not attempt cardio-pulmonary resuscitation forms were not always fully or correctly completed.
- We found there to be an inconsistent use of pain assessment tools with end of life care patients.
- Staff demonstrated a good understanding of the Mental Capacity Act.
- There was evidence of effective multidisciplinary working that put the patient at the centre of their care. This led to some good examples of joined up working that gave the patient a seamless journey.
- We saw some excellent examples of staff providing care that maintained respect and dignity for the individual. There was also good care for the relatives of dying patients, and sensitivity to their needs.
- Care was delivered with compassion, and staff prioritised the needs of patients at end of life.
- Patients and relatives were given the emotional support they required, and felt that they were involved in the planning of their care. Staff gave patients the time they needed so their visits did not seem rushed, even when the service was under pressure.
- The trust had identified that staff found it difficult to have conversations about their preferences for their care at end of life. Training to address this need had been organised.
- The trust were in the process of implementing the requirements of the 'one chance to get it right' document for the delivery of evidence based end of life care. They were meeting with their commissioners and other partners to plan end of life care services to meet the needs of local people.
- Community hospitals provided appropriate facilities for end of life care. There was provision for people with communication difficulties, this included an interpreter service.

Summary of findings

- The environments in community hospitals were designed to be suitable for patients living with dementia. Vulnerable patients were identified and effective multidisciplinary working ensured their needs were met.

- Matrons who led end of life care in community services were highly accessible to community nurses, patients and GPs. They worked across boundaries to coordinate end of life care for patients.

- Although the trust did not have a strategy for end of life care, strategic work was being undertaken to improve services. Leaders of end of life services were aware of areas or risk and where they needed to improve services.

- We found evidence to demonstrate that end of life care was an improvement goal for the trust. There was a commitment among staff and local leaders to make end of life care better for patients.

- Staff were aware that they needed further education and training particularly around advance decisions and care planning. We found that staff were engaged in making improvements to both their own knowledge and the services they provided.

- The trust sought and acted on feedback received from patients and relatives.

Summary of findings

Background to the service

Information about the service

End of life care (EoLC) was delivered by Oxford Health Foundation Trust across Oxfordshire. End of life services were delivered in the Bicester, Abingdon, Wallingford, Wantage, Didcot, City and Witney community hospitals as well as in patients' own homes. The care was delivered by generalist staff including community and hospital nursing staff as well as the hospital at home team.

Matrons with specialist training and experience in end of life care were located across the county in the trust's six integrated locality team hubs. These senior nurses led and supported specialised care across community services and within the community hospitals. The integrated locality teams consisted of an extended multidisciplinary team that included physiotherapists and occupational therapists, as well as the voluntary sector and social services staff.

These staff acted as a central point for communication with patients and GPs, in addition to providing a single point of access. This enabled effective communication across these integrated teams to ensure that caseload

priority could constantly be assessed to provide the most appropriate outcomes for patients. The integrated locality team hubs communicated daily to ensure that if one area had reached capacity, other areas could assist to ensure the most urgent needs were met.

End of life care for patients in the community or in community hospitals was provided in partnership with GPs. GPs were involved in the process of identifying patients who were predicted to be in the last year of life, and used the gold standards framework (GSF). The GSF is a range of tools, measures and quality assurance to ensure that there is an evidence based approach to end of life care.

The trust supported end of life care across a large geographical area with urban and rural areas. Community hospitals were not dedicated to end of life care, but also provided more general medical care and treatment for patients admitted by their GP or community matron.

A community hospital was also sometimes a preferred place of care that was closer to home for the patient and their family.

Our inspection team

Our inspection team was led by:

Chair: Professor Jonathan Warren, Director of Nursing, East London NHS Foundation Trust

Team Leader: Natasha Sloman, Head of Inspection for Mental Health, Learning Disabilities

and Substance Misuse, Care Quality Commission

Team Leader: Lisa Cook, Inspection Manager

The team of 36 inspecting the community services included CQC inspection managers and inspectors. They were supported by specialist advisors, including health

visitors, a school nurse, a physiotherapist, an occupational therapist, district nurses, registered nurses, a paediatrician, a pharmacist, safeguarding leads, speech and language therapists, a consultant specialising in care of the elderly, an Advanced Nurse Practitioner - Urgent Care, a urgent care doctor, a palliative care consultant and palliative care nurses. Two experts by experience who had used the service were also part of the team. The team was supported by an inspection planner and an analyst.

The team that inspected the community end of life care comprised a nurse consultant and palliative care doctor.

Why we carried out this inspection

We inspected this core service as part of our comprehensive inspection programme of NHS trusts.

Summary of findings

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 Oxford Health NHS Foundation Trust, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew. We carried out an announced visit on 29 and 30 September and 1, 2 and 3 of October 2015

During the visit we held focus groups with a range of staff who worked within the service, such as nurses and 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.

For the inspection of this core service we visited City, Didcot, Bicester, Wallingford, Abingdon and Witney community hospitals. We also visited the West, Central, and South West and North East Oxfordshire end of life care community teams. At these locations we observed the care of patients and reviewed their care plans and records. We spoke with 18 patients, six relatives and reviewed 11 patients' records. We also attended a multidisciplinary team meeting and an end of life care reference group meeting. We spoke with 38 staff members.

What people who use the provider say

Feedback was sought from patients and their families. Patients and relatives told us that they felt well cared for in community hospitals and their own homes. They spoke of being well supported by staff during the illness and death of a relative. Feedback also said that patients were treated with dignity and respect. The end of life care team were also commended on their "extremely efficient, joined up approach", giving an experience of their relatives death exactly as they wished.

Relatives fed back to the trust positively to say that they valued the community service and were glad that family members had been able to die where they chose to. There was also feedback expressing thanks to staff for being sensitive to the needs of the family members that are also caring for a dying person. This included appreciation of the need for relatives to have respite time.

Patients also expressed gratitude for the honesty, support and communication skills of the community matrons in ensuring they knew what to expect and what help was available.

Good practice

The community nursing service was skilled at engagement with hard to reach groups such as the traveller community. We observed good engagement and a respect for this group's specific cultural needs from community nurses.

