York Teaching Hospital NHS Foundation Trust

RCB

Community end of life care

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RCBXD	New Selby War Memorial Hospital		YO8 9BX
RCBL8	Malton Community Hospital		YO17 7NG

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

York Teaching Hospital forms part of the York Teaching Hospital NHS Foundation Trust and provides end of life care services on site and in partnership with Scarborough Hospital and Bridlington Hospital as well as community and hospice services. The community hospitals we inspected did not have any wards that specifically provided end of life care. Patients requiring end of life care were identified and cared for in ward areas throughout the community hospitals and in their own homes with support from the specialist palliative care team and district nurses.

The community wards we inspected were at New Selby War Memorial Hospital and Malton Community Hospital. We also saw people in their own homes and spoke to staff at the Scott Road Medical Centre and to community district nurses and nurses from the community palliative care team. Specialist palliative care was provided as part of an integrated service across both hospital and community teams.

During our inspection we spoke with a palliative care consultant, the lead end of life care nurse, the medical director, director of nursing, specialist palliative care nurses, chaplaincy staff, medical staff, nursing staff and allied healthcare professionals. In total, we spoke with 16 patients, 14 relatives and 15 members of staff.

We visited both of the community wards and people in their own homes as well as district nursing clinics. We reviewed the records of 16 patients who were receiving end of life care and 10 who were in receipt of palliative care.

We viewed seven DNA CPR forms ('do not resuscitate in the event of a cardiac arrest'). Of these, five were appropriately signed and dated and there was a clearly documented decision, with reasoning and relevant clinical information. We reviewed audits, surveys and feedback reports specific to end of life care.

Staff were aware of and had access to the trust's online incident reporting system. We saw evidence of learning from incidents to improve practice. Overall, the standards of cleanliness and hygiene were good and staff demonstrated a good knowledge of procedures for the management, storage and disposal of clinical waste, environmental cleanliness and prevention of healthcare acquired infections. Procedures were in place to ensure that equipment was maintained regularly and fit for purpose.

Community nursing staff reviewed their caseloads according to patient need; end of life patients took priority. Relatives and patients we spoke with talked positively about access to staff. We did not find evidence to suggest that community nurse staffing levels were adversely affecting the quality of patient care.

The trust had removed the use of the Liverpool Care Pathway and replaced it with an 'individualised care plan for the last days of life'. Training in the replacement approach was still being undertaken by the trust. Patients receiving end of life services had their pain control reviewed daily. We saw that care followed the National Institute for Health and Care Excellence (NICE) Quality Standard CG140. The care records we reviewed showed that staff supported and advised patients who were identified as being at nutritional risk.

We saw that the trust had an action plan in place to address areas identified as part of the National Care of the Dying Audit for Hospitals (NCDAH), and that a number of areas had been addressed at the time of our inspection. The care and treatment provided achieved positive outcomes for people who used the service. Patients receiving end of life care were supported by a multidisciplinary end of life care team, which included a specialist palliative care team, consultants, GPs and district nurses.

Community end of life services were caring. Throughout our inspection, staff spoke with compassion, dignity and respect regarding the patients they cared for. All of the patients and relatives we spoke with told us that care was good. They were treated with respect and dignity and felt involved in their care and treatment.

We found that the service had a good understanding of the different needs of the people it served. Services were planned, designed and delivered to meet those needs. We saw that patients were able to dictate both their preferred place of care and preferred place of death through advance care planning. The trust monitored the performance of its end of life treatment and care service.

Summary of findings

The end of life service had a clear local vision to improve and develop high-quality end of life care across the service. Most staff were aware of the trust's vision and strategy; however, this was not fully embedded among all staff. There was good leadership and support from local managers, and most staff felt engaged. However, there was a lack of engagement with senior management. Risk management and quality assurance processes were in place at a local level. There was visible, motivated and committed leadership in terms of end of life care at board and service levels and a number of initiatives were in place to develop services.

Summary of findings

Background to the service

The trust provides a range of acute hospital and specialist healthcare services for approximately 530,000 people living in and around York, North Yorkshire, North East Yorkshire and Ryedale. The trust provides community-based services in Selby, York, Scarborough, Whitby and Ryedale, covering an area of 3,400 square miles.

The aim of palliative care was to achieve the best quality of life for patients and their families who were affected by life-limiting illnesses. End of life care is an important part of palliative care and refers to the care of patients and their families throughout the last phase of their life. This could be a period of months, weeks, days or hours.

Palliative and end of life care services were delivered within people's own homes with access to the acute trust, neighbouring trusts and hospices.

Care was delivered by community GPs, hospital doctors, nurses, community nurses, specialist palliative care nurses, healthcare assistants and allied health professionals.

The teams worked closely with other health professionals in the hospital and community to ensure that all appropriate patients, including those with a non-malignant disease, achieved the best possible quality of life.

Our inspection team

Our inspection team was led by:

Chair: Stephen Powis, Medical Director, Royal Free Hospital, London

Head of Hospital Inspections: Adam Brown, Care Quality Commission

The team included CQC inspectors and a variety of specialists including medical and surgical consultants, junior doctors, senior managers, nurses, palliative care nurse specialist, allied health professionals, and experts by experience who had experience of using services.

Why we carried out this inspection

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

How we carried out this inspection

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

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

'Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit between 17 and 20 March 2015. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

Summary of findings

What people who use the provider say

We reviewed the survey results for the Selby and York Hospital and Community Palliative Care Team Patient Experience Survey for May 2014. This showed positive comments throughout regarding the care received and staff attitude within the service.

