

Sue Ryder

# Sue Ryder - Leckhampton Court

## Inspection report

Church Road  
Leckhampton  
Cheltenham  
GL53 0QJ  
Tel: 01242230199  
[www.suerydercare.org](http://www.suerydercare.org)

Date of inspection visit: 6 July 2022  
Date of publication: 12/09/2022

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

### Ratings

#### Overall rating for this location

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Outstanding 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

# Summary of findings

## Overall summary

Our rating of this service stayed the same. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service had systems and processes to prescribe and administer medicines safely. There was a genuine open culture in which all safety concerns raised by staff and patients were highly valued as being integral to learning and improvement.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity. Staff recognised and respected the individual as a whole and went to great lengths to make final wishes a reality. People who used the service were active partners in their care. Staff were fully committed to working in partnership to make this a reality for each person. Staff communicated effectively to understand the things important to each individual and worked hard to provide this. Staff helped patients and families to understand their conditions. There was a strong person-centred culture and staff provided emotional support to patients, families and carers in both formal and informal ways. Patients felt they were truly cared for and supported by hospice staff.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff were proud to work at the service, there was strong collaborative team working and staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff at all levels were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Storage of emergency medicines and medical gases were not always stored in line with guidance and patient weights were not always recorded on medicine charts.

# Summary of findings

## Our judgements about each of the main services

### Service

### Rating

### Summary of each main service

Hospice  
services for  
adults

Good



# Summary of findings

## Contents

### Summary of this inspection

Background to Sue Ryder - Leckhampton Court	5
Information about Sue Ryder - Leckhampton Court	5

---

### Our findings from this inspection

Overview of ratings	7
Our findings by main service	8

---

# Summary of this inspection

## Background to Sue Ryder - Leckhampton Court

Sue Ryder Leckhampton Court Hospice is operated by the National Sue Ryder charity. It offers community and inpatient hospice care support for people over the age of 18 who have life limiting conditions such as cancer, heart failure, lung disease and degenerative neurological illnesses, and serves communities within Gloucestershire.

There is a 16-bed inpatient unit, hospice at home team, virtual day service, community and inpatient therapy service, family support service, spiritual support, befriending and bereavement support. These are provided by a consultant led multidisciplinary team and a team of volunteers. Due to infection prevention and control of the risk of COVID-19, 13 of the 16 available beds were being used.

The hospice at home team helps people to stay at home if that is their preferred place of death. The services provided by the hospice worked in conjunction with people's own GP, community district nurses, and other health and social care professionals.

The location is registered with the Care Quality Commission to provide the following regulated activity:

- Treatment of disease, disorder or injury.

The service had a registered manager, who has been registered since March 2022.

Leckhampton Court Hospice was inspected in 2016 and was rated as good.

## How we carried out this inspection

We carried out a short notice announced, comprehensive inspection on 6 July 2022. The service did not know we were coming until two days before our visit which was to allow staff to arrange patient consent for community visits.

During our inspection, we visited Leckhampton Court inpatient unit and spent time on home visits with the hospice at home and therapy teams. We spoke with approximately 16 members of staff, including volunteers, registered nurses, health care assistants, allied health professionals, reception staff, housekeeping staff, catering staff, medical staff and senior managers. We spoke with three patients and two relatives and reviewed feedback from over 100 patients in the last 12 months. We attended meetings and handovers, observed patient care, reviewed patient records including prescription charts and do not attempt cardiopulmonary resuscitation decisions. We reviewed hospice policies, procedures and other documents relating to the running of the services.

You can find information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

## Outstanding practice

We found the following outstanding practice:

# Summary of this inspection

- We saw at all levels, individual and collective approaches to providing personalised care, 'doing the little things that matter'. Staff worked collaboratively to provide care specific to the patient's needs and listened to what was important to them. Staff talked passionately of how they would work and adapt their care to fulfil patient's end of life wishes.
- The service actively engaged in research studies. Staff had co-ordinated and written a number of studies with the most recent published in the Journal of Pain and Symptom Management. The service continually looked to improve practice through research, which meant patients received the most up to date evidence based care.

## Areas for improvement

Action the service **MUST** take is necessary to comply with its legal obligations. Action a service **SHOULD** take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

### **Action the service SHOULD take to improve:**

- The service should ensure patient weights are documented on medicine charts so the correct dose of medicines are prescribed. (Regulation 12)
- The service should ensure the storage of emergency equipment and medicines is in line with *Resuscitation Council* UK guidance. (Regulation 12)






# Our findings

## Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Hospice services for adults	Good	Good	 Outstanding	Good	Good	Good
Overall	Good	Good	 Outstanding	Good	Good	Good

# Hospice services for adults

Safe	Good 
Effective	Good 
Caring	Outstanding 
Responsive	Good 
Well-led	Good 

## Are Hospice services for adults safe?

Good 

Our rating of safe stayed the same. We rated it as good.

### Mandatory training

**The service provided mandatory training in key skills to all staff and made sure everyone completed it.**

Staff kept up-to-date with their mandatory training. All staff had access to a computer system to undertake electronic learning and a list of mandatory training they were expected to complete. This system showed when staff had completed training. A member of staff showed us their training list and they were up to date with all training.

Mandatory training compliance since June 2021 was consistently above 90%. However mandatory training compliance rates for all staff was 93% and this was below the service's expected minimum of 95%.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers made staff aware when training was due to expire. They reported any reduction in compliance at both the monthly quality improvement group and quarterly integrated quality and performance report. We saw up-to-date monitoring of compliant and non-compliant staff.

The mandatory training was comprehensive and met the needs of patients and staff. The training covered a wide range of clinical and non-clinical subjects specific to the specialist needs of the service.

### Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**

Staff received training specific for their role on how to recognise and report abuse. Overall compliance for level 1 and 2 adult safeguarding training was 98% and 95% respectively. Level 1 and level 2 children's safeguarding training compliance was 94% and 96% respectively. A member of staff showed us their training list which demonstrated they had completed safeguarding adults training and safeguarding children training to level 2. There was a safeguarding lead who had level 3 safeguarding training.



