Care Quality Commission

Buckinghamshire Healthcare NHS Trust

Wycombe Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Requires improvement
End of life care	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

Wycombe Hospital is one of seven hospitals that form part of Buckinghamshire Healthcare NHS Trust. The hospital is an acute district general hospital and provides a range of elective medical, and surgical services, as well as midwifery led maternity and outpatient services. Emergency services are provided for cardiac and stroke patients.

A comprehensive inspection of the acute services of Buckinghamshire Healthcare NHS Trust was conducted in March 2014. Following this inspection, urgent and emergency care and end of life care were rated as required improvement overall. However, end of life care was rated as 'inadequate' for providing effective services at Wycombe Hospital.

We therefore inspected this urgent and emergency care services and end of life care services as part of an unannounced focused inspection.

Overall, the end of life care services at this hospital 'requires improvement'. However, the service had demonstrated improvement since the last inspection. The ratings from this inspection did not affect the overall ratings for the trust (from March 2014) which was 'requires improvement'

Our key findings were as follows:

End of life care

- Overall we rated this service as 'requires improvement'. This was the same as the previous rating in March 2014. However the service had improved its rating in two of the five domains we inspected in providing an effective and caring service.
- During this inspection we found improvements. Nursing and medical care had improved and patients received better symptom control and anticipatory drugs for pain relief. Patients nutrition and hydration needs were being assessed.
- Patients and relatives gave examples of compassionate nursing care. They felt involved and informed regarding their care and treatment.
- The specialist palliative care team was well led and staff were passionate about improving the quality of services. Staff across the hospital provided good emotional support for patients. The chaplaincy provided one to one spiritual support and worked closely with the bereavement officers to ensure relatives received a sensitive and individual service following the loss of a loved one.
- Records were not always stored securely and in places could be accessed by patients and relatives. Do not attempt cardiopulmonary resuscitation (DNACPR) forms were not consistently completed.
- Patients being taken to the mortuary frequently arrived without any identification wrist bands. Technicians were reliant on a nurse from the ward coming down to the mortuary to identify the patient.
- Staffing levels in the mortuary were not safe. Technicians were often working long hours alone without support and they did not have appropriate equipment for bariatric (obese) patients.
- Patient areas were clean and staff followed infection control practices.
- There were interim care plans in use following the withdrawal of the Liverpool Care Pathway in 2014. However, these care plans, called Hearts and Minds – end of natural life, were not consistently completed to provide holistic care for patients. Staff did not have a clear understanding of end of life care and ceilings of care, which would involve the cessation of all invasive treatments and non-essential medication, were not consistently applied. The trust was working on a care pathway called "getting it right for me" and had involved staff and patients to develop this.
- The trust had participated in the 2013/14 National Care of the Dying Audit – Hospitals (NCDAH) and did not achieve five of their seven key performance indicators (KPI's) but was similar to the England average for most of the clinical indicators of care. Local audit to monitor the effectiveness of services was not well developed.

Summary of findings

- There was evidence of good multi-disciplinary working practices on the elderly care wards, with doctors, nursing staff and allied healthcare professionals working together to ensure that patients at the end of their life were cared for in the correct setting. However, there could sometimes be discharge delays. The trust was still not monitoring patients preferred place of death although rapid discharge was being supported by the specialist palliative care team.
- There was good support from the specialist palliative care team and referrals, once completed, were responded to within 24 hours. Support and advice was available 24 hours a day seven days a week. Training was available for staff in relation to caring for patients at the end of their life.
- The hospital did not have a central register to identify a patient who was on an existing end of life care pathway and this could delay their care and treatment. However, a new electronic record, the Buckinghamshire Care Co-ordination Record was being implemented to ensure that patients who were receiving end of life care were identified more easily.
- Patients at the end of their life were still being moved several times around the hospital despite trust guidelines recommending that patients on the end of life care pathway should not be moved.
- The director of nursing holding responsibility for end of life care at trust board level. A new trust strategy was being developed but communication around this needed to improve. A review of the service had been undertaken and some key areas of work were in progress which included the new care pathway and the treatment escalation plan. A dashboard was being used to monitor some key indicators relating to care but audit to monitor the quality and safety of end of life care services needed to develop. The trust had held engagement meetings with staff and patients to establish how best to move the end of life care service forward.

However, there were also areas of practice where the trust needs to make improvements.

Importantly, the trust must ensure that:

- There is a timely replacement for the Liverpool Care Pathway and all staff follow the current interim policies.
- Staff complete the end of life care plans (Hearts and Minds – end of natural life) appropriately to National Institute for Health and Care Excellence (NICE) guidelines for holistic care.
- All staff consistently and appropriately complete the DNACPR forms and discussions between patients and relatives are recorded in patient records.
- Staffing levels in the mortuary are reviewed to give staff adequate rest time between shifts and to reduce the levels of lone working.
- Mortuary staff have appropriate equipment for bariatric (obese) patients to reduce the risk of harm to staff from inappropriate manual handling.
- Deceased patients are clearly and appropriately identified when being transferred from wards to the mortuary.
- All staff involved in end of life care can identify a patient at the end of life (12 months) to ensure that referrals to the specialist palliative care team are made in a timely manner.

In addition the trust should ensure that:

- Infection control risks, in relation to storing patients' belongings in the bereavement office, are addressed.
- The provision of interpreter services enable patients who do not speak English as their first language to receive the same level of care as other patients at the end of their life
- The multi faith room environment at Wycombe hospital is improved so that the facilitate can accommodate more than two people and can offer privacy for those wishing to pray.
- Communication from senior management teams to all staff providing end of life care to improves.
- Patients who receiving end of life care are not moved unnecessarily between wards.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
End of life care	Requires improvement 	Overall we rated this service as 'requires improvement'. This was similar to the previous rating in March 2014. However the service had improved its rating in two of the five domains we inspected in providing an effective and caring service. During this inspection we found improvements. Nursing and medical care had improved and patients received better symptom control and anticipatory drugs for pain relief. Patients nutrition and hydration needs were being assessed. Patients and relatives gave examples of compassionate nursing care. They felt involved and informed regarding their care and treatment. The specialist palliative care team was well led and staff were passionate about improving the quality of services Staff across the hospital (obese) provided good emotional support for patients. The chaplaincy provided one to one spiritual support and worked closely with the bereavement officers to ensure relatives received a sensitive and individual service following the loss of a loved one. Patients being taken to the mortuary frequently arrived without any identification wrist bands. Technicians were reliant on a nurse from the ward coming down to the mortuary to identify the patient. Records were not always stored securely and in places could be accessed by patients and relatives. Do not attempt cardiopulmonary resuscitation (DNACPR) forms were not consistently completed. Staffing levels in the mortuary were not safe. Technicians were often working long hours alone without support and they did not have appropriate equipment for bariatric patients. Patient areas were clean and staff followed infection control practices. There were interim care plans in use following the withdrawal of the Liverpool Care Pathway in 2014. However, these care plans, called Hearts and Minds – end of natural life, were not consistently completed to provide holistic care for patients. Staff did not have a clear understanding of end of life care and ceilings of care, which would involve the cessation of all invasive treatments and non-essential

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medication, were not consistently applied. The trust was working on a care pathway called "getting it right for me" and had involved staff and patients to develop this.

