

St Giles Hospice- Whittington

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Outstanding	☆
Are services safe?	Good	●
Are services effective?	Good	●
Are services caring?	Outstanding	☆
Are services responsive?	Good	●
Are services well-led?	Outstanding	☆

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

St Giles Hospice - Whittington is operated by St Giles Hospice and opened in Whittington in 1983. The hospice/service provides care for adults and has 25 beds.

The hospice at Whittington offers the following services:

25 inpatient beds – 19 for specialist palliative care needs and six for patient's funded by fast track continuing healthcare funding who are less complex in terms of their end of life care needs and who would not usually therefore meet the criteria for specialist care.

Community team – a registered nursing workforce structured around localities which includes advanced nurse practitioners, clinical nurse specialists and staff nurses.

Hospice at home – led by a registered nurse this team of health care assistants provide practical and emotional care in the home for patients in approximately the last two weeks of life.

Care at home – a small team of carers who can provide up to four double up social care packages for people in receipt of fast track continuing healthcare funding.

Day hospice – patients attend for one day per week for eight or 12 weeks. Service operates four days per week. They work with their nominated nurse on personal goal setting and advance care planning as well as benefitting from peer support and reduction in social isolation. There is access to seated exercise and complementary therapy.

Wellbeing day – One day per week 'step in' or 'step out' service for people to find out more about services, seek advice or information, attend seated exercise or access complementary therapy; benefit from peer support.

Family support and bereavement - pre and post bereavement support offered at a variety of levels of intervention, either on a one to one basis, group or family based.

Advice and referral centre operates 24 hours a day seven days a week, advice for any professionals, patients known to St Giles Hospice or members of the public. Receives and triages referrals including speaking directly with person referred.

Supportive care – broad based team operating internally and externally that includes allied health care professionals; complementary therapy; community engagement and development work.

Lymphoedema - clinic service providing assessment and treatment for all forms of primary and secondary lymphoedema for both adults and children.

Phoenix service - bereavement service developed by and for young people experiencing bereavement and open to anyone across our catchment.

Specialist women's cancer support service.

Care home Service - a fully commissioned service which supports individual care homes develop and maintain their end of life care registers and proactively plan and manage end of life care for their residents.

In May 2017, the hospice provider launched its new five-year strategy and as part of this underwent a re-brand.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 7 and 8 March 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Summary of findings

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

Our rating of this service improved. We rated it as **Outstanding** overall.

We found areas of outstanding practice:

- There was strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences. The service took a leadership role in its health system to identify and proactively address challenges and meet the needs of the population. Services were developed with the full participation of those who used them.
- There was an embedded and extensive team of volunteers who helped support the service. There was a volunteer strategy, a volunteer induction and training programme. Volunteers were proactively recruited, valued staff who were supported in their role in the same manner as substantive staff. The service regularly updated its policies and processes for using volunteers and innovative practice, and the use of volunteers helped to measurably improve outcomes for people.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. People who used the service told that staff went over and above what was expected of them. Staff displayed determination and creativity to overcome obstacles to delivering care.
- There were consistently high levels of constructive engagement with staff and people who used services. Rigorous and constructive challenge from people who used services, the public and stakeholders was welcomed and seen as a vital way of holding services to account.
- There was compassionate, inclusive and effective leadership at all levels. Leaders demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. There was a deeply embedded system of leadership development.
- There was a commitment to continuing development of the staff's skills, competence and knowledge. This was recognised as being integral to ensuring high-quality care. Staff were proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice. The service also used objective structured clinical examinations (OSCE) to assess staff competence in a live manner.

We found good practice:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance. There was a holistic approach to assessing, planning and delivering care and treatment to all people who used services. This included addressing, where relevant, nutrition, hydration and pain relief needs.
- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- The service planned and provided services in a way that met the needs of local people. The facilities and premises were appropriate for the services that were delivered. The services provided reflected the needs of the population served and they ensured flexibility, choice and continuity of care. For example, services for children, young people and their families that allowed them to undertake activities together. There was extensive ongoing support and follow-on family support groups specifically for children and young people after they had suffered a bereavement. There was also a service that worked with local schools to support young people.

Summary of findings

- In April 2018, following some building reconfiguration, six continuing healthcare beds were opened, operating on a different referral and care model to the remaining 19 specialist beds. This widened access to people who previously would not have been eligible for a specialist hospice bed.
- People who used the service were encouraged to contribute to improvements and developments to ensure the service was a reflection of the people who used it.
- Staff felt positive and proud to work in the organisation. The culture centred on the needs and experience of people who used services. Staff told us that they felt pride in the organisation and the work they carried out to ensure patients received good quality care.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. Staff had access to a robust training and competency programme to ensure they had the skills required to provide good quality care. Staff were supported and encouraged in their development and there lots of examples of career progression and gaining accredited qualifications.

However:

- The provider should ensure that allergies were recorded on the main treatment and prescription charts for all patients.

Heidi Smoult

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Hospices for adults

Rating

Outstanding



Summary of each main service

St Giles Hospice - Whittington provided hospice care to adults through inpatient, day hospice and community services.

We rated the service outstanding overall because the service was outstanding in caring and well led.

Summary of findings

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Outstanding



St Giles Hospice - Whittington

Services we looked at

Hospices for adults

Summary of this inspection

Background to St Giles Hospice- Whittington

St Giles Hospice - Whittington is operated by St Giles Hospice. The hospice opened in 1983. It is a private

hospice in Lichfield, Staffordshire. The hospice has a registered manager. The hospice primarily serves the communities of the Staffordshire and North Birmingham. It also accepts patient referrals from outside this area.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, two specialist advisors with expertise in hospice care and two pharmacists. The inspection team was overseen by Victoria Watkins, Head of Hospital Inspection.

Why we carried out this inspection

We carried out this inspection as part of our routine inspection programme.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced inspection on 7 and 8 March 2019.

Information about St Giles Hospice- Whittington

The hospice has one ward and is registered to provide the following regulated activities:

- Diagnostic and screening
- Personal care
- Treatment, of disease, disorder and injury

During the inspection, we visited the ward, carried out visits to nursing homes and spent time on home visits with nursing staff. Two Care Quality Commission pharmacists spent time reviewing medicines management. We spoke with a wide range of staff including registered nurses, health care assistants, reception staff, medical staff and senior managers. We spoke with patients, relatives and visitors and reviewed patient records including prescription charts.

There were no special reviews or investigations of the hospice ongoing by the CQC at any time during the 12 months before this inspection. The hospice has been inspected four times, and the most recent inspection took place in March 2017, which found that the hospice was meeting all standards of quality and safety it was inspected against.

Activity for January – December 2018.

- There were 341 inpatient stays and 1471 Day Hospice attendances.
- There were 55 medical outpatient attendances. There were 854 cancer lymphoedema outpatient attendances

Summary of this inspection

- Patients were funded for their care and treatment by charitable funds and by NHS funding.
- There were 1905 non-cancer lymphoedema outpatient attendances. All of these patients were funded by the NHS.

Track record on safety

- No Never events
- Five clinical incidents
- One serious injury
- No incidences of healthcare acquired Methicillin-resistant Staphylococcus aureus (MRSA)
- Three incidences of healthcare acquired Clostridium difficile (c.diff)
- One outbreak of Norovirus
- Twelve complaints

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Our rating of safe stayed the same. We rated it as **Good** because:

Good



We found the following areas of good practice:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- 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.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The service had enough medical staff. Patients had access to a 24/7 medical on-call service.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medicine at the right dose at the right time.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. 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.

However:

- Policies were in place for the management of medical gases. A recent audit had identified some areas of risk for the management of medical gases. An action plan was in place and due to be completed by April 2019.

Summary of this inspection

Are services effective?

Our rating of effective stayed the same. We rated it as **Good** because:

- There was a holistic approach to assessing, planning and delivering care and treatment to all people who used services. This included addressing, where relevant, nutrition, hydration and pain relief needs.
- There was an embedded and extensive team of volunteers who helped support the service. There was a volunteer strategy, a volunteer induction and training programme. Volunteers were proactively recruited, valued staff who were supported in their role in the same manner as substantive staff. The service regularly updated its policies and processes for using volunteers and innovative practice, and the use of volunteers helped to measurably improve outcomes for people.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- 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 monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Good



Are services caring?

Our rating of caring improved. We rated it as **Outstanding** because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Patients and their families and carers told us that staff went over and above what they expected.

Outstanding



Summary of this inspection

- People were truly respected and valued as individuals and were empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service. This included families and other people involved in patient care.
- Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between people who used the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders.
- Staff recognised and respect the totality of people's needs. They always took people's personal, cultural, social and religious needs into account, and found innovative ways to meet them. People's emotional and social needs were seen as being as important as their physical needs.
- People valued their relationships with the staff team and felt that they often go 'the extra mile' for them when providing care and support.

Are services responsive?

Our rating of responsive stayed the same. We rated it as **Good** because:

- The service planned and provided services in a way that met the needs of local people. Services were tailored to meet the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care.
- The facilities and premises were innovative, were adapted if needed and met the needs of a range of people who used the service.
- The service took account of patients' individual needs. There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs.
- The services were flexible, provided informed choice and ensured continuity of care.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results and shared these with all staff.

Good



Are services well-led?

