Hartlepool Hospice Limited

Alice House Hospice

Inspection report

Alice House
Wells Avenue
Hartlepool
TS24 9DA
Tel: 01429855586
www.hartlepoolhospice.co.uk

Date of inspection visit: 3 & 4 October 2023
Date of publication: 04/12/2023

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?	Good
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. They managed medicines well. The service managed safety incidents well and learned lessons from them.

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 7 days a week.

Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

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 felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff 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.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Good 	Please see overall summary above.

Summary of findings

Contents

Summary of this inspection

Background to Alice House Hospice

Alice House Hospice is a hospice located in Hartlepool, North East England. It is operated by Hartlepool Hospice Ltd. Alice House has been registered with the Care Quality Commission since 1 October 2010 and provides inpatient and outpatient care for people with a life limiting illness.

The service has a registered manager in place who is registered to carry on the regulated activity of; Treatment of disease, disorder or injury.

The service operates across 1 floor and has 10 available beds. It also operates a day hospice service. The service offers patients pain and symptom management as well as end of life care.

Therapeutic support services are delivered from the Hospice's Holistic Wellbeing Centre which is set within the hospice grounds.

Therapeutic support services offered include; bereavement counselling, complementary therapies, mindful crafts, a mindful guidance and support group, meditation and reflexology.

For the period of October 2022 to September 2023, 169 patients had used the service.

We have previously inspected Alice House Hospice, in March 2015. At that time, we rated the service as good.

How we carried out this inspection

We inspected the adult hospice core service during this inspection. The inspection was carried out over 2 days, with supporting information requested from the service.

The team that inspected the adult hospice service comprised of 2 CQC inspectors. A third CQC inspector was present to observe the inspection. The inspection team was overseen by an Operations Manager.

During the inspection we visited the service location. We observed and spoke with senior leaders, the registered manager, staff members and patients. We also reviewed patient records and requested a number of audits, policies and related documentation about the running of the service.

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:

- The service had measured savings of around £60,000 in sickness pay costs, by early identification of staff wellbeing concerns and a referral for use of the onsite therapeutic and counselling services offered.

Summary of this inspection

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 consider implementing a formal team meeting structure or schedule.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Hospice services for adults

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

Is the service 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.

The mandatory training was comprehensive and met the needs of patients and staff. We noted that there were 15 modules of mandatory training to complete, including modules relating to autism awareness and learning disability.

Managers monitored mandatory training and alerted staff when they needed to update their training and ensured that all staff kept up to date.

Mandatory training figures for annual clinical training was 89% compliance. This meant that the majority of staff had completed the relevant training required for them to carry out their roles.

Safeguarding

Staff understood how to protect patients from abuse. 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. We reviewed information which evidenced that staff completed safeguarding children and adults training.

The level of adult safeguarding training undertaken, corresponded with their role. For example, staff completed safeguarding training at level 3 with level 4 training undertaken by the services designated safeguarding leads.

Safeguarding training compliance rates for the service were; 93% for level 3 and 100% for level 4.

Safeguarding children training was provided by the service and had an overall compliance rate of 100% at level 3. The service did not provide any care for anyone under the age of 18.

Good

Hospice services for adults

Staff knew how to identify adults at risk of, or suffering, significant harm and knew how to make a safeguarding referral and who to inform if they had concerns.

The service had visible posters which explained the process for staff to follow if they suspected abuse.

Cleanliness, infection control and hygiene

Staff used infection control measures when on the ward and transporting patients after death.

Areas were clean and had appropriate and suitable furnishings. We also noted that areas were tidy and free from clutter.

Staff used records to identify how well the service performed with cleanliness, infection control and hygiene. We reviewed infection control audits which recorded a high level of compliance. Audits and registers covered appropriate areas of cleanliness to check and complete.

Staff followed infection control principles including the use of personal protective equipment (PPE), appropriately.

We noted processes for transporting patients after death were suitable and appropriate for infection control purposes.

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 facilities and design of the service was bright and welcoming.

We reviewed evidence which demonstrated the service had a rolling schedule of equipment servicing from external organisations.

Where equipment was out of use, this was made clearly visible to staff, so as not to use.

All patient care was carried out over 1 floor at ground level. The service did have a second floor which was used for management and administration purposes.

Clinical waste was stored in appropriate containers and sharps bins were sealed and dated as per national guidelines.