The trust had participated in the 2013/14 National Care of the Dying Audit – Hospitals (NCDAH) and did not achieve five of their seven key performance indicators (KPI's) but was similar to the England average for most of the clinical indicators of care.

Local audit to monitor the effectiveness of services was not well developed. The trust had acknowledged this gap and audit needed to be introduced.

There was evidence of good multi-disciplinary working practices on the elderly care wards, with doctors, nursing staff and allied healthcare professionals working together to ensure that patients at the end of their life were cared for in the correct setting. However, there could sometimes be discharge delays. The trust was still not monitoring patients preferred place of death although rapid discharge was being supported by the specialist palliative care team.

There was good support from the specialist palliative care team and referrals, once completed, were responded to within 24 hours. Support and advice was available 24 hours a day seven days a week. Training was available for staff in relation to caring for patients at the end of their life.

The hospital did not have a central register to identify a patient who was on an existing end of life care pathway and this could delay their care and treatment. However, a new electronic record, the Buckinghamshire Care Co-ordination Record was being implemented to ensure that patients who were receiving end of life care were identified more easily. Patients at the end of their life were still being moved several times around the hospital despite trust guidelines recommending that patients on the end of life care pathway should not be moved.

The director of nursing holding responsibility for end of life care at trust board level. A new trust strategy was being developed but communication around this needed to improve. A review of the service had been undertaken and some key areas of work were in progress which included the new care pathway and the treatment escalation plan. A dashboard was

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being used to monitor some key indicators relating to care but audit to monitor the quality and safety of end of life care services needed to develop. The trust had held engagement meetings with staff and patients to establish how best to move the end of life care service forward.

Wycombe Hospital

Detailed findings

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Detailed findings

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Background to Wycombe Hospital

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We therefore inspected this urgent and emergency care services and end of life care services as part of an unannounced focused inspection.

Our inspection team

Our inspection team was led by:

Chair: Mike Lambert, Consultant in Clinical Effectiveness, and formerly Emergency Medicine Norfolk and Norwich University Hospital

Team Leader: Joyce Frederick, Head of Hospital Inspections, Care Quality Commission

The team of six included a CQC inspection manager and inspectors. They were supported by specialist advisers which included a palliative care consultant and palliative care nurses. Experts by experience who had experience of using the service were also part of the team. The team was supported by an inspection planner and an analyst.

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 Buckinghamshire Health NHS Trust, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew. We carried out an unannounced visit on 25, 26, and 27 March 2015.

Detailed findings

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 the inspection team observed how staff were caring for people who use the service. We spoke with staff, patients, relatives and visitors.

Facts and data about Wycombe Hospital

Buckinghamshire NHS Trust: Key facts and figures

1. **Context.**

- Around 739 beds (252 Wycombe Hospital)
- Population around 500,000
- Staff: 5,750

1. **Activity**

- Deaths 691 (2013)

1. **Intelligent Monitoring** – priority banding - Recently inspected (March 2015)

1. **Safety**

- 0 never events for end of life care.
- 0 serious incidents - end of life care

1. **Effective**

- National Care of the Dying Audit - 5 out of 7 organisational indicators not achieved; clinical indicators lower, but similar to the England average.

1. **Caring**

- CQC inpatient survey - similar to other truss
- FFT Inpatient : similar to other trusts (above England average overall)

1. **Responsive**

- Data not available,

1. **Well led**

- Staff survey 2014 – overall staff engagement worse 20% of trusts.
- GMC survey :

Emergency Medicine - similar to other trusts.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

End of life care

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Buckinghamshire Healthcare NHS Trust provides end of life care for the acute service over two hospital sites: Stoke Mandeville Hospital and Wycombe Hospital. On the Wycombe Hospital site the specialist palliative care team provides 24 hour support and advice regarding symptom management to patients, relatives and staff who required specialist guidance. There were 691 in-hospital deaths in the trust between April 2013 and October 2013.

End of life care is mainly provided by ward staff on inpatient wards, with specialist palliative care link nurses, consultants and other medical staff available for support when required. End of life care was also supported by other members of the multidisciplinary team: for example, acute oncologists, chaplaincy, clinical nurse specialists and the bereavement office.

This was an unannounced focused inspection to review concerns relating to end of life care service provision following a comprehensive inspection in March 2014. At the previous inspection concerns highlighted related to the availability of medication, adequate levels of nursing staff to provide appropriate care for patients at the end of their life, holistic care planning and the availability of a strategy trust wide, to replace the Liverpool Care Pathway. There were also concerns relating to availability and suitability of equipment and facilities.

During this inspection we reviewed trust policies and procedures, staff training records, audits and performance data. We also looked at computerised records and observed care being provided. We spoke with three patients, four relatives and 27 members of staff, including doctors, nurses, bereavement officers, physiotherapists, occupational therapists, mortuary technicians and members of the chaplaincy.

This report looks at the end of life service provision based within Wycombe Hospital.

End of life care

Summary of findings

Overall we rated this service as 'requires improvement'. This was similar to the previous rating in March 2014. However the service had improved its rating in two of the five domains we inspected in providing an effective and caring service.

During this inspection we found improvements. Nursing and medical care had improved and patients received better symptom control and anticipatory drugs for pain relief. Patients nutrition and hydration needs were being assessed. Patients and relatives gave examples of compassionate nursing care. They felt involved and informed regarding their care and treatment.

The specialist palliative care team was well led and staff were passionate about improving the quality of services Staff across the hospital provided good emotional support for patients. The chaplaincy provided one to one spiritual support and worked closely with the bereavement officers to ensure relatives received a sensitive and individual service following the loss of a loved one.