Our rating of well-led improved. We rated it as **Outstanding** because:

Outstanding



Summary of this inspection

- There was compassionate, inclusive and effective leadership at all levels. Leaders demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. There was a deeply embedded system of leadership development.
- Leaders had a deep understanding of issues, challenges and priorities in their service, and beyond. There was safe use of innovative and pioneering approaches to care and how it was delivered and actively encouraged.
- The strategy and supporting objectives and plans were stretching, challenging and innovative, while remaining achievable. Strategies and plans were fully aligned with plans in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership.
- There were consistently high levels of constructive engagement with staff and people who used services. Rigorous and constructive challenge from people who used services, the public and stakeholders was welcomed and seen as a vital way of holding services to account.
- There was strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences. Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- There was a commitment to continuing development of the staff's skills, competence and knowledge. This was recognised as being integral to ensuring high-quality care. Leaders proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice.
- The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.
- The service engaged exceptionally well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.
- Comprehensive and successful leadership strategies were in place to ensure and sustain delivery and to develop the desired culture.

Detailed findings from this inspection

Mental Health Act responsibilities

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service. We do not give a rating for Mental Capacity Act or Mental Health

Act, however we do use our findings to determine the overall rating for the service. Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overview of ratings

Our ratings for this location are:

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

Notes



Hospices for adults

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

Are hospices 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.

All staff completed statutory and mandatory learning. The mandatory training programme contained all the foundation level skills required to work with the patient group. For example, staff were trained in basic life support, manual handling and infection prevention control. There were ongoing mandatory training programmes where renewals and updates took place.

All staff, including bank staff, received an induction which included mandatory training. Mandatory training was delivered using a range of methods, for example, eLearning and group training. All bank staff had their mandatory training competencies signed off before they could work unsupervised.

Clinical staff were subject to competency assessments using a passport style approach which was integrated within their appraisals. A wide range of education and training opportunities, some optional and some mandatory were available. A register of staff mandatory training was maintained. This was up to date and all staff were compliant with their mandatory training. This meant staff had received a training to ensure they had received the skills required to fulfil their role.

Staff received email reminders to inform them when training was due.

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.

All staff, including volunteers had the necessary security checks at recruitment stage to ensure they were safe to work with patients. The senior leadership team and staff told us that these checks were recorded in their personal records.

All staff completed a safeguarding adults e-learning module annually following attendance on induction. Further levels of training were mandatory for staff depending on their role. The following compliance figures included the sister hospice site staff data. Sixty seven percent of staff had received safeguarding adults training at level 2, 100% had received safeguarding adults training at level 1. All clinical staff had received safeguarding children level 2 training; 25% of clinical staff had received level 3 safeguarding children training. Depending on role, staff safeguarding skills were monitored to ensure they were competent in recognising and managing safeguarding issues.

All registered nurses had an observed structured clinical examination (OSCE) to identify areas of learning. The OSCE's demonstrated nurses' knowledge and ability to escalate concerns relating to safeguarding. The training and observation sessions promoted six safeguarding principles. Facilitators used various teaching and learning activities to meet the learning. The teaching session was



Hospices for adults

mandatory for all registered practitioners and the programme was near completion. Sessions were evaluated with positive feedback. As a result, the programme was extended to health care assistants.

A safeguarding lead for children and a separate one for adults were in place, together with nominated deputies. These leads were trained to a level four which was in line with intercollegiate guidance. There was a comprehensive training programme in place to support staff understanding of mental capacity and safeguarding led by a clinical educator.

Staff had links with other key agencies and stakeholders, for example, GP's and local authority safeguarding teams. Staff liaised with these agencies for advice, guidance, to make referrals and to share information.

There was a comprehensive safeguarding children and safeguarding adults' policy in place. These policies had recently been reviewed and were based on the latest national guidelines.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

The hospice had an infection control lead and clinical leads responsible for auditing, assessing and reviewing care in practice. These included infection prevention and control.

Housekeeping staff kept the premises clean and there were schedules and checking systems in place to ensure all areas were cleaned as indicated in the schedule.

Staff recorded four incidences of healthcare acquired infections in the 12 months prior to inspection. During the period January 2018 to December 2018 there were three occurrences of *Clostridium Difficile* and one incidence of Norovirus. As a result, root cause analysis was completed. We looked at all root cause analysis findings and learning from it. During the investigation process, compliance with audits was explored, whether further training was required by staff to help reduce further incidents.

There were facilities to support good infection prevention control in all patient rooms and in the corridors outside

patients' rooms. The hospice was visibly clean. There were concealed wash facilities with hot and cold running water. There were good supplies of personal protective clothing, for example, gloves and aprons.

All clinical staff were observed to be bare below the elbows as outlined in the infection prevention control policy. All staff were observed using appropriate protective equipment such as gloves and aprons to carry out procedures and personal care activities. Patients told us that they observed hygiene by staff.

The service ensured that the health and safety of everyone who met the deceased person's body after death was protected. The environment where bodies were stored was clean and well maintained. There were private viewing facilities and access to resources for washing.

The service held quarterly infection prevention and control forums. These forums looked at audits undertaken in the quarter including antibiotic use, infection champion audits and environmental audits. We reviewed minutes from the October 2018 meeting and saw that the results of the audits were discussed and where issues were identified actions were put in place.

This meeting also looked at infection control policies and ensured that they were reviewed when their review was due. We saw that infection control policy and the legionella policy had both been recently updated.

The service also had a comprehensive program of flu vaccinations for staff. This is important in a hospice setting as patients who attend the hospice may have weakened immune system due to their treatments and conditions.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

The hospice had a housekeeping and maintenance team responsible for the building and grounds. A head steward was responsible for health and safety, including fire and estates maintenance. There was an equipment and maintenance register held under the nursing director to ensure that safety and maintenance checks were completed with no observed errors or omissions.



Hospices for adults

Staff discussed issues relating to environment and equipment at their team meetings. For example, minutes from a team meeting recorded that syringe driver management policy updates were discussed with staff. This meant that information was shared to ensure staff were updated with equipment changes.

Some equipment was available for patients on loan to enable them to stay at home. Larger items for example beds were organised from an external supplier.

Clinical waste disposal arrangements were in place throughout the hospice. People could access bins clearly labelled, for example, clinical waste only or domestic waste only. Bins were lidded and operated with a foot-pedal if in clinical areas and toilets to prevent hand contamination. We looked at sharps bins and saw that staff observed good practice while disposing of sharps. For example, they ensure the appropriate bins were available and disposed of before they became too full.

Private access for ambulances was available to enable dignified removal of deceased patients from the hospice.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

Staff carried out risk assessments on admission for each individual patient which were subject to regular review. All inpatients were subject to an holistic daily assessment process which included mental capacity. A multi-professional review of risks took place weekly. All staff could access an electronic record which supported real time updating whether on or off site. Staff could access alerts for key safety issues for individual patients such as allergies. This meant there was an electronic system accessible by staff to keep each patient safe.

Staff managed emergencies in line with policy and procedures. Patients sometimes required an emergency or unplanned transfer to hospital via 999. To ensure a smooth transition the hospice on-call consultant would be informed. On every occasion, an incident report was completed and was documented in the patient notes.

Staff managed unplanned transfers to hospital following process. In the first instance, staff would contact third party out of hours doctors to review or in hours by a member of the medical team if not already undertaken.

All unplanned transfers were reported to the inpatient operational group. Managers told us a work stream was planned to review unplanned transfers for learning and improvement.

Staff managed the increased risks experienced by people at the end of life. All patients were risk assessed for skin integrity, pressure ulcers, falls using evidence-based tools. The information was used to form management plans which were stored in patient records. There was a lead tissue viability nurse to support staff in ensuring good practice. Staff carried out quarterly wound care audits. We looked at the audit report which reported on whether there were issues identified for learning and improvement.

The service actively encouraged patient participation in managing risks. An example of this was an information leaflet given to all patients which detailed how to care for their skin and minimise the risk of pressure damage. Another example was a leaflet given to patients detailing practical tips on how to avoid falls in a new environment.

Care plans included 'ceilings of care'. The ceiling of care was not a binding advanced directive but was designed to provide continuity of care and good communication. It provided information about appropriate limitations to interventions which were likely to be burdensome, futile or contrary to the patient's wishes. This demonstrated patients were involved should their condition deteriorate.

Nurse staffing

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

Staffing establishments were planned based on skill mix and capacity. Managers used an online tool to review, compare, remodel and report on staffing care levels and costs across different care settings. Staffing levels were reviewed annually and based on feedback from service users, work with other providers, both NHS and voluntary sector. Community team caseloads were regularly reviewed by a senior nurse with the caseload holder.

Managers gathered and reviewed data about responsiveness to referrals and admissions, patient safety indicators, complaints and significant events where staffing may be an influencing factor. Staff linked with a



Hospices for adults

network of colleagues from other hospices about variations in structures and outcomes to inform service reviews. This was influenced by external demands and legislative changes but considered the health economy.

Staffing figures from January to December 2018 showed that there were no agency staff, there were 51 volunteers, there were 12 nursing students on placement and 12 other non-qualified staff on placement. Thirty staff had left the service during this period and 28 staff had taken up post. There were two medical vacancies, 15 qualified vacancies and nine healthcare vacancies. Sickness rates averaged at 6% across all disciplines.

The leadership team attended monthly meetings to review changes and impact on establishment. Within the inpatient unit, senior staff monitored unexpected variances to staffing and managed accordingly and escalated where necessary. For example, if it was necessary to reduce admissions. We were given an example of when there was a registered nurse recruitment issue. Beds were closed for a period to assure safe care as a result.