The co-location of multidisciplinary team staff, including social services staff into the integrated locality team hubs has enhanced communication about the needs and priorities of patients at the end of life.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST or SHOULD take to improve

The trust MUST ensure:

- Their ability to demonstrate how they assess patients' needs and deliver care and treatment in line with evidence based guidance.

The trust SHOULD ensure:

- A variety of foods of different textures are available for patients.

- Staff have been provided with the appropriate education so that they have the necessary knowledge and skill to deliver end of life care in line with the 'Five priorities for the care of the dying person'.

- That advance decisions, ceilings of treatment and DNACPR decisions are discussed with patients and their families. These decisions are recorded in such a way as this information is accessible to all the services that the patient may use.

- There is improvement in the collection of information about the dying persons' preferred place of care.

- There is a consistent approach to advance care planning that occurs across the organisation for patients at end of life.

- Documents used by clinical staff are appropriately version controlled so that staff can see they are using the most up-to-date document.

Oxford Health NHS Foundation Trust
Community end of life care
Detailed findings from this inspection

Good ●

Are services safe?

By safe, we mean that people are protected from abuse

We rated safe as good.

Staff reported safety incidents on a trust wide reporting system. Patients at the end of life are particularly vulnerable to developing pressure ulcers, and these were correctly reported as safety incidents.

Staff told us that they were empowered to raise incidents and concerns that affected care delivery, or had an impact on patients. Staff could tell us about actions that had been taken to prevent incidents from happening again. Incidents were robustly investigated within teams and the learning was shared across teams. The trust were working to ensure that staff received the learning from the investigation of incidents.

The duty of candour requirements were understood by the majority of staff we spoke with. The staff participated in safeguarding training and were aware of how to escalate a concern to the local authority. Medicines were stored safely and there were checks in place to keep patients safe. The trust medicines policies were followed by staff. However, the documents used to check the administration of strong medicines used in end of life care by syringe driver was not the same across teams to prevent error.

We found that community hospitals were clean and hygienic. Equipment and facilities were in a good state of

repair. End of life care patients who were admitted to community hospitals were cared for in single rooms to provide a degree of privacy, and there were facilities available to allow relatives to stay with them if needed. Equipment required to allow patients to be safely cared for at home was delivered in a timely way, where there was appropriate senior staff sign-off. The syringe driver devices used across the trust were a single model, and staff had been trained to use it correctly.

Trust staff attended a programme of mandatory training, this included adult and children's safeguarding. 88% of staff had completed the mandatory training against the trusts' target of 90%.

Records we reviewed were completed to a high standard and reflected patients needs and preferences. The Liverpool Care Pathway had been replaced with an end of life care plan. Staff were aware of the care plan but due to its recent implementation they had not yet used it. This meant it was not possible to judge how effective it was for patients. Reviews of records indicated that advance care planning and advance decisions did not always happen.

The community hospitals had closed beds to ensure that there were enough staff to ensure that patients were safe.

Are services safe?

The community teams had a high level of vacancies that meant that the service operated until 4:30pm to ensure there were sufficient staff. End of life care patients were always given priority.

Patients had appropriate risk assessments completed. These were appropriately omitted sometimes when the physical assessment may decrease the patients comfort level. The rationale for stopping risk assessments was always recorded. Patients at end of life were identified on a list for the hospital at home team that covered the service between 6pm and 8am. This was to ensure they were aware of the patients with the highest needs or that were likely to deteriorate.

The integrated community team's matron led the end of life care service. The matrons were based in the six integrated community team hubs that meant they were in constant communication with the community nurses in the area, and were accessible to GPs. They were able to respond quickly if a patients needs changed.

Detailed findings

Safety performance

• The end of life care service was delivered by a number of teams and therefore it was not always possible to distinguish when safety information related to patients receiving end of life care. Incidents that were identified related to low grade pressure ulcers. If the patient was in the last days of life the incident report clearly identified this. Pressure ulcers in end of life patients were likely to be deemed unavoidable, as reflected in the trust's own guidance. This referenced the 'skin changes at life's end' (SCALE) document (2009) that explained why patients in the last days of life will often develop pressure ulcers even with the best possible care.

• Staff knew how to report such incidents on the trust's electronic reporting system, to ensure that all pressure ulcers could be investigated if the patients were not in the last days of life.

Incident reporting, learning and improvement

• Staff knew how to report incidents on the trust's electronic system. They understood what should be reported as an incident. Staff could also describe the benefits of reporting 'near misses' (where an accident didn't happen, but could have) to gain learning from these, as well as actual incidents.

• Individual staff told us they were happy and empowered to raise incidents and concerns with their managers.

• In the integrated community locality teams, investigation of incidents was undertaken by the clinical development leads. These staff also had responsibility for ensuring that learning from incidents was shared with other staff in their team and across their network.

• There was evidence that changes had been made as a result of the learning from incidents.

• An electronic notice board on the staff intranet was being used to share learning from incidents. Staff told us that this development had helped with the dissemination of learning and other governance issues.

Duty of Candour

• The Duty of Candour legislation requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred.

• Two staff told us that there had been information shared by the trust recently about the duty of candour.

• We spoke with ten members of staff and six were able to describe the actions and responsibilities required by the duty of candour, four staff had heard the term but were unclear of its impact.

Safeguarding

• Staff demonstrated a thorough awareness of safeguarding procedures and understood how to escalate a concern to the local authority.

• Staff had received training in safeguarding vulnerable adults and children and understood what constituted a safeguarding concern for a person at end of life.

• Safeguarding training was part of the trust mandatory training for staff. Staff we spoke to verbally confirmed they had completed this training, but there were no specific figures available on compliance with this training for each community team. At directorate, level, the target for attendance for safeguarding vulnerable adults training (level 1) and safeguarding children (level 2) was 90%, for October 2014 and September 2015 the mean compliance was 89%.

Are services safe?

- There was a policy in place for safeguarding adults which was available for staff to read on the intranet.
- In some of the integrated community locality teams, co-located staff from social services were available to provide immediate advice to staff if they raised concerns about an individual. This also meant that social services staff were able to access their (separate) electronic records to cross- reference any safeguarding concerns or alerts.