Comment cards and letters received from patients were displayed throughout the service and showed positive feedback. Patients we spoke with were also very positive about the care and treatment they received.

York Teaching Hospital 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

There were effective procedures in place to support safe care for patients at the end of life and staff demonstrated a good understanding of reporting procedures within the community end of life care teams

There were good examples of incidents being shared and discussed at both board and end of life care forum meetings so that learning could be identified and used to develop the service. Medicines were provided in line with national guidance and we saw good practice in prescribing anticipatory medicines for patients at the end of their life.

We saw that DNA CPR forms were completed consistently. Of the seven forms we viewed, five were appropriately signed and dated and there was a clearly documented decision, with reasoning and relevant clinical information.

A risk register showed specific risks relating to end of life care and we saw that the trust had adequate equipment and appropriate safety checks in place for end of life care.

Detailed findings

Incident reporting, learning and improvement

- No never events had been reported as occurring within community end of life services within the last year. Never events are classified as such because they are so serious that they should never happen.
- We were told that all incidents were reviewed on a weekly basis by the director of nursing, the chief executive and the medical director and that, if they related to end of life care, they would be passed on to the end of life care lead nurse for review.
- Staff told us about and we saw the 'Nevermore' document that was cascaded to staff and gave information on incidents and learning that had resulted from them.
- Staff were aware of the process for investigating when things had gone wrong. We found that staff were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic system.
- Staff told us that they generally received feedback from incident reports they had made and that incidents were discussed where appropriate at staff meetings. We saw that a section entitled 'compliments and complaints'

had been added as a standing agenda item to the end of life care forum meetings. The end of life care lead nurse would provide feedback on investigations and share outcomes.

- Members of the specialist palliative care team told us that historically incidents had been recorded based on the directorate in which the team sat – in this case the medicine directorate. We were told that recent work had been carried out to redesign the reporting system so that end of life care incidents and complaints would be more easily identifiable.
- Patient stories were taken to end of life care forum meetings and to strategic partnership board meetings. As a result, learning was identified and action taken to improve services for patients at the end of life.

Duty of Candour

- NHS hospitals have a responsibility to inform patients when things have gone wrong and harm has been caused. We discussed the Duty of Candour with the service leads for community services. Service leads confirmed that a prompt had now been added to the trust's online reporting system. Staff could not complete an entry until they had acknowledged the prompt to address Duty of Candour.

Safeguarding

- Most staff had an understanding of how to protect patients from abuse and could describe safeguarding concerns and the process for referring them. Staff described safeguarding incidents they had been involved in and were able to demonstrate a good understanding of the process that had been followed.
- The majority of staff had received safeguarding training within community services. We saw documentation showing that 55% of staff had undertaken safeguarding training and 54% of community staff had undertaken training in safeguarding adults.
- We viewed mandatory training records and saw that all members of the specialist palliative care team had attended safeguarding training at level 1 or 2.
- We spoke with 10 patients and six relatives. No one reported any concerns in relation to safety and people were very happy with the security provided by the ward staff.
- One relative we spoke to in the community said that they were happy with the district nurse service and felt safe with them. The same relative said that the same nursing team cared for their mother, which meant they knew who was coming and already had a relationship with them.
- The district nurse team was using the NHS Safety Thermometer to monitor and analyse patient safety. Both the community wards we inspected were also using the NHS Safety Thermometer, but we found that results were not clearly displayed.
- All staff we spoke with were aware of the trust's reporting systems. They had received instructions on how to report and record incidents and accidents. The staff we spoke with told us that all incidents were reported, no matter how small.
- Most staff said they had received feedback but some said they did not always receive information on the outcome of the incident report.

Medicines management

- We saw that there were systems in place to protect patients against the risks associated with the unsafe use and management of medicines.
- There were appropriate systems for the safe custody and checking of controlled drugs and syringe drivers. On the wards we inspected we saw that all medicines were stored safely, record keeping was in line with the trust's policy, and controlled drugs were managed in accordance with the Controlled Drugs Regulations 2013.
- On the wards we inspected, we saw that a pharmacist reviewed all medication on a weekly basis and a controlled drug audit was undertaken quarterly. We looked at two medical records charts on Fitzwilliam ward and found that they had been completed correctly and had been reviewed by the pharmacist.
- We also saw on the wards that the medicine management team carried out a yearly audit. This audit covered all aspects of medication including ordering, prescribing, storage and disposal.
- During our inspection, we saw that appropriate anticipatory prescribing of medication was in place to control the symptoms of agitation, restlessness, nausea and vomiting. At New Selby War Memorial Hospital we saw that a 'medication as required' drugs chart was in place for the prescribing of anticipatory drugs for a patient who was on the end of life care pathway.
- We saw that the trust used the Palliative Care Formulary 4 (PCF4) fourth edition as guidance for prescribing medicines at the end of life. The specialist palliative care

team provided up-to-date guidance in the form of algorithms and clinical handbooks for use in the community. These were also available to staff electronically via the intranet.

