Berkshire Healthcare NHS Foundation Trust

RWX

Community end of life care

Quality Report

Berkshire Healthcare NHS Foundation Trust
Skimped Hill
Bracknell
Berkshire
RG12 1BQ
Tel:0118
605027
Website:berkshirehealthcare.nhs.uk

Date of inspection visit: 7-11 December 2015
Date of publication: 30/03/2016

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)
RWXX3	St Marks Hospital		SL6 6DU
RWXX1	Wokingham Community Hospital		RG41 2RE
RWX86	West Berkshire Community Hospital		RG18 3AS

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

Summary of findings

Ratings

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Contents

Summary of findings

Overall summary

Overall rating for this core service

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 services at Berkshire Healthcare NHS Foundation Trust were, 'outstanding' for caring and 'good' for safe, effective, responsive and well led.

Our key findings are :

- Services for end of life care were safe and there was a good culture of reporting and learning from incidents.
- Incidents were reported and process was risk was monitored. The service monitored safety information such as healthcare associated infections, pressure ulcers and medicine errors. There was safety information available, which related to workforce and patient experience.
- Learning from risks, incidents and near misses was shared with staff. Staff had knowledge of the requirements of the duty of candour.
- There were systems in place for escalating concerns about potential safeguarding concerns.
- The environment was clean and well maintained.
- Equipment was available for patients in their homes and was delivered promptly. Staff were able to order urgent equipment such as hospital beds or moving and handling equipment for patient use within 24 hours to ensure harm free care.
- Medicines, including controlled drugs (CDs),were appropriately managed. The trust used a single model of syringe driver for the delivery of end of life care medicines and staff had received appropriate training on the use of these.
- 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 could access on-call medical advice from the out of hours GP service.
- Staff provided care to patients based on national guidance, such as National Institute for Care Excellence (NICE) guideline on End of Life Care in Adults and the Priorities for the 'five priorities for the care of the dying person'.
- The trust had recently introduced a new end of life care plan to replace the Liverpool Care Pathway, which had stopped being used in England in 2013.
- There were sufficient staff to provide high quality care in community hospitals and community settings.
- Staff worked in multidisciplinary teams to coordinate patient care. The local multidisciplinary team meetings (MDTs) held at GP practices and hospices were well attended by community nurses, specialist palliative care staff and hospice staff.
- The trust used single point of access (SPA) arrangements together with a local hospice to screen referrals into the East Berkshire palliative care service. Staff told us this had helped in reducing the response time in delivering end of life care. Discharges from hospitals were managed efficiently.
- Patient outcomes were monitored by individual services and information about these outcomes was included in the trust's clinical governance reports.
- Staff had access to specialist training courses and had appraisals.
- Staff were clear about their roles and responsibilities regarding the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- The 'do not attempt cardio-pulmonary resuscitation' (DNACPR) documents we reviewed did not always record an appropriate rationale. The trust had not undertaken an audit of DNACPR documentation and were not aware that the recording of DNACPR decisions were poor.

Summary of findings

- Staff involved and treated people with compassion, kindness, dignity and respect. Feedback from patients and their families were consistently positive and included many examples of where staff had gone “above and beyond”.
- 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.
- Patients and relatives were given the emotional support they required, and felt that they were involved in the planning of their care. Staff in the community gave patients the time they needed, so their visits did not seem rushed, even when the service was under pressure.
- The trust had audited and were in the process of implementing the standards of the ‘one chance to get it right’ document. The trust had formed an end of life (EOL) care group to support the delivery of end of life across the trust. The trust also participated in an East and West Clinical Commissioning Group’s(CCG) end of life care group which consisted of commissioners, GPs, local hospices.
- Community hospitals provided appropriate facilities for end of life care. There was provision for people with communication difficulties, this included an interpreter service.
- 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.
- Complaints were handled in line with the trust’s policy and were dealt with in a timely manner. Staff were encouraged to be proactive in handling complaints. Staff received feedback from complaints in which they were involved.
- Although the trust did not have a published end of life care strategy, the service leads had identified priorities around improving the end of life care services across the trust. Staff we spoke with were aware of these priorities and described high quality patient care as a key component of the trust’s vision.
- The leadership, governance and culture were used effectively to drive and improve the delivery of high quality person-centred care. The leadership for end of life care was strong and empowered all staff to strive to deliver the best possible service.
- The trust sought and acted on feedback received from patients and relatives.

Summary of findings

Background to the service

Overall rating for this core service

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 services at Berkshire Healthcare NHS Foundation Trust were, 'outstanding' for caring and 'good' for safe, effective, responsive and well led.

Our key findings are :

- Services for end of life care were safe and there was a good culture of reporting and learning from incidents.
- Incidents were reported and process was risk was monitored. The service monitored safety information such as healthcare associated infections, pressure ulcers and medicine errors. There was safety information available, which related to workforce and patient experience.
- Learning from risks, incidents and near misses was shared with staff. Staff had knowledge of the requirements of the duty of candour.
- There were systems in place for escalating concerns about potential safeguarding concerns.
- The environment was clean and well maintained.
- Equipment was available for patients in their homes and was delivered promptly. Staff were able to order urgent equipment such as hospital beds or moving and handling equipment for patient use within 24 hours to ensure harm free care.
- Medicines, including controlled drugs (CDs),were appropriately managed. The trust used a single model of syringe driver for the delivery of end of life care medicines and staff had received appropriate training on the use of these.
- 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 could access on-call medical advice from the out of hours GP service.
- Staff provided care to patients based on national guidance, such as National Institute for Care Excellence (NICE) guideline on End of Life Care in Adults and the Priorities for the 'five priorities for the care of the dying person'.
- The trust had recently introduced a new end of life care plan to replace the Liverpool Care Pathway, which had stopped being used in England in 2013.
- There were sufficient staff to provide high quality care in community hospitals and community settings.
- Staff worked in multidisciplinary teams to coordinate patient care. The local multidisciplinary team meetings (MDTs) held at GP practices and hospices were well attended by community nurses, specialist palliative care staff and hospice staff.
- The trust used single point of access (SPA) arrangements together with a local hospice to screen referrals into the East Berkshire palliative care service. Staff told us this had helped in reducing the response time in delivering end of life care. Discharges from hospitals were managed efficiently.
- Patient outcomes were monitored by individual services and information about these outcomes was included in the trust's clinical governance reports.
- Staff had access to specialist training courses and had appraisals.
- Staff were clear about their roles and responsibilities regarding the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- The 'do not attempt cardio-pulmonary resuscitation' (DNACPR) documents we reviewed did not always record an appropriate rationale. The trust had not undertaken an audit of DNACPR documentation and were not aware that the recording of DNACPR decisions were poor.

Summary of findings

- Staff involved and treated people with compassion, kindness, dignity and respect. Feedback from patients and their families were consistently positive and included many examples of where staff had gone "above and beyond".
- 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.
- Patients and relatives were given the emotional support they required, and felt that they were involved in the planning of their care. Staff in the community gave patients the time they needed, so their visits did not seem rushed, even when the service was under pressure.
- The trust had audited and were in the process of implementing the standards of the 'one chance to get it right' document. The trust had formed an end of life (EOL) care group to support the delivery of end of life across the trust. The trust also participated in an East and West Clinical Commissioning Group's(CCG) end of life care group which consisted of commissioners, GPs, local hospices.
- Community hospitals provided appropriate facilities for end of life care. There was provision for people with communication difficulties, this included an interpreter service.
- 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.
- Complaints were handled in line with the trust's policy and were dealt with in a timely manner. Staff were encouraged to be proactive in handling complaints. Staff received feedback from complaints in which they were involved.
- Although the trust did not have a published end of life care strategy, the service leads had identified priorities around improving the end of life care services across the trust. Staff we spoke with were aware of these priorities and described high quality patient care as a key component of the trust's vision.
- The leadership, governance and culture were used effectively to drive and improve the delivery of high quality person-centred care. The leadership for end of life care was strong and empowered all staff to strive to deliver the best possible service.
- The trust sought and acted on feedback received from patients and relatives.

