

Compton Care

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

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Outstanding 

Are services well-led?

Good 

Overall summary

Compton Care is operated by Compton Care Group Ltd. Compton Care provides specialist palliative care and support services for inpatients, outpatients and community care to people aged 18 years old and above. Services provided included:

An 18 bedded inpatient unit, which includes single rooms with en-suite facilities,

A lymphoedema care centre,

A bereavement care service,

A day therapies centre based at the Compton Hall site.

Most of the care is provided in the community within patient's homes, care homes and prisons by a combined community service including a community specialist nursing team.

On-call palliative medicine advice is available 24 hours a day seven days a week to healthcare professionals who may be either in the community or in hospital within Wolverhampton, Dudley and Walsall.

Summary of findings

Compton Care at Home provides practical support for end of life patients and their loved ones. A new rapid response service was in the early stages of implementation.

A range of social, physical, psychological and spiritual services provide a holistic experience for patients and psychological support is also extended to their carers and families.

We inspected all services provided by the service.

We inspected this service using our comprehensive inspection methodology. We visited unannounced on the 15 October 2019 followed by announced visits carried out on 16 and 17 October 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.

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 stayed the same. We rated it as **Good** overall.

- Staff provided exceptional care and compassion and ensured patients privacy and dignity was maintained at all times.
- The service made sure staff were competent for their roles. The continuing development of the staff's skills, competence and knowledge 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. Volunteers were proactively recruited and were supported in their role. The use of volunteers helped to measurably improve outcomes for people.
- Doctors, nurses and other healthcare professionals worked collaboratively as a team to benefit patients

and had found innovative and efficient ways to deliver more joined-up care to people who use services. They supported each other to provide good care.

- The service planned and provided innovative approaches care, providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs.
- The service had a proactive approach to understanding the needs and preferences of different groups of people and to planning and delivering care in a way that met their needs, which was accessible and promoted equality. They proactively coordinated care with other services and providers. Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health Staff provided exceptional care and compassion and ensured patients privacy and dignity were maintained at all times. People were truly respected and valued as individuals and were empowered as active partners in their care, practically and emotionally, by an exceptional and distinctive service.
- The service had a vision for what it wanted to achieve and a strategy plan which was stretching, challenging and innovative, while remaining achievable and was 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 and there was a demonstrated commitment to system-wide collaboration and leadership.
- There was a fully embedded and systematic approach to improvement, which made consistent use of a recognised improvement methodology. Improvement was the way to deal with performance and for the organisation to learn. Improvement methods and skills were available and used across the organisation, and staff were empowered to lead and deliver change. There was a strong record of sharing work locally, nationally and internationally.

Summary of findings

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

However

- Improved arrangements were needed to provide assurance of effective staff hand washing and identification of infections to protect patients, staff and others from the risk of infection.
- Not all required staff had safeguarding children level 3 training although systems were in place to address this.
- No safety thermometer or equivalent was displayed although there were plans in place to actively share this information with staff, patients and visitors.

Heidi Smoult

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Hospice services for adults

Rating

Good



Summary of each main service

We rated Compton Care as good overall, we rated the safe, caring and well led domains as good and responsive domain as outstanding.

Summary of findings

Contents

Summary of this inspection	Page
Background to Compton Care	7
Our inspection team	7
Information about Compton Care	7
The five questions we ask about services and what we found	9
<hr/>	
Detailed findings from this inspection	
Overview of ratings	13
Outstanding practice	43
Areas for improvement	43
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Good 

Compton Care

Services we looked at

Hospice services for adults.

Summary of this inspection

Background to Compton Care

Compton Care is operated by Compton Group Ltd. The service opened in 1983 and is predominantly a charity funded organisation with some additional NHS funding.

The service has undergone recent changes including a change of name. The service primarily serves the communities of the Wolverhampton, Dudley, Walsall and South Staffordshire. It also accepts patient referrals from outside this area.

The registered manager resigned on 31 March 2019. The Head of Quality and Compliance was acting manager at the time of the inspection and has since applied to be the registered manager.

The service is registered to provide the following regulated activities:

Diagnostic and screening procedures

Treatment of disease disorder or injury

Compton Care was last inspected on 20 April 2016 and was rated good in all domains and good overall. We have inspected the service four times, on each occasion the required standards were met.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and a specialist advisor with expertise in palliative care. The inspection team was overseen by Bernadette Hanney Head of Hospital Inspection.

Information about Compton Care

The service has two sites, Compton Hall (the main site) and Cedars. The following services are located at Compton Hall: 18 bedded inpatient unit, supportive therapies, community services, the day therapy unit and administration. The following services were located at Cedars: the lymphoedema service, bereavement services and the learning and development centre.

During the inspection, we visited the inpatient unit, lymphoedema service, bereavement service, community palliative care service, which included accompanying community nurse specialists on six patient home visits, and the rapid response hub. We spoke with 22 staff including registered nurses, department managers, administration staff, maintenance staff and senior managers. We spoke with six patients and six relatives. During our inspection, we reviewed six sets of patient records.

There were no special reviews or investigations of the organisation ongoing by CQC at any time during the

12 months before this inspection. The service has been inspected four times, and the most recent inspection took place in April 2016 found that the service was meeting all standards of quality and safety it was inspected against.

Activity (April 2018 to March 2019)

- There were 298 patients admitted to the in-patient unit (IPU).
- The community nursing team recorded 6028 patient homes visits.
- The care at home team made 3052 visits to patients their own home
- There were 398 visits to patients in care homes.
- There were 355 patient physiotherapy encounters.

Between September 2018 and March 2019

Summary of this inspection

- The social work provided support to 224 patients and family members (816 encounters).
- There had been 61 patients and their family members who had received bereavement counselling (192 encounters).
- There had been 309 patients and family members who received support from the spiritual team (1501 encounters).

Between July 2019 and September 2019 (commencement of the new service)

- There had been 7396 consultations with the rapid response team of which, 5482 were with a clinical nurse specialist and 1520 with a health care assistant.

