

Lewis-Manning Hospice Care

Lewis-Manning Hospice Care

Inspection report

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Date of inspection visit: 22 November 2022
Date of publication: 30/01/2023

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

Ratings

Overall rating for this location

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

Overall summary

We carried out a comprehensive inspection of Lewis-Manning Hospice Care, as part of our inspection programme. We inspected all our key questions: safe, effective, caring, responsive and well led.

This is the first inspection of this service at their new location since they re-located in July 2020. They were inspected at their previous location in 2016. They were rated as good.

Before the inspection we reviewed information, we had about the provider, including information we had received and intelligence available.

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

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed patients and kept good care records.
- Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and supported them to make decisions about their care and had access to good information. Key services were available 5 days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and some did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Although the clinics operated for 4 days a week, safety checks on the emergency resuscitation trolley were only carried out once a week.
- Clinic staff were not always aware of the patient's wishes regarding resuscitation if they became unwell during an appointment.
- Patients were not aware of how to make a formal complaint.
- The Statement of Purpose did not list all the satellite clinics provided across East Dorset.
- Not all staff had provided a full detailed employment history.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
End of life care	Good 	See above for details.

Summary of findings

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Summary of this inspection

Background to Lewis-Manning Hospice Care

Lewis-Manning Hospice Care is a charity which helps people with life-limiting illnesses and their families across East Dorset. Services are free. Lewis-Manning Hospice Care opened in 1991, the Lymphoedema Clinic was set up in 1998 and was followed by introduction of the Better Breathing Clinics soon after. The service moved to the current location in July 2020. Some of the services provided by Lewis-Manning Hospice Care do not fall under the remit of the Care Quality Commission, for example, their day hospice. At this inspection we only inspected the lymphoedema and better breathing clinics as they come under their regulated activity.

Lewis-Manning Hospice Care deliver care for patients who have been diagnosed with life-limiting illnesses whose GP surgery falls within their catchment area in Poole, Purbeck and East Dorset.

The service has had a manager in post since June 2022 and they were registered with the CQC in September 2022.

The service is registered to provide the following regulated activity:

Treatment of diseases, disorder or injury.

Activity for the year 2021 to 2022

Lymphoedema clinic;

Total number of patients 320

Total number of new patients referrals 139

Attendances at clinics total 1412

Better breathing clinic;

Total number of new patient referrals 124

Attendances at clinics 553

How we carried out this inspection

We carried out a short notice announced, comprehensive inspection on 22 November 2022. This was announced to ensure that clinics were running and there would be staff and patients available to speak to.

During our inspection we visited Lewis-Manning Hospice Care and spent time at a satellite clinic. We spoke with 9 members of staff, including a registered nurse, a health care assistant, a physiotherapist, senior managers and trustees. We spoke with 12 patients. We attended a clinic, observed patient care and reviewed patient records. We reviewed hospice policies, procedures and other documents relating to the running of the service.

Summary of this inspection

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

Outstanding practice

We found the following outstanding practice:

- All staff spoke of the importance of working with local stakeholders, health and social care professionals and commissioners to provide the best care to patients in the East Dorset area. Part of their strategy was to provide services that were not available in coordination with other stakeholders to make sure all patients had access to good palliative care.
- Patients were asked to rate the service provided by the better breathing and lymphoedema clinics. Eighty-one patients (15 for better breathing clinic and 66 for lymphedema clinic) rated it as 'very good'. Four patients rated it as good. The top rating was very good.

Areas for improvement

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

Action the service SHOULD take to improve:

- The service should review how often they complete the safety checks of the emergency resuscitation trolley based on the frequency of the clinics.
- The service should consider improving how the staff in clinics have access to information about patient's wishes regarding resuscitation if they become unwell during an appointment.
- The service should ensure patients are aware of how to make a formal complaint. Regulation 16.






Our findings

Overview of ratings

Our ratings for this location are:

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

End of life care

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

Are End of life care safe?

Good 

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

Mandatory training

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

Staff received and kept up to date with their mandatory training. All staff had access to a computer system to undertake learning, this system showed when staff had completed training.

The mandatory training was comprehensive and met the needs of patients and staff. All staff had exceeded the 85% completion rate for mandatory training.

Clinical staff completed the training required for all health and social care staff about learning disability and autism, which included how to interact appropriately with autistic patients and patients who had a learning disability.

Managers monitored mandatory training and alerted staff when they needed to update their training.

