Shropshire Community Health NHS Trust

R1D

End of life care

Quality Report

Shropshire Community Health NHS Trust
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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)
R1DHQ	Shropshire Community Health NHS Trust - HQ	End of life care	SY3 8XL
R1D25	Bishop's Castle Community Hospital	End of life care	SY9 5AJ
R1D22	Bridgnorth Community Hospital	End of life care	WV16 4EU

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

Summary of findings

Ratings

Overall rating for the service	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Inadequate** 

Summary of findings

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Summary of findings

Overall summary

We have rated this service overall as requiring improvement. This is because:

- Systems or processes were not sufficiently established and operated to effectively ensure the trust was able to assess, monitor and improve the quality and safety of end of life care.
- There was no risk register specific to end of life care.
- There was no method of categorising end of life care incidents and complaints to monitor themes and share learning.
- On some prescription charts, guidelines stating the limits to frequency of dosages of anticipatory medicines were not always present.
- Plans did not provide sufficient information to identify the personal wishes and preferences of patients and their families.There was a lack of assessments of patient's cultural, spiritual and emotional needs.
- There was no structured end of life care training plan or register of training to ascertain the skills of staff in different roles and teams. The trust had implemented the end of life care plan prior to ensuring sufficient numbers of staff had received training on how to use it.

However we also saw that:

- End of life care provision was caring and responsive to patients' individual needs and requirements. Relatives told us how good the care was and that staff were kind, compassionate, caring and considered the patient's dignity.

Summary of findings

Background to the service

End of life care encompasses all care given to patients who are approaching the end of their life and following death. It includes nursing care, specialist palliative care, bereavement support, and mortuary services. The definition of end of life includes patients who are approaching the end of life when they are likely to die within the next twelve months.

There is no specific palliative care team within the trust. End of life care was provided within community hospitals and by community nurses, physiotherapists and occupational therapists within patient's own homes. Specialist palliative care services were provided by two hospices within Shropshire; however these were not included in this inspection.

Shropshire Community Health NHS Trust provides a range of community-based health services for adults and children in Shropshire and Telford and Wrekin, and some services to people in surrounding areas, covering a geographical area of 1,346 square miles.

During this inspection we reviewed 30 sets of patient notes and spoke with seven relatives and 19 staff including district nurses, community matrons, occupational therapists and staff nurses.

Our inspection team

Our inspection team was led by:

Chair: Dr Timothy Ho, Medical Director, Frimley Health NHS Foundation Trust

Head of Hospital Inspections: Tim Cooper, Care Quality Commission

The team included CQC inspectors and a variety of specialists, including: Community matrons; physiotherapists; occupational therapists; senior community nurses; community children's nurses; school nurses; health visitors; consultant clinical psychologist; palliative care consultant; nurse practitioner; head of quality; deputy director of nursing; palliative care nurse; substance misuse consultant, substance misuse nurse, CAMHS practitioner.

The team also included other experts called Experts by Experience as members of the inspection team. These were people who had experience as patients or users of some of the types of services provided by the trust.

Why we carried out this inspection

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

How we carried out this inspection

We inspected this service in March 2016 as part of the comprehensive inspection programme.

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

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

Summary of findings

- Is it well-led?

Before visiting, we reviewed a range of information we hold about the service provider and asked other organisations to share what they knew. We carried out an announced visit from 7 to 11 March 2016.

We did not hold a public listening event prior to this inspection as we were looking to assess changes and progress over a very defined period of time, however we did contact Shropshire Healthwatch and Telford Healthwatch to seek the views that they had recently formed on the trust. Additionally, a number of people contacted CQC directly to share their views and opinions of services.

We met with the trust executive team both collectively and on an individual basis, we also met with service managers and leaders and clinical staff of all grades.

Prior to the visit we held six focus groups with a range of staff across Shropshire who worked within the service. Around 20 staff attended those meetings and shared their views.

We visited many clinical areas and observed direct patient care and treatment. 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

Relatives of end of life patients spoke very highly of the staff and the service they had received. Comments included, “I am confident she will be looked after when I'm not with her,” “Very gentle and caring,” and “Always treated with dignity and respect.”