# Hospice services for adults

Most staff knew how to make a safeguarding referral and all staff we spoke with knew to escalate concerns to a senior member of the team when they were unsure. Staff knew how to access the service's safeguarding policy. The service had a safeguarding lead to provide support for staff. Data showed safeguarding themes and trends were reviewed in quarterly governance meetings.

Safety was promoted through recruitment procedures and employment checks. Staff had a Disclosure and Barring Service (DBS) check undertaken at the level appropriate to their role. DBS checks help employers make safer recruitment decisions and prevent unsuitable people working with vulnerable groups.

## Cleanliness, infection control and hygiene

**Staff used infection control measures when caring for patients on the inpatient unit, in the community and when transporting patients after death.**

Ward areas were clean and had suitable furnishings which were well-maintained. All areas we inspected were visibly clean. Cleaning records we viewed were up-to date and demonstrated all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). Patients were isolated and screened for COVID-19 on admission to the inpatient unit. All staff and visitors were temperature screened at the point of entry to the hospice. Staff used PPE in line with infection prevention and control principles. During a visit with home therapy staff we observed staff using PPE before entering the patient's home and disposing of this safely on leaving.

Staff worked effectively to prevent infections. The hospice had no healthcare associated infection incidents of *clostridium difficile*, methicillin-resistant staphylococcus aureus (MRSA) or vomiting and diarrhoea outbreaks in the past 12 months. The hospice reported seven confirmed COVID-19 cases in the last 12 months. The hospice investigated these seven cases and all were classified as acquired outside of the hospice. No lapses in infection control practice were identified.

Staff completed hand hygiene and infection prevention and control audits. Audits followed a set schedule and checked compliance against processes that prevented the spread of infections.

There was an infection control link nurse who had completed a two-day hospice specific infection prevention and control training course. The link nurse lead had developed a focused action plan for the improvement of practice.

The hospice completed regular water testing for legionella and bacteriological infections and prioritised high-risk areas to have more regular checks. This included notifying the relevant external agencies if required.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw staff cleaning equipment after use and labelling this to inform other staff when it was last cleaned.

## Environment and equipment

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**

The service had suitable facilities to meet the needs of patients' families.

# Hospice services for adults

The design of the environment followed national guidance. The flooring was easily cleaned, and equipment and furniture were wipeable. All corridors were wide enough to accommodate beds and wheelchairs. However, one room was only accessible to patients who could walk or use a wheelchair. Staff told us they did not use this room for patients unable to use the stairs or fitted stair lift. This was risk assessed prior to allocation.

Patients could reach call bells and staff responded quickly when called. Patients told us staff responded quickly when they pushed their call bells. We reviewed the electronic call bell system for the previous 24 hours. The average wait time was 67 seconds, with 86% of patients' call bells responded to within two minutes.

The service had enough suitable equipment to help them to safely care for patients. The hospice had a dedicated temperature-controlled room and managers told us they had good relationships with local funeral directors to allow for the swift transfer of deceased patients when needed. For patients cared for at home equipment was provided by the community service. Hospice at home staff could order equipment through the community service following assessment of the patient.

A lift was available to the upper floor. Evacuation slings were available at each stairwell for the transport of patients in an emergency.

Staff carried out daily safety checks of specialist equipment. For example, we looked at records and saw staff carried out daily safety checks of the resuscitation trolley. The contents of the trolley were in-date and the trolley was visibly clean. The Hospice had a medical equipment maintenance schedule, this showed all medical equipment had an in-date service.

Staff disposed of clinical waste safely. The domestic and clinical waste bins were clearly identified and emptied regularly. Bins for sharp items such as needles and hazardous substances were stored safely.

## Assessing and responding to patient risk

**Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.**

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff completed a full set of observations and a blood glucose reading for all patients on admission and then planned further monitoring in line with the patients' needs. A prognostic indicator score was assessed for each patient to determine the level of monitoring. A prognostic indicator score is a system for predicting how long a patient will live. It helps to support patients to set priorities and expectations for care.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. We observed risk assessments being completed after a visit to a patient being cared for at home. The risk assessments included falls, nutrition, skin care, hygiene and manual handling.

Staff knew about and dealt with risks. A daily meeting, called a huddle, took place where any specific patient risks and plans to mitigate these risks were communicated with the whole team. We saw the huddle included a wide range of staff from the multi-disciplinary team. The safety of patients was the focus of all members of staff and there was a collaborative approach in deciding plans for keeping patients safe.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). A 24-hour specialist service was available through the local acute NHS Trust.

# Hospice services for adults

Shift changes and handovers included all necessary key information to keep patients safe. We observed a multi-disciplinary handover meeting which included inpatient staff, hospice at home staff, doctors and other key team members. This daily huddle up for safer health care meeting, locally known as HUSH, included discussions of the needs of all patients. The meeting used safety information from staff and patient experience data to continually review patient safety and ongoing risk, for patients on the inpatient unit this included details of those at risk of falling. All new patients referred to the inpatient unit were discussed and a plan for admission was made based on clinical and social need. Staff from the home therapy team who supported patients at home liaised with each other. For example, one patient required mobility equipment. This was handed over to another member of staff to deliver when they visited.

Staff responded appropriately to emergency call bells.

## Staffing

**The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.**

The service had enough nursing, allied health professionals, support staff and volunteers to keep patients safe. Temporary staff would cover short notice leave and sickness. The COVID-19 pandemic had added pressure to the current workforce due to short notice absence. Staff told us their resilience was affected by this. Managers acknowledged staff concerns regarding wellbeing and the service had multiple resources for supporting staff.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The managers could adjust staffing levels daily according to the needs of patients. This was supported by a flexible workforce, devoted to providing a safe and caring service. On the day of inspection the number of nurses and healthcare assistants matched the planned numbers. Managers were working with NHS England to trial a safe staffing tool for use in palliative care. Outcome data for this trial was not yet available, but once completed the aim would be to give managers a better understanding of the staffing needs of the service.