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 received training specific for their role on how to recognise and report abuse. Staff in the clinic received safeguarding training for adults and children to level 3. The service had a safeguarding lead who had level 4 safeguarding training. Another two staff in the service also had level 4 safeguarding training and staff could go to them for advice and support.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had not made any safeguarding referrals.

End of life care

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinic areas were clean and had suitable furnishings which were clean and well-maintained. All areas we inspected were visibly clean.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff used PPE in line with infection prevention and control principles. During a clinic we observed staff handwashing prior to patient contact and using PPE.

Staff cleaned equipment after patient contact and used labels to show when it was last cleaned. During a clinic we observed staff cleaning the room between patient appointments.

All linen used on the trolleys in clinics was changed between each patient to reduce the risk of cross infection. When staff worked at one of the satellite clinics, they transported equipment and linen from the main service location. All linen was bagged and on return to the main location was put in a designated area for collect by another specialist provider for laundering.

The hospice completed regular water testing for legionella. Water flushing and water temperature checks were completed weekly, documented and signed.

Environment and equipment

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

Some of the clinics were undertaken in locations nearer to patients' homes. These environments were managed by different providers. These were classed as satellite clinics. We visited one of satellite clinics and the environment was suitable for the needs of the patients.

Maintenance records, risk assessment and audits demonstrated the main location environment was maintained and safe.

Staff carried out safety checks of specialist equipment. We looked at the records and saw that staff carried out weekly checks of the resuscitation trolley. However, this was not in line with the frequency of clinics as they ran 4 days per week. Consideration should be given to checking the resuscitation trolley when clinics take place. The contents of the trolley were in-date and the trolley was visibly clean. Clinics did not run every day and this trolley was shared with the day hospice and easy for staff to access in an emergency.

The service had enough suitable equipment to help them to safely care for patients.

Staff disposed of clinical waste safely. The domestic and clinical waste bins were clearly identified and emptied regularly. A specialist contract had been set up.

End of life care

Assessing and responding to patient risk

Staff completed and updated assessments for each patient. Staff had processes to follow if a patient became unwell during a clinic session to reduce the risk of harm.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. A member of staff told us that they completed physiological observations in clinic and recorded them using the National Early Warning Score (NEWS). NEWS is a tool which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes. Staff told us they had a policy that included actions if a patient became unwell during their clinic appointment.

Staff completed assessments for each patient at their first clinic appointment, using a recognised tool pertinent for each clinic and reviewed these at each clinic session.

Staff knew about and dealt with any specific risk issues. Each clinic had flow charts to follow if a patient was unwell during a clinic and this listed actions, they needed to take including calling for an ambulance.

Staff were trained in level 2 basic life support in case a patient collapsed and had a cardiac arrest during one of the clinics. However, staff in clinics were not always aware of the patient's resuscitation status.

Staff shared key information to keep patients safe when handing over their care to others. Patient information was shared with the GP, consultant and other relevant health care professionals following their clinic appointments.

Staffing

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

The staffing numbers for each clinic was the same each day. A new member of staff had been employed for the better breathing clinic to enable them to increase their clinics to meet the needs of their patients and local community.

Temporary staff were not used to cover any absences.

The service had a low turnover rate. One member of staff had left, and a new member of staff employed for one of the clinics.

The service had low sickness rates. From January 2022 to December 2022 there had been 5 sickness days across the clinics. There was no target set for sickness rates.

Records

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

Patient notes were comprehensive, and all staff could access them easily. We reviewed 5 sets of patient notes, all records were legible, signed, dated and timed.

When patients transferred to a new team, there were no delays in staff accessing their records.

End of life care

Records were stored securely. Paper records were stored in locked cabinets at the location. The hospice had recently changed to using digital records.

Incidents

The service managed patient safety incidents well. Staff recognised and would report incidents and near misses. Managers would investigate incidents and share lessons learned with the whole team and the wider service. When things went wrong, staff knew to apologise and would give patients honest information and suitable support.

Staff knew what incidents to report and how to report them. The hospice used an electronic system for reporting incidents. Staff told us they knew what an incident was and how to report them.

The service had no reported incidents or never events in either clinic. Incidents had been reported but these referred to services not regulated by the Care Quality Commission. Never Events are defined as serious incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Staff understood the duty of candour. They were aware it was about being open and transparent and would give patients and their families a full explanation if and when things went wrong. The service had no reported duty of candour incidents.

Are End of life care effective?