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The trust must ensure that governance systems and processes are sufficiently established and operated to so that they canassess, monitor and improve the quality and safety of end of life care services.
- The trust must establish and implement systems to assess, monitor and improve the quality and safety of the end of life care service, including a risk register.
- The trust must develop and implement an overall vision and strategy for end of life care.

Action the provider SHOULD take to improve

- The trust should ensure that end of life care plans provide sufficient information to identify the personal wishes and preferences of patients and their families.
- The trust should ensure that all eligible patients are place on the End of Life Care Plan, that staff have been trained in its use and compliance with the plan is regularly monitored.

Shropshire Community Health NHS Trust

End of life care

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We have rated this service as requiring improvement for safe. This is because:

- The trust did not have a method of categorising end of life care incidents to enable themes to be reviewed and specific learning from end of life incidents to be shared and services improved.
- Guidelines stating the limits to frequency of dosages of anticipatory medicines were not always present.
- The service did not have systems to ensure that staff regularly checked and documented fridge temperatures at mortuaries across all of the community hospitals.

However we also saw that:

- Care records were completed to a good standard and were accurate, legible, up to date and stored securely.
- The service had effective safeguarding and infection control procedures.
- There were sufficient staff to meet the needs of end of life care patients.

Incident reporting, learning and improvement

- Staff we talked with across the trust, community hospitals and community nurses knew how to report incidents using the reporting system. They received feedback from their line manager regarding incidents they had reported. If there was some learning involved for the individual this was not always shared across the teams. We did not find any evidence of shared learning from incidents across the organisation.
- The trust reported a total of 1,715 incidents between 1 December 2014 and 31 November 2015, 26 were classified as serious incidents. None of these incidents were attributable to End of Life Care services as the trust did not have a method of categorising end of life care incidents to enable themes to be reviewed and specific learning from end of life care incidents to be shared. The trust was unable to provide us with the number of end of life care incidents within the last 12 months. The trust response was, “Until recently concerns or incidents relating to end of life were not specifically identified by including a data field to indicate the concern or incident was specific to end of life care. Since including the data field no incidents have been reported.”

Requires improvement

Are services safe?

Safeguarding

- Staff we spoke with were knowledgeable about their role and responsibilities to safeguard vulnerable adults and children from abuse and they understood what processes to follow.
- Staff were aware of how to access the safeguarding policy on the trust intranet and were given support by the safeguarding lead.
- There was no specific palliative care team. End of life care was provided by staff within the community hospitals and by district nurses, physiotherapists, occupational therapists and community matrons within the community. Trust wide data demonstrated that 96% of staff had completed adult safeguarding training to level 1 and 99% of staff had completed children's safeguarding to level 1.

Medicines

- The end of life care lead nurse told us that guidance was available for staff to prescribe appropriate end of life medicines to manage patients' pain and other symptoms in line with national guidance and best practice. The trust used the West Midlands Symptom Management Guidelines. Two district nurses showed us their copies of these guidelines. However they were the 2007 version, which had been superseded by the 2012 version. At Bridgnorth community hospital, staff showed us the 2003 version of these guidelines. These out of date guidelines were immediately removed (on our request) and we guided them to their own guidelines.
- GPs prescribed medication for patients cared for in their own homes. Each community hospital had GPs allocated to them to prescribe medication for inpatients.
- Anticipatory medicines are an important aspect of end of life care; they are prescribed drugs in order to control symptoms such as nausea and pain. In three prescription charts out of 16 we reviewed, we saw that anticipatory medicines had been prescribed for pain, nausea, chest secretions and agitation but not for shortness of breath which ideally should be included. On two other prescription charts, there was no guidance provided stating the limits to frequency of dosages of anticipatory medicines.
- The syringe pump policy was out of date (dated 12 November 2012, due for review October 2015.) A syringe pump is a small infusion pump, used to gradually administer small amounts of fluid to a patient. This meant we could not be assured staff were following the most up-to-date guidelines.
- The trust had completed a retrospective audit of end of life care in the community teams and hospital inpatient wards in February 2016.The audit assessed compliance with the standards in, "One Chance to Get It Right" Department of Health 2015 and "Priorities for The Care of the Dying Person" as set out by the Leadership Alliance for the Care of Dying People. Results for prescriptions of 'as required medication' for the five key symptoms were: pain 83% compliance, agitation 80%, respiratory secretions 74%, nausea/vomiting 74% and shortness of breath 48% compliance.
- Staff on the wards we visited told us they routinely kept stocks of palliative care medicines both to treat symptoms and for pain relief. 'Just in case boxes' containing anticipatory medicines were kept in patients homes once they were identified as at the end of their life. Staff on the wards we visited told us they routinely kept stocks of palliative care medicines both to treat symptoms and for pain relief.