Patients being taken to the mortuary frequently arrived without any identification wrist bands. Technicians were reliant on a nurse from the ward coming down to the mortuary to identify the patient. Records were not always stored securely and in places could be accessed by patients and relatives. Do not attempt cardiopulmonary resuscitation (DNACPR) forms were not consistently completed.

Staffing levels in the mortuary were not safe. Technicians were often working long hours alone without support and they did not have appropriate equipment for bariatric (obese) patients.

Patient areas were clean and staff followed infection control practices.

There were interim care plans in use following the withdrawal of the Liverpool Care Pathway in 2014. However, these care plans, called Hearts and Minds – end of natural life, were not consistently completed to provide holistic care for patients. Staff did not have a clear understanding of end of life care and ceilings of care, which would involve the cessation of all invasive treatments and non-essential medication, were not consistently applied. The trust was working on a care pathway called "getting it right for me" and had involved staff and patients to develop this.

The trust had participated in the 2013/14 National Care of the Dying Audit – Hospitals (NCDAH) and did not achieve five of their seven key performance indicators (KPI's) but was similar to the England average for most of the clinical indicators of care. Local audit to monitor the effectiveness of services was not well developed. The trust had acknowledged this gap and audit needed to be introduced.

There was evidence of good multi-disciplinary working practices on the elderly care wards, with doctors, nursing staff and allied healthcare professionals working together to ensure that patients at the end of their life were cared for in the correct setting. However, there could sometimes be discharge delays. The trust was still not monitoring patients preferred place of death although rapid discharge was being supported by the specialist palliative care team.

There was good support from the specialist palliative care team and referrals, once completed, were responded to within 24 hours. Support and advice was available 24 hours a day seven days a week. Training was available for staff in relation to caring for patients at the end of their life.

The hospital did not have a central register to identify a patient who was on an existing end of life care pathway and this could delay their care and treatment. However, a new electronic record, the Buckinghamshire Care Co-ordination Record was being implemented to ensure that patients who were receiving end of life care were identified more easily. Patients at the end of their life were still being moved several times around the hospital despite trust guidelines recommending that patients on the end of life care pathway should not be moved.

The director of nursing holding responsibility for end of life care at trust board level. A new trust strategy was being developed but communication around this needed to improve. A review of the service had been undertaken and some key areas of work were in progress which included the new care pathway and the treatment escalation plan. A dashboard was being used

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to monitor some key indicators relating to care but audit to monitor the quality and safety of end of life care services needed to develop. The trust had held engagement meetings with staff and patients to establish how best to move the end of life care service forward.

Are end of life care services safe?

Requires improvement

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

We rated safe as 'requires improvement'

This was similar to the previous rating although some aspects of safety had improved. In March 2014 we had rated safe as 'requires improvement'. At that time, documentation was not appropriately completed and appropriate medicines were not always available for patients.

During this inspection we found that staffing levels in the mortuary were not safe. Technicians were often working long hours on their own without support. Staff were also being placed at risk as there was no lifting equipment for moving bariatric (obese) patients in the mortuary. Patients being taken to the mortuary frequently arrived without any identification wrist bands. Technicians were reliant on a nurse from the ward coming down to the mortuary to identify the patient.

Records were not always stored securely and in places could be accessed by patients and relatives. Do not attempt cardiopulmonary resuscitation (DNACPR) forms were not consistently completed.

Staff were aware of how to report an accident or an incident and changes had occurred as a result. For example a trust wide process has been implemented in relation to syringe drivers, as a result of learning from an incident.

Patient areas were clean and staff followed infection control practices. Changes had been made to how patients were transported to the mortuary to reduce the risk of cross infection. However, the storage of patients clothes in open bags in the bereavement office, continued to pose a risk of cross infection.

Information relating to symptom control was available in the form of line flow charts for symptom management medication. Intentional rounding was carried out every two hours; nurses used this opportunity to assess pain relief, fluid and nutrition and pressure areas. The wards had been provided with lists of anticipatory drugs that were available for patients at the end of their life.

End of life care

Incidents

- There was an electronic incident reporting system. Where staff had reported incidents they were given feedback verbally or by email, which meant they were informed of the outcome from the incident being reported.
- There had not been any serious incidents requiring investigation (SIRI's) reported in relation to end of life care between February 2014 and January 2015. From the data we had received, the trust had reported no incidents for end of life services.
- Staff were learning from incidents. For example, one incident reported that a syringe driver had failed for a patient. Following this, the trust had introduced a new process for syringe driver management. All staff that we spoke to were aware of the new policy and guidance was readily available on wards.

Duty of Candour

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

Cleanliness, infection control and hygiene

- The cleanliness throughout Wycombe Hospital very good. There was evidence of infection control audits in ward areas with an average of 97% compliance.
- Personal protective equipment (PPE), such as gloves and gowns, were readily available and staff were observed using this equipment to try and help reduce the risk of cross infection.
- Infection control guidelines were being followed by staff and policies were readily available both in paper and online. Staff had a good understanding of infection control practices and were observed complying with hand washing procedures.
- The mortuary reported that all patients who were infectious were received by mortuary staff in a body bag. This was a cause for concern previously as patients who were infectious were not always sent from the wards in a protective body bag. This could have led to the spread of infection within the hospital and particularly to mortuary staff. This risk had now been reduced.
- In the bereavement office, there remained a potential risk of cross infection as deceased patients' belongings, which could be soiled, were being stored in cupboards in open plastic carrier bags while awaiting collection from relatives. The specialist infection control nurse had visited the bereavement offices to advise on best practice but the infection risk still remained.

Environment and equipment

- A central register of equipment was held by the trust. An audit had been undertaken over the previous 18 months to ensure that the register was up to date. There was an established planned preventative maintenance programme for all medical equipment. The system could track equipment that could not be found when maintenance or a service was due.
- The trust had taken a risk-based approach to the testing of portable electrical appliances. This was reported to be in line with guidance and meant that some items would be tested annually and other items up to four yearly.
- The mortuary now had sufficient metal gauntlets to conduct a post mortem safely. There had been an accident in the work place involving a mortuary technician at Stke Mandiville Hospital. This was a serious incident (recorded under the Pathology Department responsible for this service), which required urgent treatment and surgical intervention. The gauntlets had previously been requested by staff but had not been provided. Following the accident gauntlets were provided for staff which would prevent similar accidents in the future.
- All mortuary provision for bariatric (obese) patients was provided at Stoke Mandeville Hospital. Bariatric patients who passed away at Wycombe hospital were driven by ambulance to Stoke Mandeville hospital. Relatives would then have to travel to Stoke Mandeville to view their loved one. Staff working in the mortuary at Stoke Mandeville hospital did not have lifting equipment for bariatric patients and staff have to do this manually. Staff were at risk of harm.
- In 2011, the National Patient Safety Agency recommended that all Graseby syringe drivers should be

removed by the end of 2015. There was a policy in place to expedite the trust wide removal of the Graseby syringe drivers and the trust aimed to complete this by summer 2015.