Medicines

- Medicines in the community hospitals were stored safely. Medication such as controlled drugs for use in end of life care was checked on daily basis.
- We reviewed a selection of medications to ensure that it was still within the use by date and therefore safe to use. All the medication was still in date.
- In end of life care, equipment such as a syringe driver may be used to deliver medicines over a specific period of time to control symptoms, such as pain, sickness and breathlessness. Documentation to check that medication given by syringe driver was correctly administered was available. However, we found that there were two different documents in use across the community hospitals and community teams to record this information. This had the potential to cause confusion about the information that needed to be recorded. The documents reviewed had no version control to ensure that staff were using the most up-to-date document.
- In patient's homes, medicines used for end of life care such as strong painkillers, were monitored to ensure they were being used correctly. For oral medicines, this was an approximate check to make sure that patients were using prescribed doses appropriately, as patients do not keep medicine administration records.
- The policy on removal and destruction of controlled medicines, such as the witnessed disposal of controlled medicines was understood and adhered to by staff.

Enviroment and equipment

- Community hospitals were designed to keep patients safe, and there was level access for patients in wheelchairs and clear signage. The facilities were visibly clean and hygienic. There was controlled entry to community hospital wards to keep patients and staff safe.

- The patient rooms in community hospitals were pleasantly decorated. There were attractive decorative wall panels as well as images on doors to assist patient in finding their own rooms. There were hand rails to assist patients to walk around the ward safely. Most of the community hospitals we visited had access to outside space.
- Patients admitted to community hospitals were given a single room as a priority. There were no beds allocated specifically for end of life care.
- Equipment required for patients at end of life in their own home was hired and delivered by an external community equipment provider. This equipment was given priority, and was delivered promptly when the need was assessed or anticipated. However, urgent deliveries required senior staff sign off as this was more costly. This could lead to unexpected delays.
- Community hospitals had an appropriate level of equipment that was fit for purpose. Staff did not have to request additional equipment. If there was equipment required for patients with specific needs, such as equipment for larger people this was provided.
- All staff working across end of life care services used the same syringe driver. Training in the use of the syringe driver had been delivered to all staff that needed to use the equipment. Staff that were trained in the use of syringe drivers were spread across the whole range of community services, community hospitals and urgent care services.

Quality of records

- We looked at 11 sets of patient records and found that four patients did not have an end of life care plan in place. There was little evidence that advance care planning was occurring with any consistency across the organisation for patients at end of life.
- Records we reviewed in patient's homes were completed to a high standard. Hand written care plans reflected the needs of patients and were personalised to reflect their preferences. They reflected patients current care and were completed or updated after each appointment with the community nurses.
- Records in community hospitals were completed to a high standard. However, there were multiple records in use as well as an electronic patient record. It was acknowledged that the trust had recognised this risk, and was changing to an electronic records system starting in October 2015.

Are services safe?

- There had been a new care plan for end of life patients implemented shortly before the inspection. This had been devised in consultation with a hospice charity and reflected current guidance and best practice in end of life care. However, the care plan had not yet been fully implemented across all settings.
- The incidents which had occurred around end of life care were often about resuscitation and the communication of patients and families wishes in this regard. Early communication with patients about their end of life care had not occurred for the majority of patients we discussed with staff.
- We found that advance care planning had not yet been fully implemented across all services that had patients in the last year of life. Although there was good quality information and guidance available for staff it was not used across all services. We observed some good examples of advance care plans in patient's records, but this was not consistent across the trust.

Cleanliness, infection control and hygiene

- The ward areas we visited were all visibly clean and hygienic.
- Staff adhered to good practice in hand washing; this was observed in the community hospitals and also in patients' homes.
- We observed staff that used personal protective clothing such as gloves and aprons when providing care for patients. These were changed appropriately between activities.
- Clean items of equipment that were ready for use were labelled with the cleaning date. This allowed for easy identification by staff.

Mandatory training

- Mandatory training consisted of fire, information governance, adult and children's safeguarding and end of life care. The trust data showed that 88% of staff had completed mandatory training, close to the trust target of 90%.
- There was also mandatory training provided on the documentation and discussion of do not attempt cardio pulmonary resuscitation to ensure staff were up to date with the latest legislation around this.
- All community hospitals and community teams provided end of life care for patients, the trust's data for mandatory training was therefore not exclusively for staff that delivered end of life services.

Assessing and responding to patient risk

- We found that there risk assessments were completed for patients at end of life. These included risk or falls, venous thromboembolism (VTE) and pressure ulcers. Where risks were identified but the mitigating treatment was not indicated due to the patient's condition, this was documented. For example, the administration of blood thinning injections, for managing of the risk of VTE, might not be appropriate for a patient in the last days of life.
- There were incidents of pressure ulcers reported in patients at end of life. Interventions such as regular turning, was balanced against the patient's level of discomfort on being moved to decide whether this was appropriate for the individual. Staff were promoted to refer to the 'skin changes at end of life' guidance in the end of life care plan. This guidance reminds staff that some skin damage is thought to be unavoidable in the end of life stage. The turning of the patient was not carried out if the benefits outweighed the patient's or relative's wishes for a patient to not be repositioned so frequently as to cause the patient discomfort or distress.
- The trust used a track and trigger system for observations. This was designed to help staff identify a deteriorating patient. Patients at end of life were not monitored in this way if there was to be no action based on these observations. Patients at risk of rapid deterioration were identified and this was communicated to the other services that were involved.
- Patients in the last days of life at home or being cared for within a community hospital setting could access medical care out of hours. Staff who were concerned about the deterioration of a patient got on-call medical advice from the out of hours GP service. For medical assistance during the night the 111 service was used. Most patients we observed in both settings had anticipatory medicines prescribed; these are medicines to give relief from pain or other symptoms in the last days or hours of life. They are often delivered by a syringe driver and need to be available when the patient requires them, without the need for further medical assessment. In the community, nurses liaised closely with the patient's own GP to ensure that medicines to support end of life were in place before they were needed to prevent a crisis.
- Syringe drivers and all the equipment needed to set one up were available in various locations, including

Are services safe?

community nurse office bases, where they could be accessed out of hours. For example, in the south west integrated community locality team there were boxes with the syringe driver and equipment contained in one box. This also contained a book to track the calibration date of the pump and the name of the person who stocked and cleaned the equipment after the last use. This was designed to ensure that nurses had all the equipment they needed in the event of having to set up a syringe driver.