The leadership team took steps to avoid a re-occurrence of reduced admissions because of staffing. For continuity of service for the future, a vacancy was filled with a level 4 assistant practitioner. Following further review the service invested in two nursing associate apprenticeships to commence March 2019 and September 2019 resulting in a further two level 4 practitioners, these were shared across both this site and its sister site. This was to support the nursing workforce and provide career progression for existing members of care staff.

There were 51 volunteers who worked across this hospice and another sister site. A volunteering strategy was launched in December 2018. A volunteer administrator to support the volunteer development manager was employed. Volunteers were supported in being competent in their roles. For example, volunteers working within bereavement services completed an accredited 10 week 'working with loss' programme.

Bank staff were rarely used. Part-time substantive staff regularly filled any gaps in shifts. Agency staff had not been in used in the year before inspection.

A social worker was employed on a bank contract while the role was being reviewed in line with the development

of the services carer's strategy. A counselor was employed on a self-employed basis. Both staff attended an induction and completed e-learning in line with other substantive staff.

Medical staffing

The service had access to enough medical staff. Patients had access to a 24hours a day, seven day a week medical on-call service. There was a three-tier approach for staff supporting patients in the community. Between the hours of 9am and 5pm each week day, all calls would go through to the nurse led advice and referral centre. Depending on need, calls could be escalated to a prescribing senior specialist nurse and a medical consultant.

Two patients expressed concerns to the inspection team that they found it difficult to access doctors to speak with. On one occasion a patient's relative was asked to attend at a specific time to see a doctor and they had to wait until the afternoon to see them. In both cases the patients felt they did not get the answers they needed from the doctors.

Records

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

Staff used an electronic record system which was accessible on or off site. All patient records we looked at were comprehensive, clear and up to date with consent regularly reviewed and clearly indicated in the records.

Records were legible and detailed enough to give an overview of care delivered. Risk assessments such as bed rails and falls were reviewed weekly and at the end of the episode.

Patient information was shared with referrers, for example, GPs and other professionals updating them of the outcomes. If a patient died in the hospice, the GP were informed by telephone and letter. The team also contacted other healthcare providers supporting the patient, for example, district nurses and hospital palliative care teams.

People were assured that information about them was treated confidentially in a way that complied with the Data Protection Act. Staff supported people to make and



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review choices about sharing their information. Only trained staff with secure access codes could access patient information. The electronic system had an audit trail and could identify if people accessed information inappropriately. There was evidence of consent with regular updates recorded in documentation.

Mobile computers were available so could be used during ward rounds.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medicine at the right dose at the right time.

Medicines and medicines related stationery were managed well. They were ordered, transported, stored, and disposed of safely and securely (including medical gases and emergency medicines and equipment). Comprehensive medicines policies and procedures were in place. A pharmacist was employed by the hospice, and other support services and supplies were obtained through a service level agreement with the local hospital trust. There was a system in place to ensure that medicines alert or recalls were actioned appropriately.

Policies were in place for the management of medical gases. A recent audit had identified some areas of risk and an action plan was in place and due to be completed by April 2019.

Patients received appropriate therapeutic drug and physical health monitoring with appropriate follow up in accordance with current national guidance or evidence base.

There was a controlled drugs accountable officer for the service to ensure safe management. Twenty-eight members of staff administered controlled drugs. There was a robust checking system in place. This meant there was a system in place to keep people safe.

There was a pharmacist who was the service lead for the safe and secure handling of medicines. Specialist pharmacist support for the service was 12 hours per week. In addition, there was a clinical pharmacist for 12 hours per week.

The service had 19 non-medical prescribers working in clinical teams. We checked patient records and

prescription charts for seven patients for quality. In addition, we spoke with ten members of staff in relation to the management of medicines. All of whom could assure us that there were effective systems in place to safely prescribe medicines to patients.

There were good processes for medicines reconciliation when patients were admitted. This was completed by doctors and checked for accuracy by a second doctor or nurse. They had received training from the pharmacist on how to complete this process safely. The reconciliation was then further checked by the pharmacist at their next visit.

There were safe systems for prescribing, administering and monitoring of medicines, including medicines given via syringe drivers. The systems in place when unlicensed medicines were used, or they were used outside the terms of their licence, had been identified by staff as an area for improvement. New patient information leaflets had been produced and were currently being finalised to help inform patients when their medicines were used in this way. There were suitable systems for auditing the use of medicines and these identified any issues needing improvement.

Allergies were recorded on the main treatment and prescription charts for all patients, however this was not always included on supplementary charts, for example topical preparation charts.

There were safe storage arrangements for medicines, including patient's own medicines. At the time of our inspection, no patients were self-administering their medicines, but systems were in place to support this should they wish to do so.

There were appropriate systems were in place for ensuring that patients and other healthcare professionals who would be looking after them, had suitable information about their medicines on discharge from the hospice to support their ongoing care.

There was a medicines management committee in place which met regularly and discussed any necessary actions identified. Any medicines incidents which had been reported were reviewed and monitored, so that lessons could be learnt, and improvements made if necessary.

There was a hospice formulary which gave administration instructions for the medicines most commonly used in



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the hospice setting. This formulary was divided into different groups to deal with specific symptoms such as gastrointestinal and musculoskeletal. It described the symptom, then gave first to fifth line options and had a key for special medicines which need specific considerations. This formulary helped staff identify what medicines would be best used and helped guide them when to escalate patients care to a consultant or senior nurse.

Patients were provided with information on the medicines they were prescribed and administered. For example, there were easy to read guides available on common medicines such as strong painkillers. These guides detailed what the medicine was and how it might affect the patient.

The service kept a signature log on the ward which included signatures and initials in handwriting of all staff. This allowed staff to identify who had prescribed and administered medicines quickly and easily.

There were clear instructions available for staff on how to deal with medicines after a patient's death. This was included in the care after death procedure. It detailed what staff should do with the medicine in a syringe pump after death. This ensured that controlled medicines were correctly recorded and accounted for.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. 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.

Staff had access to an electronic incident reporting system. Incidents were reviewed by managers. We saw recorded minutes from meetings that indicated trends and learning were shared with staff, the relevant trustee board governance aspect committee and operational governance groups. Staff told us about their understanding of the incident reporting system and knew and understood it well. The governance and learning from incidents was integrated and shared across the St Giles Hospice group and sister site.

Staff recorded 1410 deaths from December 2017 to December 2018, this included both inpatients and patients receiving care from the hospice at home team. Three of those deaths were followed up by the coroner.

For the same period, there were no never events. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Staff recorded five serious incidents from January 2018 to December 2018. In three of the cases root cause analysis were completed. In one case, a statutory notification was sent to Care Quality Commission and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013. There had been one norovirus outbreak which had a root cause analysis and as a result the hospice were closed to admissions for treatment. This meant the provider acted to manage the incident.

Staff were trained in, knew and understood the principles of duty of candour. They could access an organisational policy to support duty of candour in practice. Clinical incidents were checked daily by managers for statutory reporting requirements. This included duty of candour. The electronic incident reporting prompted staff to consider if the duty of candour process needed to be followed.

Are hospices for adults effective? (for example, treatment is 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 of its effectiveness. Managers checked to make sure staff followed guidance.

There was a rolling programme of clinical audit and monitoring in place with action plans. Outcomes were shared with staff through email, meetings and



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publications. We looked at audit documentation and related reports. For example, tissue viability audit and monitoring report for period October 2018 to March 2019 with related action plans.

Staff had access to several evidence-based tools. For example, outcome assessment and complexity collaborative (OACC) - Kings College. This was a suite of assessment tools. The tools supported assessment, monitoring and evaluation of symptoms clinically, and from the perspective of patients using Views on Care. They also enabled the team to review the carer's needs through use of the Carer's Support Needs Assessment Tool (CSNAT).

There was holistic approach to assessing, planning and delivery of care. Patients were supported in developing advance care plans, emergency care plans and ceilings of care. These were shared with the greater multi-disciplinary team including external providers of end of life care.

The family support and bereavement team used a framework 'Range of Response to Loss'. This identified vulnerability. This includes the use of adult attitude to grief and child attitude to grief used in collaboration with the client or patient. This meant that evidenced based tools were used to support people who used the service.

All staff actively engaged in activities to monitor and improve quality and outcomes. The service was actively engaged in several research projects and had a comprehensive research program and plan. An example was a study around the prognosis in palliative care patients. This study was looking at the prognosis of patients with life limiting diseases and aimed to provide an evidence-based study in this area.

Another example of challenging and testing evidence base was a study in progress which was looking at specific assessment and care tools interacted and their effectiveness. This had the aim of informing future evidence based clinical practice.

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 adjusted for patients' religious, cultural and other preferences.

Staff could access a nutrition policy which was updated every three years or sooner if required. Each patient on admission had a nutrition assessment which considers physical, psychological, spiritual and social aspects to ensure nutritional wellbeing. Staff used a Malnutrition Universal Screening Tool (MUST) score. They used the information using this tool to assess diet and any practical points which affected nutritional intake. For example, poor fitting dentures.

Each patient had a regularly reviewed and documented individualised plan. This was shared with the catering team to ensure the patients individual needs were met. Patients and carers could access a range of information leaflets to maximise their nutrition and hydration intake

Each patient had a weekly nutrition and hydration plan risk assessment and review. This looked at their MUST score, prompts for specialist referrals and updates to action plans.