- During inspection we learned that the withdrawal of the Graseby syringe drivers was due to be implemented on the 2 April 2015. The trust told us new drivers were being stored in the hospice prior to the equipment library to ensure that the equipment was not used inappropriately. The trust subsequently told us that the roll out of the equipment was delayed by two weeks to allow for all staff to be appropriately trained.

Medicines

- The management of medicines for patients receiving end of life care had improved since our last inspection. There were online flow charts for symptom management medication and the pharmacists had provided the wards with lists of anticipatory drugs that were available for patients at the end of their life.
- During our last inspection, it was noted as a concern that there were inadequate amounts of sedation available for syringe drivers which meant patients' who were at the end of their life could have faced delays in receiving medication for pain relief. Every ward we visited during this inspection had adequate doses of sedation available for syringe drivers.

Records

- Since our last inspection in March 2014 and in response to the national withdrawal of the Liverpool Care Pathway (LCP) in July 2014, the trust had introduced an interim care plan. It was an adaptation of the 'Hearts and Minds' care plan which was being used for all patients in the hospital and was called 'Hearts and Minds – end of natural life'. All staff demonstrated knowledge of this care plan for patients at the end of life, but its completion was inconsistent and relied upon staff recognising that a patient was on the end of life care pathway. It did not include prompts for recording nutrition and hydration or pressure area management. This information was written in the nursing notes or intentional rounding sheets. New paperwork which reflected a more patient centred care plan was being developed and was due to be piloted on participating wards in March 2015 but this had been delayed.
- The Bucks Coordinated Care Record – the (BCCR) was being developed which would enable patient consented information regarding their medical condition and any Advanced Care Planning to be electronically shared securely across organisations was being rolled out. This would help to ensure that information about the patient's medical diagnosis, advanced care plans and end of life care preferences and wishes would be communicated effectively. Staff were being trained to access this record as part of a patient's admission
- The do not attempt cardiopulmonary resuscitation (DNACPR) forms were inconsistently completed. Two forms out of the14 we observed were completed correctly. The issue with inconsistent DNACPR completion had been noted as a concern during our previous inspection.
- DNACPR forms were being used trust wide and the use was monitored through audit. The August 2014 audit relating to the trusts' compliance in completing these forms, found that overall there had been an improvement in documentation both in the completion of the forms and with the recording of DNACPR discussions between patients and their families, although there was still room for improvement. Other issues related to the verification of DNACPR forms by the responsible consultant, if the decision was made by a junior or specialty doctor. There was a very limited (15%) review of DNACPR decisions. We did not find consistent evidence of discussions with patients' and families being recorded in patient's notes. There was inconsistent completion of DNACPR forms.
- On several wards sites records were not securely stored. There were unlocked trolleys of notes in corridors where relatives, members of the public and patients had access to them. This could cause a breach of confidentiality as the notes were unsupervised in open areas.

Safeguarding

- The trust had a safeguarding leadership team. The chief nurse was the board lead for safeguarding and was supported by a lead at associate director level. The lead for safeguarding adults was supported by a safeguarding nurse based in the Emergency Department and a learning disabilities nurse. A plan was being implemented to introduce safeguarding champions at division level. These staff members would have a training role and work to ensure that staff were kept informed about guidelines and policies.

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- All issues relating to safeguarding were monitored and discussed at the trust's own safeguarding forum meetings held monthly and chaired by the director of nursing. Agenda items included but were not limited to the safeguarding scorecard, patient with learning disabilities, paediatric liaison /duty named nurse pilot, domestic abuse disclosure pathway, accident and emergency delivery improvement plan update, the prevent strategy and serious case review action plans.
- The staff that we spoke with were aware of trust safeguarding procedures and were able to give good examples of their understanding. Staff told us that there were guidelines available online and a safeguarding specialist nurse to contact if they had more complex issues to resolve. Safeguarding training for adults and paediatrics was a mandatory e-learning package. Safeguarding training was available as e- learning and as face to face. Completion of level one adult safeguarding training across the trust was 82%.

Assessing and responding to patient risk

- The National Early Warning Score (NEWS) early warning tool was used to identify deterioration in a patient's condition. There was evidence in patient notes of this tool being used trust wide. Staff were clear about procedures to follow when a patient was deteriorating. Alerting the on call medic at the earliest opportunity whilst continuing with vital sign observations.
- Intentional rounding was carried out every two hours; nurses used this opportunity to assess pain relief, fluid and nutrition and pressure areas. Evidence of intentional rounding being undertaken was observed in patient notes.

Nursing staffing

- The specialist palliative care nurses provided 24 hours care. The wards felt that they provided a good support service.
- On many wards we visited, nurse staffing levels were low. Staff told us that they felt 'stressed' due to the lack of staff and often felt pressured to cover extra shifts on their wards. This would impact on the level of care being provided to patients at the end of their life who may require a greater level of nursing care, particularly to meet their emotional needs.
- Staff told us that a lot of the more senior nursing staff had left the trust and had been replaced by newly qualified or junior nurses. This has led to a poor skill mix on the wards and would impact on patients who may require more specialist care.

Mortuary Staffing

- There was two technicians at Wycombe Hospital..
- Staffing levels in the mortuary at Wycombe Hospital was poor. Staff spent long periods of time lone working and worked over and above their hours. Staff were on call from home overnight on a one week on/one week off shift pattern. Still working a full working day before their night on call. Staff told us that they often worked later than 5pm, sometimes finishing as late as 8pm-9pm in the evening, they were then on call overnight. Often during the night technicians were called out two or three times, they then had to go to work the following morning. There did not appear to be adequate rest periods for staff.
- During periods of annual leave or sickness, the remaining member of staff had to work alone until their colleague returned. Bank or agency staff were not used to cover these absences.
- On visiting the mortuary at Wycombe Hospital , we observed an busy environment, with one mortuary technician on duty.