Three specialty doctors and one clinical fellow were employed directly by Compton Care. In addition, five consultants were contracted from a local trust to the inpatient unit and day therapies, a specialty registrar and a foundation year two (FY2) doctor worked at Compton Care under practising privileges. The service also employed 70 registered nurses, 38 health care assistants and 10 allied health professionals including physiotherapists, counsellors and social workers. The accountable officer for controlled drugs (CDs) was the matron for community care.

Track record on safety

- No never events
- One serious incident

Between 1 June 2019 and 30 September 2019, staff had reported a total of 101 clinical incidents 44 no harm, 43 low harm, 14 moderate harm, zero severe harm and zero deaths.

Two incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),

No incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)

No incidences of hospital acquired Clostridium difficile (c. diff)

No incidences of hospital acquired E-Coli

The service had received three complaints within the reporting timeframe.

Services accredited by a national body:

Compton Care had successfully achieved the Data Security Protection toolkit in March 2019.

The service was working towards:

- ISO 27001 Data Security Standard
- Investors in Diversity
- Cyber Essentials Accreditation

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Pharmacy
- Interpreting service
- Laundry
- Maintenance of medical equipment

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:

Are services safe?

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

- 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.
- Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.
- Staff kept equipment and the premises visibly clean.
- Records were clear, up-to-date, stored securely and easily available to all staff providing care. Staff completed and updated risk assessments and considered those patients who were deteriorating and were in the last hours and days of life.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service managed patient safety incidents well. When things went wrong, staff apologised and gave patients honest information and suitable support.

However

- Improved arrangements were needed to provide assurance of effective staff hand washing and identification of infections to protect patients, staff and others from the risk of infection.
- Not all required staff had safeguarding children level 3 training although systems were in place to address this.
- No safety thermometer or equivalent was displayed although there were plans in place to actively share this information with staff, patients and visitors.

Good



Are services effective?

- The service made sure staff were competent for their roles. The continuing development of the staff's skills, competence and knowledge was recognised as being integral to ensuring high-quality care. Staff and volunteers were proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice.

Good



Summary of this inspection

- Doctors, nurses and other healthcare professionals worked collaboratively as a team to benefit patients and had found innovative and efficient ways to deliver more joined-up care to people who use services. They supported each other to provide good care.
- The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs. Staff assessed and monitored patients regularly to see if they were in pain and ensured appropriate pain relief was available and gave practical support to help them live well until they died.
- Key services were available seven days a week to support timely patient care.

Are services caring?

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

- Staff provided exceptional care and compassion and ensured patients privacy and dignity were maintained at all times.
- 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.
- Staff provided a high level of emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs
- Staff involved and supported patients, families and carers to ensure they were active partners in their care.

Good



Are services responsive?

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

- The service planned and provided innovative approaches, providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs.
- The service had a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met their needs, which was accessible and promoted equality. They proactively coordinated care with other services and providers.

Outstanding



Summary of this inspection

- Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Are services well-led?

Our rating of well-led stayed the same. We rated it as **Good** because:

- The service had a vision for what it wanted to achieve and a strategy plan which was stretching, challenging and innovative, while remaining achievable and was 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 and there was a demonstrated commitment to system-wide collaboration and leadership.
- There was a fully embedded and systematic approach to improvement, which made consistent use of a recognised improvement methodology. Improvement was the way to deal with performance and for the organisation to learn. Improvement methods and skills were available and used across the organisation, and staff were empowered to lead and deliver change. There was a strong record of sharing work locally, nationally and internationally.
- 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.
- 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.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Good




Summary of this inspection

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






Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Hospice services for adults

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

Are hospice services for adults safe?

Good 

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

Mandatory training

The service provided mandatory training in key skills to all staff and there were new systems in place to make sure everyone completed it.

All staff and volunteers received a structured induction programme when they started working for the service. The induction programme included both organisational and departmental requirements.

Compton Care required all staff to complete mandatory training in a range of modules. Modules were identified separately for clinical and non-clinical staff and included conflict resolution, equalities and diversity, safeguarding adults at risk and children, principles of health and safety, information governance, fire safety, infection prevention and control, and equality and diversity and moving and handling. Mandatory training was both electronic and face to face.

Information provided before the inspection identified mixed compliance with mandatory training. Managers told us this was being addressed with improved identification of which staff required mandatory training and a programme of additional safeguarding training.

Information we received following our inspection identified an improvement in staff training. Information provided identified 94% of retail staff, 90% of clinical staff and 95% of non-clinical with an overall of 92% of all

Compton Care staff had completed all required mandatory training. Some new mandatory training modules had been introduced and staff compliance with these modules (hand hygiene 66% and PREVENT which raised staff awareness of radicalisation 43%) was on track to meet the service's target on the end of March 2020.

The organisations target for compliance with mandatory training was 90% by the end of March 2020 for all active members of staff. There was a further aim to increase compliance to 95% by the end of March 2021.

Clinical staff received annual basic life support training which included identification and management of sepsis, anaphylaxis, choking and use of the defibrillator and 78% of required staff had received this training. This training was face to face and was provided by an appropriately trained member of staff.

Managers told us there were plans in place for identified clinical staff to attend immediate life support 'train the trainer' training. These staff would then cascade immediate life support training to other clinical staff. One member of nursing staff had advanced life support training.

Medical staff were contracted by a local NHS trust who provided all mandatory training including basic life support training which and some aspects of advanced life support training such as defibrillator and use of emergency medicines drugs. Information provided by the service identified one consultant had received advanced life support and immediate life support training.

The service had a new central information technology system which recorded the dates of all staff mandatory training and identified when training required updating.

Hospice services for adults

Managers told us the new system generated email reminders the month before training was due. Monitoring staff compliance with mandatory training was both undertaken centrally and within each department.

Staff said they received email reminders which identified when mandatory training was due. The email identified dates when training courses were available, and staff were able to book directly onto the course.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Whilst some staff did not have the appropriate level of safeguarding training there were arrangements in place to address this and ensure they recognised and reported abuse and they knew how to apply it.