Environment and equipment

- During 2011, the National Patient Safety Agency mandated that all Graseby drivers (a device for delivering medicines by continuous infusion) should be withdrawn by 2015.The McKinley T34 syringe driver had been introduced into the trust and the Graseby pumps discontinued. Staff told us that syringe driver training was mandatory for all new employees. This was confirmed by the trust policy which also states annual updates are also required. The trust was unable to give us the number of staff trained on syringe drivers stating that this training information was held locally within individual teams.
- Nursing staff in the community told us that there were no issues with ordering or obtaining equipment promptly for patients who were receiving end of life care. Three relatives confirmed that all equipment had been supplied in a timely manner.This included pressure relieving mattresses for patients with a risk of developing pressure sores. However, we saw from one

patient's records that it took five days to obtain a pressure relieving mattress by which time the patient had developed a pressure sore. Another record showed that a bed and mattress took seven days to arrive by which time the patient had died.

- There was a mortuary situated at each community hospital we visited. The mortuary policy was out of date (dated 23rd of January 2009 due for review 22nd of January 2012.)We were informed that there was a weekly check of the mortuary at Bridgnorth Community Hospital by the Estates Department including fridge temperatures. Staff said porters usually checked the temperature of the fridge on a daily basis but there were no logs of these checks maintained. Staff told us that fridge temperatures checks had not taken place at Bishops Castle Community Hospital mortuary. When a body is preserved though refrigeration, at the correct temperature, between 2 to 4°, this sufficiently delays decomposition. The temperature control mechanism in the mortuary at Bridgnorth did not have an audible alarm to indicate if the fridge temperature was out of range.

Quality of records

- We reviewed 28 sets of community notes of patients who had died in the last 12 months and two sets of inpatient notes. Of these, ten patients had had district nurse involvement at the end of their lives. We saw that staff had generally completed them to a good standard and most of the records were accurate, legible, up to date and stored securely. Records showed that risk assessments of patients' nutrition, mobility and skin integrity had been regularly reviewed. All the records were legible and stored securely in locked cupboards at the district nurse bases.
- One of the inpatients had been put on the 'End of Life Care Plan' but sections were poorly completed. Two out of the 26 records we reviewed were not signed appropriately.
- The trust's end of life care audit in February 2016 showed that 31% of dying patients (those diagnosed as having only a few hours or days to live) had been put on the End of Life care plan and that there was poor compliance with the plan when they were in place. However, there was documented evidence of discussions with the patient and family/carers in regard to 'do not attempt resuscitation' (DNACPR), this was 80% compliant.

Cleanliness, infection control and hygiene

- There were infection prevention and control systems in place to keep patients safe. The ward areas we visited were visibly clean. There was sufficient provision of personal protective equipment such as gloves and aprons and hand gel and hand washing facilities were available. There were enough single rooms to protect people who were more susceptible to infection and to protect others.
- During a visit with community staff to a patient's home we witnessed good hand hygiene and the use of personal protective equipment, such as disposable gloves and aprons when administering care to a patient.
- Staff followed the bare below the elbow policy in both community hospitals and within patient's own homes.

Mandatory training

- There was no specific palliative care team. End of life care was provided by staff within the community hospitals and by district nurses, physiotherapists, occupational therapists and community matrons within the community. The trust provided records of mandatory training showing an average training compliance across the trust of 85% against an 85% trust target as at February 2016.
- Training on the new End of Life Care Plan was not mandatory.