- Nurses within the specialist palliative care team were nurse prescribers or were undertaking the appropriate studies towards achieving this.
- We saw that controlled drugs were stored, administered and recorded in line with the controlled drug guidance and that medicines for anticipatory prescribing for key symptoms were available and accessible.
- We saw medicine care plans, medication administration record (MAR) charts and daily records that recorded meetings and changes to prescriptions. The district nurse team also checked medicine stocks and had a system in place to order medicines. There was evidence of advance planning in place following multidisciplinary team (MDT) meetings, which included medicines.
- During the home visits with the district nurses we saw that there were systems in place to manage medicines effectively and safely. We saw that records were accurate and up to date.
- There was evidence that clear communication was taking place between the district nurse team and the local GPs in relation to medicine management and pain relief.
- A relative we spoke with said that they were happy with the system in place for the management of medicines and pain relief. They told us they worked closely with the district nurse team to plan pain relief for their mother.

Safety of equipment

- We noted that the premises run by the trust were clean and well maintained. There were procedures for the management, storage and disposal of clinical waste and environmental cleanliness and guidance on the prevention of healthcare acquired infections. Procedures were in place to ensure that equipment was maintained regularly and fit for purpose. Staff were provided with information detailing the procedure for equipment repairs and the reporting of faults. There were arrangements in place in patients' homes for the handling, storage and disposal of clinical waste.
- During our inspection, we examined four pieces of equipment on each ward; these included syringe drivers and oxygen monitoring equipment. All the equipment was clean, well maintained and fit for purpose.
- We saw that equipment had been serviced by a competent person and a schedule was in place to maintain the equipment.
- Systems were in place to report and respond to faults.

Records and management

- The service had direct access to electronic information held by other community services, including GPs. However, not all of the community settings had access to the same electronic system: for example, SystmOne was being used in Scarborough but not in the York area. Staff in York had access to the core patient database.
- We viewed the risk register relating to end of life care services and saw that there was a specific area of risk related to data collection and poor IT systems within the community that did not allow for data to be shared across services as required by EPACCS (the evaluation of the electronic palliative care coordination system). Staff had identified this as being a potential risk to patients if information was not readily available and that this could result in patient wishes not being known or shared appropriately.
- Community nursing services had access to the information stored within the electronic care records. This meant that staff could recognise patients receiving end of life services and access the appropriate care promptly.
- We reviewed one care plan on a home visit with the district nurse and a relative and saw that it included a good level of detail, was accurate and was fit for purpose.
- We found that the specialist palliative care team had access to hospital records but that district nurses and GPs did not. Records were therefore not accessible to all professionals involved in the care of the patient. This meant that staff within community services could not access the up-to-date care records of patients receiving end of life services.
- We checked seven DNA CPR forms throughout the wards we inspected and found that there were inconsistencies in two of the seven and in how they were completed. We saw that all decisions were recorded on a standard form.
- We saw that a DNA CPR was in place at a patient's home but there was no reason given for the DNA CPR.
- All of the DNA CPR forms were at the front of the notes, allowing easy access in an emergency, and all were completed in handwriting that was easy to read.

Good

Are services safe?

- The DNA CPR forms were recognised by the community services and were transferable between the acute hospital and the community. This meant that a decision concerning a DNA CPR would be recognised in both sectors without a new form having to be completed.
- At New Selby War Memorial Hospital, we looked at two care records and saw that DNA CPR forms were in place and that they had been signed and discussed with the patient. However, we did see that one DNA CPR form did not have the designation of the clinician written on it, which meant it was invalid.
- We saw that a 'last days of life' document had been put in place to replace the Liverpool Care Pathway; however, we found it was not being used. Staff told us that this was because community GPs were not completing the first part of the document and also because some staff had not had training on how to use the new documentation. One staff member said that she had not received training so felt unable to use the documentation.

Cleanliness, infection control and hygiene

- Overall, we found that the standards of cleanliness and hygiene were good and staff demonstrated a good knowledge of procedures for the management, storage and disposal of clinical waste, environmental cleanliness and the prevention of healthcare acquired infections. During a visit to a patient's home, we observed the nurse sanitising their hands before and after patient contact and wearing aprons and gloves when delivering personal care to the patient.
- We saw that the wards we visited were clean, bright and well maintained. Surfaces and floors in patient areas were covered in easy-to-clean materials that allowed high levels of hygiene to be maintained throughout the working day. We saw throughout the clinical areas that the general and clinical waste bins had foot opening controls and the appropriate signage was used. 'I am clean' stickers were placed on equipment including toilet seats, the resuscitation trolley and the fire evacuation trolley. This indicated that they had been cleaned and were ready to be used.
- We saw that ward and departmental staff wore clean uniforms and observed 'bare below the elbows' rules. We also saw that personal protective equipment (PPE) was available for use by staff in all clinical areas.
- Separate hand-washing basins, hand wash and sanitiser were available in the ward bays. We saw that staff sanitised their hands between patient contacts and wore aprons and gloves when delivering personal care to patients.
- While on both community wards and observing district nursing services, we found that all staff regularly used PPE and followed strict guidelines for their use. We saw staff regularly sanitise their hands before and after providing support to each patient.
- During our inspection, we saw that daily cleaning schedules were in place on both the community wards we inspected. We saw that the cleaner's trolley was well equipped and the cleaning cupboard was organised and well stocked. COSHH (Control of Substances Hazardous to Health) signs were also displayed clearly.
- We saw documentation of audits conducted in 2014 that indicated 100% compliance with hand hygiene across the trust. However, external observation audits on behalf of the infection prevention team had identified that actual compliance was nearer 34% trust-wide.
- A review of the audit tool had taken place to reflect the World Health Organization's (WHO's) 'Five Moments for Hand Hygiene'; trust-wide staff training in using the new tool was completed in November 2014. The WHO's 'Five Moments' define the five key moments for hand hygiene.