The service had low vacancy rates. The service had 2.36 whole time equivalent (WTE) registered nursing vacancies. The service was over established by 2.2 WTE healthcare assistant staff in the inpatient unit and had 2.15 WTE vacancies in the hospice at home team for healthcare assistant staff. Staff told us how each team supported each other when staffing required flexibility across the service. The service was actively recruiting for these posts.

The service had increasing rates of sickness. At the time of the inspection the hospice's total sickness rate was 7.59%. The service managed this with employment of bank and agency staff to ensure safe staffing establishment was met. Managers told us the agency staff used were familiar with the service to keep continuity of care. Managers made sure all bank and agency staff had a full induction and understood the service.

## Medical staffing

**The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.**

# Hospice services for adults

The service had enough medical staff to keep patients safe. The hospice had their own medical team which was led by the Sue Ryder medical director in palliative care medicine. The hospice employed three consultants, two speciality doctors, and two GP trainees. A consultant or speciality doctor was available for the inpatient unit Monday to Friday from 9am to 5pm. There was a member of the medical team present on the inpatient unit Saturday and Sunday from 10am to 2pm. There was an out of hours on call system for medical support 24 hours a day, seven days a week.

The medical staff matched the planned number. The service had low vacancy rates for medical staff. At the time of inspection the service was fully established. We saw a low turnover of staff. Staff told us of a positive recruitment situation, with active communication from prospective employees contacting the service ahead of published vacancies.

Managers could access locums when they needed additional medical staff. We saw good relationships with locum staff to provide cover for short notice absence and planned leave. Locum staff we spoke with said they enjoyed working at the hospice and felt they were a valued team member.

## Records

**Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.**

Patient notes were comprehensive and all staff could access them easily. Staff working for the inpatient unit, hospice at home and the home therapy team had access to computer records which they completed. External professionals, for example, community nurses and GP's had access to these records and were able to share information about patients securely. Paper records held in patients' homes were owned and managed by a local NHS trust and all staff and patients had access to these.

When patients transferred to a new team, there were no delays in staff accessing their records. All staff working at the hospice had access to all patient records both in the inpatient unit and those using the hospice at home and home therapy services.

Records were stored securely.

## Medicines

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

Staff followed systems and processes to prescribe and administer medicines safely. Supplies of medicines were provided by the local NHS Trust which included a medicine top up service every week.

Medicine guidelines and policies were available which had been approved by the Medicine Management Committee. Medicines were prescribed by doctors and administered and recorded by nursing staff. Doctors used the palliative care formulary to prescribe medicines and would seek advice from the palliative care consultant as needed.

Medicines to be mixed and used in a device to continuously deliver medicines to patients (syringe driver pump) were checked for compatibility and advice taken from pharmacists as needed. Guidelines for calculating any complex infusion rates were available on every medicine chart.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Daily multidisciplinary team meetings reviewed patients' medicines requirements. The palliative care consultant or pharmacists from the local NHS trust could be contacted for any queries or advice.

# Hospice services for adults

The pharmacist routinely checked prescription charts for accuracy and safety as well as ensuring there was individual monitoring for each patient.

Individual patient preferences in how to manage medicines were respected. This helped with a patient's independence and control. For example, the service used timers to ensure patients with a diagnosis of Parkinson's disease had their medicines at the specific time they needed them.

Staff reviewed and monitored patients with syringe driver pumps to ensure the pump was working correctly. Records showed monitoring was undertaken every four hours.

Staff completed medicines records accurately and kept them up-to-date. We viewed medicine records which showed medicine administration was recorded following policy. This included records showing the site of any applied medicine patches.

Medicine allergies or sensitivities were recorded on all medicine charts we viewed. This ensured staff were aware and alerted of any allergies in order to prevent the prescribing and administration of medicines which may cause an allergic reaction.

Patient weights were not always recorded on medicine charts which would be important to determine the correct dose of certain medicines. Although patient weights were recorded into patient notes they should also be recorded onto a patient's medicine chart. This was not always happening.

Staff stored and managed all medicines and prescribing documents safely. An emergency trolley was situated for easy access in the event of a medical emergency. However, the trolley was locked, and the key was in a keypad lock above it. Although the trolley contents were secure from being tampered with, this system meant there was a risk of delay in accessing items in an emergency. This did not follow Resuscitation Council UK guidance.

Medicines were stored in dedicated secure storage areas with access restricted to authorised staff. Patients own medicines were stored in lockable bedside lockers next to their beds. We checked storage arrangements and found medicines were stored safely and securely.

An emergency medicine was kept in each patient's bedside locker. This was an action taken following an incident. It was recorded and checked daily.

Controlled drugs (CD) were stored securely and safely in line with national guidance. Record keeping and destruction of medicines was undertaken following policy. The pharmacist routinely checked CD records to ensure they were correct.

We observed one medical gas cylinder stored in the medicine storeroom, however there was no medical gas warning sign displayed on the door. We raised this during the inspection and subsequently a medical gas sign was displayed.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. A pharmacist was available one morning a week to support the team on the safe and effective use of medicines. Pharmacists undertook a medicine history and completed a full medicine reconciliation to ensure the correct medicines were prescribed and available. The service would also contact a pharmacist for advice and queries when required.

# Hospice services for adults

Staff learned from safety alerts and incidents to improve practice. There was an open and transparent reporting system which included daily checks on medicine administration charts and syringe driver pump charts after each shift. If something was not clearly written then it was reported and asked to be re-written. Best practice was shared across all the Sue Ryder hospices in England.

Local medicine management meetings were held quarterly, and staff were able to join to share learning and feedback issues.

The Controlled Drug Accountable Officer attended the controlled drug local intelligence networks in order to share any learning relating to controlled drugs.

## Incidents

**The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

Staff knew what incidents to report and how to report them. Staff told us they knew what an incident was and were encouraged to report incidents or near misses so effective measures could be taken to minimise ongoing risk to people or the organisation. The hospice used an electronic system for reporting incidents. All grades of staff could access the incident reporting system. Staff said they felt confident in reporting incidents and there was a no-blame culture.

The service had no never events or serious incidents reported within the last 12 months.

Staff understood duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. The service was open and honest about areas of care requiring improvement, and displayed audit and safety data within communal areas.