There were up to date arrangements in place to protect patients from avoidable harm. Compton Care had reviewed and issued revised policies for safeguarding of children and safeguarding of adults at risk in April 2019.

Staff we spoke with knew where to locate the safeguarding policies and correctly described the principles and processes they would follow if they had any concerns or if they suspected abuse.

Staff and managers, we spoke with were also able to provide examples of when they had raised a safeguarding concern and told us they felt confident in the process and the way in which concerns were managed.

Staff told us safeguarding concerns would be raised with the safeguarding leads. When required, referrals to social services or the police were managed in accordance with the Compton Care policy and recorded on the electronic incident reporting system. Staff were able to name the safeguarding leads and tell us where and how they could contact them.

Safeguarding leads for both for children and adults were in place. Safeguarding leads were trained to a level four which was in line with intercollegiate guidance. Staff told us the safeguarding leads were supportive and helpful if they had any safeguarding concerns. There was a comprehensive training programme in place to support staff understanding of mental capacity.

All staff received safeguarding adults at risk level 1 training; clinical staff also received safeguarding level 2.

Safeguarding training included modern slavery, child sexual exploitation, gang culture, honour-based violence, forced marriage, female genital mutilation and domestic abuse.

Information provided showed 91% of staff had completed level 1 and 87% of staff had completed level 2 safeguarding adults at risk training. There was 75% staff compliance with safeguarding children level 1, 75% compliance with level 2. (No information was included for level 3 safeguarding children compliance). Since the inspection the service have sent us further information which identified 89% of staff have now received level 2 safeguarding adults at risk and 88% of staff had received level 2 safeguarding children.

The service provided care and treatment primarily for adults over 18 years. However, the bereavement team provided counselling for children and community teams had contact with children and families as part of their visits. The intercollegiate document Safeguarding children and young people, 2019 identifies a need for staff with direct access to children to have level 3 safeguarding children training. We were told this need had been identified and training was planned. The organisation's 'Safeguarding Delivery Plan 2019 to 2022' confirmed arrangements and which staff required which level of safeguarding. Staff requiring safeguarding levels 2 and 3 (both adults and children) would receive this training by April 2020 and thereafter every three years.

Staff training in PREVENT which raised staff awareness of radicalisation had commenced and at the time of the inspection, 53 staff had undertaken this training. This training programme was ongoing and would be completed by the end of March 2020.

The safeguarding leads received clinical supervision from an outside agency to ensure best and safe practice was met. Staff told us safeguarding concerns were discussed during team meetings, multidisciplinary meeting and case reviews to ensure best practice was identified and if any improvements were required.

The provider selected staff and volunteers through a robust recruitment process. All staff and volunteers had a Disclosure and Barring Service (DBS) check and required checks to ensure appropriate people were employed.

Hospice services for adults

Nurses professional registration was confirmed and ongoing checks of renewal of registration was undertaken with the regulatory body (Nursing and Midwifery Council).

Cleanliness, infection control and hygiene

Staff kept equipment and the premises visibly clean. However, improved arrangements to provide assurance of effective staff hand washing and identification of infections were needed to protect patients, staff and others from the risk of infection.

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.

There were facilities to support good infection prevention control in all patient rooms and in the corridors outside patients' rooms and clinic rooms. The service was visibly clean.

We observed patient rooms were deep cleaned between patients, which included equipment, furniture and the room. Clinical and domestic staff confirmed when cleaning had completed. There were identified arrangements in addition to room cleaning to replace equipment such as toilet brushes in patient rooms between each patient.

Furniture, furnishing and equipment were easily cleanable. We saw 'I am clean stickers' which indicated equipment had been cleaned before patient use.

Hand washing sinks were set at the required hand washing temperature and length of time to ensure effective hand washing. We observed staff washing their hands appropriately.

The organisation identified a need for all staff to receive annual hand hygiene training which included a hand hygiene assessment. Six staff had been trained to deliver this training. The organisation had identified a target that 95% of staff will have received this training by the end of March 2020. At the time of the inspection 66% of staff had received the training.

Hand hygiene audits for the inpatient unit were undertaken annually, the last audit was undertaken in June 2018 and identified 69% staff compliance. Actions to address the shortfalls were not identified and there had

been no subsequent recorded check of staff hand hygiene. Information provided by the organisation identified a review of infection control including audit would be undertaken by the new director of nursing.

We saw hand gels were available throughout patient areas. When visitors signed in at the main reception they were asked to use hand gel and reception staff recorded hand gel had been used.

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.

The service ensured that the health and safety of everyone who met the deceased person's body after death was protected. A side ward on the inpatient unit was being used as a temporary mortuary at the time of the inspection prior to completion of the new mortuary. The environment where bodies were stored was clean and well maintained and suitable until the deceased was collected by funeral directors.

There were two incidences of MRSA infection (one patient who had MRSA in two sites), between April 2018 and March 2019. A review of this incident was undertaken and identified a delay of one week before the patient was swabbed for MRSA and it was unclear if they had the MRSA infection on admission. We saw learning from this was a need to ensure staff awareness of the need to swab for MRSA was identified. Staff told us they swabbed all patients who had a recent admission to hospital.

The infection control lead nurse had recently left the organisation. There were plans in place for a replacement member of staff with consideration of a joint appointment with a local NHS trust. We saw the infection control lead had been responsible for auditing, assessing and reviewing infection prevention and control. Audit information was included in the infection prevention and control annual report which had been presented to the board, with three monthly updates to the clinical quality committee. We saw one outcome of the audit was a need for staff to receive further information and training around specimen labelling and handling.

Compton Care had infection control 'champions' and infection control link nurses who had a role to promote and audit infection control and prevention practice.

Hospice services for adults

The service held three monthly infection prevention and control link meetings. These meetings were multidisciplinary forums and identified, mitigated against, monitored and managed infection risk. The meetings looked at audits undertaken in the quarter including antibiotic use, infection champion audits and environmental audits. We reviewed minutes from the meeting in May 2019 and saw that the results of the audits were discussed and where issues were identified actions were put in place.