Mandatory training

- End of life care awareness training was part of the trust's mandatory training programme.
- End of life care training was incorporated into induction programmes for band 5 nurses, healthcare assistants and junior doctors.
- Syringe driver training for end of life care community services had been completed by between 80% and 100% of staff.
- During our inspection, we did not see a syringe driver in use but did observe a syringe driver and anticipatory prescribing ready to be used. We saw that the appropriate syringe driver documentation was in place.
- The trust target for mandatory training was 75%. Staff we spoke with stated that they had all received the trust's mandatory training and accessed this via e-learning or face to face.

Good

Are services safe?

- Training covered aspects of end of life care including the five priorities of care, symptom management, advance care planning, preferred place of care and spiritual care.

Assessing and responding to patient risk

- We viewed a risk register relating to end of life care. One risk related to data collection and poor IT systems that did not allow for data to be shared across services. Staff had identified this as being a potential risk to patients if information was not readily available and that this could result in patient wishes not being known or shared. This was entered at number 16 on the trust's risk register and the trust was in the process of discussing this at board level.
- End of life care teams were well placed within the localities they served. There was routine engagement by the teams providing end of life care services within the trust as well as with external organisations such as the hospitals, GPs and local hospices, so staff were kept informed and could make arrangements for patients who were awaiting referral for end of life care services. Patients were triaged and assessed accurately so that safe treatment and care were provided in order to guard against risks associated with their condition. Risk assessments in areas such as falls, pressure care and nutrition were complete and updated as the patient's needs changed.
- Contingency plans were in place to respond to major events, such as outbreaks of flu or winter weather affecting staff members' ability to travel.

Staffing levels and caseload

- Throughout community end of life services, we were told of concerns regarding the number of staff available to deliver care and treatment effectively. Staff reviewed their caseloads according to patient need and end of life patients took priority. To ensure safe levels of staffing, staff worked extra shifts. Relatives and patients we talked with spoke positively about access to staff.
- We visited two community wards and found the staffing levels to be appropriate. However, staff noted an issue concerning nights, when there was only one qualified nurse on duty. This had been highlighted by staff to the trust. We spoke with the trust about this and they provided evidence that they had listened to the staff and considered the issue. As a result, they had increased the minimum level of qualified nurses to two. We saw that this was due to start the week following our inspection.
- We completed observations during our visit to both wards and saw that, although they were busy, staff coped well with the workload and people were well cared for.
- We saw that staffing for the community palliative care team was entered on the trust's risk register as risk number 9. The team had been reduced due to staff leaving; however, staff were working extra hours to mitigate this risk.
- Specialist palliative care nurses were available from 8am to 4pm, Monday to Friday. There was no on-call specialist palliative nursing cover out of hours.
- We viewed the risk register relating to end of life care services and saw that there was a specific area of risk relating to staffing in community palliative care services and that staff were working extra hours to ensure patient safety.

Managing anticipated risks

- The trust had a risk register that identified the risks within community services. The trust board assurance framework enabled the trust to have an overview of risks that could affect the safe running of patient services.
- All the staff we spoke to were aware of the risk register and how to report risks accordingly.

Major incident awareness and training

- The trust had a major incident plan in place. We spoke with both ward managers within the community hospitals; they were aware of the trust's major incident plan and business continuity plans, which the trust had in place to ensure minimal disruption to essential services. Team leaders were aware of their roles should the trust declare a major incident and described how the teams would expedite patient discharges to create capacity within the acute trust.

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

The trust had removed the use of the Liverpool Care Pathway and replaced it with an 'individualised care plan for the last days of life'. Training in the replacement approach was still being undertaken by the trust.

Patients receiving end of life services had their pain control reviewed daily. We saw that care followed NICE Quality Standard CG140. The care records we reviewed showed that staff supported and advised patients who were identified as being at nutritional risk.

We saw that the trust had an action plan in place to address areas identified as part of the NCDAH, and that a number of areas had been addressed at the time of our inspection.

The care and treatment provided achieved positive outcomes for people who used the service. Patients receiving end of life care were supported by a multidisciplinary end of life care team, which included a specialist palliative care team, consultants, GPs and district nurses.

Detailed findings

Evidence-based care and treatment

- In all the areas we inspected, staff followed guidance set by the Gold Standards Framework (GSF). This was a way of working that had been adopted by patients and all the healthcare professionals involved in their care. We saw staff working together as a team and with other professionals in hospitals and hospices to help provide the highest standard of end of life care possible for patients and their families.
- We saw that end of life care documentation included national guidance from sources such as the Leadership Alliance for the Care of Dying People, the Department of Health End of Life Care Strategy and NICE.
- An internal audit of the 'last days of life' care plan had identified changes to improve the document following discussion with staff who had used it.
- The amber care bundle had not been implemented in community end of life care services. The amber care bundle is a tool used to help identify people in the last months of life so that they can be involved in open discussions and care planning about their future care.
- Staff we spoke with told us that changes in the specialist palliative care team meant that progress had been delayed on further embedding and expanding the use of the amber care bundle, but that now the team was more established this work would be taken forward.
- The Liverpool Care Pathway (LCP) had been phased out nationally by July 2014 and staff we spoke with in the community told us that it had not been used since then. However, staff also told us that the documentation that had replaced the LCP – 'last days of life' – was not being completed because GPs, were not filling in the first part of the document. In addition, some staff had not received training or felt that they needed more training on completing the documentation accurately.