Assessing and responding to patient risk

- Patient's records incorporated regular assessments of patients' needs to minimise risks and maximise symptom control. We saw that patients had been regularly reviewed.
- There was a 24-hour advice line for professionals to access out of hours. The advice was given by specialist palliative care nurses or palliative care consultants based at the local hospice.
- Staff told us they would call a 999 emergency ambulance for critical emergencies. If patients required

urgent but not critical treatment, staff accessed the GP who was responsible for the community hospital or caring for the patient at home. Out of hours staff contacted Shropdoc (the out of hours GP service.)

Staffing levels and caseload

- End of life care was provided by staff within the community hospitals and also by community nurses, physiotherapists and occupational therapists across the county. The district nursing service worked between 8 am to 6 pm, seven days a week. In the Telford and Wrekin areas a rapid response team worked between 6 pm to 10 pm. In the rest of Shropshire, an out of hours service, delivered by another provider, operated with one nurse covering the whole of the county between 7pm and midnight and one doctor between midnight and 8 am. This left a gap of one hour between 6pm and 7pm with no cover. The trust relied on the goodwill of the district nurses to cover this gap. However, staff told us they always prioritised end of life care patients to ensure their needs were met.
- District nurses were also able to refer patients to the hospice at home service which could provide assistance up to four nights a week.

Managing anticipated risks

- The trust had a winter management plan incorporated in their business continuity plan to ensure end of life care patients received a safe and appropriate level of service in adverse weather conditions. Staff gave us examples of actions taken during previous severe weather episodes: rostering staff with 4x4 vehicles during snow conditions, a service level agreement with the out of hours doctor service to provide or use the 4x4 vehicle during snow conditions and prioritisation of nursing workload to ensure availability of nurses with the appropriate skills to manage palliative care patients.

Major Incidents

- Staff had access to the major incident plan (dated November 2015) via the trust intranet and received training on this during their induction.

Requires improvement

Are services effective?

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

Summary

We have rated this service as requires improvement for effective. This is because**:**

- An End of Life Care Plan had been implemented across the trust. A recent audit showed that 31% of eligible patients (expected to die in next few hours or days) had been put on the plan and there was poor compliance with their use when they were in place. An action plan had been developed in response to the end of life care audit.
- Care plans did not provide effective information to identify the personal wishes and preferences of patients and their families. There was a lack of assessments of patients' cultural, spiritual and emotional needs.
- There was a lack of knowledge and use of Advance Care Planning for patients in the last 12 months of their life.
- There was no structured end of life care training plan or register of training to ascertain the skills of staff in different roles and teams. The End of Life Care Plan had been implemented prior to ensuring sufficient numbers of staff had received training on how to use it.

However:

- We found that patient's pain and symptom control was well managed.
- Staff had a good understanding of consent in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards.

Evidence based care and treatment

- A Shropshire wide, whole health economy end of life care group had been formed with representation from the local hospices, the two clinical commissioning groups (CCG's), the children's hospice, the acute trust and the community trust. The end of life care lead attended these meetings. This group was planning the end of life care strategy for Shropshire based on, "Ambitions for Palliative and End of Life Care. A national framework for local action 2015 – 2020."However, there were no timescales defined for the strategy to be developed. The end of life care lead was not clear whether any terms of reference existed for this group. Minutes of these meetings indicated ongoing planning of the EOLC strategy.
- This group had developed an, 'End of Life Care Plan' to replace the Liverpool Care Pathway. However, the trust's end of life care audit showed that 31% of eligible patients had been put on the End of Life care plan and that there was poor compliance with its use when they were in place.
- We looked at 28 care plans and saw they were mainly task focused rather than focusing on individualised, holistic assessments and plans. They did not contain enough information to identify the personal wishes and preferences of patients and their families. There was a lack of assessment of patients' emotional, spiritual and cultural needs.
- End of life care within the trust was focused on the recognition of patients who might be approaching the last few days and hours of life. However, the Department of Health's end of life care strategy (2008) and NICE quality standards for end of life care (2011) included recognition of end of life care for patients with advanced, progressive, incurable conditions thought to be approaching the last year of life. Clinical staff on the wards we visited did not demonstrate an understanding that end of life could cover an extended period, or that patients might have benefited from early discussions and care planning.
- The End of Life Care Plan had been implemented across the trust prior to ensuring that sufficient numbers of staff had received training on how to use it. The plan stipulated that a doctor must initiate the End of Life Care Plan. However, we found instances within the community and the community hospitals where nurses had implemented the plan. There was confusion regarding this amongst nursing staff who told us they were informed they could initiate the plan during their training on the End of Life Care Plan.