Our inspection team

Our inspection team was led by:

Chair: Dr C I Okocha, Medical Director and Responsible Officer, Oxleas NHS Foundation Trust

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

and Substance Misuse, Care Quality Commission

Team Leader: Lisa Cook, Inspection Manager, Care Quality Commission

The team that inspected community end of life care included CQC inspectors, medicines inspector and specialist advisors including specialist palliative care nurses and a district nurse.

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 Berkshire Healthcare NHS Foundation Trust, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit over three days between 8 December 2015 and 10 December 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 this core service we visited a range of services including community nursing teams, St.Mark's Hospital,Wokingham Community Hospital, West Berkshire Community Hospital, intermediate car team, East Berkshire Palliative care team and Single Point of Access.

During the visit we spoke with a range of staff who worked within the service, such as nurses, healthcare assistants, therapists and managers. We spoke with 72 staff. We spoke with 20 people who use services as well as carers and family members. We observed how people were being cared for and accompanied staff on home visits across the county. We reviewed 10 care or treatment records of people who use services.

What people who use the provider say

We spoke with 20 patients and relatives of patients. We spoke with patients in community hospitals and by visiting them at home. We received positive feedback from each person we spoke with. Patients and carers were pleased with the services they received and praised the professionalism of trust staff. They said staff were caring and supportive.

Patients and carers 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. Relatives repeatedly told us, "Staff go above and beyond" and gave us many examples of compassionate care.

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. 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. They described the service as "Excellent and responsive".

Patients and relatives said they were given sufficient verbal and written information about their care and treatment. When they had questions, staff answered these and provided clear explanations.

These findings were supported by the Friends and Family data, which showed the majority of patients, would be extremely likely or likely to recommend the service to a family member or friend.

Good practice

- The trust had developed an 'end of life care education' programme encompassing the five core competencies outlined in the 'national end of life care programme' along with other community providers such as hospice, GP surgeries and care

Summary of findings

homes. All eligible staff from community nursing teams, community hospital teams and palliative care nursing teams were able to attend the training programme.

- The East Berkshire Palliative Care Team arranged 'multi-agency family day' in conjunction with the local hospice three times a year to offer post bereavement support to children and their parents.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The trust SHOULD ensure:

- That advance decisions 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.
- There is formal training for nurses to verify death and the competencies of the nurses who verify deaths is assessed regularly.

Berkshire Healthcare 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

Summary

By safe, we mean that people are protected from abuse and avoidable harm.

We rated safe as good because:

Staff followed the trust's process procedures to report incidents and monitor risks. Services monitored safety information such as healthcare associated infections, pressure ulcers, medicine errors. There was safety information related to workforce and patient experience. Learning from risks, incidents and near misses was shared with staff. Staff described a culture of openness and transparency in responding to incidents and were aware of the additional requirements of the duty of candour in handling incidents.

Infection control protocols were followed. Locations were clean, and had effective infection control measures in place. The environment and equipment were well maintained. End of life care patients who were admitted to community hospitals were cared for in single rooms to provide privacy and there were facilities available to allow relatives to stay with them if needed. Equipment was available for patients in their own homes and delivered promptly. Staff were able to order urgent equipment such as hospital beds or moving and handling equipment for patient use within 24 hours. The syringe driver devices used across the trust were a single model and staff were trained in the use of the medical devices.

Medicines, including controlled drugs (CDs), were safely managed and stored. Emergency medicines were available for use and there was evidence that these were regularly checked. Anticipatory medicines (just in case medicines) were prescribed and obtained in a timely way. There was good liaison with both GPs and out of hour's services around prescription of medicines for end of life care.

Records we reviewed in patient's homes and in community hospitals were completed to a high standard and reflected patients' needs and preferences.

Patients' health and well-being were discussed in detail in handovers and risks were identified. Frequency of visits was changed in response to findings. The teams responded to requests to assess deteriorating patients or their changing needs promptly. 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 that 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 out of hours GP service was used.

Staff had good knowledge about safeguarding patients and they followed relevant procedures to protect adults at risk from abusive situations. Staff were aware of the procedure for managing safety incidents including adverse weather conditions.

Safety performance

- The trust monitored safety thermometer data in relation to care provided to patients at home and in the community hospitals. The NHS safety thermometer was a monthly snapshot audit of the prevalence of avoidable harm that included new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism (VTE) and falls.
- A number of different teams delivered end of life care and therefore it was not always possible to distinguish when safety information related to patients receiving end of life care. The adult community services and palliative care team from September 2014 to October 2015 reported twenty-seven serious incidents. Of these incidents, pressure ulcers accounted for the highest number of incidents. Pressure ulcers in end of life patients were likely to be deemed unavoidable, as reflected in the trust's '
- Staff knew how to report such incidents on the trust's electronic reporting system, to ensure all pressure ulcers could be investigated if the patients were not in the last days of life.
- Individual localities and community hospitals also monitored safety information such as healthcare associated infections, avoidable pressure ulcers. Safety performance data was discussed at the locality and board level. Service improvement plans were discussed with staff.

Incident reporting, learning and improvement

- Staff we spoke with knew how to recognise and report incidents on the trust's electronic recording system. They were able to give us examples of range of reportable incidents such as accidents, pressure ulcers, mediine errors, slips, trips and falls. Staff stated they were encouraged to report incidents.
- All incidents were reviewed by the team lead or ward manager and shared with the locality manager. Staff told us they tried to problem solve locally in response to incidents wherever possible.
- Incidents reviewed during our inspection demonstrated that investigations and root cause analysis took place and action plans were developed to reduce the risk of similar incident reoccurring. We were given an example of an incident related to a syringe driver (these are used to deliver medicines to control pain and other symptoms continuously over 24 hours) at St. Mark's Hospital. Staff had not followed the correct checking and documentation procedure, which had resulted in medicine becoming crystallised within the syringe. Staff had taken immediate actions to rectify the problem and to prevent any harm to the patient. An investigation was carried out and staff given further training on use of syringe drivers and advice regarding the correct documentation procedure.
- Staff told us they received feedback on the incidents they had reported. Minutes of monthly team meetings confirmed the themes of incidents were fed back to staff.
- The sharing of learning from incidents and complaints also took place across the trust via the trust's recently introduced monthly bulletin 'learning Curve'.
- Duty of candour legislation requires an organisation to disclose and investigate mistakes and offer an apology if the mistake results in a severe or moderate level of harm.
- Staff across all the services were familiar with the requirements of the duty of candour legislation. All staff who we spoke with understood the principles of openness and transparency that are encompassed by the duty of candour. Staff were aware of the importance of investigating incidents and potential mistakes. They were aware that the duty of candour now made an offer of meeting with the patient/family and sharing the findings of investigations a legal requirement.

Good

Are services safe?