Pain relief

- There were appropriate systems in place to protect patients against the risks associated with the unsafe use and management of medicines on the wards we visited and for patients who were at home. Staff followed clear guidelines for prescribing medicines for patients receiving end of life care. Records showed that anticipatory planning was undertaken to reduce the risk of escalating symptoms. Appropriate systems for the safe custody and checking of controlled drugs and syringe drivers were in place and reduced the risk of inappropriate use.
- During our inspection, we did not see a syringe driver in use but did observe a syringe driver and anticipatory prescribing ready to be used. We also saw that the appropriate syringe driver documentation was in place.
- Patients receiving end of life services had their pain control reviewed daily. Regular pain medication was prescribed in addition to 'when required medication' (PRN or pro re nata), which was prescribed to manage any breakthrough pain. This is pain that occurs in between regular, planned pain relief. We saw that care followed NICE quality standard CG140. This quality

standard defines clinical best practice in the safe and effective prescribing of strong opioids for pain in the palliative care of adults. We saw that a PRN drugs chart was in place for the prescribing of anticipatory drugs for a patient.

- We saw that all patients had their pain relief reviewed regularly by clinicians. The pain records were clear and information was clear and easy to read. All records had been shared with the patient or their family.
- Patients we spoke with told us that staff had discussed pain relief with them and they understood what they were taking and the effect the medicine would have.
- On a visit to a patient's home, we spoke with a relative; due to their ill health, the patient was unable to talk to us. The relative told us that when their mother first left hospital they were worried that the pain management was not right. They told us that they shared their fears with the district nurse who came out and did not leave the patient's home until the correct pain management for the patient was in place. The relative explained that this demonstrated a commitment by the district nurse team to provide high-quality care and, in this case, pain relief.

Nutrition and hydration

- On Fitzwilliam ward and in people's homes, we saw that patients' nutritional risk score had been completed appropriately.
- The care records we reviewed showed that staff supported and advised patients who were identified as being at nutritional risk.
- We saw the malnutrition universal screening tool (MUST) score being used. This is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition or obese. It also includes management guidelines that can be used to develop a care plan. It is for use in hospitals, the community and other care settings and can be used by all care workers.
- All the patients we spoke with said that the food at both community hospitals was good and there was plenty of fluid on offer.
- Where people were unable to eat due to their ill health, we saw that care plans were in place for staff to monitor their food and nutrition.

Outcomes of care and treatment

- The care and treatment provided achieved positive outcomes for people who used the service. The patients and relatives we spoke with indicated that they were happy with the services provided.
- Patients receiving end of life care received support from a multidisciplinary end of life care team, which included a specialist palliative care team, consultants, GPs and district nurses. In accordance with the GSF, multidisciplinary team meetings took place weekly to ensure that any changes to patients' needs could be addressed promptly.
- We were told by the trust that it was in the process of developing the amber care bundle to be used within community services. The care bundle enabled patients to receive consistent information from their healthcare team. It helped patients and their relatives to be fully involved in making decisions and knowing what was happening with their care, and it helped staff realise when they should talk with patients about the treatment and care they would prefer. By having conversations about preferences and wishes and ensuring that everyone involved was aware of care plans, patients were more likely to have their needs met.
- The end of life care teams engaged with external services such as social services. This allowed staff to provide holistic care and ensure that patients received an effective service.
- Patients received care and support from a variety of sources, including consultants, nursing staff, GPs, district nurse teams and a specialist palliative care team that also employed Macmillan nursing staff.
- Patients told us that they were involved in any decisions made and that staff looking after them communicated with them. They also told us that their wishes were taken into account. For example, one person had expressed the wish to die in hospital and we saw that the hospital had facilitated this.
- We saw that the end of life care teams also liaised closely with local authority social workers.

Competent staff

- Key members of the specialist palliative care nursing team were identified as leads in specific areas of end of life care; these included implementation of the 'last days of life' care plan, advance care planning, and implementation of the amber care bundle.

Good

Are services effective?

- The specialist palliative care team provided training and education programmes for ward- and community-based nursing staff within the trust. Since 2014, end of life care had been mandatory as part of the trust induction programme. The palliative care team had developed an additional one-day end of life care training session for nursing.
- Staff received training via e-learning as well as face to face. Staff we spoke to were positive about the training they received. They demonstrated a good knowledge of safeguarding, infection control and mental capacity assessments. They understood how to support people to make decisions for themselves and how to achieve this decision-making. However, not all staff we spoke with on the community wards had received specific end of life training.
- Staff had all received an annual appraisal but there was no system in place for regular supervision of staff.
- There were end of life resource folders kept on the wards and in clinical areas. These provided staff with information on where they could obtain additional support or advice and details of aspects of symptom management and care at the end of life.