One outcome of the meetings was a water safety plan. There had been a review of the water system to ensure effective reduction of legionella risk with the use of carbon dioxide. Taps were run twice a week and water sampling was undertaken monthly to check for the absence of legionella to confirm appropriate arrangements were in place.

For the year 2018 to 2019, 37% of staff had a flu vaccination, there was a plan in place to improve uptake for 2019 to 2020. This is important for staff providing support to patients who may have weakened immune system due to their treatments and conditions.

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.

Staff calls bells were available throughout patient areas and when they were rung by patients or their loved ones they were quickly answered by staff.

The Patient-Led Assessments of the environment (PLACE) 2018 rated the Compton Hall site as the 10th worst out of 1,197 hospitals and hospices. The service scored 77 per cent for condition, appearance and maintenance. The national average was 94 per cent. The building also scored poorly in relation to how buildings supported care for those who were disabled, looking at access for people in wheelchairs and handrails, 67 per cent compared to a national average of 84 per cent. The chief executive agreed with the findings and said they had a three-year strategy in place to improve the organisations Grade 2 listed building which had represented a challenge. During the inspection we observed considerable building work was being undertaken and had addressed the findings of the PLACE audit.

Resuscitation equipment was accessible in an emergency. Staff did daily checks of resuscitation trolleys and the checks were recorded to demonstrate the equipment was safe for use.

The service had a housekeeping and maintenance team responsible for the building and grounds.

Maintenance arrangements were identified electronically. The system identified, planned maintenance and servicing and reactive needs identified by other staff such as faulty equipment. The head of estates and estates team had access to the system to ensure timely maintenance was undertaken.

Compton Care used approved contractors for identified equipment for example, the fire alarm, system, fire extinguishers, the boiler, electronic doors and air conditioning system. We saw the electronic system included service contracts, contact details and proof of liability insurance.

There were suitable arrangements to promote the security of patients and staff. There were security cameras in the grounds and the reception area. The building was secure, and access was restricted with the use of staff electronic keys. All visitors signed in at main reception.

Clinical waste disposal arrangements were in place throughout the hospital. 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 ensured the date of opening was recorded and sharps bins were disposed of before they became too full.

Assessing and responding to patient risk

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

Staff carried out risk assessments on admission for each individual patient which were subject to regular review. All inpatients were subject to a holistic daily assessment process which included mental capacity. A multi-professional review of risks was undertaken weekly.

Hospice services for adults

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 accessible information was available for staff to keep each patient safe.

The service used an early warning score for inpatients who were not end of life and had not completed a do not resuscitate (DNAR). This tool assessed patients' observations and identified early signs of deterioration to enable timely treatment.

The service had developed a sepsis identification tool with a national charity. There had previously been no tool to identify sepsis for palliative care services. This tool was now available for use by other services for palliative care patients.

Staff managed emergencies in line with policy and procedures. Patients sometimes required an emergency or unplanned transfer to hospital via 999. 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. On every occasion, an incident report was completed and was documented in the patient notes.

The daily patient review also identified patients who were deteriorating and in the last days and hours of life with the use of a Frailty Recognising End of Life and Escalating Deterioration (FREED) tool. The FREED tool identified (in red) on the front page, if the patient was acutely unwell and for active treatment a need to call 999. Staff managed the increased risks experienced by people at the end of life. All patients were risk assessed for skin integrity, pressure ulcers and falls using evidence-based tools. The information was used to form management plans which were stored in patient records.

There was a program of mandatory training which tested the competence of clinical skills through role play and scenario-based training led by the in-patient clinical nurse specialist which covered anaphylaxis and other medical emergencies.

The service had reported nine patient deaths to the coroner, those which we looked at identified possible industrial diseases.

Between 1 June and 30 September four patients were transferred from the inpatient unit to the local NHS hospital for assessment of acute symptoms.

Staffing

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

Staffing figures from April 2018 to March 2019, identified there were 35 nursing staff, 11 health care assistants and 55 non-qualified staff working 37 or more hours a week. There were 35 nursing staff, 27 health care assistants and 38 non-qualified staff working less than 37 hours a week.

The organisation had invested in technology which supported staff resource planning processes and used software to help manage staff duty rotas. This provided data and a full overview of resources available to manage the patient safety requirements.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The ward manager for the inpatient unit could adjust staffing levels daily according to the needs of patients. A recognised staffing tool was used to identify baseline staffing requirements. Rotas were planned but staffing numbers were flexed to respond to increasing dependency and complexity of the patients. Rotas were reviewed on a daily and shift basis across assessing the needs of patients. We saw the numbers on duty accurately reflected requirements.

The service identified that workforce planning was continually evolving as they developed and enhanced service provision for the community. Each year a formal budget plan considered staffing levels in terms of patient safety, capability and capacity, location, service requirements which included annual leave, some sickness short and long term, time for training and development and organisational development initiatives.

Hospice services for adults

Line managers were involved in developing the budget process which was then assessed by the director of nursing, leadership team and the trustees as the financial budget was agreed and signed off.

The service had low vacancy rates. There were 33 new staff appointed and 33 staff who had left between April 2018 and March 2019.

The service had one clinical nurse specialist who was training to undertake the advanced nurse practitioner (ANP) role. The ANP spent one day a week supporting and training nurses and the other four days a week supporting the medical staff reviewing and providing treatment to patients on the inpatient unit. There were plans in place to recruit a further qualified ANP.

For continuity of service for the future, the service had invested in two trainee nursing associates (TNA) who were in their final year of training. Following success of the TNA programme there were plans to introduce more TNA's next year. The organisation had successfully employed apprentices who had secured permanent posts as health care assistants. This was to support the nursing workforce and provide career progression for existing members of care staff.

A manager told us they were working with human resources to review and manage sickness absence, actions included a return to work interview, review of number of sickness episodes within six months and the follow up of non-receipt of sickness certification.

Gaps in duty rotas were mostly filled by substantive staff working additional hours.