There was also a catering support assessment which looked holistically at a patient's nutrition needs and preferences. This included areas such as food allergies, cultural considerations and plate size. There was a kitchen on site which could accommodate different dietary needs and order in specific food types.

There was specific nutrition treatment plan for patients at high risk of malnutrition. This was an easy to follow algorithm with prompts. The plan was based on best practice national guidelines.

Patients could access a range of hot and cold food and snacks 24 hours a day, seven days a week. The healthcare assistants had completed level 2 food and hygiene certificates. This meant they could make small meals out of hours. Patients could request options off menu. Special diets such as vegetarian and gluten free were also catered for. Patients and carers told us that the quality of food was good, and their needs were met.

Meals were also offered to patient's relatives which enabled patients to eat together with their families.

Pain relief

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



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The hospice managed the pain of people who were approaching the end of life effectively, including people who may not be able to communicate. Staff used evidence-based tools to assess pain, for example, Abbey pain scales for those with dementia. They used tools with animation, for example smiley faces and pain ladders for those who additional communication needs.

There were many different methods and approaches to pain relief which were available to all patients.

Syringe pumps were available and used appropriately with patients to deliver continuous pain relief if required.

Staff took account of patient's preferences in relation to pain relief methods. An example of this was a patient who was reluctant to have morphine. Their wishes were followed, and alternative pain relief was prescribed and administered.

Where relevant patient's care plans included an appropriate pain assessment and management plan. Anticipatory medicines prescribed appropriately in people identified as approaching the end of life. Anticipatory medicine would be given in collaboration with the district nurse and patient's GP.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

Information about the outcomes of people's care and treatment (both physical and mental where appropriate) was routinely collected and monitored. Clinical teams used patient and family reported outcome measures using questionnaires (Patient/Family Reported Outcome Measures) to access experiences and what could be done differently.

Patients and families completed a discharge questionnaire for comments. Staff sent out questionnaires upon discharge or at an agreed point care. All questionnaires were returned to the quality and audit manager who compiled a report based on feedback for learning purposes.

Staff participated in relevant quality improvement initiatives, such as local and national clinical audits. There was an annual audit programme, which was created using tools created by Hospice UK.

All patients had an individualised care plan in place that set out their advance care preferences. It covered activities of daily living, family and carer support, infection control, mental capacity, tissue viability, advance care planning and symptom management.

There was provision for recording preferred place of care and death within the electronic record. The records were regularly reviewed and audited. Managers told us that they had looked at 16 inpatient records, there were two patients with informal wishes documented. Ten had documented that the offer was made to discuss advance care planning but declined by patients.

Patients who accessed the day hospice had an allocated nurse who explored with them their own goals and wishes. This helped develop a programme of care specifically based on their identified outcomes.

There was a specialist women's cancer support service funded by a charity. The service supported women who had been affected by cancer and focussed on empowering them to self-manage their ongoing emotional, psychological and physical symptoms. It had been running for a year and had seen 58 clients in the 12-month period. The service undertook a year review of the support service and this showed that 79% of referrals were 'self-referred' and 96% of all enquiries were responded to in 48 hours. In the survey sent out to all referrals, a question posed was 'how likely are you to recommend St Giles Hospice to friends and family if they needed similar support?' 89% of patients said they would be extremely likely to recommend the service and 11% would be likely to recommend the service.

The service was registered with and working towards Outcome Assessment Complexity Collaborative outcome frameworks where applicable. The Outcome Assessment and Complexity patients' opinions on the IPOS questionnaire (Integrated Palliative care Outcome Scale). The IPOS are a family of tools to measure patients' physical symptoms, psychological, emotional and spiritual, and information and support needs. The results showed that most people found the questionnaire easy or needed a little help completing it. The majority of



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patients (eight out of nine) agreed or strongly agreed that the questionnaire had helped them describe their symptoms. Eight out of nine patients also agreed or strongly agreed that using IPOS helped them talk with the nurse about their symptoms and concerns.

The service undertook a tissue viability audit to specifically look at outcomes for patients in this group. The audit showed in 100% of cases audited, correct care was provided to patients, 46% (11) of pressure areas showed improvement, 42% (10) no change was identified and in 12% (three) there was a deterioration.

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 monitor the effectiveness of the service.

All new starters were subject to a three-month probationary period. This could be extended. There was a formal process for completing and recording a successful probation period. This meant those who did not pass their probationary period were unlikely to proceed into a substantive role.

All staff had an induction ensuring they fully understand their role and the part they played in the wider organisation. The induction program was comprehensive and provided staff with the information they needed. It helped them gain an understanding of the hospice and wider group. An example of this was a 'know your organisation quiz' which included questions such as how many people live in the St Giles Hospice catchment area?

All staff received appraisals that linked with competencies. 100% of medical staff had an up to date appraisal and 91% of nursing staff. Any outstanding appraisals were either booked or planned to be booked. Appraisals were comprehensively completed on a well-structured proforma.

Nursing staff competencies were observed using an annual programme of structured clinical examinations. These observations were recorded in education passports. Regular updated training opportunities and personal development plans were devised within individual appraisals. For example, tracheostomy care competencies were checked for registered nurses. They

would be observed in practice and in training. The facilitators used questions and answers to test knowledge, for example, to describe how tracheal trauma could be reduced.

There were link nurses for a number of areas for examples nutrition, infection control and manual handling. Additional training days were allocated for link nurses to enable them to support their colleagues.

Nursing staff received verification of death training which was supported by competency assessments.

There was a tailored development plan for health care assistants which included passports which were mapped against the care certificate standards. This passport included evidence-based competencies which were required to be completed. This ensured that these staff were competent for the roles they performed.

There was also a competency passport for registered nurses which included relevant evidence-based competencies.

The service also used objective structured clinical examinations (OSCE) to ensure staff were able to be tested for competence in a live manner. These OSCE's were based on a variety of subjects such as dealing with a distressed relative and tracheostomy care.

The service had clinical practice educator who arranged education activities and sessions for staff. This included evaluating staff satisfaction with training and development. An example of this was a questionnaire and assessment of the OSCE program. The audit showed almost all the nurses who underwent these assessments felt they were beneficial to them and would like to do more in future.

Newly qualified registered nurses underwent a preceptorship and there was a comprehensive preceptorship framework in place for this process. All newly registered nurses completed the Principles & Practice of Palliative and End of Life Care training in the first 18 months of employment. The hospice also supported placements for student nurses.

Staff were offered either peer supervision or one-to-one clinical supervision. This was facilitated by either level 2 psychology trained staff or a level 4 clinical psychologist.



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All volunteers were offered individual induction 'Know Your Own Organisation' study day, communication training and bereavement training. Mentorships and coaching were available if identified as a need.

All staff and volunteers attended training that helped develop skills to support people in distress. Sage and Thyme Level 1 communication training.

There was a comprehensive system of training and annual competency checks for nurses regarding medicines management. The pharmacist had input into the training and induction programme which included training for junior doctors.

There were also adhoc workshops and sessions provided for staff on key aspects of their role. One such workshop centred on how to understand bereavement and included topics such as how grief can affect people and self-awareness who supports the supporter.

The clinical educator was an active and engaging member of the team. They provided an invaluable service to staff and then in turn improved the experience of patients. They were visible and available to staff for support and education. The education program they designed was comprehensive and tailored to staff needs and responsive to the needs of the service.

Multidisciplinary working

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

Staff were working with external primary care providers on developing a more integrated care service approach with shared records, processes and procedures. The aim was to reduce duplication and enabling a more collaborative and consistent approach to care provision ensuring patient's needs were shared and understood by all.

Staff worked in partnership with external providers of end of life care in assessing, planning and delivering care and treatment. This included GP's, primary care nursing teams, allied health professionals, social care providers, secondary care and other voluntary sector workers. All relevant teams, services and organisations were informed in writing, over the telephone or by email if people were discharged from the service.

Discharges were undertaken at an appropriate time of day and only done when any necessary ongoing care is in place. We saw these recorded in-patient records, in discussions with staff and those who used the service. The hospice at home team had close working relationships with district nurses so that patients could be supported at home for as long as possible if they wished to be there.

Records demonstrated holistic review and consideration of patient needs by the multi-disciplinary team members.

Seven-day services

The service ran seven days a week, 365 days a year. People could access most of the services seven days a week.

People could access an out of hours service. Out of hours for inpatient services was provided by the GP service (Badger). The GP provided telephone contact within 30 minutes and on-site review within one hour. Second on-call out of hours was a medical consultant; this was provided by consultants employed by the service on a rota basis and additional support is provided by a medical consultant out of hours agency.

Health promotion

People were supported to manage their own health, care and wellbeing and to maximise their independence. There was a corridor in the hospice dedicated to complementary therapies and patients looking after their own wellbeing. There were health promotion materials displayed throughout the hospice; displayed on the walls, in the form of leaflets and helplines and organisations to support ongoing health promotion.

Patients could access a 'wellbeing day' held each week for people to find out more about services, seek advice or information, attend seated exercise, access complementary therapy and benefit from peer support.

Consent and Mental Capacity Act (Deprivation of Liberty Safeguards only apply to patients receiving care in a hospital or a care home)

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.