Requires improvement

Are services effective?

- Advance care planning (ACP) is a nationally recognised means of improving care for people nearing the end of life and of enabling better planning and provision of care, to help them live and die in the place in the manner of their choosing.Although staff we spoke with were aware of ACP, the end of life care lead told us that currently there was no training for staff on ACP and we did not see any evidence of its use.

Pain relief

- Patients identified as needing end of life care were prescribed anticipatory medicines. These 'as required medicines' were prescribed in advance to properly manage any changes in patients' pain or symptoms. We saw that these medicines had been administered appropriately.
- Palliative medicines (which can alleviate pain and symptoms associated with end of life) were available at all times. Ward and community nurses had adequate supplies of syringe drivers (devices for delivering pain medicines continuously under the skin) and medicines to be used with them.
- We did not see any use of pain assessment tools within patient's records we reviewed. This meant that we could not be assured that patient's pain was assessed and controlled in a consistent way. However, relatives of end of life care patients told us that staff had controlled their loved one's pain to ensure they were as comfortable as possible.

Nutrition and hydration

- The trust's end of life care audit reviewed records in relation to assessment and appropriate responses to issues around hydration and nutrition with 86% compliance. Clinically assisted hydration and nutrition had 11% compliance and evidence of ongoing review and assessment 77% compliance (within the community nursing teams) In the community hospital inpatient wards the results were 76%, 57% and 86% respectively.
- Records we reviewed did not show that staff conducted in-depth assessments or regular reviews of patients' nutritional and hydration needs.
- If patients were recognised as in need of rehydration, nursing staff within the hospitals and the community were able to provide subcutaneous fluids to help the patient absorb fluids.
- Staff had access to an up to date policy (dated January 2016) on administration of subcutaneous fluids to ensure they were following the most up-to-date guidance.
- The end of life care lead acknowledged that more staff training was required in relation to nutrition and hydration.

Patient outcomes

- The trust did not have a process of measuring outcomes for patients against their preferred place of death.
- The trust's end of life care audit concluded that there was good evidence of care provision in the records they reviewed but that this would have been improved by the consistent and full use of the End of Life Plan across all teams and settings.Even when the plan was in place there was poor documentation in relation to spiritual needs and discussions about these. A basic action plan had been developed in response to the audit. These actions included to roll out the end of life plan across all teams, disseminate the results of the audit to teams and to conduct a re-audit. However, there was no clear strategy as to how this was to be achieved other than to use the end of life care operational group to drive this forward.
- We observed care being delivered in the community. We saw staff made every effort to ensure that people's needs were met, including medicines being delivered, equipment being provided and support for relatives being put in place.

Competent staff

- There was no structured, end of life care training plan. Staff were able to access courses on end of life care provided by the local hospices. However, there was no register of training to ascertain the skills of staff within different roles and teams. The end of life care lead told us that they had trained 350 staff on the End of Life Care Plan. However, they had no method of knowing the percentage of staff trained within different teams to ascertain future training needs or whether it was safe to use the plan within teams.

Requires improvement

Are services effective?

Multi-disciplinary working and coordinated care pathways

- As there was no specific palliative care team within the trust, specialist services were provided by two hospices within the Shropshire area. Records demonstrated and relatives of patients confirmed that there had been effective multidisciplinary team working between district nurses, occupational therapists, physiotherapists and hospice at home service when providing care.
- District nurses attended meetings at GP surgeries to discuss the ongoing needs of patients. MacMillan nurses, the hospital outreach team and community matrons also attended these meetings.