Safeguarding

- All the staff we spoke with were able to describe what constitutes abuse and were confident in how to escalate any concerns. Staff were able to explain the types of concerns which would result in a safeguarding alert being raised and included concerns relating to children.
- The palliative care team, community nursing teams and inpatient wards had local safeguarding leads that staff could access for support.
- Staff told us they had received training in safeguarding adults and children at risk and were aware of the trust's safeguarding policy. Safeguarding concerns were reported as incidents and any concerns discussed during handover meetings and shared across the team. We saw an evidence of a safeguarding issue which was raised as an incident by East Berkshire palliative care team(EBPCT). Evidence demonstrated investigations and root cause analysis had taken place and action plans were developed to reduce the risk of a reoccurrence.

The percentages of staff who had completed the safeguarding training varied across end of life care services. For example; 100% of staff working in EBPCT had completed the level two safeguarding training as of November 2015. Over 85% of staff in community nursing teams had completed the training as of October 2015 against the trust's target of 85%.

Medicines

- The EBPCT staff did not hold stocks of medicines. They had a system for checking controlled drugs (CDs), these are strong pain killers and sedatives used in end of life care.
- On our inspection we found that anticipatory medicines were prescribed and obtained in a timely way. These are medicines that patients may require near the end of their life to relieve symptoms such as pain and restlessness. The management and ordering of medicines was given priority by the teams. There was good liaison with both GPs and out of hour's services around prescription of medicines for end of life care.
- Medicines in the community hospitals were stored safely, including in locked cupboards or fridges when necessary. Checks on the temperature of medicines fridges were monitored and recorded daily. Medicines required for end of life patients were available in the community hospitals.
- We reviewed the storage and administration of controlled drugs in community hospitals. They were stored appropriately and medicine records were accurately completed. Emergency medicines were available for use and there was evidence that these were regularly checked. The trust guidance on the administration as well as the destruction of unused CDs was followed.
- The trust used one model of syringe driver device. There was a policy and protocol for the use of the device in order to reduce the risk of medicine administration error. Staff had attended training to ensure that they were competent to use this device.
- The community nursing teams had a system in place to check that CDs were being administered to patients correctly. Records of administration were kept when patients were being given medicines by syringe driver.

Environment and equipment

- Community hospitals were designed to keep patients safe, and there was level access for patients in wheelchairs and clear signage. There was controlled entry to community hospital wards to keep patients and staff safe.
- Dedicated facilities for end of life care patients and those close to them were available at West Berkshire Community in the Rainbow unit. There were four patient rooms dedicated to care for patients at the end of life, including accommodation for their relatives.
- There were no beds allocated specifically for end of life care at the other community hospitals we visited. Patients who were approaching the end of their life were admitted to community hospitals and were given a single room as a priority. All these hospitals provided 'quiet' rooms for communication with patients and relatives.
- Community hospitals had sufficient moving and handling equipment to enable patients to be cared for safely. Equipment was maintained and checked regularly to ensure it continued to be safe to use. Labels on equipment indicated when the next service was due.

Good

Are services safe?

- There were suitable arrangements for the handling, storage and disposal of clinical waste, including sharps in wards and home environments.
- Ward staff told us they had good access to equipment needed for pressure area care. Pressure relieving mattresses were hired and delivered by an external equipment provider and were available within 24 hours.
- An external supplier provided equipment for patients to use in their own home.Priority was given to getting equipment to end of life care patients. Staff were able to arrange for same day/urgent delivery of equipment for patients who were returning home for their end of life care.
- All staff working across end of life care services used the same model of syringe driver. Training in the use of the syringe driver had been delivered to 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 and community hospitals.

Quality of Records

- There was a combination of paper and electronic patient record systems. A minimal set of paper records were kept in the patients' home with key information recorded such as care plan, skin monitoring forms and consent forms. These were scanned into the electronic record when completed.
- Records we reviewed in patient's homes and in community hospitals were completed to a high standard. Hand written care plans reflected the needs of patients and were personalised to reflect their preferences. They reflected patient's current care and were completed or updated after each appointment with the community nurses.
- The trust was conducting a monthly audit to review the quality of records in the East Berkshire palliative care team The team's compliance was high on most of the audit outcomes (May-October 2015). Action plans were developed and implemented to address the areas where improvements were identified; for example; on distributing service information leaflets to patients and their relatives.

Cleanliness, infection control and hygiene

- The locations we inspected were clean, and with effective infection control measures in place.
- We observed a high degree of compliance with hand hygiene, isolation procedures and the correct use of personal protective equipment (PPE), such as gloves and aprons. Staff adhered to the trust 'bare below the elbows' policy in wards and home environments.
- Hand washing facilities and hand sanitiser gel were available throughout the ward areas. We observed staff using portable hand sanitiser gel before and after patient contact during home visits.
- Staff told us that they had completed infection control training, and were able to tell us about precautions taken to prevent and control the spread of infection in community. The percentages of staff who had completed the infection control training varied across the end of life care services. The data provided by the trust demonstrated that overall,93% of staff had participated in training on infection control and prevention.

Mandatory training

- Mandatory training covered a range of topics including fire safety, health and safety, basic life support, safeguarding, manual handling, hand hygiene, communication, consent, complaints handling and information governance training. Staff told us they were up to date with their mandatory training. Staff received an electronic reminder when the training was due.
- The data provided by the trust showed us that the staff working in EBPCT 99.5% compliant with mandatory training as of November 2015.
- 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 who delivered end of life services.

Assessing and responding to patient risk

- Risk assessments were undertaken for patients at end of life in relation to venous thromboembolism (VTE), falls, malnutrition and pressure ulcers. These were documented in the patient's records and included actions to mitigate any risks identified. Where the mitigating treatment was not indicated because of 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.

- Incidences of pressure ulcers were monitored and investigated. Where there was deterioration in a pressure ulcer, the causes of this were reviewed and actions were put in place to prevent further deterioration and new occurrences. 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 encouraged to refer to the 'skin changes at life's end' (SCALE) document' guidance on the trust intranet. This guidance reminds staff that some skin damage is thought to be unavoidable in a patient in the last days of life. The repositioning of a patient was not carried out if this caused the patient pain or distress. Repositioning might be done less frequently or not at all if this was the wish of the patient or their relatives.
- In the community hospitals, nursing staff used the national early warning score (NEWS), to record routine physiological observations such as blood pressure, temperature and heart rate. 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 in a community hospital setting could access medical care out of hours. Staff who were concerned about the deterioration of a patient could obtain medical advice from the out of hours GP service.Most patients we observed in both settings had anticipatory medicines prescribed; these were medicines to give relief from pain or other symptoms in the last days or hours of life. They were often delivered by a syringe driver and needed to be available when the patient required 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. This would ensure that there were no delays to the administration of medicines when the patient needed them.
- Staff at the East Berkshire palliative care team (EBPCT) were able to seek advice about symptom management 24 hours a day from on call palliative care consultants who worked at the local NHS Hospital.
- There was good guidance in place for staff on advance care planning but awareness of this was limited. The trust had recognised staff required further education in end of life care to include advance care planning.