Managers investigated incidents thoroughly. Patients and their families were involved in investigations. We saw incident investigations were monitored monthly for compliance against the incident reporting policy.

Managers debriefed and supported staff after any incident. Staff confirmed managers supported them when they were involved in incidents. Staff were encouraged to reflect on incidents they had been involved in. Staff could give us examples of when procedures had changed or additional training had occurred due to an incident. All staff we spoke with during our inspection were committed to providing an excellent service to their patients.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff we spoke with confirmed they received feedback from reported incidents, both those relating to their immediate area of work and those that had been reported elsewhere in the hospice. This promoted shared learning from incidents throughout the hospice. Staff said learning from incidents was communicated to them through handovers, huddles, team meetings, emails and notice boards. The service shared learning from the wider Sue Ryder hospice network.

The service supported the sharing of positive practice through the facilitation of medical away days for other Sue Ryder hospices.

# Hospice services for adults

Staff met to discuss feedback and look at improvements to patient care. The multi-disciplinary team attended a monthly quality improvement group meeting. We viewed minutes from these meetings and saw areas of improvement had been implemented in practice, such as the use of specialist beds for patient's at high risk of falling.

## Are Hospice services for adults effective?

Good 

Our rating of effective stayed the same. We rated it as good.

### Evidence-based care and treatment

**The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.**

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Managers monitored performance against national targets and benchmarked practice and outcomes against other Sue Ryder hospices.

We saw medicines for pain, breathlessness, nausea and vomiting, distress, agitation and seizures were prescribed in advance in line with National Institute for Clinical Excellence guidelines for care of the dying adult in the last days of life and palliative care for adults.

Leckhampton Court Hospice was the only Sue Ryder Location with the provision of a dedicated research nurse. The service actively engaged in research studies. Staff had co-ordinated and written several studies, circulated in national and international publications. The most recent published in the Journal of Pain and Symptom Management. This study explored the behaviours of patients who take their strong opioids (pain relief medication for moderate to severe pain) as unmeasured sips. The service continually looked to improve their practices through research.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. The daily huddle meeting included the family support team and chaplain. This helped the service to identify and communicate the psychological and emotional needs of patients and those close to them.

### Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.**

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Staff told us the service catered for patients' religious, cultural and specialist dietary needs. These were identified at the pre-admission assessment and shared with catering and ward staff.

Patients had access to freshly cooked meals seven days a week. All meals were cooked on site by a dedicated catering team. Patients had access to an alcohol trolley as well as ice cream and other snacks throughout the day.

# Hospice services for adults

The catering team had a good understanding of each patient's needs and adapted meals to suit each individual. We saw how a patient with limited upper limb mobility had their meals adapted to be eaten as a finger food meal. The catering team told us how they would access religion specific foods.

Staff used a palliative specific nutritional screening tool to monitor patients at risk of malnutrition. We saw nutritional assessments completed in patient records on admission to the inpatient unit and reassessments were up to date.

## Pain relief

**Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff explained they used a pain assessment tool that contained pictures and numbers suitable for those with communication difficulties., They also used the Abbey Pain scale for patients unable to communicate their pain.

Patients told us they received pain relief soon after requesting it. Patients told us staff were responsive to their needs and ensured pain medicine schedules were followed.

Staff prescribed, administered and recorded pain relief accurately. During a visit with the hospice at home team we observed staff checking with the patient if their pain relief was sufficient. They also checked when they were taking it. The patient had 'just in case' medicines. These were prescribed by their GP and could be used by qualified nurses if the patient was in pain. A patient on the inpatient unit described how staff were diligent in giving pain relief medicine at the right time.

## Patient outcomes

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**

The service participated in relevant national clinical audits. The hospice had systems and processes to monitor, audit and benchmark the quality of services, and the outcomes for patients receiving care and treatment.

Outcomes for patients were positive, consistent and met expectations, such as national standards. The hospice monitored patient's preferred place of death outcomes. The hospice worked hard to achieve this for patients. During our inspection we observed staff working across hospice services and with other healthcare agencies to make sure they supported patient choice. From June 2021 to May 2022 of those patients that expressed a preferred place of death, 87.5% of patients died in their preferred place of death. Staff told us all patients on arrival at the inpatient unit were asked about their preferred place of death and this was added to their records.

Information on clinical quality outcomes, for example healthcare associated infections, falls and acquired pressure damage, were monitored and tracked over time.

The hospice used the Outcome Assessment and Complexity Collaborative (OACC) tool to measure patient outcome. The OACC is a suite of measures used to assess the care that matters most to people and their families at the end of life,



# Hospice services for adults

such as control of their pain, breathlessness and fatigue, the opportunity to discuss worries, or to achieve one more personal goal before they die. The OACC was well documented within the patient records as part of the multi-disciplinary team meetings. By collecting this data the multidisciplinary team caring for patients were able to plan care, treatment and support to best meet the needs of each individual patient.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Data was reported and reviewed as part of the integrated quality and performance report (IQPR).

Managers shared and made sure staff understood information from the audits. The IQPR was reviewed by national Sue Ryder executives and charity trustees and communicated with hospice staff through the quality improvement group. We reviewed meeting minutes and saw that action was taken in response to any areas of concern.

## Competent staff

**The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. We saw training records that supported staff to provide specialist care. Staff spoke positively of the training opportunities available to them, and took the opportunities offered.

Managers gave all new staff a full induction tailored to their role before they started work. Managers and staff told us of the induction process and support to achieve competencies as part of this process in preparation for employment in the hospice.

Managers supported staff to develop through yearly, constructive appraisals of their work. However, compliance rates had been affected by the COVID-19 pandemic. Managers told us staff had regular one to one clinical supervision and had access to formal reflective groups and individual sessions that were accommodated within working hours. Staff we spoke with told us they were up to date with their appraisal, which they found constructive and inclusive. However, appraisals were placed on hold during the COVID-19 pandemic and the current formal annual appraisal compliance was 69%. Managers had planned staff appraisals in order to get back to usual high rates of compliance.