Multidisciplinary working and coordination of care pathways

- A member of the specialist palliative care team attended the community multidisciplinary team meetings, which took place each week. This provided them with an opportunity to review all current cases and share experience or ask for advice.
- The community teams did not have effective data collection or data-sharing systems in place. This meant that staff were not able to record and share information necessary to ensure that the ongoing needs of the patient were met and decisions about the patient's care could not be accessed widely.
- The specialist palliative care team worked closely with GPs, district nurses, consultants and social services. People were provided with the contact details of the teams.
- The specialist palliative care team employed Macmillan nurses who coordinated end of life care for people on the end of life care pathway. They also visited both community wards weekly and provided support to patients, relatives and staff.

Referral, transfer, discharge and transition

- Staff told us that patients were referred to end of life care services through a number of routes, including GP or consultant referral, or they could visit local hospices or self-refer. The service actively used the GSF to plan the right care for people as they neared the end of their life.
- There was a rapid discharge service, hospice at home, which was available in York from 8am to midnight and 24 hours a day in Scarborough. In Scarborough, there was access to nurse-led beds to offer patient choice if returning home was not an option.

Availability of information

- Patients and relatives we spoke with told us that they were provided with all the information required to make decisions about their care and treatment.

Consent

- Patients and relatives we spoke with told us that staff did not provide any care without first asking their permission.
- We saw an example where a member of staff asked the consent of a patient before helping them with their medicine.
- Staff demonstrated a good knowledge of mental capacity and how to enable people to make decisions for themselves. Staff told us that they had received training in mental capacity and dementia care.

Good

Are services caring?

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

Summary

Community end of life services were caring. Throughout our inspection staff spoke with compassion, dignity and respect regarding the patients they cared for.

All of the patients and relatives we spoke with told us that care was good. They were treated with respect and dignity and felt involved in their care and treatment.

Detailed findings

Dignity, respect and compassionate care

- We observed throughout our inspection in the community hospital and in people's homes that staff spoke with compassion, dignity and respect regarding the patients they cared for. This was in accordance with the national End of Life Care Strategy (Department of Health, 2008).
- We observed staff speaking with patients and providing care and support in a kind, calm, friendly and patient manner. Patients and relatives told us that they were treated respectfully by staff and commented positively about the care received.
- We spoke with the relatives of a patient who was receiving end of life care; the relatives described the excellent support received from the nursing and medical staff.
- We saw that all end of life care patients were placed in side rooms on the wards unless they requested otherwise. This provided privacy for the patient and their friends and relatives. We also saw that facilities were available for families to stay with their loved ones should they wish to do so.
- We saw how staff gently supported one patient when they wished to use the toilet and did not rush them.
- At mealtimes, we saw that one person was supported to eat. We again saw that staff were patient and communicated well with this person, which appeared to put them at ease.
- Where staff were assisting people to move, they ensured that people were covered and their clothing was in place; this maintained their dignity.
- We saw a district nurse caring for a person who was at the end stage of their life. The nurse was respectful and extremely caring. The nurse supported the person with kind words and a gentle touch. They were careful when adjusting the person's position and used the correct method for moving the person. Throughout the care intervention, the nurse talked constantly to the person, providing security and treating them as an individual.

Patient understanding and involvement

- All of the patients we saw said that they felt involved in their care and understood what was happening. This was also the case for patients' relatives.

Emotional support

- The specialist palliative care team and community teams supported people emotionally. All the patients and relatives we spoke with valued the support offered by the nursing teams.
- The chaplaincy service provided an on-call service 24 hours a day, seven days a week for patients and their relatives. The chaplaincy service conducted last rites and blessed the deceased as required. The chaplaincy service told us that they provided support in the community and that they would also coordinate with local services so that people could receive the support they needed.
- The chaplaincy service provided multi-faith pastoral and spiritual support, including out-of-hours cover via an internal on-call system.

Promotion of self-care

- Due to the complex needs of patients receiving end of life care services, it was not always possible to promote self-care. However, the patient records we looked at included person-centred care plans based on the individual needs and preferences of patients.
- The trust did not record or audit information on patients who died in their preferred place. This meant that it was unclear how many end of life care patients had had their wishes granted or whether there could be any improvements made or if there were additional training requirements in relation to this.

Good

Are services responsive to people's needs?

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

Summary

We found that the service had a good understanding of the different needs of the people it served. Services were planned, designed and delivered to meet those needs. We saw that patients were able to dictate both their preferred place of care and preferred place of death through advance care planning. The trust monitored the performance of its end of life treatment and care service.

We saw numerous letters and cards expressing positive feedback from patients and relatives about end of life care. Staff were aware of the trust's policy for handling complaints and had received training in this area.

Staff told us that there was active reflective practice and learning following complaints. For example, improvements had been made in facilitating timely patient discharge from hospital as a result of learning from a complaint.

Detailed findings

Planning and delivering services that meet people's needs

- During our inspection we saw that general palliative care was delivered by district nursing services throughout the community in partnership with York hospice at home, York sitting service, hospice beds and Marie Curie. There were also community hospital end of life care beds at Selby, Malton, Whitby and Scarborough
- The trust had developed its own end of life care strategy, identifying key priorities relating to meeting the needs of people in the region. There was an emphasis on areas such as raising awareness of issues relating to death and dying among the local population. One aspect of this that had been identified was the need to develop local initiatives to engage with people during the annual 'Dying Matters' week.
- In response to increasing numbers of referrals to specialist palliative care of patients with a non-cancer diagnosis, the integrated team had worked to develop clinical pathways for patients with specific conditions at the end of their life. Examples we were given included patients with heart failure and patients with chronic obstructive pulmonary disease (COPD).