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The service had a specific mental capacity assessment document which gave clear guidance on when and how to complete the document. This was accompanied by a best interest's decision checklist. Both documents reflected the latest guidance and legislation in relation to mental capacity.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.

Staff could access guidance on Deprivation of Liberty Safeguards. There was eLearning and policies and procedures for staff to follow should either a standard or urgent authorisation need to be made.

Some advance care plans were in place where patients had made their wishes known. There was also notes on 'What's important to you' where patients were asked about their preferences.

delivered. Patients were supported in accessing things of value that gave them comfort, even when they were inpatients at the hospice. There were lots of examples; pets could stay with them on the ward. We were given an example of a patient who wanted to see their horse one last time, and this was facilitated at the hospice. There had been Harry Potter themed parties. One young patient who wanted to watch a movie with their friends but couldn't attend the cinema due to their health. Therefore, a cinema night was organised including pizza and treats. Staff told us they tried to make every day a meaningful day for people who used the service.

Patients told us that staff asked them what name they would like to be called and used this name in all interactions and all staff would always introduce themselves in a respectful way.

Staff told us of one occasion when they had arranged for a patient's pet horse to attend the hospice to fulfil the wishes of the patient.

The hospice had also hosted and arranged several weddings at the request of patients staying at the hospice. They had also provided support from hospice staff when patients wanted to attend.

Staff recognised that people needed to have access to, and links with, their advocacy and support networks in the community and they supported people to do this. They ensured that people's communication needs were understood, seek best practice and learn from it. Links with the community and information was stored on a central spreadsheet accessible by all staff in the St Giles Hospice group. Family members and carers could stay with their loved ones and were encouraged to do so. We saw chaplains involved with patients and their families providing them with religious and spiritual support when they requested it.

There was a strong visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promotes people's dignity. Patients were always treated with dignity by all those involved in their care, treatment and support. Consideration of people's privacy and dignity was consistently embedded in everything that staff did. This included awareness of any specific needs as these were recorded and communicated. For example, providing space for partners to sleep over at the hospice.

Are hospices for adults caring?

Outstanding



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

Compassionate care

Staff cared for patients with very high levels of compassion. Feedback from patients confirmed that staff treated them well and with kindness. Patients and staff provided numerous examples of where staff had gone 'the extra mile' to provide care.

Patients who used services and those close to them were active partners in their care. Staff were fully committed to working in partnership with patients and making this a reality for each person. We saw this evidenced in our observations, contained within care records in the form of care planning that involved all people assessed as appropriate. Feedback from patients, their families and carers demonstrated that staff empowered people to have a voice and realise their potential.

Staff displayed determination and creativity to overcome obstacles to delivering care. Patients' individual preferences and needs were reflected in how care was



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Staff found innovative ways to enable people to manage their own health and care when they can and to maintain independence as much as possible. Staff gave us example of when they supported patients with challenging personal circumstances. Staff told us they continually sought to adapt to accommodate people who had protected characteristics under the Equality Act 2010.

People we spoke with, without exception, told us they valued their relationships with the staff team and felt that they often go 'the extra mile' for them when providing care and support. Staff took the time to interact with people who used the service and those close to them in a respectful and considerate way. All patients, families and carers we spoke with told us that staff went above and beyond what they expected. We observed compassionate interactions between all staff and people who used the service. We saw evidence of appreciation from people in the form of cards, gifts, donations and fund raising.

Staff were thanked by people who used their service for their caring and compassionate input. Staff did not formally collect compliment data; however, compliments and thanks were received frequently. We were told that between January 2018 to December 2018, one unit received 109 thank you cards and approximately 300 compliments counted manually, for example, from Patient Reported Outcome Measures.

Staff understood and respected the personal, cultural, social and religious needs of people and how these may relate to care needs. They took these needs into account in the way they delivered services. There was a dedicated room for prayer, (facing east for Muslim people), contemplation and ceremonies. It was therapeutic with windows that looked out in to the hospice's well-maintained grounds.

Staff showed an encouraging, sensitive and supportive attitude to people who use services and those close to them. We saw this in one to one interaction between patients and others involved in their care. Staff displayed warmth and appropriate levels of intimacy. Staff were supported by a psychologist to reflect on how they cared for patients with compassion.

Staff told us they felt safe to raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes. All staff we spoke with told us they had never witnessed behaviour like this from either staff, patients, or carers and relatives.

People's privacy and dignity needs were understood and always respected, including during physical or intimate care and examinations. Patient's had private spaces with privacy curtains. We saw all staff knock before entering and checking it was ok to enter in to each patients' private space.

The service treated patient's personal data and information sensitively. They also provided patients with a leaflet called the care privacy statement. This outlined the services commitment to confidentiality and explained clearly to patients how their information may be used while they were receiving care and gave them options as to how to access their information.

Staff responded in a compassionate, timely and appropriate way when people experienced physical pain, discomfort or emotional distress. We observed this by listening to responses to call bells. We discussed this with patients and their carers. All responses were positive.

People who had died at the service awaiting the undertakers continued to be cared for with dignity and respect. Care was taken to discharge people via a discreet, private and enclosed space to continue to offer compassionate care until the point of discharge. Families could spend time with their loved ones in a private space.

Emotional support

Staff provided significant emotional and spiritual support to patients to minimise their distress. Support was available to inpatients, outpatients and bereaved families, friends and carers.

People who used the service were active partners in their care.

Staff understood the impact that a person's care, treatment or condition had on their wellbeing and on those close to them, both emotionally and socially. People were given appropriate and timely support and information to cope emotionally with their care, treatment or condition. For example, patients could self-refer for psychological support for surviving cancer.



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This was provided as an outpatient service supporting patients and their families to re-build relationships, discuss issues and concerns related to intimacy and sexual health.

Carers, family and dependants could access emotional support and information at the right time. Staff care planned and reviewed at every interaction. Carers needs were also assessed regularly using the Carer's Support Needs Assessment Tool. Together staff and carers developed an individual plan to meet their needs. Staff used palliative care outcome score (IPOS) which provided a multidimensional perspective on a patient's situation including their physical, psychological, social, emotional and spiritual concerns and needs were explored and supported.

People could access a therapeutic spiritual suite. The room promoted tranquillity. Patients and their family members could use the room as a place of contemplation and prayer. Prayer mats and a range of religious texts, for example, a Koran for use by Muslim patients were available. There were water features with a window overlooking it facing east for Muslim patients. There were a range of chaplains available and other spiritual support.

Patients had access to religious and spiritual support. We saw the chaplain with patients and their families providing one to one support and bedside prayers and hymns. Ceremonies could and were carried out such as weddings. We were given examples of when patient preferences for comfort were supported. For example, allowing pets in to their rooms in their final moments.

The service offered local communities' access to bereavement help points. These operated in 13 separate locations across the hospice catchment area. For example, at local grocers. The service was available five days a week including some evenings. The help points ensured people could access bereavement support within a maximum of 48 hours face to face.

The service also provided specially tailored emotional support for children and young people (from the patient's family) through their Phoenix service. This allowed patients to undertake activities with the children and young people close to them whilst being offered emotional support. This included advice and support, sibling sessions and activities such as arts and crafts.

The support offered by the hospice did not stop at discharge. For example, the service had developed a specialist women's cancer support service. This service was funded by a charity. The service supported women who had been affected by cancer and focussed on empowering them to self-manage their ongoing emotional, psychological and physical symptoms. The service had access to help point which ran sessions and provided emotional support to patients and their families. We saw one piece of feedback from a patient relative which described that they were feeling very depressed after the loss of their loved one. They accessed the help point and said that the service allowed them to feel connected to others, less lonely and gave them a purpose. They credited the service with improving their mental health and went as far as to say it had saved their life.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment. Patients were at the centre of their care and treatment; and staff ensured a patient centred approach was used at all times.

Staff communicated with people so that they understood their care, treatment and condition and any advice given. A family support and bereavement service also triaged referrals to explore patients' needs with them directly and to identify the appropriate intervention by either the hospice or alternative providers if appropriate.

Staff made sure that people who used services and those close to them were able to find further information, including community and advocacy services. They could ask questions about their care and treatment. They were supported to access further information through direct conversations with staff, leaflets, inhouse services and partner agencies who worked on or off site.

People were empowered and supported, where necessary, to use and link with support networks and advocacy, so that they had a positive impact on their health, care and wellbeing. Family support was offered both pre and post bereavement.

Staff routinely involved people who used services and those close to them (including carers and dependants) in



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planning and making shared decisions about their care and treatment. We saw this recorded in care records and through discussions with people who engaged with the service. People told us they felt listened to, respected and had their views considered.

Staff encouraged completion of the Family and Friends Test – ‘how likely were you to recommend St Giles Hospice to friends and family if they needed similar care?’ This helped them learn from the views of those who used the service and help make improvements.

People’s carers, advocates and representatives including family members and friends, were identified, welcomed, and treated as important partners in the delivery of their care.

There was also a family support service provided by the hospice which offered a range of emotional, practical and psychological support to people and their affected by a life limiting illness. The family support team was based at the hospice and allowed relatives to be involved in the patient’s journey.

Families were regarded holistically and if needed psychological support for families was arranged. A ‘kisses to keep’ initiative was in place where patients’ ‘kisses’ were on paper for families to keep. Patients were supported to do photo albums and other memory initiatives such as boxes to leave for their families.