- Staff in one community hospital told us they were concerned that a lack of clear communication about advance decisions which, could be shared with the out of hours GPs. This meant that there was more chance that the dying person would be taken into the acute hospital if they deteriorated without a robust plan being in place. This highlighted the importance of having an agreed advance decision and plan of care in place.
- The hospital at home service provided care between 6pm and 8am and would respond to requests for changes of treatment such as the starting of a syringe driver for a patient. As an urgent care service this team also had good access to out of hours GP services.
- Advice about symptom management was available 24 hours a day and was provided by the Sobell House Hospice, for nurses and GPs.
- There was good guidance in place for staff on advance care planning but there was limited awareness of this. The trust had recognised that staff required further education in end of life care to include advance care planning.

Staffing levels and caseload

- We found that staffing levels were appropriate for current need and requirement community hospitals. As a result of a review of safe staffing levels bed numbers had been reduced. Staff told us that their ability to deliver high quality care had increased since the closure of beds. This had made a positive impact on staff morale.
- The community teams were under pressure to deliver the service due to staff vacancies and a high demand for the service. There were 93 vacant posts against an establishment of 808, across 42 community teams. The high level of vacancies was recorded as a risk. However, end of life care was prioritised for patients.
- The integrated community teams were fully staffed with matrons that led end of life care services.

Managing anticipated risks

- The matrons in the integrated community locality teams were aware of all patients who were deemed to be end of life, being cared for by the community nursing teams. The matrons were based in the integrated locality team hubs. This ensured that they were informed of patients with escalating risks. The matrons were able to respond themselves or could delegate the responsibility for an assessment to be completed to the duty clinician or therapist. This was designed to ensure that there was a timely response if a patient, GP or relative telephoned the hub to advise of a patient's deterioration and change of needs.

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

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.

We have rated effective as requires improvement. The trust were active in trying to make improvements to end of life care for patients. However, the trust was not able to demonstrate that it was consistently assessing patients needs and delivering care and treatment in line with evidence based guidance.

The trust were in the process of implementation of the five priorities for the care of the dying person across the trust. This was not yet embedded in end of life care practise.

Staff had a good understanding of Mental Capacity Act (2005).

Patient's care records we reviewed demonstrated that care was planned and delivered in line with best practice guidance. Patients had their needs assessed and personalised care plans were written. Although not all patients had anticipatory care plans in place. The trust had responded slowly to the withdrawal of the Liverpool Care Pathway in 2013. However, a new end of life care plan had been implemented in August 2015; this meant that we were not able to see its impact on the effectiveness of end of life care across the trust. Community hospitals had an aspiration to move towards gold standards framework (GSF) accreditation. The GSF is a range of tools, measures and quality assurance to ensure that there is an evidence based approach to end of life care.

We found that pain assessment took place and staff were responsive to this, however there was inconsistency in the use of assessment tools, and the type of tool used across the trust.

Staff had access to relevant training and support. The teams we spoke with valued the expertise of the specialist palliative care team and used this service for referrals where patients had complex symptoms that were difficult

to manage. There was planning for further training in end of life care, some of which had been started. It was not possible to assess the impact this training had on the quality of end of life care.

Our observation of practice, review of records and discussion with staff confirmed there were effective multidisciplinary team (MDT) working practices. Staff worked collaboratively to understand and meet the range and complexity of patients' needs

A combination of electronic patient records and paper records in patient homes were used, and there were some inconsistencies in the information recorded, such as preferred place of care. There were plans to develop an electronic summary care record that would record key information about a patient's preferences for end of life care. This record would be available to GPs, community matrons and nurses as well as the ambulance service. This development would help ensure that care was provided in accordance with the patient's wishes.

The trust had audited do not attempt cardio-pulmonary resuscitation (DNACPR) and found they were not always fully completed. There is a plan in place to ensure that medical and nursing staff that complete them have the appropriate training. Do not attempt cardio-pulmonary resuscitation (DNACPR) documents were correctly stored in the front of patient's hospital notes. The location of these records was clearly recorded in patient's own homes. However, the DNACPR documents we saw did not always record an appropriate rationale.

Detailed findings

Evidence based care and treatment

- Patient care was not consistently delivered using evidence based guidance such as the Priorities for the 'Five priorities for the care of the dying person' and the National Institute for Health and Care Excellence (NICE) guidance on End of Life Care in Adults. The trust's own external audit of end of life care, conducted in March 2015, had identified that staff were not sufficiently knowledgeable about the priorities for the care of the dying person.

Are services effective?

- The trust's 'One chance to get it right' taskforce aimed to develop and implement improvements to end of life care across the trust. This group had recently developed and implemented a new end of life care plan with partners. This would replace the Liverpool Care Pathway (LPC), previously used for patients in the last days of their life, which ceased to be used in England in 2013. The trust had stopped using the LCP but had not replaced it comprehensively until the implementation of the new 'care plan for the dying patient in the last hours or days of life'.
- The trust had produced written information for staff on the use of anticipatory care planning. However, we found that not all patients had anticipatory care plans in place. The trust had identified this as a risk and was planning to provide education for staff and GPs.
- End of life care patients were provided with individualised person centred care plans. Care plans that we reviewed, particularly in the community setting, were comprehensive and reflected the patient's needs and preferences.
- The trust had implemented an end of life care plan in July 2015; this was devised by the trust in collaboration with a hospice charity to replace the LCP. However, as it was new the staff we spoke with had not had any experience of using it.
- Patients who were in the last days of life or in a rapidly deteriorating state were identified in a timely way and their care was reviewed. They had their needs met in at appropriate intervals, with escalation of their needs to the 'out of hours' services. Patients who were in the last days of life had a comprehensive plan of care in place, including a communicated DNACPR status.

Pain relief

- Pain relief was available to patients at end of life. The nursing staff in the community teams were skilled at ensuring that patients were using their pain relief medicines, and monitoring their effectiveness. If these were ineffective this was escalated to the patient's GP. However, the consistent use of pain assessment tools as standard practice was not in place. Where these were found they were being used effectively to record the type, location and measure of pain.
- We reviewed documentation which demonstrated that medicines for pain were selected and administered, then after an appropriate time period the effectiveness monitored.