Specialist palliative care services

- The York Macmillan service was based at St Leonard's Hospice. The team consisted of specialist nurses, allied health professionals and a family support worker. Specialist palliative care beds, day services and bereavement services were provided by St Leonard's Hospice
- At Scarborough hospital, all specialist palliative care services were provided by St Catherine's Hospice.
- Key members of the specialist palliative care nursing team were identified as leads in specific areas of end of life care; these included implementation of the 'last days of life' care plan, advance care planning, and implementation of the amber care bundle.

Equality and diversity

- The specialist palliative care team told us of a traveller family where one member of the family was an end of life care patient. The team was able to facilitate the traveller ending their life in their caravan with the family present.
- Throughout our inspection staff spoke with compassion, dignity and respect regarding the patients they cared for. On one visit to a patient's home we saw that the nurse treated the patient respectfully and with dignity. They were welcoming towards the patient and their relative and supported them in a professional and sensitive manner.
- Staff told us that they had received training in equality and diversity. They demonstrated a good knowledge of how religion, sex, disability or race could impact on the delivery of care to patients and how it formed the basis of their care plans, together with the person's physical and emotional needs.
- The trust had compiled an equality objectives document in compliance with the Equality Act 2010. The document explained the need for the trust to set equality objectives, how the trust was developing these, and progress to date. In addition, the trust produced an annual equality, diversity and human rights report and an equality and diversity strategy. This meant that

Good

Are services responsive to people's needs?

equality and diversity were addressed by the trust; this included all staff working for the trust and the patients being treated in both the acute and the community sectors.

Meeting the needs of people in vulnerable circumstances

- Staff we spoke to said that some patients were admitted due to a lack of care packages in the community. We spoke to one person at the end of their life who said that they had been admitted to hospital because they were not able to get a care package. However, they said that they were very happy with the care they were receiving and wanted to stay in hospital.

Access to the right care at the right time

- Staff identified when people were in the end stages of their life and care planning documents were completed for patients relating to end of life care.
- The care planning involved consultants, nursing staff and the palliative care team. The specialist palliative care team visited people who were leaving hospital, which allowed them to establish a relationship. In many cases the team had visited people on a number of occasions prior to the person's discharge.
- Staff reported problems with social services being able to implement care packages in the community. This sometimes led to end of life care patients not being able to have a timely discharge home.

Complaints handling and learning from feedback

- Reported complaints were handled in line with the trust policy. Staff encouraged patients and relatives to speak to them about their concerns. If a patient or relative wanted to make a formal complaint, staff told us that they would consider local resolution in the first instance. Most staff said that they would refer the patient or relative to the Patient Advice and Liaison Service (PALS) if they were not happy with their care.
- Staff told us that they received few complaints and were unable to recall the last complaint they had received. Across community end of life services we saw many examples of complimentary letters and thank you cards. One relative told us: "I have nothing to complain about; I would tell you if I did."

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

The end of life service had a clear local vision to improve and develop high-quality end of life care across the service. Most staff were aware of the trust's vision and strategy; however, this was not fully embedded among all the staff.

There was good leadership and support from local managers and most staff felt engaged, but there was a lack of engagement with senior management.

Risk management and quality assurance processes were in place at a local level. The end of life service held governance and patient safety meetings and records showed that risks were escalated, included on risk registers and monitored each month.

Across all community end of life services, staff consistently told us of their commitment to provide safe and caring services, and spoke positively about the care they delivered. At a local level all staff felt listened to and involved in changes within their team and spoke of regular involvement in staff meetings.

The trust had a clear vision and strategy for end of life care services and had applied resources appropriately to develop these services as a priority. This had included the appointment of a non-executive director to lead end of life care services. There was visible, motivated and committed leadership in terms of end of life care at board and service levels and a number of initiatives were in place to develop services. These initiatives included the development of non-cancer pathways for patients at the end of life, the development of communication training on DNA CPR discussions, and the development of mandatory training in end of life care for key staff.

Detailed findings

Service vision and strategy

- The staff we spoke with were aware of the vision and plans for the trust and told us that they had attended recent workshops where they had met with a senior member of the management team.
- The end of life service had a clear local vision to improve and develop high-quality end of life care across both acute and community services.
- The trust had an end of life care strategy that had been developed after a review of the key outcomes from the national End of Life Care Strategy (2008), Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (the Francis report; 2013), The Route to Success in End of Life Care – Achieving quality in acute hospitals (2010), More Care, Less Pathway: A Review of the Liverpool Care Pathway (2013) and One Chance to Get it Right: Improving people's experience of care in the last few days and hours of life (2014).
- There was a non-executive director nominated as the lead for end of life care within the trust. We saw minutes of meetings they attended where end of life care was discussed both at board level and with specialist staff at the end of life care forums.
- The senior end of life care team met and produced quarterly reports that were submitted to the executive board to inform them of end of life care issues. The team comprised the lead nurse for end of life care, specialist palliative care consultants, the directorate manager and the non-executive board member.
- A clinical commissioning group (CCG) led the 'end of life care board' that was in operation and was attended by the lead nurse for end of life care. We were told that the board provided the structure for all strategic planning work across the region. A locality board had been developed in York to implement work plans and feed into the end of life care board.
- The trust's strategic objectives for end of life care included increasing public awareness of end of life care, ensuring dignity and respect, minimising suffering, and focusing on patients' needs and preferences.
- We viewed evidence of strategic priorities being discussed at end of life care meetings and saw that these were incorporated into the trust's action plans in relation to developing end of life care services. For example, we saw that a patient story relating to poor communication over an advance care plan for a patient with COPD was discussed at board level. In addition, we saw that training in advance care planning had been

delivered to COPD staff and that a pathway had been developed to identify trigger points when discussions about advance care planning should be initiated with patients with COPD.