Staffing levels and caseload

- The trust employed specialist palliative care nurses in EBPCT who provided end of life care service in East Berkshire with support from community nurses and other providers such as hospice nurses and domiciliary care agencies. End of life care service in West Berkshire was mainly provided by community nurses and intermediate care team with support from other providers, for example, hospice nurses. Community nurses provided seven day working from 8:30am to 4:30pm.Outside of these hours the out of hours nursing service would visit patients if required. This was to ensure continuity of care for patients 24 hours a day. Care for end of life patients was included in the daily caseload of visits for community nurses.
- The staffing for community nurses and intermediate care varied across the different localities. The data provided by the trust demonstrated that as of October 2015,the vacancy rate for community nursing service was more than 10% in three out of six localities. The vacancies or sicknesses were covered by bank or agency staff.
- Community nurses told us visits to patients who were receiving end of life care always took priority over other visits, for example, wound care. If they had a member of staff go off sick, they would review their workload for that day and move visits if necessary.
- The EBPCT was almost fully staffed with one full time nursing vacancy. This service offered a seven day service across East Berkshire.
- We found that staffing levels were appropriate for current need and requirement in community hospitals. Most staff at all grades across community hospitals we

Good

Are services safe?

visited told us that the staffing levels felt sufficient and, although there were some vacancies, they were managed effectively with the help of trusts' own bank staff. This ensured staffprovided safe care.

- A doctor employed by the trust or allocated GPs, provided general medical cover for the community hospitals. For example, in West Berkshire Community Hospital medical cover was provided between Monday to Friday, 9am to 5pm, by a doctor employed by the trust who was experienced in palliative and end of life care. Out of hours, medical cover for community hospitals was provided through the out of hours GP service.
- The EBPCT was supported once a week by a GP employed by the trust who assessed and reviewed needs of complex patients and offered advice.

Managing anticipated risks

- Community teams had contingency plans in case of adverse weather conditions. Staff also received email alerts if there was a weather warning. Patients were categorised by need, this ensured that in the event of major disruption those requiring the most urgent care, such as patients receiving end of life care, were prioritised.
- Staff told us that they had developed good links across the community services, which enabled support to be given in case of adverse weather and had access to four wheel drive vehicles that would help get them to patients' homes.
- Staff in the community hospitals told us during bad weather they would get to their nearest hospital to work if possible. Staff said they would ensure there were extra supplies of food, drinks and medicines if bad weather was anticipated so they could continue to meet patients' needs.

Good

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 rated effective as 'good' because:

Staff provided care to patients based on national guidance, such as National Institute for Care Excellence (NICE) guideline on 'end of life care in adults and the priorities for the 'five priorities for the care of the dying person'.

The trust's end of life care steering group had recently developed and implemented a new end of life care plan (September 2015) and 'care of the dying' policy (December 2015) The new care plan supported implementation of the priority of care (One Chance to Get It right 2013).

Patient outcomes were monitored by individual services and information about these outcomes was included in the trust's clinical governance reports. Staff had access to specialist training courses and had appraisals.

The trust was contributing data about palliative and end of life care to the national minimum data set (MDS).The community hospital teams and community nursing teams had participated in internal audits such as falls prevention and management, national early warning score (NEWS), hand washing and care planning. Action plans were developed and implemented following the outcomes for these audits.

Staff worked in multidisciplinary teams to coordinate patient care. The local multidisciplinary team meetings (MDTs) held at GP practices and hospices were well attended by trust staff. Staff felt the multidisciplinary way of working was very strong and effective across this core service. Community nursing staff attended gold standards framework (GSF) meetings with GPs to ensure that they were aware of patients identified as being in their last year of life.

Patients at risk of malnutrition or dehydration were risk-assessed by trained staff. Patients received the nutritional support they needed. Referrals for nutrition and dietetics support had been developed to ensure staff had access to specialist advice. Patients' pain and response to pain relief was appropriately monitored.

The trust used single point of access (SPA) arrangements together with a local hospice to screen referrals into the East Berkshire palliative care service. Staff we spoke with were complimentary about the SPA service and said that this had helped in reducing the response time in delivering end of life care. Discharges from hospitals were managed efficiently, and most were timely to allow the patient to be looked after in their preferred place of care.

Staff were clear about their roles and responsibilities regarding the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. 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 reviewed did not always record an appropriate rationale. The trust had not undertaken an audit of DNACPR documentation and were not aware that the recording of DNACPR decisions were poor.

Evidence based care and treatment

- Patient needs were assessed and care and treatment was 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. For example, clinical staff followed guidance on nutrition support,
- A review of nursing records showed symptom control for end of life patients was managed in accordance with the relevant NICE Quality Standard. This defines clinical best practice for the safe and effective prescribing of strong medicines for relief of pain in end of life care.
- Care after death was managed in accordance with local policies, guidance from the National End of Life Care Programme and the National Nurse Consultant Group (Palliative Care).

Good

Are services effective?

- In September 2015 the trust introduced a new care plan for end of life patients. The end of life care steering group led the development of the care plan and the plan reflected current guidance and best practice, supporting implementation of the priority of Care (One Chance to Get It right 2013). This replaced the Liverpool Care Pathway (LCP), which ceased to be used in England in 2013. The trust had not replaced the LCP until the implementation of the new 'care plan for the dying patient in the last hours or days of life'.
- The new end of life (EOL) care plan was introduced to community nursing team following with training that supported its use. It was introduced to community hospitals in November 2015 and the trust had plans to introduce the care plan to other community services such as intermediate care in January 2016. As the EOL care plan was new, most of the staff we spoke with had not had experience of using it.
- We looked at 10 sets of patient records and found four patients did not have an end of life care plan in place. The trust was conducting audits to determine the use of end of life (EOL) care plan across all the services. The audit conducted September to November 2015 had shown poor use of the care plan across EOLC services. The trust had plans to implement further training for using the care plans across the different settings.
- We found that 'Planning for my future care' which was the advance care plan designed by the trust was not 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. The trust had identified this as a risk and was planning to provide education for staff.
- End of life care patients were provided with individualised and person centred care plans. Care plans that we reviewed, particularly in the community setting, were comprehensive and reflected the patient's needs and preferences.
- Patients who were in the last days of life or in a rapidly deteriorating state were identified in a timely way and their care reviewed. They had their needs of care provided 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 (always include for EoLC and inpatients, include for others if applicable)

- Staff asked patients about their pain and with pain relief given as required at regular intervals.
- All staff were pro-active in managing patient's pain. We reviewed nursing records for patients in the last days of life and saw pain assessments were included in the documentation.
- End of life care pain management guidelines were available for medical and nursing staff with additional support from the East Berkshire Palliative care team (EBPCT). The EBPCT and community nursing teams were also able to request urgent prescription for pain relief medicines from GPs using a fast track referral form. This ensured there was no delay in responding to patient's symptoms as they occurred.
- The nursing staff in the community teams were skilled at ensuring that patients were using their pain relief medicines, and monitoring their effectiveness. If pain was not controlled, this was urgently escalated to the patient's GP.
- We reviewed documentation, which demonstrated that medicines for pain were selected and administered, then after an appropriate time period the effectiveness monitored.
- Equipment was available for starting treatment with a syringe driver, so that anticipatory medicines could be used. Community and hospital nurses said they felt competent to set up a syringe pump for a patient. Support and advice were available for the nursing teams for patients receiving end of life care and pain management.

Nutrition and hydration (always include for Adults, Inpatients and EoLC, include for others is applicable)

- Assessment of a patient's nutrition and hydration status was completed. The community and EBPCT nurses and the community hospital teams used the 'Malnutrition

Universal Screening Tool' (MUST). Any interventions were required these were documented in the patient record. Referrals to nutrition and dietetics ensured patients received the nutritional support needed.

- The new end of life care plan included a detailed assessment on m
- We observed an assessment of a patient's nutrition and hydration status undertaken by a palliative care nurse in a patient's home. The nurse had offered detailed advice to the patient's carer regarding management of the patient's nutrition and hydration status; there were planned actions to follow if there were any signs of deterioration.