Medical staffing

- The specialist palliative care team provided on call consultant cover 24 hours a day seven days a week. Junior doctors on the wards told us that the medical cover within the specialist palliative care team was very supportive and they could always contact someone should they need guidance with complex end of life care symptom management.

Are end of life care services effective?

Requires improvement

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 'requires improvement'.

End of life care

This demonstrated an improvement on the previous rating. In March 2014 we had rated effective as 'inadequate'. At this time, we found that end of life care was not being provided in line with national guidance. Patients experienced delays in pain relief and essential nursing care to relieve patient symptoms was not delivered appropriately

During this inspection, we found that processes to improve end of life care were in development. The 'Hearts and Minds – end of natural life' care plan an adaptation of the generic care plan was being used. However, this did not include key aspects that would reflect the holistic approach to end of life care. On some wards, this care plan was filed in the notes with nothing written on it. Work was being undertaken to provide a pathway for adult patients called 'Getting it right for me.' Following a review of the five priorities of care and National Institute for Health and Care Effectiveness (NICE) guidance the new pathway had been developed. The new pathway was about to be trialled.

National guidance in relation to end of life care best practice was available in folders on all the wards we visited. Patient's pain was not assessed consistently but anticipatory medicines were being prescribed appropriately to respond to patient's need for pain relief. Patients nutrition and hydration needs were being assessed. The roll out of the new syringe drivers, which would replace the Graseby syringe drivers, had not been fully implemented. Although there was a clear plan as to how this was to be achieved there was limited knowledge of this in the wards.

Staff could not provide a clear definition of end of life. Some staff felt it to be within the final hours of a patient's life, but did not recognise the 12 month end of life pathway. There was some evidence of ceilings of care in patients' notes although this was not consistent trust wide.

The trust had participated in the 2013/14 National Care of the Dying Audit – Hospitals (NCDAH) and did not achieve five of their seven key performance indicators (KPI's) but was similar to the England average for most of the clinical indicators. Local audit to monitor the effectiveness of services was not well developed. The trust had acknowledged this gap and audit needed to be introduced.

There was evidence of good multi-disciplinary working practices on the elderly care wards, with doctors, nursing staff and allied healthcare professionals working together to ensure that patients at the end of their life were cared for in the correct setting. The daily facilitator meetings (DFM) were not always well supported by staff leading to delays in discharge, although, when required, patients were supported to have an early discharge. Support from the palliative care team was good and referrals, once completed, responded to very quickly.

Support and advice was available 24 hours a day seven days a week. Training was available for staff in relation to caring for patients at the end of their life.

Evidence-based care and treatment

- The trust was in the process of replacing the Liverpool Care Pathway (LCP) which was withdrawn in July 2014. Inpatient ward staff were following best practice guidelines from the specialist palliative care team and referring to the NICE QS13 'quality standard for end of life care for adults when required. This document provided staff with information about providing good end of life care. Most staff told us that they referred to this guidance if they required clarification about a matter relating to providing end of life care to their patients. A replacement for the LCP was being developed, to be published in October 2015.
- There was no evidence of adequate holistic care planning for patients at the end of their life, which was recommended in NICE guidelines QS 13 (3). The 'Hearts and Minds – end of natural life' care plan which was available for staff, was an adaptation of the current generic care plan. However, this document did not include key aspects that would reflect the holistic approach such as, nutrition and fluid intake, pressure area management, pain management and how to recognise a deteriorating patient. On some wards, this care plan was filed in the notes with nothing written on it.
- Work was being undertaken to provide a pathway for adult patients called 'Getting it right for me.' There had been a three phase approach. The first phase had been workshops for staff with an aim of raising the profile of end of life care as well as educating staff about what good end of life care looks like. The second phase was engagement with members of the public and patients. This had led to 11 volunteers forming a group to develop the resource further. Following a review of the

five priorities of care and NICE guidance and with joint working with a staff group the new pathway was developed (the third phase). The new pathway was about to be trialled.

- There was some evidence of ceilings of care in patients' notes. This included the cessation of all invasive treatments and non-essential medication. This was not consistent across the trust. The impact of this was that staff did not know from looking at a patients' notes, what the appropriate treatment or level of care should be to meet the patient's needs.
- New guidelines issued in October 2014 by the British Medical Association, The Resuscitation Council (UK) and the Royal College of Nursing, stressed the importance of resuscitation decisions being part of end of life planning. Involving the patient in treatment escalation plans and focusing on what treatments were appropriate for a patient at a given stage in their illness and as it progressed. The trust had established a group to develop a treatment escalation plan. The new document was about to be trialled on two wards in April 2015.
- The symptom management process, although widely used, was not being evaluated for effectiveness. This meant that patients with more complex end of life care symptoms may not have been managed effectively, with no tool in place to monitor this.
- None of the ward nursing staff whom we spoke with could accurately provide an end of life definition. Believing it to be within the final hours of a patient's life. The General Medical Council's (GMC 2010) definition of patients that are on the end of life care pathway is those who are likely to die within the next 12 months including those who are likely to die imminently.

Pain relief

- Throughout the trust pain assessment tools were not used for end of life care and there was inconsistent assessment of patient's pain. However, intentional rounding was carried out every two hours and nurses used this opportunity to assess pain relief. Intentional rounding was being undertaken and was observed in patients' notes.
- Anticipatory medications were being prescribed appropriately.
- Pain management in end of life care had not been audited to establish whether pain was being managed effectively. The trust management told us that policies were being developed but there were no timescales for this to be actioned.

Nutrition and hydration

- The National Care of the Dying Audit Hospitals (NCDAH) confirmed that 36% of patients on the end of life care pathway received an assessment of their nutritional needs; this was lower but similar to the England average at 41%. The same audit showed that 36% of patients at the end of their life received a hydration assessment; this was lower but similar to the England average of 50%.
- Nutrition and hydration was not reflected on the 'Hearts and Minds Care Plan – end of natural life'. On the intentional rounding sheets, on the wards that participated in intentional rounding, the nutrition and fluid intake for end of life care patients was clearly identified.

Patient outcomes

- There was limited information made available that related to the monitoring of quality and outcomes. The trust was not using the End of Life Care Quality Assessment Tool (ELCQuA) although it had been recognised that an audit tool did need to be used.
- The trust has failed to achieve five of their seven key performance indicators (KPI) in the NCDAH. An improvement plan was in place to ensure that the trust achieved these essential KPI in the next audit.
- The trust figures were below England average for the majority of the clinical KPI's in the NCDAH but the range was not an outlier and this was therefore similar to the England average and other trusts.