Managers identified any training needs and made sure staff received any specialist training for their role. Staff were given the time and opportunity to develop their skills and knowledge. Staff had been given opportunities for their continuous professional development and were encouraged to undertake training and education. We were told of focused training sessions provided on site, with frequent support from external specialists. Recent courses provided on site for care staff included, the care of tracheostomies (an opening created at the front of the neck so a tube can be inserted into the windpipe to help with breathing), and male catheterisation (a procedure used to drain the bladder and collect urine).

The service had specialist link roles. Training was given to staff in a link role to fulfil the expert support required. The falls prevention lead had completed a level 2 falls prevention course. There were also link roles in tissue viability, medicines management and infection, prevention and control. Managers had a vision and planned to incorporate all staff groups into the link role system.

# Hospice services for adults

Advanced communication skills training was planned in conjunction with another local hospice and acute NHS trust. Individual cognitive stimulation therapy courses were being provided in conjunction with another local hospice. Cognitive stimulation therapy is a programme of themed activities designed to improve mental abilities and memory of someone with dementia.

Managers recruited, trained and supported volunteers to support patients in the service.

## Multidisciplinary working

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Meetings held twice a week were attended by all disciplines within the hospice. We reviewed five sets of patient records and saw comprehensive documentation detailing discussion and planning of care.

Staff worked across health care disciplines and with other agencies when required to care for patients. Hospice at home staff worked closely with the local community NHS trust to provide coordinated care for patients. They had weekly contact with the acute NHS trust palliative care team. GP services had direct access to the palliative care consultant for expert support via the computer system. Staff referred patients for mental health assessments when they showed signs of mental ill health.

## Seven-day services

**Key services were available seven days a week to support timely patient care.**

The hospice at home service provided care seven days per week and offered a maximum of three visits a day. They were also able to provide some overnight care if required to support the patient and their family. The inpatient unit was available 24 hours a day seven days a week.

Consultant led ward rounds happened four days a week on the inpatient unit. There was an out of hours rota for medical support.

The therapy team supported people in their own homes and on the inpatient unit from Monday to Friday.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. There was an out of hours, on call system for medical support 24 hours a day seven days a week. The hospice had access to specialist care provision through the local acute NHS trust.

## Health promotion

**Staff gave patients practical support to help them live well.**

The service had relevant information for patients to use and make their own choices. Staff discussed options with patients as to how they wanted to live their lives and provided support to meet those choices.

Therapy teams supported people to maintain or improve their independence. The family support team provided practical support as well as emotional support, for patients and their families. Therapy programmes such as respiratory workshops were provided to empower people to be independent in managing their symptoms.

# Hospice services for adults

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.**

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We observed staff checking whether patients and their families understood their discussions during home visits with the hospice at home service. Written leaflets were provided to patients to explain how their information was shared between professionals.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. We saw in one patient's record, a weekly discussion of the patient's mental capacity, documentation of assessment and referrals for care and treatment decisions. A best interest meeting was also documented. Decisions were made in line with legislation with inclusion of patients and the views of those close to them.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We saw a ReSPECT form in a patient record within their home. ReSPECT stands for Recommended Summary Plan for Emergency Care and Treatment. The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they would not have capacity to make or express choices. This form had been signed by the patient and listed their wishes regarding further treatment. The ReSPECT form was readily available to visiting professionals and the family were aware of the content.

Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Compliance with mandatory Mental Capacity Act and Deprivation of Liberty Safeguards training was 55%. This new training package was released in June 2022 and the service acknowledged it will take some time to reach their expected compliance rates. Training compliance on the previous module in May 2022 was 96%. The service had plans to support completion of this training module across all relevant staff. Staff we spoke with understood the relevant consent and decision-making requirements of this legislation and guidance.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Deprivation of liberty safeguards referrals were reviewed monthly by the senior management team. Mental Capacity Act and Deprivation of Liberty Safeguards use formed part of the routine audit schedule. We saw an audit in May 2022 showed improvements in completion of mental capacity act documentation from the previous audit in October 2021.

## Are Hospice services for adults caring?

Outstanding



Our rating of caring improved. We rated it as outstanding.

## Compassionate care

**People are truly respected and valued as individuals and are empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service.**

# Hospice services for adults

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients. Staff took time to interact with patients and those close to them. We observed staff interacting with patients and their family during home visits with the hospice at home team and on the inpatient unit, they treated patients with respect and showed genuine care towards them.

All staff, including volunteers, were aware of the importance of providing compassionate care and the impact their actions had on the patient and their families during this time of their lives. Support was always given by caring and empathetic staff who put patients and those close to them at the heart of everything they did. Staff talked about providing the “humanity” in healthcare. All conversations and observations during our inspection, without exception, demonstrated this.

Big and small acts of kindness were embedded in how staff looked after patients. Staff we spoke with explained during a time of infection prevention and control restrictions, additional effort was made to accommodate a festive occasion for a patient and their young family. Risk assessments were completed to create a safe environment for all at the hospice, whilst creating lasting memories for the patient and those close to them in the patient’s final days of life.

Staff also told us about how they had listened to a patient’s wish to see attend the local remembrance parade and another who wished to see the lights at Christmas. Both patients were enabled to achieve these wishes through the use of the onsite minibus and the time of dedicated staff.

People’s privacy and dignity was always considered. Feedback from patients also confirmed this. We saw staff knock before entering patients’ rooms. One relative wrote, “they were all caring, treating our loved one as an individual, with dignity and being thoughtful with other family members” and “they were amazing in their attention to providing comfort and care”.

Staff followed policy to keep patient care and treatment confidential.

Patients said staff treated them well and with kindness. Feedback from people who used the service, those who were close to them and stakeholders was continually positive about the way staff treated people. We saw thank you cards and survey feedback which included people saying how grateful they were that their loved ones spent their last days with the support of the hospice staff. Relatives fed back how the hospice had “enriched our lives at a time, when the world was narrowing”.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We observed staff asking patients about their beliefs and how they wanted to be cared for. Staff were confident in how they adapted their provision of care specific to a patient’s personal, cultural, social and religious needs. Staff were candid when telling us there was a limited diversity in the people that engaged with the service, but managers were aware of this and working with the community to raise the hospice profile amongst minority groups.