Patient outcomes

- The trust was contributing data about palliative and end of life care to the National Minimum Data Set (MDS). The MDS for Specialist Palliative Care Services is collected by the National Council for Palliative Care on a yearly basis, with the aim of providing an accurate picture of specialist care service activity. It is the only annual data collection to cover patient activity in specialist services within the voluntary sector and the NHS in England, Wales and Northern Ireland. The collection of the MDS is important and allows trusts to benchmark themselves against national data.
- The trust was not required to contribute to the Royal College of Physicians National Care of the Dying Audit 2014. The standards of care evaluated in this audit are based on the End of Life Care Strategy (DoH, 2008) and reflect recent national policy guidance. However, the trust had undertaken an audit (July 2015) to review the compliance of end of life care services across the trust against 34 recommendations from 'One Chance To Get It Right 2014'. The Thames Valley Strategic Clinical Network commissioned the audit. The trust had developed an action plan following the outcomes of this audit. We saw implementation of some of the recommendations from the audit during our inspection. For example, following the outcome of this audit, the trust had recently introduced individualised end of life (EOL) care plan and an overarching 'care of the dying adult patient' policy across all EOL services, which reflected five priorities of care.
- The trust was not working towards an independent accreditation standard, within the community hospitals, such as the gold standards framework (GSF), nor were staff using an end of life quality assessment tool. The GSF is a model that enables good practice to be available to all people nearing the end of their lives, irrespective of their diagnosis. Through the GSF, palliative care skills for cancer patients could be used to meet the needs of people with other life-limiting conditions.
- Data from the trust's quality account report for the period between 2014-2015 showed that the community hospital teams and community nursing teams had participated in internal audits such as falls prevention and management, national early warning system (NEWS), hand washing and care planning. Action plans were developed and implemented following the outcomes for these audits.

Competent staff

- There was an induction programme for all new staff and staff who had attended this programme felt it met their needs.
- Staff told us they had regular annual appraisals. As of October 2015,100% of staff within EBPCT had completed an appraisal. For community nursing teams the appraisal rate was over 90%, which was above trust target of 85%.The appraisal rate for community hospital staff was 95%.
- Staff in the EBPCT received a monthly group supervision from a consultant psychologist who was employed by the trust. All the staff we spoke with found these supervision sessions beneficial and told us that they could receive individual supervision sessions if that was requested.
- Hospital nursing staff told us they did not receive formal supervision. Staff however were supervised clinically and felt that handovers and ward rounds provided them with learning opportunities. Therapy staff received regular supervision sessions.
- The trust had developed a competency framework for supporting band 4 staff. This underpinned the development of skills required to deliver high quality end of life care.
- Staff had access to specific training to ensure they were able to meet the needs of their patients. The trust had developed an 'end of life care education' programme

encompassing the five core competencies outlined in the 'national end of life care programme' along with other community providers such as hospice, GP surgeries and care homes. All eligible staff from community nursing teams, community hospital teams and palliative care nursing teams were able to attend the training programme. Staff reported an increased level of confidence in end of life care following participation in this course. This was shown by the course evaluations.

- Palliative care nursing staff attended one-day workshop in 'challenging conversations in EOL care' at a local hospital, along with GPs. They told us that they found this training helpful. The trust provided clinical update training on the use of syringe drivers and medicines used in EOL care. This was attended by staff from community and hospital settings.
- Nursing staff in the EBPCT were encouraged to undertake palliative care degree linked with Oxford Brooks university. We were given an example of a palliative care nurse who was undertaking 'assessment and symptom management' module in EOL care.
- Twenty staff members at the West Berkshire Community hospital had been booked on a distant learning course on caring for patients in the end of life stage via Newbury College. The course was due to start in January 2016.
- The listening in action initiative at West Berkshire community hospital had facilitated rotation of staff on the wards to "upskill" their knowledge and skills in the care for end of life patients.
- Staff we spoke with were positive about the training they received and told us that learning needs were discussed at appraisal meetings, and then within the team leaders group. It was anticipated that learning needs met both service and professional objectives. Staffwere given opportunities to attend conferences and other courses. Stafftold us they felt they had the training to ensure they had the skills required to offer specialist interventions in EOL care setting.
- The trust had an EOL care education lead that had organised several work shops and study days focussing on EOL care. These were designed for staff working within multidisciplinary settings in community. The examples of these included learning disabilities study day and memory clinic workshops.

Multi-disciplinary working and coordinated care pathways

- Community teams based within each locality had a wide variety of staff working in them. This included therapy and nursing staff and some localities were co-located with mental health and social care staff which enhanced joint working.
- Staff felt that integration between community services and various disciplines was good. Staff felt able to consult with colleagues and there was good rapport with ward staff in community hospitals. Specialist nurses and palliative care nurses were available to consult for advice on patient care and this had enhanced communication about the needs and priorities of patients at the end of life. It was described by staff as a collaborative and supportive environment. Staff told us said they didn't feel isolated and worked within a supportive team
- There were good local working arrangements with local hospices. Each team worked in an integrated and multidisciplinary way. The local multidisciplinary team meetings (MDTs) held at GP practices and hospices were well attended by community nurses, specialist palliative care staff, hospice services staff and hospital staff. These meetings ensured excellent communication and coordination of patient care. Staff felt the multidisciplinary way of working was strong and effective across this core service.
- Staff in EBPCT and West Berkshire Community hospital had good links palliative care and oncology consultants who worked at the local hospitals. Patients and families were complimentary about the care received from this service.
- 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 were attended by medical staff, nurses and therapists as

well as social services. There were also excellent links with other providers, such as charities and voluntary organisations to ensure that care for patients was coordinated.

- Community nursing staff attended GSF meetings with GPs to ensure that they were aware of patients identified as in their last year of life.
- The trust had a contract with a Marie Curie service who provided a night sitting service for end of life care patients in their homes. The staff we spoke with were complimentary about the working arrangements with this service.

Referral, transfer, discharge and transition

- The trust used single point of access (SPA) arrangement together with local hospice to screen referrals into the East Berkshire palliative care service. Referrals were reviewed and forwarded to appropriate services from SPA. The purpose of this was to streamline the referral process so that patients received end of life care more quickly. The SPA used the triage tool designed by the trust and the hospice in deciding the appropriateness of the service. Staff we spoke with were complimentary about the SPA service and said that this had helped in reducing their response time in delivering EOL care.
- The system for arranging 'fast track' funding for nursing home placements for patients at the end of life worked well. There were effective 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.
- Discharges from hospitals were managed efficiently, and mostly were timely to allow the patient to be cared for in their preferred place of care. Examples were given of effective co-ordination with the local acute hospitals. In West Berkshire, the intermediate care team provided urgent care support for end of life care patients who were discharged home from acute or community hospitals, as their preferred place of care. In East Berkshire this support was provided by 'hospice at home' service funded by local authority. Sometimes there were delays in being able to discharge patients quickly due to the availability of carers or suitable care home placements.

Access to information

- All of the community services used the same electronic record keeping system to record information about patients. This had enabled the staff to access other teams' records and helped in smooth coordination of care. For example, community nurses and palliative care nurses could access each other's records which kept them updated with patients' condition and requirement of care.
- In community hospitals, patient records were completed on paper. Records were uploaded onto the electronic patient record system upon discharge of a patient. This meant that community nursing and therapy staff were able to access the full hospital record of the patient.
- The record keeping systems used by the acute hospitals and the GP practices were not accessible to the community staff. This meant that community services relied on the information contained in the referral. However, the handover systems between services were effective. For example information was shared between professionals at the GSF meetings.
- Do not attempt cardio-pulmonary resuscitation' (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 the form easily.
- Information needed to deliver effective care and treatment was available to all staff in a timely and accessible way. The trust's intranet had comprehensive information related to palliative care such as relevant guidance, referral forms and the contact details of local palliative and end of life care support network.
- Information leaflets were available to patients and their relatives. These could be translated if required.