Competent staff

- The specialist palliative care team supported the delivery of regular updates on end of life care to all staff on the trust induction programmes, the preceptorship programme, annual and three yearly nurse updates, and medical devices study days. They also taught on the healthcare assistant cancer journey course which was run by the cancer and haematology department. The team had input in the trust's induction for medical staff and 'breaking bad news' training. The trust's intranet

learning and development site referred to the leadership alliance for the care of dying five priorities and stated that the training will support the trust in delivering these priorities.
- Sixty eight staff had completed a palliative care update in the previous three years. There were bespoke modules booked to take place in September 2015 and January 2016.
- Staff were clear that they would refer to the palliative care specialist nurses if they had any queries or required support.
- Specialist palliative care nurses provided support to the hospital wards and there was a consultant available to give support 24 hours a day seven days a week.
- Senior nursing staff told us that all ward and community nursing staff had been given training to be able to operate the new syringe drivers when the Graseby driver was withdrawn on 2 April 2015. They further informed us that ward staff champions would be trained by specialist palliative care nurses and the champions would then go back to their wards to support other staff members on the day of implementation. Our inspection was eight days prior to the implementation date. Nursing staff told us that they had received no training, or training materials and were not aware of ward champions or in some cases, the actual implementation date. The organisation of this project was not cohesive. Staff were under prepared for the implementation date. This would impact on patients receiving medication through syringe drivers to manage their pain effectively in a timely manner.
- Most staff, across inpatient wards had received annual appraisals.This was confirmed by reviewing staff files. According to the information provided by the trust 92% of all staff in the specialist division, of which the palliative care team were part, had a current appraisal.
- The bereavement team frequently dealt with distressed relatives and very sensitive situations but had not been offered any form of supervision or training in relation to this.

Multidisciplinary working

- Daily facilitator meetings (DFM's) were held on wards in the morning and afternoon. This was a multi-disciplinary meeting to look at discharges and to provide a formal handover to medical staff and nurses starting their shifts. Doctors told us that they were not always able to attend these meetings which sometimes led to a delay in decision making. This could delay discharge for patients at the end of their life, who wanted to receive palliative care in their own homes from the community nurses rather than in the hospital environment.
- There was an emphasis on patients being able to go home to be cared for in the community. These meetings were separate from the daily DFM. They also confirmed that support from the palliative care team was very good and that referrals, once completed, were responded to very quickly.
- There was evidence of good multidisciplinary team (MDT) working practices on the elderly care wards. Where doctors, nursing staff and allied healthcare professionals worked together to ensure that patients at the end of their life were cared for in the correct setting.
- A chaplain would also attend multidisciplinary meetings.

Seven-day services

- The specialist palliative care service was available 24 hours a day, seven days a week. Specialist palliative care nurses were available to support patients, relatives and staff. Staff told us that the team were easy to contact, responded very quickly and provided very good support.
- There was a palliative care consultant available during the day on site, and during evenings, overnight and at weekends on call. Medics told us that they also found the consultant easy to contact and valued the support they were given to ensure that patients at the end of their life were able to be given the appropriate treatment 24 hours a day.
- Allied Health Professionals (physiotherapists and occupational therapists) were also available during the day, being attached to individual wards. At night, a physiotherapist was on call for urgent cases.
- Diagnostic imaging provided a service 24 hours a day seven days a week. A radiologist was on call overnight and at weekends for urgent reporting.
- The bereavement service provided support Monday to Friday in the mornings.
- The mortuary team were available Monday to Friday during working hours, with a technician on call overnight and at weekends.

Access to information

End of life care

- All staff had access to information in relation to caring for patients on the end of life care pathway through the specialist palliative care team. There were also end of life care folders on wards and information available on the intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Most staff knew about the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA). Some staff could give clear examples and had received mandatory training in relation to this.
- We identified a concern that would normally be reported under our maternity and gynaecology core service but we have reported here as our inspection did not include this core service. Staff in the bereavement office had identified that the patient's wishes were not appropriately sought in relation to the burial of foetal remains and products of conception. The trust was not following national guidelines for the handling of products of conception. Guidance on labelling, paperwork and the wishes of parents were not followed and there was a risk that hospital burials would occur when parents were expecting to arrange funerals. This had happened on at least one occasion in December 2014 and there were two further unresolved queries by parents.

Are end of life care services caring?

Good

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

We rated 'caring' as 'good'

This demonstrated an improvement on the previous rating. In March 2014 we had rated caring as 'requires improvement'. At this time, we observed staff to be caring and treating patients with dignity and respect but this was not consistent. Patients did not always have the emotional support they required.

During this inspection, we found that in addition to nurses on the general inpatient wards, specialist palliative care nurses provided emotional support to patients within the hospital. Patients and relatives gave examples of compassionate nursing care. They felt involved and informed regarding their care and treatment. Patient's privacy and dignity was observed and relatives receiving distressing news were taken to quiet rooms to discuss matters privately. Relatives told us that they were offered emotional support by nursing staff following their bereavement.

The chaplaincy provided one to one spiritual guidance throughout the trust and worked closely with the bereavement officers to ensure relatives received a sensitive and individual service following the loss of a loved one.

Compassionate care

- We observed kind, supportive interactions between staff and patients. Relatives were treated sensitively and nurses were caring towards those who were distressed.
- The wards used the friends and family test, but this was not specifically designed for patients at the end of their life. The friends and family test survey did not accurately portray patient satisfaction for end of life care provision.

Understanding and involvement of patients and those close to them

- We spoke to patients who were receiving end of life care and their relatives. One relative told us "the care here is excellent; it is good old fashioned nursing care". A patient told us, "you cannot fault the care here, the nurses are wonderful". Overall, patients we spoke to were very happy with the care provided at the hospital and felt involved in the decision making relating to their treatment.They told us that nurses had given them time to talk over any concerns, which made them feel informed and supported.
- Relatives told us that they felt included in all decisions relating to their loved ones care plan and even though some discussions were difficult and sometimes distressing, they were informed and updated at every opportunity.

Emotional support

- The specialist palliative care nurses provided emotional and practical support for all patients at the end of their life.

End of life care

- One to one spiritual guidance was offered by the chaplaincy service. The chaplaincy worked closely with bereavement officers to ensure that bereaved relatives received a sensitive service both on the telephone and in person.

Are end of life care services responsive?

Requires improvement

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

We rated responsive as 'requires improvement'.