The service provided a dedicated chaplaincy support who told us of their positive and accessible relationships with faith and spiritual leaders outside of the hospice.

Early progress had been made before the COVID-19 pandemic to welcome feedback and engagement from wider religious faith leaders and they hosted lunches on the hospice site. Staff told us there were plans to restart these engagement lunches.

# Hospice services for adults

## Emotional support

**Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.**

Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw use of the integrated palliative care outcome scale to support measurement of patient's psychological, emotional and spiritual needs.

We observed staff during home visits with the home therapy and hospice at home teams empowering patients to be partners in their care, practically and emotionally. Staff offered patients additional services to help with the psychological side of their illness.

The service had a Family Support Team who were fully integrated into the multidisciplinary team and used information at the weekday huddles to inform and pro-actively support patients and those close to them.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. There was a private room for providing a quiet space to support communicating bad news or supporting patients' spiritual and religious needs. The chaplaincy team told us that to improve there were plans to relocate this space to a larger room on site.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff had completed basic communication training, and some staff had completed specialist communication training.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. During the home visits we observed staff talking with patients about how their diagnosis impacted on them and their families. Staff made sure families had access to emotional support pre and post bereavement. The hospice chaplain enabled patients time to talk about their views and wishes, and to understand what really mattered to the individual. They gave an example of how they were able to relieve a patient's anxiety about the wellbeing of their parents at home, by visiting the patient's parents and seeking visual assurance of their safety.

The service provided a befriending service which offered emotional support and friendship to patients.

## Understanding and involvement of patients and those close to them

**Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. All patients we spoke with told us communication was clear and they understood what was going on. They said communication was consistent and they felt included in conversations about their care.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Patient care records showed communication with families and carers. In a patient survey, undertaken from January 2021 to March 2022, 118 out of 121 patients said that staff communication was positive and effective.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. A service user group was started in March 2022 with good attendance. The purpose of this group was for service users to discuss key activities and projects to improve the service. Patients and their families had been able to discuss their

# Hospice services for adults

experiences during the COVID-19 pandemic and compared them to experiences of those from before. The service had plans to restart real-time feedback with the support of on-site volunteers, this feedback mechanism had been suspended during the COVID-19 pandemic. The service engaged patients and those close to them through a regular patient survey.

Patients gave positive feedback about the service. Patient survey results were consistently positive and hugely complimentary of staff and the service. Staff described how families of deceased patients were engaged with fundraising efforts for the hospice and we saw numerous thank you and compliment cards addressed to staff. One patient told us “this is how all of healthcare should be” and “I only wish the hospice was bigger so more people would benefit”.

Staff supported patients to make informed decisions about their care. Staff supported patients to make advanced decisions about their care. We saw a ReSPECT form in one patient record at a home visit which detailed their wishes about future treatment. Their family were aware of the contents of this.

## Are Hospice services for adults responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

## Service delivery to meet the needs of local people

**The services were tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care.**

Managers planned and organised services so they met the needs of the local population. Patients’ individual needs and preferences were central to the delivery of tailored services. The therapy service had been expanded to provide services where gaps had been identified and to support community patients during the COVID-19 pandemic. Staff told us how this service had doubled over the last two years. The service helped identify symptom needs and emerging medical diagnoses earlier. This had allowed for more support to patients with complex palliative care needs, and had given patients a wider choice for their preferred place of death. For example, where the patient did not want to be admitted, the service was able to provide them with support, treatment and equipment to help maintain their independence at home. The expanded therapy service had been able to support patients with respiratory needs with the development of a breathlessness service. This service has provided patients with specialist education and support for the management of respiratory symptoms related to their illness.

The hospice had a large communal area for patients, their family and friends including an area to make drinks and relax away from patient rooms. The patients and their families had access to well maintained, tranquil and picturesque outdoor spaces.

The hospice was situated within a Grade 2 listed building which meant development of the environment was restricted. There was a flat terrace space available with views over the grounds for patients who could walk or use a wheelchair. Due to the confines of the building the flat terrace was not readily accessible to patients unable to walk or use a wheelchair. However, staff told us they did their best to accommodate any patient who wished to use this space.

# Hospice services for adults

Staff could access emergency mental health support 24 hours a day seven days a week for patients with mental health problems, learning disabilities and dementia. This was provided through a service level agreement with the local acute NHS trust.

The service had systems to help care for patients in need of additional support or specialist intervention. We saw active use of specialist equipment which had been rented specifically to support the needs of a patient. We saw individualised interventions for the safety of a patient at high risk of falling, this included a falls alarm mat and a specialist bed. The hospice had arrangements with the local acute NHS trust for access to specialist services, these included tissue viability, speech and language therapists and safeguarding.

Senior managers were working with local commissioners, NHS trusts and primary care providers to plan hospice and end of life care for patients in the region. Service leads and managers attended strategy meetings and offered services to support where there were gaps in provision.

The inpatient unit, hospice at home and therapy services worked effectively together to provide the right care in the right place for their patients. Staff gave examples of where the use of the therapy and hospice at home services had enabled patients to be cared for in their home environment avoiding admission, this had kept the inpatient unit beds for patients needing onsite support.

The hospice had access to a minibus and maintained a registered driver. The minibus was used for transporting patients to and from the hospice. This meant the service did not rely on the local ambulance provider for all transportation needs, and improved the accuracy of transportation times for patients.

Staff told us about their involvement in the community. The Family Support Team were passionate about breaking through the taboo of bereavement, especially for children and had facilitated talks at local schools.

Staff told us about virtual masterclasses they had facilitated on 'metastatic spinal cord compression' which was well attended by local community physiotherapist and occupational therapists. Metastatic spinal cord compression happens when cancer cells grow in or near the spine and press on the spinal cord. This can cause a range of symptoms that can get worse if left untreated. For example the losing the ability to walk and move around.

## Meeting people's individual needs

**The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**

The hospice was designed to meet the needs of families and people close to patients. There were kitchen facilities to provide food and drink for visitors. All patients and visitors had access to external space. Relatives told us these were tranquil areas they had used as a reflective space. However, one patient told us the provision of en-suite facilities would improve their experience.