Managers limited their use of agency staff and requested staff familiar with the service. Between April 2018 and March 2019 Compton Care had used 102 hours of agency staff. Agency workers who were booked were required to have up to date statutory and mandatory training records. A profile was shared by the agency of the staff's training records. If the training was not up to date or current, then they would not be offered agency work with Compton Care.

Managers made sure all bank and agency staff had a full induction and understood the service. All agency workers receive an orientation by a senior nurse who would also remain their point of contact during their shift. Agency workers were also directly supervised by a registered

nurse. During their orientation, an overview and guidance of Compton Care procedures was shared, including health and safety procedures, emergency exits and procedures, an overview of facilities and they were also introduced to other staff/teams as appropriate to their role.

Compton Care operated its own bank and had a bank worker policy which set out staff requirements. All bank workers received the same initial orientation as agency workers. In addition to the initial orientation bank workers were also required to complete Compton Care statutory and mandatory e-learning modules, moving and handling training and attend the corporate induction.

There was one full time physiotherapist and one physiotherapy assistant who worked Monday to Friday supporting patients in the inpatient unit, day therapies and patients own homes

Compton Care had a team of five social workers providing patient and carer support and advice on matters such as finances. The social worker team manager was employed on a full time basis, the other four staff worked part time.

Within the supportive care department there was a full-time manager who provided psychotherapy, a part time art therapist, a children's counsellor was employed on a contracted basis whilst the service recruited into a permanent post. There was a full-time spiritual care coordinator and chaplain who were supported by an assistant and number of volunteers.

Compton care directly employed a full-time bereavement service manager who also provided counselling and a children's counsellor. The team was supported by a team of volunteers. Volunteer counsellors were recruited specifically for the role as bereavement counsellors. The volunteer counsellors completed 50 hours training over 13 weeks with ongoing assessment, monthly group supervision, two one to one sessions a year, annual review and ongoing training.

The service had three community engagement workers (one of whom was the team manager).

There were 786 volunteers who worked throughout Compton Care, working within retail outlets, hospitality, reception, the inpatient unit, estates, counselling, patient transport and fund raising. There were 52 volunteers

Hospice services for adults

trained to provide caring support. A volunteer services manager was employed to oversee see arrangements for volunteers. Volunteers were employed to work within specific departments for identified days and hours and were considered as part of the department team. Volunteers were supported in being competent in their role and received the same training as permanent staff.

Medical staffing

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

The medical staff matched the planned number on all shifts. The service directly employed three specialty doctors, a pharmacist and one clinical fellow.

The medical director held responsibility for monitoring activity levels and supervising medical staff, to ensure workloads were appropriate and patient safety optimised.

There were five palliative care consultants (one full time equivalent and four part time consultants) contracted by a local trust, who spent their working time within Compton Care. There were 13 medical staff who had practising privileges.

Consultants were employed to provide support to the inpatient unit (IPU), the community and day therapies.

Clinical care was consultant led with multi-disciplinary working across all settings. Consultants provided planned support with ward rounds, caseload reviews, multi-disciplinary team (MDT) meetings, outpatient reviews and joint home visits.

Palliative medicine doctors were on site at Compton Hall 9am to 5pm Monday to Friday. The first on call doctor could also be present during the day at the weekend.

There were two consultants supported by at least one other doctor available for both the inpatient unit and community Monday to Friday 9am to 5pm. Out of hours the service had a shared palliative care registrar rota with other local NHS trusts for first registrar on call. The registrar on call would provide palliative care advice for

inpatients on the inpatient unit, local hospitals and community palliative care patients. The registrars were supported by consultants who were identified as second on call.

The medical team was also supported by a prescribing clinical nurse specialist on IPU.

The consultants were supported by a specialty registrar and a foundation year two doctor.

The service always had a consultant and registrar on call during evenings and weekends. Palliative care doctors worked with other palliative care services supporting services both in hospitals and community 24 hour a day, seven days a week.

The service had no medical vacancies. The service had recently recruited two palliative part time consultants.

Managers made sure locums and any doctors on placement had a full induction to the service before they started work.

Records

Patient notes were comprehensive, and all staff could access them easily. The service used electronic patient records. We reviewed six sets of patient records and each contained all the appropriate information. Records could only be accessed by those who had authority to do so.

Referrals from healthcare professionals were received using a referral form for specialist palliative care services. Patient details were entered onto the electronic patient record according to the information received.

The service had access to the clinical portal at the local NHS trust which allowed staff to view outpatient letters, imaging and pathology results when patients received their secondary care in that setting.

When patients transferred to a new team, there were no delays in staff accessing their records. All clinical services used the electronic patient record system so when patients transferred from one service line to another, their records were easily accessible.

On discharge from the service (either as an inpatient of from community services), all patients were provided with a clinical letter for their GP, with copies sent to key clinicians for example their oncologist.

Hospice services for adults

Records were stored securely. As patient records were electronic, they were password protected and so access was restricted to those who were authorised to use the system.

Compton Care were completing records process audits across the whole organisation which was part of the work to achieve the ISO 27001 data security quality standard. The results of the audits had not been published at the time of the inspection. The aim to achieve the ISO27001 data security quality standard across the whole organisation was recognised as an area of focus following changes to legislation and was split into three phases:

- Phase 1 – Gap analysis
- Phase 2 – achieve the DSP toolkit – completed
- Phase 3 – achieve ISO 27001 accreditation (due to complete early 2020)

A spot check of patient records looking at medicine incidents, falls and pressure ulcer documentation were reviewed weekly. A full electronic patient records audit was planned for early 2020 as staff become more familiar with the new system.

Medicines

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

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.

Patients received appropriate therapeutic medicines and physical health monitoring with appropriate follow up in accordance with current national guidance.

There was a controlled drugs accountable officer for the service to ensure safe management. Controlled drugs are medicines which require additional arrangements for their storage and administration under the Misuse of Drugs legislation (and subsequent amendments). We observed robust controlled drugs checks were in place, with checks undertaken and recorded at each staff handover. This meant there was a system in place to keep people safe.