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 an appropriate tool to identify patient need and levels of deterioration. Patient needs were escalated appropriately, within the context of the service.

Staff completed risk assessments for each patient on admission, using an appropriate tool. We reviewed template documents which would allow recording of initial and ongoing clinical information.

Staff knew about and dealt with any specific risk issues. We reviewed audits which had been carried out around areas such as tissue viability and venous thromboembolism (VTE). The service provided us with evidence that they had adopted guidelines around the management of sepsis, from a local NHS trust which they partnered with for service provision. This evidenced that the service was sighted on prevalent patient care issues, which could arise.

The service had access to therapeutic support, which was part of the service's overall holistic offering, such as counselling. This aimed to support the mental wellbeing of patients, within the context of their admission to the service.

Staff told us that the process for any transfer out arrangements, were considered in line with the needs of the patient, for example, if a patient was receiving end of life care, a transfer out in the event of deterioration would not happen. For other patients, where appropriate, transfer to a local NHS emergency department was arranged. Medical staff provided a handover of the patient's presentation to the receiving hospital trust.

Staff shared key information to keep patients safe when handing over their care to others, during daily morning huddle meetings.

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.

The service had 45 staff members who were involved in the provision of patient care. These included; a clinical lead, junior sister, practice development nurse, registered nurses, senior health care assistants and health care assistants.

Staff received an induction which included being provided with an employee handbook. The handbook provided clear expectations and instructions regarding the reading of policies and procedures used by the service and the mandatory training staff were required to complete. All policies and training required to be read or undertaken was appropriate and in line with the service provided.

Managers told us that staffing levels were consistent, with baseline numbers implemented. Numbers were not reduced if there were lower numbers of patients. This reflected the management of complex needs that patients could present with.

The service used bank staff, several of which were former permanent employees who knew the service well. Bank staff had an induction process, which was clear and well defined within the same induction booklet provided to permanent members of staff.

The service used a low level of agency staff, which totalled 1 shift in the previous 12 months. We reviewed documentation of the agency staff member held on file which documented their suitability for the role in relation to their skills, registration and training.

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.

The service had a service level agreement (SLA) with a local NHS Trust that provided 4 sessions a week of consultant cover, which equated to 4 half days. The hospice also utilised the trust's medical trainees, in its role as a teaching facility. The hospice employed 3 doctors directly.

Staff told us about the process for accessing medical support for patients. Medical staff were on site for the hours of 9am to 5pm. Out of hours and weekend cover was provided by an on call doctor, who could advise staff over the phone or attend on site. If required, the on call doctor had access to a consultant within a local NHS Trust.

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. Records were paper based and stored securely. Staff told us that they were able to access the information they needed, when they needed it, in an easily organised manner.

Medicines

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

The hospice had an SLA in place with an external pharmacy provider for the supply of all medicines. As part of this service arrangement, they provided 3 training sessions a year on medicines management.

We noted that medicines reconciliation and stock levels were checked daily by ward staff.

Medicines were ordered on a designated day of the week and authorised by doctor. If further stock was required, additional orders could be placed. The service had access to an emergency medicines stock out of hours and additional medicines could be prescribed by medical staff and sought from local pharmacies, if needed.

The service used medicines destruction kits and we noted that all medicines were disposed of appropriately as part of clinical waste.

During the inspection, we reviewed 5 medicine administration records (MAR) charts, these were complete and up to date with minimal omissions or errors. MAR charts showed oxygen was prescribed and the required dose and duration was appropriately documented. We also noted that 'as required' (PRN) medicines were prescribed with a relevant maximum dose clearly recorded within the records.

We reviewed audit documentation from the service which included prescriptions forms and controlled drugs. This evidenced comprehensive and proper management of medicines.

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 told us that they knew what incidents to report and how to report them in line with service policy. An incident form would be filled in by a staff member and this would be reviewed by the service management.

Good

Hospice services for adults

We reviewed the service's incident log covering the previous 12 months. We noted that there was a description of the incident recorded, the date it occurred, and the actions taken. This meant that a clear and concise overview of incidents, could be ascertained by a staff member reviewing the document.

We were provided with evidence of root cause analysis training, which had been completed by the services Information Governance Manager. Root cause analysis aims to find the cause of any incident through the investigation of the circumstances of an incident.