The COVID-19 pandemic had created difficulties for people attending the day-hospice and alternative provision was made with a virtual programme for outpatient attendances. The hospice was looking to maintain elements of the virtual programme and build a hybrid model of virtual and on-site day hospice services.

We saw clear records of individualised care plans. It was evident the person receiving the service was central to the process and had been an active participant in the way they wanted their care to be delivered, based on a mutual



# Hospice services for adults

understanding of their physical, psychological, emotional, and spiritual wishes. People had been asked about their preferences and wishes in relation to diet, exercise, psychotherapy, relationship and spiritual counselling. Records showed conversations had been held about what was important to that individual, including relationships, and day-to-day activities.

Staff kept detailed records of patient preferences including developing advance care plans and treatment escalation plans, which documented how they wanted to be treated at the end of their life.

Staff supported relatives to be involved in the care of the patient in response to a specific patient need and wishes. We spoke with a patient and their relative about their needs to manage a particularly technical aspect of their care. Nursing staff had trained the patient with support of their relative to safely manage this treatment which then allowed the patient to continue their treatment at home as they wished.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. We saw individualised care planning for a patient living with a learning disability. The patient and their relatives were active partners in their care.

Patients were given a choice of food and drink to meet their cultural and religious preferences. The catering team spoke with service users daily about their food and drink requirements and had access to the relevant resources to meet their cultural and religious preferences. The chef was able to alter menus to meet any specialist needs. Examples given included making food specifically requested by patients and preparing food to enable patients to maintain their independence, for example, finger food and soft food.

Staff had access to communication aids to help patients become partners in their care and treatment. Staff understood how to meet the information and communication needs of patients with a disability or sensory loss. There was an accessible information policy and staff could access it. Staff had access to communication aids to help patients become partners in their care and treatment. Patients told us staff took time to explain their care and treatment.

## Access and flow

**Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.**

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Expected admissions were discussed daily by the multidisciplinary team, with priority given to those patients with greater clinical needs and those with hospice as their preferred place of death. Where patients did wait for admission, the hospice at home teams and therapy team provided at home support until a bed became available. Staff told us they provided daily telephone calls to support patients and their family members if admission was delayed outside of their working hours.

Technology was used innovatively to ensure patients had timely access to treatment, support and care. The home therapy team advised a patient they would send information about their treatment plan via electronic-mail with a link to an on-line exercise class run by their staff to help them maintain their mobility.

Managers worked with the wider Sue Ryder network as part of an ongoing project to review and improve occupancy and flow of patients into Sue Ryder inpatient units. The work had identified strategies to improved access and flow which included a dedicated admission and discharge co-ordinator. At the point of inspection Leckhampton Court did not have a dedicated admission and discharge co-ordinator but was looking to implement this in the future.



# Hospice services for adults

Managers and staff worked to make sure patients did not stay longer than they needed to. The hospice reported an average length of stay between seven and 10 days and had a focus on early discharge planning when appropriate.

Managers monitored the number of patients whose discharge was delayed and took action to reduce them. We saw close communication between senior managers and external key stakeholders where patients required onward care and services. Senior staff monitored, and reported monthly any delayed provision of care and worked collaboratively to resolve issues contributing to these delays.

## Learning from complaints and concerns

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.**

The service took concerns and complaints seriously and were passionate in ensuring patients and their families had the best experience possible.

Patients, relatives and carers knew how to complain or raise concerns. Leads monitored and investigated complaints and responded by identifying actions to resolve them. From April 2021 to June 2022 there had been one formal complaint received relating to care in 2020. Senior managers told us they valued feedback of any type and worked together to understand and resolve any problems identified.

Managers investigated complaints and identified themes. Complaints and concerns were reviewed at the quarterly quality improvement group to identify any themes or trends and if any changes in practice were required. The service had a very low number of complaints and concerns. Complaints were investigated and responded to in line with hospice policy. Complainants were signposted to the parliamentary health service ombudsmen should for the complaint not be resolved.

The service clearly displayed information about how to raise a concern in patient areas, and displayed a 'you said, we did' board.

Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints featured as a standing agenda item on the monthly quality improvement group.

## Are Hospice services for adults well-led?

Our rating of well-led stayed the same. We rated it as good.

## Leadership

**Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**



# Hospice services for adults

The leadership structure comprised of a service director, registered manager, head of operations and service leads. The hospice leadership team were supported by the national Sue Ryder quality team and other central teams such as human resources. Leaders demonstrated the required levels of experience, capacity and capability needed to deliver high quality and sustainable care. They worked collaboratively with partner organisations and professionals to deliver high-quality, patient centred services. Patient and family experience were always considered.

We saw how leaders lived the organisation's values through strong collaborative teams and the creation of a flat hierarchal structure. Staff told us the senior leadership team were visible and approachable and we observed this at the daily huddle meeting. Staff of all grades were seen to be active and engaged in team discussions, and showed professional confidence to address staff senior to their role.

The leadership team were able to explain the priorities and challenges for the service. This included the expansion of services being offered in the community and how this may be achieved through a combined model of face-to-face and virtual support. They were able to explain how these priorities and challenges were being approached and remedied.

The leadership team demonstrated an understanding of the wider palliative care and end of life sector in their region and of their local community. Leaders understood the importance of their workforce to the success of the service and had invested in staff education and development programmes.

Staff of all grades felt valued and told us they enjoyed working at the hospice. All staff we spoke with told us they were proud to work at the hospice, were proud of their peers and leaders and appreciated strong, support and collaborative relationships.

## Vision and Strategy

**The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**

The hospice's vision and strategic aims were aligned with the national Sue Ryder charity, "to provide care and support for more people" and to "influence new models of care across the UK". The hospice's values were aligned with the national charity "to be supportive, connected and impactful". All the staff we spoke with were fully aware of and proud of the vision of the service.

The team demonstrated commitment to system-wide collaboration and leadership, and had created good working relationships with key stakeholders.

It was clearly serving and involving the local community and responding to their needs was an integral part of the service's ambitions. Leaders explained the change in emphasis from inpatient to community-based care that was taking place in palliative care settings within the region and nationally, to allow people to stay at home. They told us how they were working to facilitate this new model.