This was similar to the previous rating. In March 2014 we had rated responsive as 'requires improvement'. At this time, not all patients were referred appropriately to the specialist palliative care team. Patient had been moved several times during their inpatient stay and patients preferred place of death was not monitored.

During this inspection, staff told us that the hospital did not have a central register to identify a patient who was on an existing end of life care pathway and this could delay their care and treatment. However, a new electronic record, the Buckinghamshire Care Co-ordination Record was being implemented to ensure that patients who were receiving end of life care were identified more easily.

A patient who spoke Polish was in pain and nearing the end of their life was not given access to an interpreter. There was inconsistent use of interpreter services throughout the hospital. There was no information readily available for patients for whom English was not their first language.

The trust was improving its complaints recording process as it currently could not identify any complaints specific to end of life care.

Access to the specialist palliative care service was good, and within 24 hours, when a referral was made although patients were not always identified in a timely way. Patients at the end of their life were still being moved several times around the hospital despite trust guidelines recommending that patients on the end of life care pathway should not be moved. The trust was still not monitoring patients preferred place of death although rapid discharge was being supported by the specialist palliative care team.

The chaplaincy service provided good support to patients, carers and staff and was available 24 hours a day. However, the multi faith room did not provide privacy and was not big enough for more than two people to pray comfortably. The bereavement officers worked closely with the chaplaincy and provided a good service for relatives who had suffered a bereavement

Service planning and delivery to meet the needs of local people

- The trust did not have a system to ensure patients already on the end of life care pathway were identified when they were admitted to hospital. However, the Buckinghamshire Care Co-Ordination Record (BCCR) was being implemented, this was an electronic information sharing record that will enable hospital and community staff to identify and share consented information with each other and other providers. This should ensure that patients on the end of life care pathway will be easily identified upon admission and their care managed appropriately reducing the risk that they would not receive the level of care and treatment they required. Wards had access to the Patient Management System (PMS, an IT system) in which patients on the end of life pathway could be identified but this was sporadic.
- Nursing staff told us that PMS was only used by doctors and nursing staff recorded patient information in patient notes. Therefore it was unclear how these patients would be identified in a timely way.
- Patients at the end of their life were cared for on the wards. Throughout the trust, rooms were available for relatives to discuss difficult or distressing news in privacy.
- There was a single point of access for patients to be referred to the palliative care team. For a referral to be made it was essential that patients were identified and the referral made in a timely manner to ensure that the support could be provided.

Meeting people's individual needs

- Although some staff mentioned an interpreting service, most staff told us that patients for whom English was not their first language were often accompanied by relatives or friends who interpreted for them.
- A patient receiving end of life care on one ward spoke Polish as a first language and no English. It was recorded in the patients' notes that throughout the previous day

and night the patient had been visibly distressed. At no time had an interpreter been sought to speak with the patient to offer reassurance and obtain further information about what was causing the distress. The ward waited for a relative to visit over 24 hours later to assist with interpreting. This individuals needs were not met in a timely way.

- The chaplaincy service provided 24 hour support for patients of all faiths and patients who did not belong to a particular denomination but required spiritual guidance. While the permanent chaplains were of the Christian faiths, they had access to religious leaders from other world faiths as and when they were requested. The chapel and the multi faith room were well presented and open to patients, staff and relatives.
- The multi faith room was very small, only accommodating two people at a time to pray and had a glass panel in the door which did not afford privacy for those wishing to pray.
- The bereavement service had employed three new members of staff. This had made the workload more manageable for existing staff. The bereavement officers responded to the needs of the local community in dealing with the death of a relative and worked in partnership with the chaplaincy team.

Access and flow

- The specialist palliative care nurses were fairly visible on the wards. Some wards knew how to contact the specialists but did not know the name of their palliative care nurse. Palliative care specialist nurse visited twice weekly. Once referred all wards reported waiting no more than 24 hours to see the specialist nurse.
- Of two patients that we tracked, we observed that one patient who was at the end of their life had been moved several times around the hospital. In the patients' notes and after tracking was complete, it was confirmed the patient had been moved four times in a period of only a few days, contrary to NICE guidelines in relation to end of life care provision.
- Discharges back into the community for patients receiving end of life care was often delayed due to the lack of nursing home beds and delays in setting up packages of care with other providers.
- The trust was still not monitoring patients preferred place of death although rapid discharge was being supported by the specialist palliative care team.

Learning from complaints and concerns

- The trust management told us there was not a specific category for end of life care on the electronic system in relation to complaints recording. Trust data on complaints, did not specifically indicate end of life care complaints and no complaints were identified overall. This had now been rectified and the trust has introduced a category for end of life care. There were no examples yet of learning that had taken place as a result of complaints specific to end of life care.

Are end of life care services well-led?

Requires improvement

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 'requires improvement'

This was similar to the previous rating. In March 2014 we had rated well led as 'requires improvement'. At this time, the service strategy was out of date and the trust leadership and monitoring of the service standards needed to improve. The specialist palliative care team was well led.

During this inspection, there was a leadership team for end of life care with the director of nursing holding responsibility at trust board level. A new trust strategy was being developed but communication around this needed to improve. The leadership of the mortuary service was not a visible presence and staff often felt unsupported when they were busy. Staffing in the bereavement office had improved and three additional bereavement officers had been employed to ease the workload for existing staff

A review of the service had been undertaken and some key areas of work were in progress which included the new care pathway and the treatment escalation plan. A dashboard was being used to monitor some key indicators relating to care but audit was required to monitor the quality and safety of end of life care services.

The specialist palliative care team was well led and staff were passionate about improving the quality of services.

End of life care

Staff in the trust expressed a desire to ensure that patients at the end of their life were provided with the best possible care. This was confirmed by the patients and relatives that we spoke with.

The trust had held engagement meetings with staff and patients to establish how best to move the end of life care service forward.

Vision and strategy for this service

- The trust wide strategy for end of life care was about to expire and a new strategy was in development in accordance with new national guidance published in 2014 following the withdrawal of the Liverpool Care Pathway. It was due to be published in October 2015. Patients had been invited to become involved in the review and 11 people had volunteered and the Patient (user) Reference Panel had been formed.
- There was a clear vision to provide individualised patient care, encouraging people to 'live well until we die.' A strap line had been adopted by the EOLC team 'End of life care is everyone's business.'
- The specific aims of the Palliative Care Service were that patients could be seen at any point in their illness (malignant and non-malignant) as an inpatient or an outpatient within the acute, community or hospice setting. To provide access to specialist nursing and medical advice for symptom management; psychological support for patients and relatives/carers; staff support; complex discharge planning (hospital team); information; advance care planning and high quality end of life care in any location through guiding principles for good end of life care.
- Staff across the inpatient wards were not familiar with any vision or strategy for end of life care, but most were aware that there was a strategy being developed.