The service also provided us with copies of 4 quarterly incident themes and trends log. We reviewed these documents and noted that it grouped similar incidents together to corelate actions taken in response to incidents and any lessons learned.

The service reported no never events in the past 12 months. Never events are serious incidents that are wholly preventable.

The service had means in place to implement the duty of candour. We reviewed the duty of candour policy used by the service. The content of the policy was detailed, methodical and informative to the reader.

Staff told us that they were aware of the duty of candour and what this meant for their role and the service as a whole.

Is the service 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 followed relevant guidance from The National Institute for Health and Care Excellence (NICE), Medical Royal Colleges and also local guidelines.

Staff also followed the 'Palliative care and end of life care symptom control guidelines for cancer and non-cancer patients' (2021) developed by the North East and North Cumbria Clinical Network.

Patients had an individualised care plan. If the patient was at end of life, this included an individualised care and communication record for a person in the last days or hours of life. This was in line with NICE guidelines and quality standards, such as QS13 (End of life care for adults) and NG31 (Care of dying adults in the last days of life).

Staff used the Care for the Dying Patient Document for end of life patients to deliver person-centred care.

Staff supported patients mental health needs by providing support for bereavement and counselling. Specialist psychological support could be accessed through a local NHS trust.

Changes to practice and best practice guidelines were reviewed as part of clinical governance meetings, held every 3 months. We noted that clinical policies and procedures reflected NICE guidelines.

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 carried out nutrition and hydration risk assessments on admission and care plans were in place to manage needs. Patients could be referred to a dietitian for additional support.

Where required, staff monitored food and fluid intake and completed fluid balance charts. In samples of records we reviewed, fluid balance charts were complete and up to date, where applicable.

Patients were offered a choice of food on a menu, including the catering for special or cultural diet needs.

Nutrition and hydration included in intentional rounding tool, completed at least every 4 hours by staff. Intentional rounding is the structured process whereby staff carry out regular checks with patients using a standardised protocol to address issues of positioning, pain, personal needs and placement of items.

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.

We observed and noted that staff used a recognised pain score tool to assess pain.

Patient records we reviewed evidenced appropriate pain relief medicines were given to patients to manage symptoms. Where pain relief was given, records showed this was followed up within 30 minutes to check if pain relief was adequate.

Pain management also included an intentional rounding tool, completed at least every 4 hours by staff.

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 monitored patients preferred place of death and reported well against this patient outcome. Over the previous 12 months the service recorded 100% compliance of patients preferred place of death against a target of 85%.

The service used the Integrated Palliative Care Outcome Scale (IPOS) tool, which is nationally recognised. The IPOS tool is a questionnaire which assesses a patient's physical symptoms, social and psychological wellbeing and their relationships with others.

The service used the Australia-modified Karnofsky Performance Scale (known as AKPS), which is a measure of the patient's functional status or ability to perform their activities of daily living. AKPS is scored from 100% to 0% in steps of 10%. It is based on the patient's ability to perform common tasks relating to activity, work and self-care.

Medical staff participated in routine clinical audits, such as Thromboprophylaxis in palliative care and learning was shared with the team to improve practice.

We noted that the service carried out a program of clinical audit including for example, mouthcare and medicine reconciliation to benchmark performance against best practice guidelines.

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.

We noted that medical staff had appropriate General Medical Council (GMC) revalidations and clinical appraisals within their staff files. The provider worked with a local NHS trust's responsible officer for all medical staff appraisals.

The service had a practice development nurse in post who oversaw training and development of staff. This post holder also managed a team of 4 nurses and 2 health care assistants.

Staff undertook an induction period of 2 weeks which included organisational orientation and e-learning. An induction checklist was signed off by line manager to confirm that an induction had been successfully completed.

We reviewed competency booklets for nursing staff and health care assistants. Booklets were signed off by the practice development nurse and line manager to confirm role competency.

The practice development nurse role also covered medical staff competencies and we noted that the service provided ad hoc training days and a yearly continual professional development (CPD) training day for medical and nursing staff, covering areas such as delirium, blood transfusion and use of syringe pumps.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. For example, staff told us they had been supported to undertake an advanced qualification in end of life care at a local university.

Multidisciplinary working

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

We reviewed patient records which evidenced that routine input from multi-disciplinary staff and healthcare professionals took place. The hospice had a daily MDT meeting and huddle every weekday morning which included medical, nursing and support staff input to review resources and patient risk.