- Where patients' records did not include pain assessment tools there was no record of impact on patients. Staff had knowledge of pain assessment, and responded to the patients' need for pain relief.
- Equipment was available for starting treatment with a syringe driver, so that anticipatory medicines could be used. Community and hospital at home nurses were competent to set up a syringe pump for a patient.
- The results from the national care of the dying audit (Voices, 2014) reported results for questions about pain relief, which were better or in line with the average for England.

Nutrition and hydration

- Community hospitals made food and fluids available for patients who were assessed as safe to eat. A variety of different foods were available including a range of different textured foods. However, staff told us that the cook / chill system in use made it difficult to get foods of different textures for patient that required this.

Patient outcomes

- Training to implement the five priorities for dying people, was being planned for nurses and doctors, but had not yet been fully implemented.
- There was confusion among senior staff about the difference between a do not attempt cardio-pulmonary resuscitation (DNACPR) and an advance decision.
- There was a possibility that patient's wishes and preferences regarding their last days may not be understood or recorded if this information was not recorded while the patient still had capacity to make decisions regarding this.
- There were no community hospitals that were accredited against the gold standards framework (GSF). However, it is acknowledged that this was in the pilot stage nationally. The GSF is a range of tools, measures and quality assurance to ensure that there is an evidence based approach to end of life care.
- The trust were working towards community hospitals gaining accreditation against the GSF standards. However, this required a financial investment, and the trust were investigating what was needed to deliver this.
- The trust were meeting representatives from other trusts to help them compare their service with another in order to learn and share good practice.
- The results from the national care of the dying audit were not available specifically for the trust but were

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published for the Thames Valley. Overall care provided by community nurses in the last three months of life reported was 'excellent' at 47% this was above the England average at 45%. This was higher than in-hospital figures.

Competent staff

- Across community hospitals the appraisal rate for nursing staff was 68%, the trust target was 100%. For community nursing teams the appraisal rate was 95% and the hospital at home team it was 90%.
- In the community hospitals staff told us there was training available in end of life care especially for health care support workers.
- Staff in the community and in community hospitals were able to access additional training on end of life care, such as after this learning need was recorded at their appraisal. At the time of inspection fourteen members of staff had attended an end of life care study day, a further seventeen staff were booked to attend in October 2015.
- The end of life care matrons and clinical development leads had worked with the Sobell House hospice to produce an on-line training package for staff and this was being implemented.
- The integrated community locality team matrons ran training for all new nurses on end of life care as part of their induction programme. The matrons also delivered trust training sessions as part of the advanced competency module in end of life care.
- A specific package of training for junior doctors was in planning stage. This would be provided by the clinical development leads and practice educators.
- Sixteen members of staff from the community had completed specialist post-graduate training in end of life care at a local university. These staff had become link nurses for end of life care. In this position they were able to promote best practice among other community nurses. They met bi-monthly to help them to support the community nurses, community hospitals, integrated community locality teams and mental health teams. The link nurses were used as a reference group by the trust for the design and implementation of changes to end of life care practise.
- A training needs analysis for end of life care had been carried out, to identify learning needs for community and hospital nurses. However, there were no results or plans from this work available.

- The trust had identified GP champions who had a special interest and additional training in end of life care. These champions benefited patients by promoting best practice in end of life care to other GPs across Oxfordshire.
- The integrated community locality team matrons that led on end of life care told us that they were concerned that they had not been able to meet for group supervision for the last twelve months.

Multi-disciplinary working and coordinated care pathways

- The integrated community teams had a wide variety of staff working within them. This included therapy staff, nurses and mental health staff. Social services staff (social worker and occupational therapist) were co-located to ensure that they were accessible and could be involved in joint working.
- This model had been in place less than a year and had not yet been formally evaluated. Staff told us that this service design enhanced their ability to work across disciplines and were positive about the change.
- The co-location of multidisciplinary team staff, including social services staff into the integrated locality team hubs has enhanced communication about the needs and priorities of patients at the end of life.
- Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team (MDT) working practices were in place in the community hospitals. The MDT meetings we observed were attended by medical staff, nurses and therapists as well as representatives from social services. There were also excellent links with other providers, such as charities and voluntary organisations to ensure that care for patients was co-ordinated. Notes of these meetings were shared with the patient and family. There was also a log of referrals that had been made on behalf of patients to ensure co-ordination and avoid duplication of effort.
- Community staff attended gold standards framework meetings with GPs to ensure that they were aware of patients who had been identified as in their last year of life.
- We were told that the out of hours service had records which identified patients that were at the end of life.

Are services effective?

Anticipatory care plans written by the patient's GP would also be held by the out of hours service where these had been completed. A similar record was maintained with the hospital at home team.

- There was a care home support team based at each integrated community locality team hub to support patients in these settings. A clinical development lead told us that the end of life care facilitator was no longer in post; this had led to work within care homes becoming more reactive. We were told that there were no plans to recruit an end of life facilitator in the current structure of the integrated locality teams. The trust anticipated that the matrons would perform this role.
- In the larger community hospitals such as Abingdon and Witney consultants and their teams (provided by the Oxford University Hospitals Foundation NHS Trust) provide daytime medical care, there was also involvement from the patients own GP.

Referral, transfer, discharge and transition

- We found that sometimes patients in community hospitals were not identified as being in their last year of life. Documentation reflected that there was a lack of training for GPs and medical staff working in community hospitals around end of life care.
- There was a system for referral to the specialist palliative care team based at Sobell House via the patients GP. Referral was for specialist treatments to manage symptoms. Staff from Sobell House would visit patients jointly with community staff, matrons and GPs, or provide advice over the telephone.
- The system for arranging 'fast track' funding for nursing home placements for patients at the end of life worked well. There were good relationships with the continuing healthcare team. However, other sources of funding for placements did not work well, for example the interim funding to support patients to be cared for short-term in a nursing home. This could lead to delays in being able to discharge patients who did not wish to remain in a community hospital.
- The trust have identified a fall in the number of carers who were available to provide care packages to enable patients to be discharged from hospitals. This was cited as a significant cause of delays to discharge.