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The lead for the better breathing clinic told us they based their assessment of patients on The Breathing, Thinking, Functioning (BTF) model. This is a tool to help health professionals understand and manage chronic breathlessness. It also explains why breathlessness happens and supports health professionals to provide personalised breathlessness management for their patients.

The lymphoedema nurses were members of the British Lymphology Society (BLS). This is a charity run service which produces guidelines and policies that are adhered to as best practice. Their guidance was used by staff in their lymphoedema clinics.

Patient outcomes

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

The service was not able to participate in relevant national clinical audits as they provided palliative care, so they were not eligible.

End of life care

Outcomes for patients were monitored by the service for their clinics. Each clinic sent patients questionnaires and from these results they found patients had positive outcomes.

Managers and staff used the results to improve patients' outcomes. For example, the better breathing clinic had used the results from the outcomes to appoint another member of staff due to the high demand on this service.

Staff carried out a comprehensive programme of repeated audits to check improvement over time and used the information from the audits to improve care and treatment. For example, as mentioned above obtaining an additional member of staff to run more better breathing clinics across East Dorset.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All staff had to complete competency assessments to make sure they were able to meet the needs of their patients.

Managers gave all new staff a full induction tailored to their role before they started work. We spoke with a member of staff who had recently started work with one of the clinics. They told us they had an induction programme and were supported through this by other staff in the clinic.

Staff were supported to develop through yearly, constructive appraisals of their work. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us they had appraisals yearly to discuss their objectives and development.

Staff attended team meetings or had access to full notes when they could not attend.

Managers made sure staff received any specialist training for their role. Staff confirmed they were able to attend any training relevant to their role.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

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

Staff regularly updated other health care professionals involved in the care of their patients following clinics and worked with them to improve their care.

Five-day services

Key services were available 5 days a week to support timely patient care.

The lymphoedema and better breathing clinics operated 5 days per week Monday to Friday and at different locations throughout East Dorset area.

End of life care

Health promotion

Staff gave patients practical support to help them manage their symptoms and improve their quality of life.

The service had relevant information available. Patient information leaflets were available in the clinics to support patients with their conditions.

Staff assessed each patient's health when first assessed at clinic and provided support for any individual needs to improve their lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Patients were referred to the service by other health care professionals and patients were contacted prior to their first clinic appointment. Staff asked patients for their consent prior to starting any treatment. Patients had to sign a consent form allowing staff to share their treatment with other healthcare professionals.

Staff made sure patients consented to treatment based on all the information available.

Staff recorded consent in the patients' records as a copy of consent form to share information was held in their records.

Clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Deprivation of Liberty Safeguards was not applicable to this service.

Are End of life care caring?

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff interacting with patients and family members in clinic, they treated patients with respect and showed genuine care towards them.

Patients said staff treated them well and with kindness. We spoke to 12 patients who all gave hugely positive feedback about the care and treatment they had received. Patient survey results were positive and complementary about the staff.

Staff followed policy to keep patient care and treatment confidential.

End of life care

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients said that their emotional wellbeing and needs were considered as well as their physical health needs. Patients were able to call the service if needed and said that they always received a call back.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Patients told us that their relatives or friends could attend appointments with them.

Staff talked with patients, families and carers in a way they could understand.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Feedback forms were available in the clinics.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service. We spoke to 12 patients who all gave positive feedback about the care they had received.

Are End of life care responsive?

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

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the local population. Managers told us they worked with system partners to find the gaps in service provision and attempted to resolve them. Clinics were provided at different locations to reduce patients' requirement to travel.

End of life care

Facilities and premises were appropriate for the services being delivered. The main location was situated not far from a local NHS hospital and had good transport links. A car park was provided for patients and their family/carers.

Managers monitored and took action to minimise missed appointments. The number of appointments cancelled in the last 12 months was 11. This was due to several reasons for example, staff sickness. Missed sessions were booked in as soon as possible following cancellation.

Meeting people's individual needs

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

The service was able to meet patients' individual needs and preferences. The main location had the clinics on the ground floor to assist patients who had limited mobility. This was the same for one of the satellite clinics we visited.

Staff in each of the clinics told us they liaised with other health care professionals involved in patients care and treatment. They obtained consent from the patient prior to do doing this.

To improve staff knowledge and skills they had completed training on learning disability and autism, which included how to interact appropriately with autistic people and people who have a learning disability. This is now a national requirement for all health and social care providers.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff had received training on the accessible information standard.

The service was able to provide information leaflets in languages spoken by the patients and local community.