Referral, transfer, discharge and transition

- Access to all inpatient beds or community nurses for all patients across Shropshire was managed by a single point of access. GPs made direct referrals (via this system) to the district nursing teams. The community hospitals received referrals from GPs or the acute hospitals.
- All the trust community hospitals stated they provided end of life care but there were no designated end of life care beds.
- Some patients at the end of their life were identified and fast tracked for discharge if they wished to transfer their care to their home or to an alternative service. One bereaved relative told us that their loved one was discharged to die in their own home at their request with speed, and with all the appropriate equipment care and support needed.
- Staff told us that there were sometimes delays due to trying to access care packages for patients. The trust did not monitor how quickly rapid discharges were completed. Responding to patient's choice for their preferred place of care is part of national best practice guidance.

Access to information

- Community staff had access to patients' risk assessments and care plans as these records were left in individual patient's homes and inpatient staff had access to both nursing and medical records within the community hospitals. This meant care and treatment could be planned and delivered in a timely way.
- The district nurses notified the out of hours services of any patients that were at the end of their life. This meant that a red flag would come up on the out of hours computer screen to alert them if the patient or family contacted them.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Nursing staff were knowledgeable about processes to follow if a patient's ability to give informed consent to care and treatment was in doubt. Staff demonstrated a good understanding of consent in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards. We observed community staff gaining informed consent appropriately prior to carrying out any procedures during a home visit.
- We reviewed seven do not attempt cardio pulmonary resuscitation (DNA CPR) forms and found five out of seven were completed accurately. Of the two forms which were not completed correctly, One form had the 'capacity' box ticked as "no" with an explanation of, "Capacity not assessed due to deafness." The 'Summary of communication with relatives section' stated "None today". Another form had the sections on 'communication with patient' and 'evidence of discussion with family' left blank.This meant that we could not be assured that all patients were having their capacity to consent appropriately assessed prior to decisions being made. 'Deafness' does not indicate lack of mental capacity.
- The trust end of life care audit reviewed DNA CPR forms to ensure there had been evidence of discussion with the patient and family in relation to DNA CPR and that there was an appropriate form was present in the patient records. The community hospital inpatient wards 100% compliance.
- The trust informed us that there was currently a DNA CPR audit taking place across the trust.

Good

Are services caring?

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

Summary

We have rated this service as good for caring. This is because:

- Relatives spoke very highly of the staff saying they were caring, gentle and always treated people with dignity and respect.
- Relatives said they were kept fully informed and were involved in decisions about care.
- Staff provided emotional support to patients and their families. One relative said, “They have shown kindness and care to all of the family.”

Compassionate care

- Six relatives of patients spoke very highly of the staff and the service that their loved ones had received.
- They said staff were very caring and gentle and always treated people with dignity and respect.
- Ward staff told us that, whenever possible, end of life patients were nursed in side rooms to preserve dignity and privacy for them and those visiting them.
- We observed that nurses were attentive to an end of life care patient, nursed in a side room and responded quickly when they were in pain.
- One relative told us, “Happy, kind, caring staff who are respectful and make me feel very welcome.”Another relative said, “They have shown kindness and care to all of the family.”
- The Friends and Family test results for community inpatient services (November 2015) showed very positive feedback with 100% of responders extremely likely/likely to recommend the trust.

Understanding and involvement of patients and those close to them

- Patients and those close to them were involved with their care.Relatives told us that they had been consulted about decisions and understood what was happening and why.One family member had been invited to a multidisciplinary meeting with staff to discuss future care needs for their relative.
- Relatives and partners said that staff kept them fully informed of their loved ones condition and any changes to their care.One relative explained that when they had had to leave and their mother had been unsettled, the staff nurse had taken the time to phone them at home to confirm that she had now settled.
- One relative told us that the nurses explained what they were doing and that the GP had gone through the End of Life Care Plan with them.They said, “I have read the End of Life Care Plan and totally agree with it.”

Emotional support

- All the relatives we spoke with said that staff had been very supportive and understanding. Chaplains are attached to each community hospital.
- One relative told us, “The staff also give me great emotional support.”
- Another relative explained how the district nurse and hospice nurse had visited them, to provide support, following the death of their loved one.
- District nurses told us that, where possible, they tried to double up on end of life care visits to enable one nurse to manage the physical needs of the patient and the other nurse to provide emotional support to the patient and their family.
- Staff told us that there were no chaplains attached to the community hospitals.However, they had good relationships with local clergy who were willing to come in and see patients.
- We reviewed 14 thank you cards sent to the community teams which all contained very positive feedback. Comments included: “Comforting that you were calling in every day,” and “Thank you for your kindness, compassion and love.”