Access to information

- Access to information in community hospitals was complex as patient records were held in different paper and electronic systems. It was difficult to find information about patients due to the number of different places information was recorded.
- Some staff did not have access to the electronic patient record due to the implementation of a new record system in October.
- It is acknowledged that the trust had multiple record systems but were implementing a system where records were consolidated on one electronic system.
- Patients in their own homes had a minimal amount of paper records with them at home. DNACPR forms were held at home with the patient. In order to direct emergency services to the form, the 'message in a bottle scheme was used' with a sticker clearly displayed for a doctor, nurse or paramedic to find it easily.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed that staff gained consent from patients before carrying out observations and care.
- Staff we spoke with had an understanding of the Mental Capacity Act (MCA) and understood the making of best interest decisions.
- Staff were less able to describe the Deprivation of Liberty Safeguards (DoLs) and what this meant for them and for patients. In community hospitals, patients had mental capacity assessments carried out when they had been admitted with confusion or appeared to have problems with cognitive function. This was documented appropriately. MCA assessments were clear about establishing whether the patient had the ability to make an informed decision or if there was a communication problem that needed to be addressed.
- For patients assessed as not having mental capacity to make decisions, best interest decisions were sought by talking with their family.
- The trust had undertaken an audit of DNACPR documentation in August 2015. They found that the documentation and communication of the decisions was unacceptable. We reviewed 20 DNACPR forms. We found that five patients were not involved in their DNACPR decision and there was no reason documented why that was. There were four forms where it was not recorded that either the patient or their family was

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involved in making the decision. The clinical reasons why resuscitation would be futile that was recorded on the forms was inappropriate on seven of the forms audited.

- The trust were aware that the recording of DNACPR decisions were poor and an action plan had been put in place. This included training and competencies for senior nurses to be able undertake and record DNACPR decisions.

Good ●

Are services caring?

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

We rated this service as good.

Staff across all the teams we visited described with passion how they were committed to providing caring, person centred end of life care, and saw it as a vital service to patients. Staff we saw treated patients with dignity, respect and kindness. We saw examples of where staff had provided patients with care which was above expectation.

Relatives we spoke to told us that staff delivered compassionate care and that staff were very attentive to their needs and that of the dying person. Relatives commented that they were communicated with appropriately and sensitively. Patients and their relatives were informed and involved in planning their care as much as they wanted to be. Staff always gave the patients they saw enough time to ensure that the interactions were through and did not appear rushed.

Sometimes staff found it difficult to have conversations about patient's preferences for their end of life care. This important aspect of end of life care was sometimes left to GPs and matrons. This made communication about patients' preferences inconsistent across the trust. There were workshops for staff on having difficult conversations planned for November.

Detailed findings

Compassionate care

- We witnessed patients being treated with dignity and compassion across the community services and in the community hospitals.
- Staff we observed were passionate about delivering end of life care and felt that it was everybodys' business to get it right for the patient.
- We saw some excellent examples of sensitive care for end of life patients. For example, a patient had hand massage to music; this was explained in a care plan that was shared with the family so that they would be able to participate.

Understanding and involvement of patients and those close to them

- Patients and their relatives told us that they received a high standard of care, and were involved in decisions as much as they wanted to be.
- Relatives told us that staff communicated to them in sensitive and unhurried way.
- We observed home visits with patients which were not rushed, giving plenty of time to ensure that patients were able to articulate their needs. This included a home visit to a traveller community where the individual and cultural needs of the patient and family were taken into consideration.
- Patients and family members told us that they were involved in decisions about their plan of care and treatment. They expressed that their level of involvement was what they chose.
- The needs of family members caring for a dying person were always considered. This included assessment of carer stress and support for arranging respite care. Feedback from relatives highlighted how important this aspect of end of life care was to them.

Emotional support

- Emotional support was provided to patients and their families through a variety of services, including the voluntary sector. Community matrons and ward staff were able to refer bereaved relatives for support through the chaplaincy service.
- The trust had a spiritual and pastoral care service that could support patients and relatives; this was overseen by the trust chaplains. This service was for spiritual care but could also access local clergy and faith leaders.
- The design of the integrated locality teams meant that referrals to social services for a carer's assessment could be made very quickly, where a patient's primary carer was thought to require further support

Are services responsive to people's needs?

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

Summary

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

We rated responsive as good.

The trust were in the process of implementing the standards required by the 'one chance to get it right' document. This document sets out an organisation's priorities and standards in the care of people at end of life. The trust were meeting with their commissioners, GPs, local hospices as well as their own end of life care staff in planning services to meet the needs of local people.

Community hospitals provided facilities and care appropriate for delivering end of life care, including provision for family members to be able to stay with the patient. We found that there was provision to support the spiritual and emotional needs of patients and their families. The trust sought feedback from patients and used this to develop and improve their services.

Equipment was available to support end of life care in patients own homes. Equipment in community hospitals was suitable and fit for purpose to meet the needs of patients at the end of life. There was access to translation services for patients whose first language was not English. There was also access to a sign language service for patients with hearing loss. There was good engagement and respect for communities such as travellers.

The environment in community hospitals were designed to be suitable for the needs of people living with dementia. Matrons had run training and implemented a document called 'knowing me' that was designed to ensure staff knew a patients preferences if they were living with dementia. Vulnerable people were identified and effective multidisciplinary team working helped ensure that their needs were met.

Trust staff attended the GP gold standards framework (GSF) meetings to ensure that all patients who were identified as in the last year of life were identified by the service. Matrons based in the integrated locality team hubs led on the provision of end of life care. The referral pathway to the matrons was very simple and they were accessible. The matrons worked across the community service as well as community hospitals and care homes. Some nurses had received training in the verification of expected death; this increased family choice when making arrangements for a patient after death.

The trust were able to give an example of where a complaint had led to changes in practice.

Detailed Findings

Planning and delivering services which meet people's needs

- Information about the needs of local people was used to inform how services were planned and delivered.

- The trust had started working with its commissioners, acute hospitals and hospices to deliver the outcomes of the 'one chance to get it right' document.As a result of this initial work the trust had formed an end of life care reference group this was made up representatives of the trust staff and its partners.Part of the work of the end of life care reference group was about ensuring that services were planned around the needs of the local population.If community staff or GPs found there were patients whose needs were not being met, this meeting provided a multidisciplinary forum to explore planning to remove barriers to providing end of life care for patients.