Access and flow

Patients could access the specialist care and treatment when they needed it. Waiting times from referral to first appointment were in line with their standards and good practice.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes.

Managers worked to keep the number of cancelled appointments to a minimum.

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible.

Staff supported patients when they were referred or transferred between services.

Learning from complaints and concerns

It was easy for people to give feedback however; patients did not know how to raise concerns about care received. The service would treat concerns and complaints seriously, investigated them and share any lessons learned with all staff.

End of life care

Patients, relatives and carers did not know how to complain or raise concerns.

The service displayed information about how to make a compliment and concern in patient areas. However, this did not include details on how to make a formal complaint.

From the 1 April 2021 to 31 March 2022 the service had not received any complaints.

Staff understood the policy on complaints and knew how to handle them. The policy detailed the action that would be taken if a complaint was received and the stages to be followed if the complainant was not happy with the outcome.

Are End of life care well-led?

Good 

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

Leaders had the skills, knowledge, experience and integrity that they need to run the service effectively. The manager had been at the service for less than a year and had been registered with the Care Quality Commission since September 2022. Staff told us leaders were visible in the service and approachable. There was clear line of leadership with the Chief Executive Officer (CEO) leading the service. Staff were aware of who their line manager was and who they reported to.

Leaders understood the challenges to quality and sustainability, and they could identify the actions needed to address them. The CEO told us when they started, they reviewed all services provided and made changes to these to maintain financial stability and to meet the needs of the local population. As part of the review of services a new location was located and refurbished to meet their needs.

We observed relationships between senior leaders, including trustees, and operational staff was effective. Trustees were chosen for their skills and knowledge they would bring to the board and service. Trustees maintained their governance responsibilities, attended all board meetings and had a good understanding of quality and safety. Some of the trustees chaired subgroups which fed into the main board meetings.

The service had a Statement of Purpose that described the services offered to include satellite clinics. However, this did not list all the addresses of the satellite clinics.

Vision and Strategy

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

End of life care

There was a clear vision and a set of values, with quality and sustainability as the top priorities. Senior staff were able to describe their vision and values. These were displayed on their website for members of the public to read.

A robust, realistic strategy for achieving the priorities and delivering good quality sustainable care had been developed. Senior staff told us they were approaching the end of their 3-year strategy and were due to share their next 3-year strategy with staff. An important part of their current strategy concentrated on how the service could deliver exceptional care to more people across East Dorset and surrounding areas.

Lewis-Manning Hospice Care vision, values and strategy had been developed using a structured planning process in collaboration with staff, people who used services, and external partners. Senior staff told us they were looking to work closely with other system partners and provide services to meet the needs of people who require palliative care support.

Staff were aware of, and had an understanding of the service's vision, values and strategy and their role in achieving these. Staff told us for example, it was about providing the best care to patients to ease their symptoms. Staff had been involved in devising their values.

The strategy was aligned to local plans in the wider health and social care economy, and services have been planned to meet the needs of the relevant population. Senior staff told us they worked closely with other system partners to review the needs of people and planned services where there were gaps in provision.

Culture

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

Staff felt supported, respected and valued. Several members of staff we spoke with had worked at the location for many years. Staff told us they liked working there. Some staff told us they had been promoted to more senior roles as the provider encouraged promotion to aid retention and increase morale.

The culture centred on the needs and experience of patients who used services. Staff were focused on providing the best care and treatment to patients to improve their symptoms and quality of life.

Staff told us they felt positive and proud to work in the organisation.

Managers had access to policies, procedures and support to address behaviour and performance that was inconsistent with the vision and values, regardless of seniority.

The culture encouraged openness and honesty at all levels within the organisation, including with patients who used services. Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution. Staff were able to raise any concerns with their line manager or other senior staff. One of the trustees was the Freedom to Speak up Guardian and said staff could contact them anytime and contact details were provided for staff.

There were cooperative, supportive and appreciative relationships among staff. Staff and teams work collaboratively. Staff told us they worked well together to provide a high standard of care and treatment to patients.

End of life care

Staff were aware of their responsibilities to meet the duty of candour. They had not been required to implement duty of candour at the time of our inspection. They also reported on duty of candour as part of their quality accounts each year to commissioners.

Staff told us they had access to a lone working policy and knew what it contained. We did not see a copy of this policy, but staff felt confident they knew how to follow the actions to maintain their safety.