- The strategy reflected the recently developed strategy of the Joint End of Life Care Programme Board for Scarborough and Ryedale and the Vale of York CCGs. The latter was formed in 2013 and has members from York Teaching Hospital NHS Foundation Trust, Scarborough and Ryedale and York CCGs, St Catherine's Hospice and St Leonard's Hospice, as well as from the health and social care sectors for Scarborough and Ryedale and York.
- We saw documentation that showed the trust's vision for all end of life care patients. The document stated that the vision was for everyone to have the best possible end of life experience and to ensure that people were treated, wherever possible, as individuals and with dignity and respect, in familiar surroundings, in the company of family or friends (if they wished), with their psychological, spiritual and religious care needs assessed and met, and with pain and other symptoms managed as effectively as possible.
- The NCDAH for 2012/13 showed that Scarborough Hospital was performing better than York. The trust told us that it had three specialist palliative care teams, one each based at York and Scarborough sites and a community York team, operating five days a week from 8am to 4.30pm.
- Out-of-hours services were provided through 24-hour telephone advice from an on-call palliative medicine consultant in the region. At Scarborough, there was access to a telephone advice service run by St Catherine's Hospice.
- There was a rapid discharge service, hospice at home, which was available in York from 8am to midnight and 24 hours a day in Scarborough. In Scarborough, there was access to nurse-led beds to offer patient choice if returning home was not an option.
- We saw documentation showing that there had been 1,250 referrals (total deaths 1,295) between April and November 2014 to the specialist palliative care team, of which 91% related to patients with cancer conditions.

Governance, risk management and quality measurement

- Staff were able to demonstrate how performance was measured in relation to accident and incident reporting. Regular staff meetings were held at which quality was discussed and staff discussed how to improve performance. They understood that there was a risk register in place and knew how to escalate incidents.
- Ward managers performed a variety of audits on both community wards based on patient safety, including audits of health and safety and infection control. Medicines audits were carried out by pharmacists.
- Regular staff meetings were held at which quality was discussed and staff discussed how to improve performance.
- The trust had developed an internal audit programme for end of life care. This included a care after death audit, DNA CPR audits, a last days of life audit and audits of the use of specific medicines for patients at the end of their life.
- Weekly clinical review meetings were held when the specialist palliative care team would meet with allied healthcare professionals and the lead chaplain to discuss patient care and any issues.
- Weekly mortality reviews were carried out. These involved the chief executive, the director of nursing, the medical director and, where appropriate, the end of life care lead nurse. Learning from patients' experiences was shared and cascaded through the end of life care forum, the end of life care board and the end of life care locality meetings.

Leadership of this service

- We saw evidence of good local leadership at ward level and community level with end of life care being seen by ward managers and staff as a priority in terms of quality and meeting patient needs and wishes.
- Staff told us that they thought the middle management structure, including the ward managers, was very good and they were supported by effective leadership. Staff were very positive about their immediate line managers and how well they were supported both professionally and personally.
- Staff told us that they felt disengaged from the senior management team sometimes and did not always feel supported. They told us that, when suggestions were made, they did not always receive feedback.

Good

Are services well-led?

Culture within this service

- There was a consistent commitment by the specialist palliative care team to provide a high quality of care to people across the trust.
- There was evidence that ward staff felt proud of the care they were able to give and that the culture of end of life care was centred on the needs and experiences of patients and their relatives. Staff told us that they felt able to prioritise the needs of people at the end of their life in terms of the delivery of care.
- One of the trust's strategic objectives was to shift the perception that 'death is failure' to one where 'a good death is a successful care outcome'. We viewed training programmes and education materials and saw that the 'last days of life' care plan provided a structure that supported this.
- The community wards were not dedicated to end of life care; they were mixed wards where staff were multi-skilled and not focused solely on end of life care. We saw that, where required, support was provided by the specialist palliative care team.
- The specialist palliative care team in the form of Macmillan nurses attended both community hospitals weekly, or as and when required, and provided support and advice to patients, relatives and staff. This was confirmed by patients, relatives and staff. They also held learning sets with staff on end of life and palliative care. In addition, staff received training in syringe drivers from the trust. The team said that it was available at any time to provide support to people.

Public and staff engagement

- On both community wards we saw that relatives of patients at the end of life were encouraged to participate in the Family's Voices bereavement survey, which asked them to document their experiences of care in the last days of life, although results of the survey were not yet available.
- Staff told us that staff engagement was good. They spoke positively about being able to raise concerns with their immediate managers and to make suggestions for improvements.
- We viewed a strategy action plan that included a plan to raise public awareness of advance care planning. Specific actions included suggested activities to engage with 'Dying Matters' week.

Innovation, improvement and sustainability

- The trust had secured an agreement with St Catherine's Hospice to have access to nurse-led beds for patients who were likely to die within the next seven days. This created choices for patients in the last days of life when the hospice would not normally be an option. This project was recognised as best practice by Hospice UK and had been reported in the Telegraph on 20 January 2015 as a new way of providing care and choice.