- The community hospitals provided appropriate facilities for the delivery of end of life care.This included the ability to provide space for relatives who wished to stay with the patients.We found examples of where accommodation had been used flexibly to ensure that a patient's wishes were met.Where there was insufficient space for a bed to allow a relative to stay overnight, a reclining chair was provided instead.

- There were facilities in community hospitals to support the religious and cultural requirements of patients with the provision of a multi-faith room.The spiritual and pastoral team worked across the trust in order to

provide support for both patients and staff.This team also facilitated reflective practice sessions to support staff when there has been an incident or crisis within a team.

- The trust used feedback from patients and relatives using the service in order to ensure that they were meeting peoples' needs. An example of this was where the end of life care service helped a relative carer who was under significant strain by organising respite care for the patient.Had this not occurred the patient may not have been able to stay at home in the long term. Patients also expressed gratitude that the end of life service takes a joined-up approach to providing care that reflects the patient's preference, such as wanting to die near family.

- The staff in community hospitals had access to contact numbers for local clergy in the case that dying patients required sacramental care.End of life care patients would be referred to the trust chaplains if that was their wish.

- Equipment was provided to support patients who wished to die at home.This was delivered by an external provider.The service was responsive and equipment could be delivered quickly to patients' homes to facilitate discharge or prevent admission to hospital.

Equality and diversity

- Hospital wards were designed for ease of access and were often decorated in a way that was suitable for patients living with dementia.The toilet facilities were fully accessible for patients with a physical disability.

- Translation services for patients were available if this was required, and staff where aware of how to access these. The trust website showed details of the interpreter service and it was explained in six additional languages.

- The translation service included access to a sign language interpreter.

- The community nursing service was skilled at engagement with groups such as the traveller community.We observed good engagement and a respect for this groups specific needs from community nurses.

Meeting the needs of people in vulnerable circumstances

- Community hospitals had been designed to be dementia friendly, with high contrast fittings in toilet and bathroom areas, and visual signage.Patient rooms were also identified with pictures as well as numbers.High contrast paintwork was used where hospitals had been refurbished or recently built such as Bicester community hospital.

- The matrons organised a conference in April 2015 regarding the skills in recognising dementia to raise awareness of the issue.This was attended by the chief executive.As a result of this work the group also developed a document entitled 'knowing me' that was used to ensure that staff were aware of the needs and preferences of a person living with dementia.This document has been shared across community services and community hospitals.

- The end of life care matrons used their network to ensure they were able to provide a service for hard to reach patient groups.For example homeless people could be referred to the matrons, via the Luther Street GP surgery or the hostel.The network of matrons also support staff in prison service if required.We observed effective engagement and early intervention with an end of life patient living in a traveller community.

- The integrated community locality teams used their therapists flexibly, including those from a mental health background in ensuring that vulnerable people were able to access end of life care services.An example of this was where the relative of a patient was displaying stress behaviours to staff.A therapist with a mental health background was asked to provide their assessment of the situation.This led to greater understanding of the vulnerability of this individual in this context by the multidisciplinary team.Appropriate support and care planning to include the vulnerable person was put into place.

Access to the right care at the right time

- End of life care patients had timely access to initial assessment and were identified in the community.This was due to community staffs attendance at gold standards framework (GSF) meetings with GPs. As part of the GSF, GPs hold a list of all patients assessed to be in their last year of life, this information was shared with

Are services responsive to people's needs?

community teams.However, as 30 GP practices held these meetings the integrated community locality teams matrons or community staff did not have capacity to attend every meeting.

- Matrons expressed concern that there were patients at end of life that they did know about.Eleven of the surgeries provided an electronic handover to ensure that Matrons were informed of patients that were discussed at the GSF meetings.

- Matrons did not entirely rely on referrals from GPs and would accept them directly from other members of the multidisciplinary team.

- The trust's own audit on preferred place of care found that around 75% of patients died where they had expressed a wish to.This was based on a small amount of data.Information on a patients preferred place of care was not always readily available or communicated.This information would be collected on the end of life care plan.This had only recently been implemented and had not yet had an impact on the communication of the patients' preferred place of care.A plan to introduce an electronic end of life summary care plan was being progressed through the end of life reference group.This would be a summary record that was accessible to community staff, ambulance services and GPs.This would help to ensure that the patients' wishes and preferences were communicated across services such as hospital at home, ambulance and out of hours.

- Care for patients identified as at the end of life was given priority, in community hospitals and in patient's own homes. All services that worked across 24 hours kept lists to ensure that they were aware of the patients with the most urgent need, for symptom control and pain management.

- The hospital at home service supported end of life care patients overnight between 6pm and 8am.This service host a list of up to 40 patients across the county with end of life care needs.Patients requiring pain relief or symptom control had open access to this service overnight.

- Out of hours doctors were sometimes not responsive to requests to changes in medicines (particularly in a syringe driver) as they had not seen the patient before and had limited access to medical records.This was highlighted as a risk by community and hospital nurses and matrons.

- Specialist palliative care advice was available to staff day and night, this was provided by the Sobell House Hospice.

- Some nurses providing end of life care had been trained in the verification of expected death.This meant that when patients died at home the family had control of when to contact the funeral director to remove the deceased patient.

- The death certificate could be collected from the community hospital or sometimes the family would be asked to collect it from the GP practice.We were not aware of any feedback to confirm that families were satisfied with this process.

- The integrated community locality team matrons that led end of life care were able to see patients in community hospitals.They did not see any barriers to providing a service to all end of life patients.

Learning from complaints and concerns

- Although staff were concerned that there may be issues that had not been shared, several staff were able to give us examples of where changes had been made in response to complaints.

- Complaints relating to end of care were received infrequently. There had been one in the previous year about delays in setting up a syringe driver due to problems obtaining medicines.This complaint was investigated and the process had been simplified to ensure that this would not be repeated.

- Information on how a patients or relative could make a complaint was displayed on the wards of community hospitals we visited.

Are services well-led?