Governance

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

There were effective structures, processes and systems of accountability to support the delivery of good quality and sustainable services. These were regularly reviewed, and improvements made as required. We reviewed audits and minutes of monthly or quarterly meetings where staff discussed these and other topics.

We saw all levels of governance and management function interacted with each other appropriately and effectively. The subgroups fed their main points from each of their meetings into the board meeting. We reviewed minutes of several meetings, for example, clinical leads meetings and minutes of performance and clinical governance subcommittee.

Staff at all levels were clear about their roles and accountabilities. The senior leadership team shared information with all staff.

Arrangements with partners were governed and managed effectively to encourage appropriate interaction and promote coordinated, person centred care. A designated member of staff monitored the contract with the local NHS Commissioners. A yearly quality account was devised and shared with them.

Feedback from people who used services and their families was regularly discussed at Board meetings. We were sent copies of the board meetings and a section was devoted to feedback. We reviewed 3 board meeting minutes and observed consistent positive feedback received.

Quality and risk information about the service was reviewed during board meetings and included financial information, risks and key performance indicators (KPI's) for the services offered.

We reviewed 4 staff records which included the Chief Executive Officer (CEO) and a trustee and observed successful completion of all pre employment checks which included Disclosure and Barring Service (DBS), checks, and fit and proper persons checks for the CEO and trustee. However, on one of the member of staff's employment history they had used years worked from and to, rather than months and year worked. For the staff who had professional qualifications, such as a physiotherapy qualification, we saw that these credentials had been checked.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

There was a systematic programme of clinical and internal audit to monitor quality, operational and financial processes and a system to identify where action should be taken. A summary of the audit results was reported to the board via one of their subcommittees.

End of life care

Arrangements for identifying, recording and managing risks, issues and mitigating actions had been devised. There was alignment between the recorded risks and what senior staff say was 'on their worry list'. We saw evidence of their risk register and each risk was given a score, the higher the score the more of a risk. Each risk was reviewed, and a new score devised.

There were processes to manage current and future performance and were regularly reviewed and improved. Senior staff told us about the plans they had to grow their better breathing clinic by setting up more satellite clinics. They were also looking into the future and working with other providers to improve service provision for patients who require support at home.

Potential risks were considered when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. The service had a business continuity plan to manage any risks.

Information Management

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

There was a holistic understanding of performance, which included patients views with information on quality, operations and finances. This information was used to measure improvement. Audits provided data on compliance with areas reviewed. These were reviewed by staff and actions devised when shortfalls were identified.

There were clear and robust service performance measures, which were reported and monitored. We saw evidence that KPI's were monitored and some were used to help apply for more funding from commissioners when required for services offered.

There were effective arrangements to ensure that data and notifications were submitted to external bodies as required.

The provider had arrangements to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, were in line with data security standards. We did not ask to see their policy on data management to confirm the arrangements met the providers standards, however their quality account for 2021/22 stated they had met the standards for data security and protection toolkit.

Data systems were secured and monitored.

Engagement

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

Patient's views and experiences were gathered and acted on to shape and improve their services and culture. We saw the feedback about the lymphoedema and better breathing clinics in their quality account for 2021/22. Feedback was very positive and included how the service had improved and helped patients manage their symptoms.

End of life care

Friends and family test results for lymphoedema clinic rated them as 'very good' in February 2021 (most recent results) as total of 19 patients responded. For the better breathing clinic, they had 5 responses and 4 rated them as 'very good' and 1 was 'good'.

Staff were actively engaged so their views were reflected in the planning and delivery of services and in shaping the culture.

There was a positive and collaborative relationship with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. Senior staff told us they worked closely with their partners to help provide services for patients across East Dorset. They were also setting up clinics at locations across East Dorset to help reduce the travel time for patients.

Lewis-Manning Hospice Care was transparent and open with all stakeholders about performance. They completed a yearly quality account that was shared with the local NHS Commissioners. A copy was also available on their website for other stakeholders, patients and their relatives/carers.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation.

Leaders and staff strived for continuous learning, improvement and innovation. Staff told us they followed all the latest guidance and best practice for all the clinics, they showed us evidence of this during our inspection. The staff for lymphoedema and better breathing clinics were members of organisations for each of their specialities and attended relevant study days.

Lewis-Manning Hospice Care provides palliative care and they were not eligible to participate in any national audits. They did monitor their own patient outcomes.

Improvements had been made within the last year to services for example, the better breathing clinic had recruited an extra member of staff due to the demand so they could expand. They also had plans to look at home visits in the future.