The hospice also held a weekly MDT meeting on Wednesday, which was attended by senior managers and the wider team to review all admissions, deaths, discharges and the needs of complex patients.

The hospice had a SLA with a local NHS trust for support and services including laboratory, pathology and in other areas such as multi-faith chaplaincy input.

We noted there was a regular MDT working with other healthcare professionals, including regular meetings and input from GP's, a local NHS trust and with the local community palliative care nursing team.

Good

Hospice services for adults

Seven-day services

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

The hospice inpatient ward was operational 24/7. In addition, the unit had a 24 hour helpline telephone number for patients or relatives to use if support or advice was required.

Medical staff were onsite during routine business hours every weekday, with on call support for any out of hours or weekends escalation.

The day hospice service was provided 1 day per week.

Other services such as physiotherapy, occupational therapy, speech and language support were available during weekdays only.

The hospice's therapeutic offering was also available on weekdays only.

Health promotion

Staff gave patients practical support to help them live well within the context of their needs.

We noted that health promotion information was available on the hospice website.

As part of its wellbeing and therapeutic offering the service provided a health and well-being counselling service for staff, patients and relatives.

Non-end of life care patients with specific needs, such as weight management, smoking cessation or alcohol dependence could be referred to local NHS services.

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 told us they understood the legal framework and processes around consent and the provisions of the Mental Capacity Act 2005. Mental capacity was covered as part of the service's safeguarding training.

We reviewed patient records which included written consent from patients and discussions about their needs and preferences.

Written consent was sought in the first instance however staff were aware that if a patient was unable to provide consent on a specific decision, then medical staff would carry out a mental capacity assessment. If the patient was assessed as lacking capacity, a best interest decision would be made with MDT input and involvement of patient relatives or representatives.

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) records were completed appropriately and evidenced involvement from a patient or their relatives or representative.

Good

Hospice services for adults

Is the service caring?

Good

Our rating of caring went down. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

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.

Patients said staff treated them well and with kindness. A common theme that we found was that 'staff could not do enough for me'.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. For example, following the passing away of people from certain cultures, staff had organised compliance with post death practices.

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. This was through a referral to the onsite therapeutic and holistic offering the service provided.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. An importance on bereavement counselling was prevalent within the service.

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. For example, the hospice had the facility for family members to stay overnight within the hospice to provide continual support to a loved one and not be disadvantaged by living a large distance away.

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. Patients told us staff took the time to make sure they were cared for in the way that they wanted. A common theme with patients we spoke with, was how quickly staff responded to call bells being pressed.

Good

Hospice services for adults

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We noted that a translation service was available for staff to use in supporting patients. 'This is Me' passports could also be used by the service. If a patient did not have one of these, staff could help them complete one if appropriate.

Staff supported patients to make advanced decisions about their care, through talking about advanced care planning, what they wanted for the end of their life and where it was important for them to pass away.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff told us the service monitored and evaluated feedback received through patient and carer experience questionnaires. The findings from the feedback were collated into a Patient and Carer Experience Action Plan.

The service implemented a 'Friends and Family Test' from which data was gathered via postcards and patient questionnaires and analysed on a quarterly basis by the Clinical Governance Group.

Patients gave positive feedback about the service. We noted that comments about the service were overwhelmingly positive. The most recent friends and family test feedback was recorded at 100% of responses agreeing they were 'extremely likely' to recommend the services they had used.

Is the service responsive?

Good

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

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The hospice provided 2 main areas of activity. The hospice services incorporated a day hospice and an inpatient unit. A long stay unit had closed earlier in 2023. The hospice provided services for the people of Tees Valley and County Durham.

The day hospice operated 1 day per week from 10am to 3pm, with 1 bed. A full holistic nursing assessment was completed on admission to the day hospice service and was a programme for up to 8 weeks. It was accessible to any palliative care patients within the hospice catchment area.

After 8 weeks, a patient was discharged back to community and a discharge letter was also sent to the patient's GP. Patients could be referred to the day hospice by any healthcare professional, most referrals were from the specialist community palliative teams and the service was only available to adults over 18.