Good

Are services effective?

Consent, Mental Capacity act and Deprivation of Liberty Safeguards (just 'Consent' for CYP core service)

- We observed staff explaining procedures, giving patients opportunities to ask questions, and seeking consent from patients before providing care or treatment. Verbal consent to treatment was also recorded in all the patient records that we reviewed.
- Staff were clear about their roles and responsibilities regarding the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DOLs).Staff had received mental capacity act training and various resources were available on trust intranet should staff need more support.
- For patients assessed as not having mental capacity to make decisions, best interest decisions were sought by talking with their family.
- We reviewed 10 DNACPR forms. We found that five patients were not involved in their DNACPR decision and there was no reason documented why they were not involved. On four forms it was not recorded that either the patient or their family was involved in making the decision. The trust had not undertaken an audit of DNACPR documentation and were not aware that the recording of DNACPR decisions were poor.
- The DNACPR forms which were transferred with some patients from the acute hospitals were partly completed and had not been reviewed to ensure they clearly reflected the DNACPR status.

Outstanding ☆

Are services caring?

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

Summary

By caring, we mean that staff involved and treated people with compassion, kindness, dignity and respect.

We rated caring as "outstanding".

Staff involved and treated people with compassion, kindness, dignity and respect. Feedback from patients and their families were consistently positive and included many examples of where staff had gone "above and beyond". All family members, including pets, were supported to visit the hospital. Family and carers could stay at the hospital.

We observed a strong, person-centred culture. All staff were committed to providing compassionate care not only to patients but also to their families, and post bereavement. Patients and their families were truly respected and valued as individuals and were empowered as partners in their care.

The results of the patient survey feedback questionnaire for East Berkshire Palliative Care Team (April 2015-November 2015) demonstrated overall high satisfaction of the patients with the service.

The results of the Friends and Family Test data demonstrated overall that patients would be extremely likely or likely to recommend the service they were seen by to friends or family. This was consistent for all community health services. Feedback comments were positive and highlighted the clinical excellence of staff.

Staff valued and respected the needs of both, the patients and of their families. We saw where patients' emotional, social and religious needs had been taken into account and were reflected in how their care was delivered.

A social worker employed in the East Berkshire palliative care team (EBPCT) offered support, counselling and therapy sessions for children and young adults whose parents were receiving end of life care support.

There was good access to the trust's chaplaincy service for patients and their families. Emotionally, relatives were well supported by staff at the hospital, the specialist palliative care team community teams and the chaplaincy department. At West Berkshire community hospital a holy communion service was held every Sunday. The chaplaincy service offered counsel, pastoral and religious care to patients and their family. Where relatives required further support, additional support was made available via external bereavement and counselling services.

Compassionate care

- Feedback from patients and their relatives was consistently positive about the way staff treated them. All the staff valued the relationship between patients and their family. Relatives repeatedly told us, "Staff go above and beyond" and gave us many examples of compassionate care.
- We found the care, treatment of patients within all services was flexible, empathetic, and compassionate. Staff developed trusting relationships with patients and their relatives. All family members, including pets, were supported to visit the hospital. Family and carers could stay at the hospital.
- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. We observed staff communicating with patients in a respectful way in all situations. Staff ensured confidentiality was maintained when attending to care needs.
- Patients told us "the staff are very caring, friendly and excellent" and staff responded quickly to their needs. We visited patients in their homes with palliative care nurses. All patients we spoke to were positive about the nursing service and local healthcare. We saw evidence ofstrong relationships with palliative care nurses, a high level of trust and appreciation of support provided.
- Patient choice was respected where possible; taking into account a person's culture, beliefs and values. A trusting relationship had been established with the patients and their families. We received a number of positive comments from relatives.
- On a home visit to a patient that had difficulty communicating, we saw excellent holistic care, including psycho-social assessment undertaken by a

palliative care nurse. The nurse demonstrated a good awareness of this patient's needs. The nurse provided good support showing kindness and gave the patient the time they needed.

- Staff in multidisciplinary meetings demonstrated knowledge, skill and a caring attitude towards patients during their discussions.
- The results of the patient survey feedback questionnaire for EBPCT (April 2015-November 2015) demonstrated overall high satisfaction of the patients with the service.
- The results of the Friends and Family Test data (October 2015) demonstrated overall that patients would be extremely likely or likely to recommend the service they were seen by to friends or family.This was consistent for all community health services and community hospitals. Feedback comments were positive and highlighted the clinical excellence of staff.

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.
- None of the patients or relatives we spoke with had any concerns with regard to the way they had been spoken to, and all were complimentary about the way they were treated. Relatives told us that staff communicated to them in sensitive and unhurried way.
- We found that patients at end of life were identified effectively and there were early discussions about their preferences for care. We did not observe advance care planning or decisions in the documentation.
- End of life care plans we saw were individualised to reflect the choices and preferences of the patient. We observed the assessment process used by the palliative care team and how this was used to inform discussions and plan person centred care.
- 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.
- We witnessed several examples of nursing staff explaining to patients and their relatives about care and treatment options and involving them in the care. Time was given to patients and relatives to discuss their concerns. For example, during a home visit we saw that the palliative care nurse took time to discuss the changes in medicines with the relative and ensured there had been understanding of the reasons why.
- Communication training, based on the 'Sage and Thyme' model was provided for staff. The 'Sage and Thyme' model provided evidence based communication skills training to all levels of staff and gave a structured and quick approach for dealing with the concerns of patients and their family.

Emotional support

- Staff offered excellent emotional support for patients and their families. Emotional support was provided to patients and their families through a variety of services, including the voluntary sector. Community nurses and ward staff were able to refer bereaved relatives for support through the chaplaincy service.
- We observed a good assessment of patient's emotional needs during a home visit. One family told us they had received good emotional support and were as well prepared as possible for the final days and hours of their relative's life.
- A social worker employed in the EBPCT offered support, counselling and therapy sessions for children and young adults whose parents were receiving end of life care support. This service was also offered for a few weeks following their parent's death depending on the need. The team arranged 'multi-agency family day' in conjunction with the local hospice three times a year to offer post bereavement support to children and their parents.
- Families were asked for feedback on the service when patient's died. We noted examples of the availability and signposting of counselling services and psychological support where required. There was access to the spiritual support team for bereaved families.
- We found that the support of families, partners or next of kin were always considered. Assessment of carer stress was also reported on regularly and support was offered.
- The chaplaincy service provided support for carers, family, friends and trust staff. Nursing staff reported

good access to the chaplaincy department. Regular prayer meetings were held to support patients individually or as a group, including at the patient's bedside if requested. We observed the chaplain offering comfort to patient's relatives in the communal area in a community hospital. We received positive feedback regarding the service.

- At West Berkshire community hospital a holy communion service was held every Sunday. The chaplaincy service offered counsel, pastoral and religious care to patients and their family. Chaplain visited all new patients daily and offered support including leaflets about service provided and contact with other faiths. There was a multi faith prayer room which took into account the needs of other faiths.

Good

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".

People's needs were mostly met through the way end of life care was organised and delivered.

The trust had audited and were in the process of implementing the standards of the 'one chance to get it right' document. The trust had formed an end of life (EOL) care group to support the delivery of end of life across the trust. The trust also participated in an East and West Clinical Commissioning Group's(CCG) end of life care group which consisted of commissioners, GPs, local hospices.