The service also provided a comprehensive information pack for patient’s relatives and friends. This included a carers support assessment which contained several questions designed to assess whether the patient’s carer may need help with and ascertain how much they wanted to be involved with the patients consent.

Are hospices for adults responsive to people’s needs?

(for example, to feedback?)

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 services in a way that met the needs of local people.

The services provided reflected the needs of the population served and they ensured flexibility, choice and continuity of care. The facilities and premises were appropriate for the services that were delivered. There were six continuing healthcare rooms and 16 specialist single side rooms. All 22 single rooms were spacious enough to accommodate a put-up bed. A separate family suite was available for overnight stay. There was a room at the side of the bed in the multi-bay room for a camp bed should this be required.

People could access ample free car parking and Wi-Fi. Relatives who had difficulty with transport had potential access to a volunteer driver to support visiting. Visitors were able to make tea and coffee and there was the ability to purchase food whether to eat with their relative or in a separate space.

There was a family room to enable relatives to be seen away from patients if necessary. There was spiritual space available for personal reflection that considered people’s personal spiritual, cultural and religious needs, including washing facilities and access to chaplaincy for varying faiths.

The grounds were maintained well and suitable for the people who used the service. Some of the rooms had access to well maintained, flower gardens with suitable garden furniture and decorative ornaments to improve the aesthetics and had a therapeutic feel. There was a communal rooftop terrace that overlooked the well-kept gardens and grounds beyond the hospice.

A viewing room was available should relatives wish to visit their loved one between them leaving the ward and being taken to the undertakers, although most relatives saw the patient in the room in which they died.

A bereavement drop in service was open to and accessible to all members of the community regardless of when and where someone had died. These were offered across the St Giles Hospice group catchment area and were supported by volunteers.

Patients were able to access a day hospice provided on site.

A carers’ buddy system was piloted with non-recurrent funding from a local authority. The project funded a



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specific carers coordinator post and volunteer training to widen access to carers support at end of life. Funding was not continued to fund the project long term. However, there were benefits and learning from the project which was incorporated into the delivery of a family support team's work. This including widening the development and use of volunteers to support carers and family members.

Patients from all clinical services could access a range of therapies, including complementary therapies. There was a complementary therapy suite. This was a quiet corridor of rooms allocated specifically for complementary therapies. Using feedback from people who used the service, the provision was extended to accept private paying clients. This meant that patients who wanted to use the service outside the budgeted allowance could do so.

Meeting people's individual needs

The service took account of patients' individual needs.

Peoples individual needs and preferences were central to planning and delivery of tailored services. The service made extensive efforts to meet patients and family's individual needs. An example of this was the Phoenix service for bereaved children and young people (from the patient's family). This service allowed families to undertake activities together. It also provided advice, support and guidance through one to one, family support groups and peer support groups. This service also provided a follow-on family support group for children and young people after they had suffered a bereavement. The Phoenix service also worked with local schools to support young people.

The hospice was equipped to meet the needs of children and young people spending time with their families. This included the provision of indoor and outdoor activities such as arts and crafts and complementary therapies.

Where patients had a preferred place of death attempts were made to facilitate this. Partnership working took place with community services and district nursing services to enable discharges. The rapid discharge to die pathway was available to all patients known to St Giles Hospice group, wherever they were including in hospital.

Patients had the opportunity to access the supportive care centre which held numerous activities designed to support patients and meet their needs in a holistic manner. Activities included complementary therapies sessions and a walking group.

The hospice group also offered several useful and practical services to meet all the needs of their patients. These included bereavement help support sessions and citizens advice bureau sessions and specific finance and benefits session.

The hospice group was truly inclusive of all life limiting conditions and worked hard to meet the individual needs of patients in these groups. They did this by offering access to specialist nursing and other support staff such as an after-cancer support service. Disease specific sessions were regularly held at the supportive care centre including a multiple sclerosis group and a pulmonary fibrosis support session. The content of these sessions was tailored to meet the needs for each patient group. For example, the multiple sclerosis group arranged exercise sessions which helped with symptoms of the disease.

There was also a café which allowed patients the opportunity to socialise with others.

There were many leaflets and practical help guides available for patients and their families. These included subjects such as what to say to someone who is dying and how to support relatives who have suffered a bereavement. Each leaflet contained details of useful contacts.

There was also a leaflet available for patients which explained how they could go about ensuring their funeral wishes were recorded. This included an easy to complete form where patients could list their wishes and include information such as digital passwords and what they would like to wear. This form could then be kept safely by the patient with the knowledge that their wishes were recorded.

A guest room was available where those close to patients wished to stay overnight.

The service had a comprehensive procedure for care after death. This included all points of the patients' needs and the needs of their family. It gave staff a clear procedure to follow and prompts for them to consider. For example, it



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explained the process for personal care after death and what to do with patient's belongings. It was written sensitively and, in a patient, centred way. It was flexible enough to meet the individual needs of patients.

Staff carried out comprehensive individualised care plans to identify and meet the information and communication needs of people with a disability or sensory loss. These additional needs were recorded in care records. All shared patient information required consent, which was recorded in patient care records.

Services were delivered, made accessible and coordinated to take account of the needs of different people, including those with protected characteristics under the Equality Act and those in vulnerable circumstances. For example, patients suffering with motor neurone disease alongside multiple co-morbidities including diabetes and respiratory issues.

Some patients requested the withdrawal of treatment. In each case a case review was held involving key stakeholders. For example, families, carers, respiratory staff, primary care staff and human rights experts. Processes were in place to ensure that this was managed openly and sensitively so that people have a comfortable and dignified death.

All staff were trained in equality and diversity and the complexities of safeguarding which would include mental capacity which might mean allowing people to make difficult choices.

People could access services in a timely way. There was a 24 hour a day, seven day a week advice centre which could be accessed by people known and unknown. The local community could self-refer, and the same standards would be met.

People with a range of disabilities could access and use services on an equal basis to others. There was wheelchair and access to those with disabilities, including those with sight and hearing loss.

Key staff worked across services to coordinate people's involvement with families and carers, particularly for those with multiple long-term conditions.

Staff were involved in a research study with a local university to explore the experiences of people attending the service's multiple sclerosis support groups. The study

found that the participants valued the contact with other people with MS and liked the fact that the group was based around exercise that improved their wellbeing. The findings from the research led to a service review.

All patients were considered as being affected by disability. The leadership team considered the changing needs of patients, for example, increased number of patients affected by dementia and frailty. Staff were working with external providers in reviewing and remodelling services within frailty aiming to have a proactive management of patients that fall into this age bracket to prevent avoidable hospital admissions. A remodel of the service had been carried out as a result and shared at a national conference.

A community engagement manager was employed and worked with a local learning disability group. The group discussing issues relating to loss, bereavement and end of life care as a mutual learning exercise.

Spiritual care coordinators linked with local faith leaders, including from the local Muslim community. This meant that they could work together for the benefit of patients. In addition, the hospice held 'teach us to pray' groups. These sessions helped people to practice personal prayers and were inclusive of all religions.

Access and flow

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

There were systems in place to help people stay in the community if they wanted to. The community team had an advanced practitioner. They worked in hours and could provide same day symptom management. This meant they could prevent crisis admission and ensure preferred place of care/death was achieved.

Patient care and treatment was tailored to the individual their preference and need. Patients were offered a service at the Whittington and in the community. Patients had fast track admissions 24 hours a day, seven days a week, either direct from the community or transfer from hospital. To prevent unnecessary delays, for example, in



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accessing transport an advanced nurse practitioner could clerk the patient in the community. This ensured a medical review, drug chart and DNACPR (if appropriate for admission) were available.

Patient referrals were processed through the advice and referral centre. Once triaged, a team member contacted the patient directly to discuss their personal needs and check the information was correct. Patient centred care plans were developed to manage symptoms. This ensured that the patient accessed the right service and intervention type for their needs thereby supporting effectiveness.

Weekly multi-disciplinary meetings on the inpatient unit discussed patients and service provision to ensure that when appropriate patients were discharged to their preferred place of care therefore freeing up capacity to admit those on the waiting list. A daily bed meeting is held to discuss and prioritise patient access to inpatient services. There was an admission and discharge facilitator who practically and actively supported patient transition into and out of the inpatient unit.

The service had undertaken an innovative project with another provider around reducing admissions from nursing homes. This project provided support from designated hospice staff to educate nursing home staff and provide an additional level of support. An example was the development of a 'planning ahead register'. The project team met with each nursing home and identified residents who were approaching the end of their life. These residents were then given specialise support including having a core care plan in place and receiving additional support visits. The project was working to identify what commonly resulted in admissions and worked to tackle these areas.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results and shared these with all staff.

People we spoke with told us they knew how to make a complaint or raise concerns and felt comfortable doing so. Staff understood the system and had access to policy and procedures to guide them in managing complaints.

People were encouraged to raise concerns in several ways. For example, using a free text option within Patient Reported Outcome Measures or directly on the service website.

People who used the system to make a complaint or raise concerns were treated compassionately and given the help and support. Staff received specific communication training to help them respond sympathetically to people who were distressed, or who were dissatisfied. Staff were expected to report and escalate any concerns so that they can be practically addressed promptly and to provide an opportunity for a senior member of staff to explore these with patients or families if necessary where the concern was not resolved immediately.