The inpatient unit consisted of 10 beds, which were commissioned by the local health and care system. Patients could be referred to the service from local health professionals, GP's, acute trusts and district nurses or community palliative care nurses. The inpatient service was available for patients within the local area. The average patient length of stay was 17 days.

The registered manager told us there had been no mixed sex accommodation breaches and we noted that all rooms in the inpatient unit were single.

The hospice also provided counselling services and day therapies which were accessible for members of the public within the local catchment area.

Staff told us that upon referral, patients were prioritised for admission using the RUN-PC tool. The RUN–PC Triage Tool is an evidence-based tool used to prioritise patients referred to palliative care services by urgency of need.

The hospice had regular meetings with commissioners and worked with system partners within the local Integrated Care Board, to promote services around end of life care for patients.

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 service utilised a translation and interpretation service if a patient would benefit from this. Information leaflets were in English however, they could be provided in other languages or formats such as braille or large print, if required. Sign language services were also accessible.

The service could admit bariatric patients and had specialist equipment such as hoists, chairs and beds in place, to facilitate these admissions.

We noted that autism, dementia and learning disabilities (LD) training for staff had been implemented. Support for patients with additional needs included the use of 'This Is Me' passports and also detailed assessments on admission which helped formulate person-centred care plans to meet individual preferences.

We observed that the facilities and equipment had been considered to maximise considerations for people with a cognitive impairment. For example, clocks included a visual aid to assist in identifying if it were AM or PM and specialist activity boxes included sensory aids and appropriate crafts.

We noted that staff were aware of making reasonable adjustments for the benefit of patients, such as placing patients with a learning disability or dementia needs closer to the nurses station and facilitating greater input from relatives.

The unit had open visiting for friends and family and there was also a facility for relatives to stay overnight, within 1 of 2 separate rooms, which had been specifically utilised for that purpose.

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 monitored.

We reviewed referral to admission data for the service and noted:

- For the inpatient unit, referral to admission times ranged from 0 – 44 days, although most patients were admitted in 10 days or less.
- For end of life care, admission times were 2 days or less, although most were admitted on the same day.

Good

Hospice services for adults

- For the hospice day service, admission times ranged from 1 – 41 days.

Staff told us that they contacted patients who did not attend day hospice services as part of a welfare call. We noted an example whereby when a patient did not attend the service, staff made contact and ascertained that the patient had been admitted to hospital. The patient was kept on file for a return to day hospice when they had been discharged from hospital.

Patient discharges were reviewed and discussed at the weekly MDT meeting. Patients who were discharged from the inpatient ward or day hospice had a discharge checklist completed in their patient records. This included information such as treatments provided and any discharge medication. A discharge letter was also sent to the patients GP.

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 provided information on how to raise complaints in an induction pack for each patient. In addition, this information was also available on provider's website.

A complaint policy and procedure was in place. We reviewed the policy and noted it was appropriate and contained the relevant information and processes to follow.

Complaints would be investigated by an appropriate lead for example the registered manager, consultant or clinical lead. Standardised templates for documenting complaint investigations and response letters were in use.

We noted that no formal complaints had been received by the service in the previous 12 months. Where complaints were received, managers told us that they would be reviewed at the quarterly clinical governance meetings to look for trends, with a view to identifying improvements.

Is the service well-led?

Good

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.

Recruitment of leaders and management positions focussed on a robust job description and person specification, to ensure that staff had the correct skills, knowledge and experience needed to run the service. The assessment process incorporated a test of these skills, for example the registered manager post required the completion of a written tender bid.

Senior leaders were sighted on the issues that had the potential to impact the service and had mitigation strategies in place.

Staff members spoke highly of their management and told us they were visible and accessible.

Staff were supported to undertake qualifications, to improve their knowledge and practice. This was then fed back and promoted to colleagues. We noted evidence of career progression, for example the current joint Chief Executive Officers (CEO) had risen in seniority within the service over a number of years and had been part of an aspiring CEO program, in their previous roles.

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.

Senior leaders were sighted on 3 key areas over the medium to long term:

- Ensure the sustainability of the service;
- Expansion of the services offered; and
- Increase collaboration and partnership working with system partners.

The service was part way through its current 5 year strategy which had been published in 2020. This strategy included aspects such as vision, mission and the values of the service. Within the strategy, challenges to the service were identified and strategic goals were detailed to meet or overcome the challenges faced.