Governance, risk management and quality measurement

- A score card was used to monitor and report on the quality of the service provided against a number of agreed performance indicators. The score for April 2014 to February 2015 was green (good) across the board for indicators relating to care. These were also discussed at the service delivery unit (SDU) (specialist palliative care) clinical governance meetings. We reviewed the minutes for the last two meetings and saw that the indicators were monitored and discussed at these meetings. Minutes from the general team meeting also showed that this information was discussed.
- An agreement using the Commissioning for Quality and Innovation Framework (CQUIN) was awaited, with an aim of securing improvements in quality of services and better outcomes for patients, while also maintaining strong financial management. This would help to frame the measurement of success.

Leadership of service

- The responsibility for leading and developing the end of life care service for the trust appeared to be with the specialist palliative care team matron, consultant and a project lead. At board level this was the director of nursing.
- Communication between the leadership of the service and the staff on the inpatient wards was not always clear. In relation to the management of the implementation of the new syringe drivers, there were substantial inconsistencies in relation to the understanding at ward level, of when, how and what was happening despite management telling us that all the wards were aware, trained and ready for the implementation. Some senior nurses we spoke with were not aware of the changeover at all. Staff were not aware of the new strategy being developed or timelines for its publication. Some staff and patients had attended the 'One chance to get it right' meeting which looked at improving end of life care, but generally staff who did not attend the meeting were unaware of the outcome of this. The communication of these changes was not cascaded to staff as a whole.
- The matron in the specialist palliative care was described as a good leader.
- The leadership of the mortuary service was not a visible presence and staff told us that they rarely saw their senior manager and often felt unsupported when they were busy. They also had long periods of working alone, with a heavy workload. A third member of mortuary staff based at Stoke Mandeville had left the department and was never replaced.
- Most staff told us that they felt supported by their immediate line managers, but felt disconnected from the senior management team.

End of life care

- Most staff felt that the board were not a visible presence within the trust. Most nurses could not name the chief nurse.

Culture within the service

- Staff within the specialist palliative care service were passionate about end of life care and they worked effectively with ward staff and multi-disciplinary teams.
- Hospital staff described good, supportive working relationships with the specialist palliative care team
- Staff throughout the trust expressed a desire to ensure that patients at the end of their life were provided with the best possible care. This was confirmed by the patients and relatives that we spoke with.
- Some staff reported that they had been told not to speak to the inspection team regarding any concerns they had about the end of life care service. This bought into question the openness and transparency of the trust.

Public and staff engagement

- Staff and patients had been heavily involved in looking at improving the end of life care service. Meetings had been held to encourage both groups to contribute to ideas for service development.
- A working group, that involved patients and the public, had been initiated as a response to these meetings.

Innovation, improvement and sustainability

- The end of life care project lead had been employed by the trust to review the end of life care service. They had given a presentation to the trusts assistant chief nurse in January 2015. This out lined the progress of the project and the approach that had been taken in creating the tools to support the service. Areas of improvement which had been identified included identification of people at the end of life, effective person centred care planning which encompassed a holistic assessment of need, high quality, evidence based care and symptom control management 24/7 and public and clinic engagement in developing end of life care at the trust.
- The specialist palliative care consultant had been the lead in developing a new do not attempt resuscitation/ treatment escalation plan which was due to be piloted. A new end of life care plan had been developed with input from service users and was about to trialled a on some wards.
- The had been improvement in relation to staffing in the bereavement office. Three additional bereavement officers had been employed to ease the workload for existing staff
- As part of the project there had been recognition of the need for the trust to conduct a yearly end of life care audit which would need to include the views of carers post bereavement. This was to be developed.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

The hospital MUST ensure

- There is a timely replacement for the Liverpool Care Pathway and all staff follow the current interim policies.
- Staff complete the end of life care plans (Hearts and Minds – end of natural life) appropriately to National Institute for Health and Care Excellence (NICE) guidelines for holistic care.
- All staff consistently and appropriately complete the DNACPR forms and discussions between patients and relatives are recorded in patient records.
- Staffing levels in the mortuary are reviewed to give staff adequate rest time between shifts and to reduce the levels of lone working.
- Mortuary staff have appropriate equipment for bariatric (obese) patients to reduce the risk of harm to staff from inappropriate manual handling.
- Deceased patients are clearly and appropriately identified when being transferred from wards to the mortuary.
- All staff involved in end of life care can identify a patient at the end of life (12 months) to ensure that referrals to the specialist palliative care team are made in a timely manner.

Action the hospital SHOULD take to improve

- The hospital SHOULD ensure Infection control risks, in relation to storing patients' belongings in the bereavement office, are addressed.
- The provision of interpreter services enable patients who do not speak English as their first language to receive the same level of care as other patients at the end of their life
- The multi faith room environment at Wycombe hospital is improved so that the facilitate can accommodate more than two people and can offer privacy for those wishing to pray.
- Communication from senior management teams to all staff providing end of life care to improves.
- Patients who receiving end of life care are not moved unnecessarily between wards.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **Staffing** **How the regulation was not being met:** The trust did not take appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed to provide care and treatment to patients. • Mortuary staffing. Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010. Which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **Records** **How the regulation was not being met:** Patient records were not always accurate maintained. • Documentation for end of life care • Documentation for DNA CPR • Identification of deceased patients from ward to mortuary Regulation 20(1)(a) HSCA 2008 (Regulated Activities) Regulations 2010. Which corresponds to regulation 17 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment **Safety, availability and suitability of equipment** **How the regulation was not being met:** The trust did not have suitable arrangements to protect patients and others who were at risk from the use of unsafe equipment. • Mortuary equipment for bariatric patients Regulation 16(1)(a)(2) HSCA 2008 (Regulated Activities) Regulations 2010. Which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Care and Welfare** **How the regulation was not being met:** The trust did not take proper steps to ensure that each patient was protected against the risks of inappropriate and unsafe care. • Care planning for end of life care • Referrals to specialist palliative care team. Regulation 9 (1)(a) (b) HSCA 2008 (Regulated Activities) Regulations 2010. Which corresponds to regulation XX of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.