The community hospitals and community teams delivered patient centred care in a timely way. The trust had made provisions ensuring treatment and support was available to patients and their families 24/7.Trust staff attended the GP gold standards framework (GSF) meetings to ensure that all patients identified as in the last year of life were known to the service.

The needs and preferences of patients and their relatives were central to the planning and delivery of care. 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. There was provision to support the spiritual and emotional needs of patients and their family. The trust sought feedback from patients and used this to develop and improve their services.

Support was available for patients living with dementia and patients with a learning disability. We were given examples of staff working closely with mental health teams and other support services to meet the needs of patients in vulnerable circumstances.

Services were responsive in getting end of life care patients home from hospital quickly. The hospital based palliative care team liaised closely with community teams to facilitate discharges and arrange care.

The trust was monitoring waiting times and referral to treatment times. The information provided by the trust demonstrated that between April 2015 to August 2015, the palliative care team was not consistently meeting their target of contacting new patients within 24 hours. The team had consistently met their target for contacting patients with non-urgent referrals within three days over the same period. Staff from community nursing teams told us patients did not wait for treatment and that referrals were always addressed promptly.

Complaints were handled in line with the trust's policy and were dealt with in a timely manner. Staff were encouraged to be proactive in handling complaints. Staff received feedback from complaints in which they were involved. Patients we spoke with felt they would know how to complain if they needed to.

Planning and delivering services which meet people's needs

- Information about the needs of the local population was collected to inform the commissioners of 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 (EOL) care group, this was made up of representatives of the trust staff. In addition there was trust representation in the East and West end of life care group which was about ensuring that services were planned around the needs of the local population. If community staff or GPs found patients whose needs were not being met, this meeting provided a multidisciplinary forum to discuss and plan ways to remove barriers to providing end of life care for patients.
- The purpose of community hospitals varied across the trust due to commissioning arrangements. There were dedicated facilities for end of life care patients in West Berkshire Community Hospital the 'Rainbow unit'. Hospitals in East Berkshire provided end of life care for patients occasionally.
- However, all the community hospitals provided 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 was used flexibly to ensure that a patient's wishes were met.

- There were facilities in community hospitals to support the religious and cultural requirements of patients the provision of a multi-faith room .The chaplaincy service worked across the trust in order to provide support for patients, families and staff.
- The East Berkshire Palliative care team (EBPCT) ensured that patients and relatives had open access for telephone advice and to call in to request assistance from teams. The team was very well connected with other services including community nursing, local hospitals and hospice. The telephone communications with patients we heard during our inspection were responsive to need and patient centred.
- The trust used feedback from patients and relatives using the service in order to ensure that they were meeting peoples' needs. Examples of improvements made in the service following patient feedback were displayed in community hospitals.

Equality and diversity

- Mandatory training for all staff included training relating to equality and diversity issues. The majority of staff had completed this training and demonstrated an understanding of equality and diversity.
- Translation and Interpreter services were available and staff knew how to access this when needed. These services also included sign language.
- Staff were able to support patients who could not access the services readily. Staff had provided end of life care services to patients in traveller sites and travel lodges.
- All of the services we visited were accessible to patients using mobility aids by use of ramps and /or lifts. Parking facilities for disabled people were available at the community hospitals. Hospital wards were decorated in a way that was suitable for patients living with dementia. The toilet facilities were fully accessible for patients with a physical disability.
- The trust was engaging with local communities by holding various forums and training sessions. For example, the trust had held a forum for Punjabi speaking service users and a group for Punjabi speaking relatives from Slough on power of attorney and future planning in end of life care.

Meeting the needs of people in vulnerable circumstances

- There was support available for patients living with dementia or who had a learning disability, and for staff caring for these patient groups.
- Staff had completed basic dementia awareness training. The inpatient wards we visited had a named dementia champion. 'Dementia care assessment' was incorporated in the patient's initial assessment pack, which assisted staff to meet the needs of these patients.
- Staff told us that specialists could be contacted if support was required when working with patients with a learning disability - there was no barrier to referrals. Staff gave examples of working with a patient with learning disability that included regular input from the mental health team.
- The trust had organised 'memory clinics' in Slough for patients living with dementia. They had also arranged a 'dementia conference' highlighting the importance of end of life care needs in patients living with dementia. Staff had also attended learning disabilities multidisciplinary study days focussing on EOL care and had found it beneficial.

Access to the right care at the right time

- Community staff attended 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 community teams. This meant the nurses could make contact with the patient before they required any input from the nursing team. The community teams we spoke with said that early contact was effective for patients, who were empowered to refer themselves back to the team when they felt ready to accept support. GPs were also involved in the decision for patients to seek help from the community nurses. We were told that GP support in end of life care was excellent.
- Services were responsive in getting end of life care patient's home from hospital quickly. The hospital based palliative care team, which included a clinical

nurse specialist, a nurse consultant in palliative care, and a palliative care pharmacist liaised closely with community teams. Staff told us that sometimes the availability of social services home care led to some people not being able to return to their preferred place of care.

- The trust had not conducted any recent audits on preferred place of care for patients at end of life. Therefore, 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.
- 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 trust was monitoring waiting times and referral to treatment times. The information provided by the trust demonstrated that between April 2015 to August 2015, the palliative care team was not consistently meeting their target of contacting new patients referrals within 24 hours. The team had consistently met their target for contacting patients with non-urgent referrals within three days over the same period. Staff from community nursing teams told us patients did not wait for treatment and that referrals were addressed promptly. The patients we spoke with also told us that the nurses had attended them promptly and they did not have to wait for care.
- The evening and night nursing team service supported end of life care patients overnight between 4:30pm and 8:30am.Patients had open access to this service overnight for pain relief or symptom control.
- Specialist palliative care nursing advice was available to staff and patients seven days a week between 8:30am to 4:30pm.Staff were also to seek advice from on-call palliative care consultants who worked at the local NHS Hospital 24 hours a day, seven days a week.
- The verification of death of a patient was undertaken by a doctor in community settings and in most of the community hospitals. Nurses providing end of life care were not trained in the verification of expected death. 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.
- We were told by the nurses at the West Berkshire Community Hospital that they were undertaking verification of death although they had not received any training. There was no checklist that could help the nurses with death verification. The end of life lead for the trust told us all nurses who verify deaths would be receiving formal training in January 2016. A verification policy was being developed by the trust at the time of inspection.
- The community nurses and palliative care nurses 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

- The end of life care services monitored both complaints and concerns. Complaints relating to end of care were received infrequently. The data provided by the trust for the months April 2015 to June 2015 listed three complaints in respect of end of life care services.
- Complaints were dealt with in a timely manner, and staff were encouraged to be proactive in handling complaints.
- Complaints were handled in line with trust policy; staff showed us that patients were given information on how to complain. The trust had a clear complaints process.
- Complaints leaflets were available at the entrance to ward areas, and also in patient notes, where these were kept in patients' home. Patients we spoke with felt they would know how to complain if they needed to.
- Learning from complaints was shared at team meeting and at locality and trust level. The trust recently introduced a bulletin, 'Learning Curve', to share learning from incidents and complaints across the trust.
- We were told by the end of life care service leads concerns related to delays in the collection of

Good

Are services responsive to people's needs?

equipment such as beds and hoists, from patients' homes after their death. The trust had made improvements by liaison with the equipment provider to implement same day collection service.

Good

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

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.

We rated 'well-led' as 'Good'.