A pharmacist was employed 16 hours per week and there was a service level agreement in place with a community pharmacy to provide the medication for IPU. The community pharmacy had a wholesale dealers license and could provide stock medication as well as dispense prescriptions. The community pharmacy provided one pharmacy technician visit per week to do a medicine stock review and order medicines as required. The community pharmacy also provided an out of hours service. The service told us on rare occasions they had contacted the local trust out of hours for unusual intravenous antibiotics that were not routinely stocked by community pharmacies

We checked patient records and prescription charts for six patients. We saw appropriate arrangements were in place to prescribe and record administration of patient medicines including a reason if medicines were not administered.

There was a non-medical prescribing (NMP) policy that identified accountabilities of non-medical prescribers including the continual professional development and supervision requirements. All NMPs were expected to complete a minimum of six hours per year continuous professional development (CPD) in relation to prescribing and an annual review with a medical prescriber. Compton Care provided six one hour 'prescribers' forum sessions per year and NMPs were expected to attend a minimum of two of these.

The service had 13 non-medical prescribers working in clinical teams.

Prescribers had to show they were up to date with required training to continue to prescribe medicines. Any prescriber identified at annual appraisal to be not actively prescribing or showing evidence of CPD for more than 12 months was escalated by their line manager to the NMP Lead and were ineligible to prescribe within Compton Care until further evidence of training and competence had been provided.

The community service manager was the non-medical prescribing lead and completed regular audits of non-medical prescribing. The pharmacist provided prescribing data to the medicines management group meeting. The medical team completed an annual prescribing audit on the in-patient unit.

Hospice services for adults

There were appropriate processes for medicines reconciliation when patients were admitted. This was completed by doctors and checked for accuracy by another staff member. The reconciliation was then further checked by the pharmacist at their next visit.

Allergies were recorded on the main treatment and prescription charts for all patients.

There were safe and secure storage arrangements for medicines including intravenous fluids. Access to rooms and cupboards where medicines were stored was restricted. There was an electronic system enabling only qualified staff with an electronic key to access medicine storage areas. The system also tracked which staff and when had accessed medicine storage.

There were appropriate systems 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 inpatient unit to support their ongoing care.

There was a medicines management committee in place which met every three months and discussed any necessary actions identified. We saw medicines incidents which had been reported were reviewed and monitored, so that lessons could be learnt, and improvements made if necessary. The community pharmacist attended the internal monthly medicines management group meeting.

Patients were provided with information on the medications they were prescribed and administered.

The service had 44 medicine incidents reported between July 2018 and June 2019. All incidents were identified as low harm. Senior managers reviewed the numbers and trends of incidents. Trends in medicines incidents included governance (11 incidents), administration and prescribing (10 incidents), storage (9 incidents), omissions (9 incidents) and dispensing (five incidents). Incidents were investigated, and considerations identified to improve practice. For example, the use of new measuring 'conicals' to reduce wastage and when administering controlled medicines from a bottle. There was a plan to assess the effectiveness of the conicals and if they decreased the amount of wastage.

The service had commissioned an external review of medicines management which took place through August and September 2019. The final report and recommendations would be shared throughout the organisation.

The service had systems to ensure staff were made aware about safety alerts and incidents, so patients received their medicines safely. Any alerts relating to medicine incidents, themes and trends were circulated across all service leads to ensure safe practice

At the time of our inspection, the service was using paper documents for prescribing. There was a plan for electronic prescribing. The medical director was exploring electronic prescribing with other electronic prescribing services nationally in preparation for introducing electronic prescribing to Compton care in the future. The service was trialling an electronic medication sheet when a patient was discharged, and this was updated by the community team.

The Accountable Officer for controlled drugs (CDs) completed quarterly CD audits, along with CD incidents these were discussed internally at the medicines management group and were also reported to the local controlled drug local intelligence network (CDLiN).

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff reported all incidents that they should report. We were not aware of any incidents which were not reported when they should have been.

The service had recently introduced an electronic incident reporting system. Staff told us when they had previously used a paper-based incident reporting system they did always receive feedback, however felt the new system was an improvement and included a record of

Hospice services for adults

feedback. A copy of the electronic incident report went to the department manager and other applicable senior staff such as medicines lead or estates manager. The incident report would be investigated by the service lead.

Staff reported serious incidents clearly and in line with policy. There had been one serious incident reported between April 2018 and March 2019. The incident related to a fall with significant harm. We reviewed the incident and found appropriate actions were in place to reduce the risk of subsequent similar incidents.

During the same period, there had been nine deaths reported that had been reported to the coroner. The deaths were reported due to possible industrial disease.

There had not been any never events from April 2018 to March 2019. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

The duty of candour is a statutory (legal) duty to be honest with patients or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future. There was an operational duty of candour policy to support and guide managers in decision making regarding the implementation of duty of candour.

The head of quality and compliance and the director of nursing ensured that an appropriate investigation of the incident was completed including fulfilling the requirements under duty of candour. The new online incident reporting software identified incidents that meet the duty of candour threshold. This ensured all incidents, whether beyond the service's control or avoidable, were declared to individuals.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. The duty of candour had been applied on two occasions from April 2018 and March 2019.

Managers debriefed and supported staff after any serious incident. Staff attended learning from death review

meetings and managers provided support to staff when difficult situations and serious incidents arose. Staff told us they were debriefed and received support from managers.

Safety Thermometer

Staff collected and monitored safety performance and there were plans to share this information actively with staff, patients and visitors.

The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination

Whilst the service monitored the number of new pressure ulcers, falls with harm and catheter infections this information was not displayed on the in-patient ward for staff and patients to see. The in-patient matron told us they planned to introduce a record which would be prominently displayed of incidents of patient falls, urinary and catheter infections and service acquired pressures ulcers.

Are hospice services 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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

The service held monthly meetings to review recently published National Institute for Health and Care Excellence (NICE) guidelines and any other relevant inquiries and assess whether any were relevant to the service or where possible learning and further development was required.