Complaints were dealt with to ensure openness and transparency, confidentially and regular updates for the complainant. Staff were mindful of a timely response and explanation of the outcome, and a formal record was kept. From January 2018 to December 2018, there were 12 complaints managed under the formal procedure. All complaints were managed informally in the first instance where possible and resolved to people's satisfaction. Two of the complaints were upheld and eight were upheld in part. The target for dealing with complaints was 20 days which was met.

Concerns and complaints were used as an opportunity to learn and drive improvement. Managers provided us with examples of where they had identified a theme from complaints and that they had introduced training to staff because of the learning from the theme.

Are hospices for adults well-led?

Outstanding



Our rating of well-led improved. We rated it as **outstanding**.

Leadership

There was compassionate, inclusive and effective leadership at all levels. Leaders demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. There was a deeply embedded system of leadership development.



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The St Giles Hospice Whittington worked managerially closely with the sister site, including a shared leadership team; although each location had a separate registered manager.

Leaders demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care.

Leaders had an inspiring shared purpose and strived to deliver and motivate staff to succeed. The leadership team consisted of a board of trustees with a range of relevant expertise to contribute to the service. There was a group chief executive officer and a senior leadership team made up of a supportive care director, a nursing director, medical director and deputy chief executive. In addition, there were clinical and operational managers and a corporate leadership team. The chief executive officer was consistently representing the service and had achieved an honorary lecturer at a local university.

There was a deeply embedded system of leadership development and succession planning. We saw this in their development programme and in discussions with staff about their achievements supported by the organisation. An example of the comprehensive succession planning was a succession planning document, which detailed all senior roles and the plans for succession. This document included internal supply, external supply and actions to mitigate risk and each role was given a red, amber or green status. It was reviewed regularly, and achievable actions were detailed and carried out.

The leadership team told us they had an effective recruitment and selection process for leaders and trustees. Their approach was to attract and recruit prospective employees whose personal values and behaviours aligned with the service values.

There were clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership. There was a leadership planning and succession planning. External business schools were used to work with the leadership team in understanding trusteeship, business and strategy. Trustees had annual appraisals. As part of the skills audit and to ensure trustees critically challenged performance and strategy, 'areas of interest' were identified. This meant trustees were expected to

have some awareness of external issues that might impact the hospice. For example, a trustee with an interest in workforce would keep up to date with NHS workforce strategy developments.

The executive team ensured there were comprehensive and successful leadership strategies in place to ensure and sustain delivery and to develop the desired culture. Leaders had a deep understanding of issues, challenges and priorities in their service, and beyond.

The leadership team were supported in their professional development in several ways. There were teamwork development days. Some leaders had formal coaching. Senior community nurses were involved in a leadership development programme. This meant that leaders consistently sought to develop their leadership skills to help maximise efficiency and achieve local objectives.

Leaders understood the challenges to quality and sustainability, and they identified the actions needed to address them. A skills audit was completed for leaders and learning opportunities were identified as a result. The trustees in place were reaching the maximum time in post period. As a result, five new trustees were appointed; a lawyer and a practicing GP. A professor, who would focus on St Giles Hospice' education and research agenda and two medical consultants; one from acute care and one mental health.

Leaders were visible and approachable. All staff we spoke with told us that they could access a member of the leadership team. They told us they felt valued and could opening discuss issues or concerns which would lead to resolution.

The leadership team were each allocated a lead in projects relating to the health economy to help the delivery of improved end of life care for local people. This work involved leadership alongside other voluntary sector partners, other hospices and the NHS.

The leadership team set out clear expectations of staff and ensured that they performed within their roles. They had clearly set out procedures which allowed staff to have clarity on what their role was and what was expected of them. An example of this was the standard operating procedure relating to guidance for ongoing assessment. This procedure set out exactly which staff member was responsible for each task and part of a patients journey and included day and night shifts.



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The service was an active participant of a nursing associate steering group. This group sought to effectively implement the role of nursing associates. Through their involvement in this group the service was ensuring the future sustainability of their nurse staffing workforce.

Vision and strategy

The strategy and supporting objectives and plans were stretching, challenging and innovative, while remaining achievable. Strategies and plans were fully aligned with plans in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership.

The service had a strategy outlining local objectives and plans. The strategy and plans were fully aligned with plans in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership. The service was a specialist palliative care team in the West Midlands and formed part of the Staffordshire and Stoke on Trent Sustainability and Transformation Partnership. This meant there was systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans.

The service had a five-year strategy with key streams such as sustainability and living with dying. This strategy was summarised into an easy read format for staff and patients to read. The aims of the provider for the next five years were to:

- Grow the capacity of the bereavement service.
- Develop services for young people who were bereaved.
- Provide increased support and opportunities to those who wanted to make written plans of their wishes.
- Work with schools and young people to change future attitudes around dying.
- Campaign for improvements in end of life care with national and local partners.
- Extend work with local businesses and organisations to increase openness and confidence about dying and bereavement.
- Improve engagement with the community, recognise and build on support.

The leadership team monitored and reviewed progress against delivery of the strategy and local plans. The leadership team worked collaboratively with staff in

achieving a three-year service plan that helped with business and financial planning. Teams had work plans, objectives and key performance indicators to allow systematic monitoring. Leaders met regularly to discuss outcomes.

Leadership staff promoted a clear vision and a set of values, with quality and sustainability as the top priorities. Staff and volunteers took part in a consultation to agree the service values. It was agreed 'ask what matters, listen to what matters, do what matters'. The values were inspired by a dementia awareness guest speaker.

Staff knew and understand the vision, values and strategy, and their role in achieving them. Staff and key stakeholders were involved in the development of the strategy, vision and values. Carers and Family Support strategy and engagement days were planned with carers and key organisational stakeholders. When a business case was proposed for a new service, the template required how the service would involve stakeholders and how it would be evaluated. Leaders monitored and reported on a range of human resource metrics to review the wellbeing of the workforce, this included biennial staff surveys. There was a workforce plan which was developed in parallel with a 3-year service plan and education strategy.

Staff were recruited using values-based questioning. Staff induction, training and supervision focussed on the importance of person centred and holistic care; empowering people to make their own choices and maintain independence wherever possible.

The leadership team monitored and reviewed progress against delivery of the strategy and local plans. The service strategy aligned to local plans in the wider health and social care economy, and how services were planned to meet the needs of the population. The leadership team worked collaboratively with staff in achieving a three-year service plan that helped with business and financial planning. Teams had work plans, objectives and key performance indicators to allow systematic monitoring. Leaders met regularly to discuss outcomes.

Culture

There was strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and



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people's experiences. Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Leaders had an inspiring shared purpose to deliver and motivate staff to succeed. There were high levels of satisfaction across all staff. There was strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences.

There was a culture of inclusiveness to support people who worked for and used the services. For example, training to understand equality, diversity and inclusiveness of those with protected characteristics. There were examples of when staff had identified, managed and inclusively supported people. This was done with compassion and understanding.

Staff felt supported, respected and valued. We saw this evidenced in the commitment to staff learning and development. There was support in ensuring staff were competent and there was scope for career progression. Staff were nominated by each other for a 'What Matters' award scheme. This was a way to identify staff who made a difference to others, highlighting care and support of patients, carers and each other.

Staff felt positive and proud to work in the organisation. The culture centred on the needs and experience of people who used services. People who used services were empowered and supported to manage their own health, care and wellbeing and to maximise their independence. The leadership team told us the hospice was about living as well as dying.

Staff told us that they felt pride in the work they carried out to ensure patients received good quality care.

Staff behaviour and performance that was inconsistent with the vision and values, regardless of seniority was addressed. Staff had a meaningful appraisal process to set out objectives and address values and behaviours. We were given examples of when staff performance had been addressed and action taken to support staff to make positive changes.

The culture encouraged openness and honesty at all levels within the organisation, including with people who used services and in response to incidents. Leaders and

staff understood the importance of staff being able to raise concerns without fear of retribution. We saw evidence of learning and action taken because of concerns raised.

Staff at every level were supported with their development needs. This included high-quality appraisal and career development conversations. We saw this evidenced across the service in career progression opportunities, support in achieving higher level qualifications, including master's degrees. There were apprenticeship programmes and a highly supported volunteer programme. There was a clinical practice educator who worked across the St Giles Hospice group who supported this development. The program they designed around the education program was comprehensive and tailored to staff needs and responsive to the needs of the service.

Staff attended forums that include medicines management, nutrition, non-medical prescribing and infection control to ensure national guidance was reviewed and reflected within our policies and procedures. The forums enabled reflective practice and opportunities to learn and improve.

There was a strong emphasis on the safety and well-being of staff. Clinical psychologists supported staff individually if needed and attended multidisciplinary meetings to help explore and guide care. Clinical staff were trained to level 2 psychology. If a patient died at home with staff present it was routine for staff to return to base before going home. This provided emotional support to staff.

Wellbeing messages were spread across the service in the form of posters, leaflets and messages of positivity. This was for staff and people who used the service.

Governance

The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.

Shared governance systems were in place across the two locations (St Giles Whittington and a sister site).

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. These were regularly



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reviewed and improved. There were five sub-committees that met quarterly, each with terms of reference and nominated attendance from trustees and managers. These were care services; workforce, education and research; finance and estates; income generation; and marketing, public and community relations.

There was evidence of regular engagement with other professionals within the health economy to improve care outcomes. Staff worked in partnership with external providers of end of life care in assessing, planning and delivering care and treatment. This included GP's, primary care nursing teams, allied health professionals, social care providers, secondary care and other voluntary sector workers.