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

Summary

Although the trust did not have a published end of life care strategy, they were fully aware of the improvements that were needed. Strategic work was being undertaken and staff were aware of the vision for the service. There was evidence of a commitment to improve the quality of end of life care and timely access to it. Groups were engaged in finding ways to communicate and work across services to ensure a seamless journey for patients. However, not working to a strategy risked work within the end of life strategic groups lacking cohesion and shared purpose. There was also the risk of work being duplicated by different parts of the group.

The trust were actively engaged with commissioners, GPs and local hospices in trying to improve the end of life care across the trust. The trust had an aspiration to gain accreditation for its community hospitals against the gold standard framework standards.

Staff were aware that they needed further training on advance decisions and advance care plans for patients in the last year of life.Communication and documentation of DNACPR and advance decisions was not consistent across the trust. There were plans to improve this with the implementation of the recommendations from the 'priorities of care for the dying person'.

The local leadership of the service had a good understanding of end of life care and where improvements were needed. Senior leaders were also engaged with making changes and developing the service. Staff felt that the leadership were supportive of them and valued the input of the integrated locality team matrons. We found there was an open and supportive culture within the services we visited. Staff were empowered and happy to raise concerns with managers.

The trust sought feedback from patients and relatives and acted on it. Staff were engaged in the proposed changes to services and were keen to have more training to address gaps in knowledge that had been identified.

Detailed findings

Service vision and strategy

- The trust had a well communicated set of core values across services. There was awareness among staff of the trust's strategy and priorities. However, there was no published strategy for end of life care. This made it difficult to see how the organisation measured its progress against goals. None of the stakeholders that were engaged with developing end of life services were providing clear leadership.
- It was not possible to see progress being monitored and reviewed as there was no strategy in place.
- There was a vision to move community hospitals towards an application for accreditation against the gold standard framework. This was an aspiration however, and work had not yet begun as this is at the pilot stage nationally.
- The community matrons were able to articulate the purpose of their service, and their role within the integrated locality team. Senior managers understood the importance of end of life care. There were education events to develop staff, such as the 'one chance to get it right' communication skills workshop planned for November and December 2015.
- The end of life reference group, an Oxfordshire wide multi-disciplinary group, was working to improve services across the community by engaging with stakeholders and partners.
- During the inspection we attended the end of life care reference group. This group had representation from the clinical commissioning group, GPs, community matrons, as well as representatives from local hospices, acute hospital and palliative care charities. Oxford Health staff made a valid contribution to the meeting. There were concerns expressed by all stakeholders about the need for more training for staff on end of life care. Particularly around having difficult conversations. There was also an understanding that the current arrangements for information sharing; around DNACPR, but also preferred place of care, advance decisions and care plans needed

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to be improved. The meeting was also concerned that there was activity such as audits and training needs analysis that was occurring in a fragmented and uncoordinated way that risked duplication of effort.

- The trust have invested and engaged with their stakeholders around end of life care, however this has not led to a coordinated strategy for end of life care.

Governance, risk management and quality measurement

- There were mortality review meetings for patients that died in community hospitals. These were attended by the consultant team (provided by Oxford University Hospitals NHS Foundation Trust), GP, governance team and nursing staff to identify learning for improvement.
- In the community the GPs led this process with the community nurses; this was part of the GSF process to identify learning.
- There was no after death analysis data collected.
- Information on patient's preferred place of care were not always captured, although data was collected and logged by the community matrons, the patient's preferred place of care was not consistently discussed or recorded. The trust had completed a spot audit and found that 75% of patients died in their preferred place of care.
- The trust conducted mortality meetings to provide feedback after a patient's death in a community hospital. The results of these meetings were shared with the hospital staff. There was no specific after death analysis as specified in the gold standards framework to comprehensively assess the quality of the service in the community.
- The risk register for the trust indicated that only small numbers of patients had an advance care plan in place, and that staff found conversations about the end of life planning difficult. A study day on having difficult conversations had been arranged for November 2015.
- The risk register reflected that advance care planning conversations and decisions were not always occurring with patients at end of life.

Leadership of this service

- Matrons based in the integrated locality team led end of life care for patients in the community, they also had involvement with patients that were admitted to community hospitals. They were based in the integrated

locality team hubs, so had exposure to real time information about patients from community teams, therapists, GPs and other members of the multidisciplinary team (MDT).

- Staff told us that there was good support and leadership for end of life care. They had confidence in the matrons to provide expertise and training to improve end of life care for patients.
- Leaders within the service had engaged with their partners and stakeholders with the aim of ensuring that there was seamless care for patients. There had been substantial work and planning carried out with the aim of embedding the five priorities of care for the dying person.
- A steering group had been appointed to replace the 'One chance to get it right taskforce', in order to monitor progress and developments.

Culture within this service

- We found an open and supportive culture in end of life care services with staff being engaged, open to new ideas and interested in sharing best practice in end of life care.
- The community nurses we spoke with told us that end of life care was always considered a high priority for them. They also stated that end of life care was an intrinsic part of their work for patients.
- Teams were supportive of each other and aware of the emotional stress of working in end of life care. The handover meeting was seen as a time for checking on team wellbeing.
- There were systems in place to ensure that staff affected by the experiences of caring for patients at end of life were supported.

Public engagement

- The trust website was well presented, but it was not easy to find information about end of life care services.
- The trust actively sought feedback from patients and it was clear that this was valued.
- There were user forums that offered patients a chance to discuss the provision of services as well as share their own experiences.
- An event was held in March 2015 in conjunction with Oxford Brookes University facilitated by community

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matrons from the trust. This was intended for the public and professionals. The subject was defining quality in end of life care, as well as the difficulties people have in making advance decisions.

Staff engagement

- Staff engagement workshops had been held to discuss the end of life care pathway, to ensure that staff were aware and able to contribute to proposed changes to services.

- The link nurse network was a group of clinical staff who had received additional training in end of life care. As staff with a higher level of expertise and experience this group was consulted by the trust on issues around the provision of end of life care.

- Staff felt that they required further education and training around end of life care, this was being planned.

- Staff we spoke with felt that their views counted and that they were listened to. Some expressed frustration at the slow pace of improvements in end of life care. However, other staff told us they felt as if there had been too many changes within the trust.

Innovation, improvement and sustainability

- In order to educate staff about good practice in having difficult conversations with patients and families, a theatre group had been engaged to facilitate a seminar.