The service recently assessed their compliance against the NICE Quality Standard 10 Chronic Obstructive Pulmonary Disease in Adults and were compliant with

Hospice services for adults

the standard. This audit has led to consideration for auditing the use of oxygen in chronic obstructive pulmonary disease (COPD) for patients on the inpatient unit and whether discussions about rescue packs had occurred with patients both on IPU and in the community.

Research and sharing of best practice were encouraged to ensure the service was providing evidenced based services. Compton Care had a research and development governance group, audit and quality improvement group and a NICE assurance group. The research and development governance group met every three months and reviewed any new research requests and oversees ongoing research studies.

The service were members of Hospice UK and received weekly communication and updates, related to best practice.

Senior managers had assessed their compliance against the recommendations from the Lampard inquiry and this had led to the development of a policy for visiting celebrities.

The service was part of the local cancer research network (CRN) and the CRN attended meetings at the service to share research studies. The medical team were also members of the West Midlands Palliative Care Physicians (WMCARES) research collaborative.

The head of quality and compliance was a member of the health foundation Quality network and attended relevant events where best practice was shared.

Staff protected the rights of patient's subject to the Mental Health Act and followed the Code of Practice. Staff knew when and how to explain to patients their rights under the Mental Health Act.

The service provided a range of services that met people's needs by recognising the patient was approaching the end of their life and conducting appropriate holistic assessments in partnership with them and their close family and friends. Care was tailored to their individual needs and wishes and was focused on helping people to live well until they died.

To ensure care was personalised and bespoke, the service planned to make better use of the integrated

palliative care outcome scale (IPOS) cohort data to inform future service design and strategy. This work was to help ensure services were continuing to care in the most effective way for the whole population.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. The Compton Care on-site kitchen provided three meals a day, with snacks and hot and cold drinks offered at regular intervals and on request.

Water jugs were at bedsides and within patient reach. We saw they were refreshed regularly. A choice of cups, mugs, glasses, straws and beakers were available to suit individual needs and preferences.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Sub-cutaneous and intravenous fluids were prescribed where clinically indicated. Fluid balance and/or renal function was monitored when required. The hydration status of patients nearing end of life was assessed daily.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Patients' nutritional needs and preferences were assessed by a named nurse on admission and an individualised nutrition care plan was completed. Details of medical dietary requirements including cultural dietary needs were passed to the catering staff. This included whether patients had a special diet (diabetic, low salt etc), allergies and whether patients required a soft or liquidised diet.

Nursing staff, a hotel service assistant and volunteer supported patients with nutritional requirements during mealtimes.

The multidisciplinary team were strongly encouraged to respect and prioritise nutrition over other aspects of care at mealtimes.

Specialist support from staff such as dietitians and speech and language therapists were available from the

Hospice services for adults

local NHS trust. The local dietitian had completed a review of provision two years ago and provided regular training sessions for staff to enhance nutrition for palliative care patients.

Relatives were encouraged to eat with the patient and there were facilities for relatives to order food and access free beverages.

The “Love on a Plate” initiative, which provided nutritional food which patients enjoyed commenced following a project that two members of staff completed as part of a management course. This had now progressed to a nutrition steering group which reviewed and improved nutritional provision for patients.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and ensured appropriate pain relief was available.

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. We saw the service used a pain assessment tool which was in picture format and consisted of five faces representing different stages of comfort and happiness. This tool was also suitable for patients with a learning disability. The service was going to also introduce the ‘Abbey pain relief score’ which was a pain assessment tool for patients who were unable to verbally communicate their level of pain.

Staff prescribed, administered and recorded pain relief accurately. There were many different methods and approaches to pain relief which were available to all patients. We saw community nurse specialists discussing pain relief options with patients. We visited one patient who said they did not like taking tablets and had been prescribed a pain-relieving patch. We observed community nurse specialists also gave advice in relation to ‘top up pain relief’ whilst they ensured the level of pain relief was appropriate.

We visited four patients who all told us the positive effect the community nurse specialists had to reduce their pain and improve their quality of life.

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 or take tablets. Their wishes were followed, and alternative pain relief was prescribed and administered.

Patient outcomes

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

The service participated in all relevant national clinical audits, managers and staff used the results to improve patients’ outcomes. Information about the outcomes of people’s care and treatment (both physical and mental where appropriate) was routinely collected and monitored.

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

Patients who accessed the day therapies and the lymphoedema service identified their own goals and wishes. This helped develop a programme of care specifically based on their identified goals.

The service was registered with Outcome Assessment Complexity Collaborative (QACC) outcome frameworks. Outcome measures are particularly helpful in palliative care as they use a standard set of assessment tools. As a result of assessment, the tool(s) identified a team strategy for improved symptom identification, better communication and provided a consistent clinical picture of each patient.

As part of the QACC framework the service used the Karnofsky Performance scale. We saw this tool was actively used and discussed with other clinicians during case reviews and multidisciplinary meeting to identify the stage of their illness and assess management on their symptoms. Whilst individual outcomes were assessed at the time of the inspection the service was not assessing overall service outcome. For example, the number of patients who following contact with the service demonstrated overall improvement of symptom control. The service also used ‘What matters to me’, which identified things which were important to the patient and their loved ones.

Hospice services for adults

The service had undertaken an audit of care of dying adults in the last days of life in June 2017. The audit identified positive findings which included: all patients records identified the patient was dying and all identified this had been discussed with those important to the patient, all patients had received oral care in the last 24 hours of their life and had their hydration status recorded, all patients had appropriate anticipatory medicines prescribed, 90% of the records identified the preferred place of death was recorded. Recommendations were also identified such as the use of 'MyCare' document, exploring better recording of the advanced care plan and recording the patient's wishes in relation to shared decision making. A subsequent re-audit had been recently been undertaken although the results were not available at the time of the inspection.

Managers carried out a comprehensive audit programme. The organisation had a clinical audit programme that was agreed and developed collaboratively across the service. Audits were based on the service's priorities and audited against standards set in local or national guidelines, recommendations from independent reviews or patient safety alerts.

Managers shared and made sure staff understood information from the audits. Audits were shared with staff at team meetings and copies were available within the service. We saw evidence of this within meeting minutes and staff told us they were updated on audit results.