The service had developed 3 strategic goals and had set out descriptors or targets as to how to achieve these.

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. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us that they felt respected, supported and valued. We spoke with leaders who aimed to promote a team ethos of caring for patients with dignity and respect no matter what their role within the service. We observed positive interactions between all members of staff regardless of seniority.

The service promoted equality and diversity, with the first survey about such having been carried out earlier in the year. This had led to additional information being disclosed to the service, to better support staff members at work.

Staff said that the service had an open and welcoming culture, where they felt they could raise concerns with both their colleagues and leaders without fear. There was a genuineness among staff that having to raise concerns about others was an exceptionally rare occurrence.

Senior leaders told us that to support staff with raising any concerns, a Freedom to Speak Up Guardian had been appointed and an associated policy was in place.

Good

Hospice services for adults

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.

An appropriate governance system was in place and senior leaders could effectively describe the way that this operated.

For the purposes of regulated activity that the service carried on, the governance structure was described as:

- Sub-groups for areas such as medicines management, clinical risk and models of care reported into a Clinical Governance Group.
- The Clinical Governance Group reported into Senior Management Team which included the joint CEO's and registered manager.
- The Senior Management Team reported into the Finance and Risk Management subcommittee.
- The Finance and Risk Management subcommittee reported into the board of trustees who acted in the capacity of directors of the provider as a limited company.

Information flow was bidirectional and was cascaded to front line staff from managers present in the subgroups of the overarching Clinical Governance Group. This took the form of staff email bulletins and discussion at daily morning huddles.

Staff concerns or feedback were escalated by means of incident reports being completed or, by utilising the open door policy of senior management to speak up about a matter directly.

However, aside from the morning huddle, there was no formal team meeting structure or schedule in place. This could support in providing another effective medium to both disseminate and escalate issues that required implementation or action.

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.

Senior leaders could articulate the risks facing the service which were appropriately reflective of the wider health economy, system pressures and speciality sector.

The service used a risk register to assess and mitigate risks facing the business. During our inspection we requested a copy of this document. The risk register was broken down into categories of risk and within each category there was a detailed a description of the risk, owner, mitigation in place and pre and post mitigation scores.

A business continuity policy was in place which was detailed and informative for any unexpected events. Senior managers were able to discuss aspects of this for example, if a power cut happened and could not be fixed, then an agreement was in place for the power company to provide an onsite generator.

Senior leaders described that staff and trustees had input into decision making and service development via workshops and sessions which had been held in preparation of the services strategy.

Good

Hospice services for adults

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.

Senior leaders told us about the ongoing program of internal audit which included the following areas; prescriptions, care for the dying, controlled drugs, patient safety incidents and use of bedrails. This information was used and analysed to formulate an action plan, for any required improvements, which was in turn presented to the Clinical Governance Group.

Paper records were used for patient care data collected. This was stored in a secure manner which was accessible to staff who needed it. Other business critical records such as policies and procedures were stored electronically on computers which could be password protected.

Immediately prior to our inspection the service had become aware of an issue with submitting notifications to external organisations, as required. Management were honest and transparent about this issue and described the action plan to be implemented to rectify this, on an ongoing basis.

The service had a Caldicott Guardian in place. A Caldicott Guardian is a designated person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.

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 service engaged with staff through an annual staff survey, the results of which were then shared with staff. This meant issues highlighted could be discussed in further detail, to better support staff.

Leaders told us about a staff appreciation day which had taken place earlier in the year and included a BBQ.

A wellbeing referral could be made for staff to benefit from the counselling and therapeutic services offered by the onsite holistic centre.

Senior leaders told us they had engaged with a local LGBTQ+ rights organisation. This had resulted in awareness raising training for specific end of life care issues, which could better support care for members of this community.

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.

Staff were encouraged to undertake advanced education in the area of end of life care, at a local university. This has been secured by specific funding that had been awarded to the provider.

Good

Hospice services for adults

Senior leaders also told us that a member of the medical staff had published a journal article around the model of care for a long term hospice unit setting.

The hospice was also part of a 10 member provider collaborative across the ICB which aimed to share and promote best practice.

During our inspection we noted a piece of innovative practice around prevention of staff sickness and associated cost savings. The service had measured savings of around £60,000 in sickness pay costs, by early identification of staff well being concerns and a referral for use of the onsite therapeutic and counselling services offered.