All service committees received reports and discussed key issues at committee meetings. The main trustee board met quarterly and received minutes previous meetings. They received minutes from each of the trustee board governance committee. They also received hospice update papers, updates on strategic priorities, financial information and sometimes a presentation on a service area and/or an issue for debate and discussion. The senior management team were present for the whole board meeting.

All levels of governance and management functioned effectively and interacted with each other appropriately. The leadership team attended governance meetings and information was fed in to local teams at team meetings, in the form of minutes and emails.

There were health & safety representatives across all departments and a health and safety committee who met quarterly. Health and safety was a standard item on all trustee board governance aspect committees.

The hospice had a Medicines Management Committee responsible for policy and practice within the hospice. There is drugs formulary in place to support practice.

There was a rolling programme of clinical audit and monitoring in place with action plans. These were reported and monitored by the relevant operational groups and reported to the relevant trustee board governance aspect committee and Commissioners. We looked audit documentation and related reports. Audit outcomes were shared with local teams, the wider multidisciplinary team.

There was also an audit programme in place to review nutrition; overseen by the Nutrition Steering Group who met quarterly and were supported by a dietician.

Staff at all levels were clear about their roles and they understood what they were accountable for, and to whom. There were clear lines of accountability with team leaders overseeing staff and helping them to achieve their objectives. This was evidenced in staffing structures and understanding of roles and responsibilities.

Managing risks, issues and performance

The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

There were robust arrangements for identifying, recording and managing risks, issues and mitigating actions.

There was a culture of risk awareness, but staff were not risk averse. Staff continually recognised and addressed risks as they arose. This was both within their environment and in relation to patients specifically. These risks were clearly communicated through the effective governance structures in place and reached the senior staff they needed to. The structures also allowed for the flow of information from board level to frontline staff.

There was a risk register and a corporate risk register that was reviewed by leadership team and completed quarterly. The Trustee Board Aspect Governance Committee and board meeting addressed the risk register. The register included risks from across the organisation. New risks were added as they as they occurred, which made the risk register a live document and process. The risks were reflective of what staff told us and we observed. All risks were regularly reviewed, and realistic, robust action was taken to mitigate these risks.

The care services governance committee played a key role and function in the management of risks within the service. This committee looked at and scrutinised key information about risks within the service and ensured action was taken to mitigate them. An example of this was the regular presentation of incidents at the group



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including their grading and a summary of the incidents themselves. The committee would look for themes and trends and scrutinise the actions taken to reduce the risk of recurrence.

The committee received several reports regarding different streams of risk including corporate risk, clinical risks and operational risks. Some of the reports received included complaints, medicine errors and infection control outbreaks. This gave the committee a broad and full picture of risk within the service.

The service and committee also took account of risks from external sources and worked to mitigate these. For example, they had a comprehensive action plan in place to address risks identified in a public review of another provider. This showed that the service was dynamic and proactive in their approach to managing risk.

Potential risks were considered when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities.

There was a broad range of policies and procedures. These set out the hospice's expectations and approach to safety in key areas such as recruitment, risk assessment and management, medicines management, safeguarding and mental capacity and deprivation of liberty. These were accessible electronically by all staff. There was a Clinical Policy Group to ensure these documents were reviewed in line with best practice, new legislation, national standards or latest guidance.

Engagement

There were consistently high levels of constructive engagement with staff and people who used services. Rigorous and constructive challenge from people who used services, the public and stakeholders was welcomed and seen as a vital way of holding services to account.

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively. For example, hospice staff worked with a local children's nursery to dispel myths and encourage them to attend the hospice.

People who used the service were invited to contribute to the overall development of the service. Focus groups were held and attended by female cancer survivors to ask for ideas for improvements. The group highlighted issues with symptoms relating to relationships, intimacy and sexuality. As a result, staff linked with female cancer charities and developed an enhanced specialist outpatient clinic for women to help them deal with the effects of the treatment. This included long standing physical, spiritual, social and psychological issues. The clinic provided an opportunity to seek the support and any subsequent treatment they may need to improve their overall quality of life.

The service was registered with and working towards Outcome Assessment Complexity Collaborative outcome frameworks where applicable. The Outcome Assessment and Complexity patients' opinions on the IPOS questionnaire (Integrated Palliative care Outcome Scale). The IPOS are a family of tools to measure patients' physical symptoms, psychological, emotional and spiritual, and information and support needs.

The provider issued a news and reviews magazine several times a year to supporters of the hospice and members of the public. This magazine gave some updates to different St Giles Hospice sites including St Giles Whittington. It also offered opportunities for members of the public to engage with the hospice in fundraising activities. The magazine also highlighted ways to seek support at different sites of the St Giles Hospice group and included the hospice support helpline. The magazine also included real stories told in the words of the people who used the hospices.

Staff were engaged and listened to using a variety of methods. For example, there had been a 'listening in action' pilot event where staff views could be used to shape the service. There were staff comments boxes, internal briefs available on openly accessible websites and a secure social media platform where staff could exchange views and support development. The referral process for the family support and bereavement service was reviewed and redesigned following feedback regarding responsiveness and choice.

St Giles Hospice group was a registered charity and fund raising was crucial to enable the service to continue to provide care to patients. Two thirds of the costs of running the service came from the public. A wide range of



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events and initiatives were put in place to raise money. This included sponsored events, fairs, raffles and events where those who used the hospice services were remembered. A planned schedule of events was in place for 2019.

The provider had developed a specialist women's cancer support service. This service was funded by a charity. The service supported women who had been affected by cancer and focussed on empowering them to self-manage their ongoing emotional, psychological and physical symptoms. It had been running for a year and had seen 58 clients in the 12-month period.

St Giles Hospice group engaged well with the public and valued the input provided by volunteers. A national garden business supported the hospice by providing a gardener and volunteers to ensure the gardens were maintained so they could be enjoyed by patients.

There was a quarterly newsletter 'News Bites' compiled at the managers forum, which was circulated to staff and volunteers. This provided updates on health system wide news as well as internal changes and updates.

St Giles Hospice group linked with local businesses to give a 10% off loyalty card to people who joined the weekly lottery.

In 2018, St Giles Hospice group celebrated 35 years of proving care. A range of 'birthday' celebrations took place across the period of a week in local communities as well as at St Giles' hospices.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

The service was committed to learning and improving the service. An example of this was a recent improving inpatient unit processes project review. This review sought to identify and assess improvements that had been made or could be made to improve patient care on one of the wards. There were several streams looked at which included ward rounds and discharge. There were a number of processes which were identified for improvement and to ensure efficiency in the streams. As a

result, actions were planned and monitored and this ensured continuous improvement. Staff were seeing the results of the actions and provided feedback to the project about the positive impact they had experienced.

The service was actively engaged in several research projects and had a comprehensive research program and plan. An example was a study around the prognosis in palliative care patients. This study was looking at the prognosis of patients with life limiting diseases and aimed to provide and evidence-based study in this area.

Staff participated in relevant quality improvement initiatives, such as local and national clinical audits. There was an annual audit programme which was created using tools created by Hospice UK. Audit outcomes were shared with local teams, the wider multidisciplinary team and Care Services Trustee Governance Aspect Committee and Commissioners.

Another example of challenging and testing evidence base was a study in progress which was looking at specific assessment and care tools interacted and their effectiveness. This had the aim of informing future evidence based clinical practice.

In January 2018, the service were nominated for and won the Best Innovation Award with collaborative partners in the Great People Awards.

In February 2018, the service received recognition of a Placement of Excellence for nursing students from Birmingham City University because of the 'exceptional' feedback on the support offered.

In July 2018, the nursing director was nominated for the Staffordshire Dignity Award in the Leadership category.

The service submitted 14 posters for national conferences in 2017 and had 9 accepted. In 2018 they submitted 5 and 4 were accepted.

The supportive care director was asked to present on the nationally recognised and accredited advanced pain and symptom management course.

The chief executive officer was asked to present at the Hospice UK national conference in November 2018.

The chief executive officer was asked to present at the North Shore Hospice Alliance in New Zealand and to Clinical Leads at Hammond Care in Sydney in the summer of 2018.



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The chief executive officer was asked to present to a selected group of Hospice Leaders at St Christopher's to share early research findings and to contribute to the development of a future hospice strategy.

The chief executive officer was asked to present at a Keele University Conference on compassion. An abstract

had been accepted on this topic for the XXXVIth International Congress on Law and Mental Health conference in 2019. They had also been made an Honorary Lecturer for the School of Law at Keele University.

Outstanding practice and areas for improvement

Outstanding practice

People were truly respected and valued as individuals. They were empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service. Staff worked collaboratively with all who accessed the service with compassion. Feedback from patients and people who used the service was that staff went over and above what was expected of them. Staff consistently displayed determination and creativity to overcome obstacles to delivering care and providing people with what they requested that would make their time in the service a reflection of what they specifically wanted and needed.

Staff at all levels were recruited and developed to enhance their skills, competence and knowledge to ensure high-quality care. Staff at all levels, including administrative staff, were proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice.

There was an embedded and extensive team of volunteers who helped support the service. There was a volunteer strategy, a volunteer induction and training programme. Volunteers were valued members of the service who were provided with support and who felt part of the hospice team.

Areas for improvement

Action the provider SHOULD take to improve

The provider should ensure that allergies were recorded on the main treatment and prescription charts for all patients.