Although the trust did not have a published end of life care strategy, the service leads had identified priorities around improving the end of life care services across the trust. Staff we spoke with were aware of these priorities and described high quality patient care as key components of the trust's vision.

There were robust governance arrangements in place and we saw evidence where quality, risk and performance processes were regularly reviewed and improved at both local and board level.

The leadership, governance and culture were used effectively to drive and improve the delivery of high quality person-centred care. The leadership for end of life care was strong and empowered all staff to strive to deliver the best possible service. The clinical lead was enthusiastic and proactive in driving forward the end of life agenda for the trust and there was good support from the director of nursing and trust board members. Staff felt supported by their managers.

Patient feedback was collected and used in planning the services. These included patient survey feedback and learning from complaints, as well as proactive work to gather views direct from patients and from their relatives across different community services.

There were high levels of staff satisfaction. Staff demonstrated commitment to delivering the end of life strategy for the trust. Staff were aware of the developments in end of life care and had a good understanding of how to drive the service forward. All the staff we spoke with told us they felt proud of working for the trust and enjoyed working within end of life care. The culture was caring and supportive. Staff were actively engaged and there was culture of innovation and learning.

Service vision and strategy

- The trust had a well communicated set of core values across services. The trust's vision 'The best care in the right place: developing and delivering excellent services in local communities with people and their families to improve their health, well-being and independence' was embedded in staff working for end of life care services. There was no published strategy for end of life care however, there was a written action plan for 'one chance to get it right' which identified priorities around improving the end of life care services across the trust.
- The service leads told us their priorities included supporting more complex patients in community and further developing dementia care for end of life patients across the trust. Further priorities included, developing specialist nursing roles to support end of life care patients with long term condition such as heart conditions and supporting staff in using the newly introduced care plans for end of life patients. Managers were able to discuss this strategy and describe the challenges the trust had in implementing it.
- Staff we spoke with were aware of these priorities and described high quality patient care as a key component of the trust's vision.
- We found some elements identified as service priorities were being implemented. This included work undertaken in dementia care for end of life patients, and training provided to staff in effective use of individualised care plans.
- The end of life care steering group was working towards improving end of life care services across Berkshire by engaging with stakeholders and partners.

Governance, risk management and quality measurement

- The EBPCT and community teams we visited had regular team meetings at which performance issues, incidents, concerns and complaints were discussed. Where staff were unable to attend team meetings, steps were taken to communicate key messages to them.

Good

Are services well-led?

- The EBPCT had a quality dashboard. It showed how the service performed against quality and performance targets. Staff told us that these were discussed at team meetings.
- The community nursing service had a 'scorecard' to collate performance and safety issues which was discussed at locality meetings.
- The end of life core services had a robust governance structure that went from team level to the trust board.
- Community nursing teams and EBPCT had regular meetings where information was shared and issues were escalated to the locality patient and safety quality (PSQ) group which met monthly. The locality clinical directors chaired PSQ. Summary locality PSQ information was provided to the quality executive group (QEG) which was chaired by the chief executive and attended by each locality and clinical director. Minutes of the meetings showed issues were escalated, followed up and feedback provided.
- Formal complaints relating to end of life care were reviewed in a quarterly meeting that occured with the trust's patient experience lead, the deputy director of nursing and the end of life lead.This was shared more locally at team meetings. Minutes of clinical governance meetings showed that patient experience data was reviewed and monitored.
- There was no separate risk register for end of life care. Risks related to end of life care were captured in the community teams' and community hospitals' risk registers. The risk registers also recorded action being taken to reduce the level of risk. The more significant risks were escalated to the trust's risk register where they were reviewed by the trust's executive committee.
- The service did not conduct mortality review meetings for patients that died in community hospitals. However, the after death analysis of patients who died in community hospitals was carried out and presented to end of life care steering group to identify learning for improvement. In the community the GPs led this process with the community nurses, as this was part of the GSF process to identify learning.

Leadership of this service

- Leadership within end of life care was strong, with clearly defined responsibilities for all staff responsible for delivering care. The trust lead for end of life care was enthusiastic and proactive in driving forward the end of life agenda for the trust, and reported good support from the director of nursing and the trust board members.
- All the staff we spoke with felt their line managers and senior managers were approachable and supportive. They were all aware of the service lead for end of life care and reported good access to them and the specialist palliative care team.
- All staff demonstrated a good awareness of developments within the service.
- The trust supported staff to develop their leadership and management skills. For example, staff who were leading the teams were encouraged to be enrol on the trust management course.
- 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.

Culture within this service

- Staff spoke positively and passionately about the care and the service they provided. Quality and patient experience were seen as a priority and everyone's responsibility. There was an open culture in raising patient safety concerns, and staff were encouraged to report any identified risks.
- Front-line staff worked well together, and there was obvious respect between, not only the specialities, but across disciplines. We were told by a junior physiotherapist how they felt welcomed in the team where they had started their rotation a few months earlier. The physiotherapist said they felt very much part of the team and well supported by the team leader.
- 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.

Good

Are services well-led?

- Teams were supportive of each other and aware of the emotional stress of working in end of life care. The handover meetings and supervision sessions were 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.
- There was a lone working policy to support staff working out in the community. There were arrangements for staff to follow including buddying, senior support and a central point of contact to telephone at the end of a shift. Personal equipment was available for staff including personal emergency alarms. Staff working evening or twilight shifts told us they worked in pairs for safety.

Public engagement

- In order to improve services the trust provided to patients in their last days of life and their friends and/or relatives the trust used patients' surveys. It asked them a number of questions about their experience and that of their relative. We were given examples of changes made to the service as a result of this feedback. For example, when a named palliative care nurse for a patient was on holiday, arrangements were made to ring patients or relatives by another member of palliative care team to maintain continuity of care. This was implemented as result of patient feedback on the survey.
- There were examples learning from complaints and more proactive work to gather views direct from patients receiving treatment from different community services such as access to internet andprovision of cooked meals for patients in community hospitals.
- The trust held a palliative care user group to give patients and carers an opportunity to share their views on palliative care services within east Berkshire. The group met twice a year and staff told us that the response to this group was positive.

Staff engagement

- The trust was proud of four consecutive years of improved feedback from staff in the NHS staff survey results. This positioned the trust in the top 20% of mental health NHS trusts. The Friends and Family test results for April 2015 to June 2015 results showed of staff would recommend the trust as a place to work, which was also above the national average of 63%.
- The trust was taking a variety of different opportunities to engage with staff which were also helping the trust to address issues raised in the staff survey. Information was sent to staff regularly by email and newsletter. Staff were encouraged to look at the staff intranet for any engagement opportunities.
- The trust had introduced mobile working for staff who were issued with laptop computers. The staff we spoke with had positive views on the mobile working and thought it gave them flexibility to use different community bases and increased their integration with other community teams.

Innovation, improvement and sustainability

- All staff within end of life services demonstrated a strong focus on improving the quality of care and people's experiences through a range of local and national audits, feedback questionnaires and public involvement.
- The service was forward looking, encouraged innovation to ensure improvement and sustainability of the service. The service leads considered 'safety and quality' as the priority in the cost improvement plans.
- The leaders did not think there were any financial constraints to the service and told us that the budget was available for recruiting staff and developing services.
- Innovation was encouraged from staff members across all disciplines. For example; 'Multi-agency family day' was arranged by EBPCT in conjunction with the local hospice three times a year to offer post bereavement support to children and their parents.
- Staff felt valued by the trust and motivated to provide an excellent service to end of life patients.