Good

Are services responsive to people's needs?

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

Summary

We have rated this service as good for responsive. This is because:

- The trust engaged with the wider health economy in planning and coordinating end of life care services.
- Arrangements were in place for services to respond to the additional needs of vulnerable people or people from minority groups.
- A rapid discharge system was in place to enable patients to die at home. We saw staff made every effort to ensure that patient's needs were met, including medicines being delivered, equipment being provided and support for relatives being put in place. District nursing services were responsive to end of life care patients.
- Facilities and arrangements were in place in the community hospitals for relatives wishing to stay overnight. This included recliner chairs, pull-down beds, en-suite facilities and an area where relatives could prepare drinks for themselves.

Planning and delivering services which meet people's needs

- The end of life care lead attended the Shropshire whole health economy end of life care group to plan a strategy for end of life care based on evidence-based practice.
- The trust did not currently have their own bereavement information leaflets but used those supplied by Age UK. They were planning on gaining feedback from a patient group, to ascertain what information they should include when developing end of life care and bereavement information leaflets.
- Staff in the community hospitals facilitated rapid discharge to enable patients to return home if they wished to die there.One relative told us, "All in all I couldn't speak more highly of the whole team, they were wonderful and my partner got their wish to die at home."
- We saw an example in a patient's records where the rapid response team cared for a complex, distressed, dying patient, enabling them to die at home.They stayed with the patient for four hours providing symptom control and support to the family.
- A palliative care suite had been developed at Bishops Castle community hospital.This consisted of a room adjacent to a relative's room which had ensuite facilities.Reclining chairs were available if relatives wished to stay overnight.Tea and coffee facilities were also available.There was a small landscaped garden with seating area which relatives could access.

Equality and diversity

- Translation services were available for patients at the end of life and their relatives.
- The community hospitals we visited had good access for disabled patients and had disabled toilet facilities.
- Staff treated patients with the utmost respect regardless of their race, religion and sexual orientation. Relatives confirmed that they and their loved ones were shown dignity and compassion throughout their care.

Meeting the needs of people in vulnerable circumstances

- A learning disabilities trained nurse from the hospice had developed easy read materials for patients with learning disabilities and training for staff.They attended both the health economy wide end of life care and the operational end of life meetings to share best practice in relation to caring for patients with learning disabilities.
- The trust employed three Admiral Nurses who were qualified in mental health to support patients living with dementia.However, due to commissioning arrangements, they only covered the Telford/Wrekin area of the county and the remainder of Shropshire had no access to these nurses.

Good

Are services responsive to people's needs?

Access to the right care at the right time

- The trust did not monitor how rapidly patients were discharged from inpatient services if they wished to be cared for at home or how many patients achieved their goal of dying in their preferred place.
- Community staff told us that end of life patients were always prioritised within their workload to ensure they received a timely and appropriate service.
- Community nurses told us they responded to 'urgent' referrals within 24 hours and non-urgent referrals within 48 hours. Information provided by the trust identified 99% of urgent referrals were seen within 24 hours, against a target of 100% and 99% of non-urgent referrals were seen within 48 hours, also against a target of 100%.

Learning from complaints and concerns

- The trust had no method of categorising or monitoring complaints for end of life care to enable a thematic review to take place.This meant that trust wide learning from complaints was not possible to improve the quality of care.
- Community and inpatient staff that we spoke with told us they had not received any complaints in relation to end of life care.
- We did not see posters or leaflets displayed on how to make a complaint within any of the community hospitals.

Inadequate

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

We have rated this service as inadequate for well-led. This is because:

- Systems or processes were not sufficiently established and operated to effectively ensure the trust was able to assess, monitor and improve the quality and safety of the end of life care service.
- There was no overall vision or strategic overview of end of life care.
- There was no clear governance structure for end of life care.
- There was no risk register specific to end of life care. There was no method of categorising end of life care incidents and complaints to monitor themes and share learning.