The service was engaging with partners of the Integrated Care System to explore the creation a regional palliative care hub. Leaders shared learning and knowledge from neighbouring Sue Ryder hospices that had already adopted this model.



# Hospice services for adults

The hospice had recently completed a carbon footprint assessment as part of their wider goal to support UK government agenda 2030 sustainable development goals. The project identified core areas of high carbon production and actions to begin to reduce the carbon footprint of the organisation.

## Culture

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**

We spoke with a range of staff during our visit, including members of the leadership team, managerial staff, doctors, nurses, healthcare assistants, therapists, domestic, catering, community and inpatient staff. Without exception, staff we spoke with felt valued and told us they enjoyed working at the hospice. Staff members told us the hospice was an excellent place to work and was made up of individuals who all had one common purpose, to provide high quality, person centred care and to bring “the humanity” back to healthcare.

Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff at all levels were actively encouraged to speak up and raise concerns, and all policies and procedures positively supported this process.

There was strong collaboration, team-working and support across all services with a common focus on improving the quality and sustainability of care and patient’s experiences.

There were embedded mechanisms for providing all staff at every level with the development they needed. These included high-quality appraisal and career development conversations, and personal development and career enhancement through individualised educational and training plans.

The senior leadership team told us staff well-being was one of their core priorities and staff confirmed this when we spoke with them. Staff told us managers always asked about their well-being at departmental meetings and they had access to support services such as 1:1 and group reflective sessions and a 24 hours a day, seven days a week employee assistance programme.

Staff gave examples of how they felt valued, from receiving individual afternoon tea boxes and personalised gifts to being invited to hospice wide staff BBQ’s.

## Governance

**Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**

The service had a strong governance structure that supported the feed of information from frontline staff to senior managers and trustees. Each service line was led by a manager, clinical service lines reported into the registered manager and non-clinical service lines reported to the head of operations. Both the registered manager and head of operations reported to the service director.

The service had a clear governance process to continually improve the quality of service provided. Staff understood their roles and responsibilities in relation to governance. Governance arrangements were clear and appropriate to the size of the service.

# Hospice services for adults

Each service line held monthly meetings to discuss quality and performance which was communicated to the senior leadership team. We reviewed meeting minutes and saw these meetings had a clear structure. Staff had access to minutes of meetings when they were unable to attend. Across the various meetings, a broad range of governance and operational matters were covered.

## Management of risk, issues and performance

**Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**

The management were committed and passionate about patient care and providing a high-quality service. They understood the challenges the service faced, in particular, staffing, recruitment and the funding challenges experienced by hospices and the impact this could have on the service. Senior managers described these main risks to the service which we noted were on the risk register. Mitigating actions and a responsible person in charge of the risk had been clearly noted, along with review dates

The service had an electronic system to record, mitigate and monitor risks. Risk registers we saw were up to date and included documentation of risk assessment and mitigating actions. Risks across the organisation were discussed quarterly as part of the integrated quality and performance report. Data was displayed in a format that aligned with the Care Quality Commission's key lines of enquiry. The data was up to date and displayed trends over time.

The hospice had an audit programme that was reviewed annually. Audit findings were used to make improvements and provide assurance about the management of risk and quality.

## Information Management

**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**

The service used a combination of electronic and paper patient records, with most of the information being stored electronically. Access to electronic records was restricted and password protected, and paper records were stored in a locked environment to avoid confidential patient information being accessed by unauthorised people. Staff told us patient information was easily accessible. Consent for the sharing of patient information across healthcare specialities was documented.

The service completed regular audits about their information governance processes and performed well in all aspects of the audit. This included staff understanding of confidential personal information, policy review, statutory training and access and accuracy of service user information.

There were arrangements to submit notifications and data to the relevant external bodies, including the Care Quality Commission and Clinical Commissioning Groups.

# Hospice services for adults

## Engagement

**Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

The hospice worked in partnership with other services to ensure the palliative and end of life care needs of patient and families were met within the community they served.

The service engaged well with patients, staff, volunteers, public and local organisations to plan and manage services and collaborated with partner agencies effectively. There were consistently high levels of constructive engagement with staff and people who used services, including equality groups. The hospice welcomed rigorous and constructive challenge from people who used their services, the public and stakeholders and was seen as a vital way of holding services to account.

Services were developed with the full participation of those who used them, staff and external partners seen as equal partners. The service had a system to obtain routine feedback from their patients and families and had plans to re-introduce real time feedback with support of volunteers on-site. The service reviewed themes from their complaints and compliments to gain insight into what patient's thought of the service. Staff spoke positively of a newly started service user group and the positive initial feedback the service had received.

We saw there was regular communication with staff through the Clinical Director's weekly message. There was good attendance of staff and leaders at monthly team meetings.

We saw the service had a leadership role in its health system to identify and proactively address challenges and meet the needs of the population. The service provided challenge about the wider provision of palliative care in their local community.

The hospice was held in high esteem by their local community. The hospice had recently won a community voted charity of the year award for the second year running.

## Learning, continuous improvement and innovation

**All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**

The service was committed to improving services by learning when things went well or not so well and promoted training and innovation.

The service was committed to providing regular training opportunities to staff. We saw information about education sessions including specialist communication and clinical skills specific to patient need.

Leaders encouraged innovation and participation in research. The service had a dedicated research nurse, and we saw regular meetings with leaders to discuss current and future research projects that could be of benefit to the patients using the service. The service was involved in two open studies and were actively reviewing six further projects to consider. We saw regular publication of multiple research papers, including qualitative studies and double blind randomised controlled trials. Staff within the hospice had papers published in the British Medical Journal, European Journal of Palliative Care and Journal of Pain and Symptom Management.

## Hospice services for adults

There was a clear, systematic and proactive approach to seeking out and embedding new and more sustainable models of care. There was a strong record of sharing work locally and nationally. The service had shared their reflections of their new therapy community service in response to the COVID-19 pandemic with the wider Sue Ryder charity as part of the 'Achieving Clinical Excellence' scheme.