Service vision and strategy

- There was no overall ongoing vision or strategic overview of the service. The end of life care lead attended the Shropshire wide multi-provider end of life care group. However, no trust wide end of life care strategy had been developed or timescales outlined for this to be done.
- The end of life care lead had recently developed an end of life care operational group, (within the last few months), with representatives from the district nursing teams and community hospitals. The aim was that the end of life care link nurses would disseminate best practice back to their individual teams. Staff confirmed that they had attended these meetings and were feeding back to their teams. However, not all teams had assigned a representative or were aware of the group.

Governance, risk management and quality measurement

- Systems or processes were not sufficiently established and operated to effectively ensure the trust was able to assess, monitor and improve the quality and safety of the end of life care service.
- There was no clear governance structure for the end of life care service. The end of life care lead had developed an end of life care operational group with representatives from the district nursing teams and community hospitals. The aim of this group was to discuss the recent audits of end of life care, NICE guidelines, any actions from the Shropshire wide group and develop and improve the end of life care service. However, this group did not feed into any other quality structures within the trust.
- The Director of Nursing (DoN) informed us that their role included the remit for the executive lead for end of life care. There was also a non-executive lead for end of life care. The DoN stated that the end of life care operational group was the strategy group which reported to the quality and safety committee and from there to the board. However, the end of life care lead was unaware of this structure or that the DoN was the executive lead for end of life care. Minutes of the quality and safety committee between November 2015 and January 2016 did not reflect any reports on end of life care discussed. The only reference to end of life care was within the January 2016 minutes which stated that end of life care had been highlighted as a potential priority to be put on the trust's quality account.
- The trust had no method of categorising incidents and complaints for end of life care to enable a thematic review to take place. This meant that learning from end of life care incidents and complaints was not happening to improve the quality of service.
- There was no risk register specific to end of life care. The community health service divisional register stated, “End of Life Pathway not fully embedded across local health economy.” There was a rudimentary action plan in relation to the end of life care audit. Actions include: to roll out the End of Life Plan across all teams and ensure consistent use and to disseminate the results of the audit to all teams. However, there was no specific

strategy or plan as to how this would be achieved or performance managed. There was no trust wide policy or guidance on how the End of Life Care Plan would be implemented across the trust.

- The Shropshire wide providers (including the acute trusts, hospices, CCG's and community trust) had agreed to implement the End of Life Care Plan. However, staff told us that some GPs were refusing to use the plan. The end of life care lead had asked the community nurses to report when this occurred through the incident reporting system. They were then planning to report back to the clinical commissioning groups to improve compliance with use of the End of Life Plan. This issue was not on any risk register to ensure senior management oversight and monitoring of the risk.

Leadership of this service

- The end of life care lead was committed to improve the end of life care service and had gained quite a high profile across the trust for their end of life care role in the year they had been in post. However, they had no designated time dedicated to end of life care within their role as an adult consultant nurse.
- Most of the community and inpatient staff were aware of the operational end of life care group and some teams had representatives who fed back on issues relating to end of life care. However, none of the staff we spoke with knew that the DoN was the executive lead for end of life care.

Culture within this service

- Staff we spoke with in the community hospitals and in the community were committed to providing high quality end of life care.
- Staff told us they worked in very supportive teams where they learned from each other. They conducted peer debriefs when patients died to provide support for each other.
- District nurses were able to describe good lone working practices to ensure staff safety and had access to the loan working policy on their intranet.

Public and staff engagement

- There was no survey for relatives in relation to end of life care.
- The end of life care lead told us that they would like to conduct a survey of recently bereaved relatives.They had contacted the local hospice to see if there were any existing patient groups to find out what information they would like and to find the best method of gaining feedback from the recently bereaved.
- The results of the end of life care audit had been sent to the DoN, commissioners and individual teams within the community and community hospitals.
- There was a consultation before the End of Life Care Plan was finalised, with staff and a patient panel. The plan was revised as a result of feedback.
- The end of life care operational group had been formed to share best practice relating to end of life care and disseminate learning amongst individual teams.

Innovation, improvement and sustainability

- The end of life care lead acknowledged that improvements were required to governance and staff training to improve the consistency and quality of the implementation of the End of Life Care Plan.