Improvement was checked and monitored, although we did identify this was not the case with the annual infection prevention audit. The audits were monitored for completion each quarter and reported up through to the audit steering group and clinical governance committee.

The Gold Services Framework was launched in 2000 to improve standards of end of life care in all settings. The service supported primary care with GSF with their allocated CNS attending their GSF meetings and where possible advised GPs on patients who should be added to their GSF register. As an organisation they had delivered GSF type training for nursing homes in the past and had over the last two years worked with Wolverhampton CCG to support the delivery of palliative care across care homes.

The service had a learning from deaths group, this had met to agree terms of reference and was to proactively

review deaths to identify areas where the service could work differently. We saw that patient deaths for the previous week were also discussed during the multidisciplinary team meeting.

The service had successfully achieved the Data Security Protection toolkit in March 2019. They were currently working towards:

- ISO 27001 Data Security Standard
- Investors in Diversity
- Cyber Essentials Accreditation

Competent staff

The service made sure staff were competent for their roles. The continuing development of the staff's skills, competence and knowledge was recognised as being integral to ensuring high-quality care. Staff were proactively supported and encouraged to acquire new skills and share best practice. Volunteers were proactively recruited and were supported in their role. The use of volunteers helped to measurably improve outcomes for people.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service operated a robust recruitment and selection process ensuring pre-employment checks were completed.

Each role had a three-month probation period, so performance could be assessed during this time.

Managers gave all new staff a full induction tailored to their role before they started work. Upon commencing employment staff attended a corporate induction as well as working to their own departmental inductions aligned to skills and competency assessments. They are also set statutory and mandatory training modules that each member of staff is required to complete, completion rates are regularly monitored, and data is shared with line managers.

Registered nurse's revalidation process was monitored to ensure that they were registered with the appropriate professional body.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Hospice services for adults

Managers actively encouraged staff to maintain their continued professional development through attendance at internal and external study days, Staff were encouraged to attend regional and national conferences and feedback learning to teams. Compton Care had showcased their work through posters and presentations at the Hospice UK conference. The last two years poster competitions at West Midlands Collaboration Actioning Research in End of Life and Supportive care (WM CARES) PRIDE had been won by one of Compton Care lecturer practitioners.

A monthly journal club was held to discuss research and best practice and held spotlight sessions which were focussed update sessions.

The clinical educators supported the learning and development needs of staff. In addition, short clinical training sessions were available with the clinical manager.

The service had a learning and development team that provided training for trained and untrained staff for both Compton Care staff and other external staff.

As part of the talent management process the development of staff was supported. This included staff on the University of Wolverhampton Trainee Nursing Apprenticeship (TNA) programme who were to be developed into the workforce once their training was complete.

Compton Care were a training site for student nurses, medical students and interested doctors on placements.

Compton provided education to both Compton staff and external health and social care professionals from basic skills through to master's level. A new online training system had been implemented to improve statutory and mandatory training.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff received annual performance appraisals as a formal way of managing skills, competencies and their development for the future. Objectives were set and reviewed twice annually through the appraisal programme. Any staff skill gaps were identified through appraisals with training and supervision offered to ensure that staff can effectively meet the patient's' needs.

Appraisal compliance figures varied depending on role. We reviewed data which showed compliance with appraisals was at 100% for some roles, which included the social work, leadership and finance teams. Compliance across the rest of the roles, which included but was not limited to registered nurses, healthcare assistants and clinical nurse specialists, ranged between 48 and 75%. Delivery of staff appraisals was still ongoing, and we were told every member of eligible staff would receive an appraisal by the end of March 2020.

Clinical supervision was available for counsellors and some nursing staff, either in groups or as individuals. However, some staff told us they did not receive supervision. Managers agreed a need to ensure there was equity of access to supervision and were looking at developing group supervision for all staff.

Staff competencies were in place and included basic life support, management of syringe drivers and medicines management. The planned care matron told us they were developing a staff competency framework which was aligned to national standards and would support the service to care for patient who had more complex needs.

Managers made sure staff received any specialist training for their role. The service had an annual learning and development budget for individuals to access role specific learning and development. This was based on organisational, professional and individual requirements and learning needs were agreed through discussions with staff at appraisals and one to ones. Ten health care assistants had achieved level 4 in palliative care. Eleven staff had been funded to undertake level a BSc in palliative care and two staff have undertaken a BSc in Lymphoedema care. In addition, two staff had a post graduate certificate in lymphoedema care and one staff member had a post graduate certificate in palliative and end of life care.

Managers identified poor staff performance promptly and supported staff to improve. The service had a performance management policy and processes were used when any underperformance was identified. Support was then given to the staff member, to meet the required standards, using an improvement plan.

The service recruited, trained and supported volunteers to support patients in the service. Each volunteer was required to apply for an identified position and hours,

Hospice services for adults

after which they were interviewed, and two references were requested. As with clinical staff, each volunteer underwent a formal induction, an overview of the service's vision and values, an explanation of the services provided and a session with human resources. During induction volunteers also received training on health and safety, fire safety, information governance, equality and diversity and safeguarding adults and children and received any additional training required to undertake the role they had volunteered to undertake.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked collaboratively as a team to benefit patients and had found innovative and efficient ways to deliver more joined-up care to people who use services. They supported each other to provide good care.

Staff worked effectively as a multidisciplinary team. Staff held regular and effective multidisciplinary meetings (MDT) to discuss patients and improve their care. All clinicians were involved in regular MDT, including nursing and medical staff, social workers, the spiritual coordinator and counselling services. This provided an opportunity to ensure patients had effective and individualised care plans and for peer review of clinical practice. The service had a process and system which catered to patient needs through individualised care plans for each patient. Their choices and preferences were documented and communicated across the multidisciplinary team. Teams included staff who had a broad range of skills, experience and qualifications and strong partnerships with other health and social care providers were created to maintain continuity of care through effective communication.

Staff worked across health care disciplines and with other agencies when required to care for patients. The service received direct telephone communication from patients and relatives, GPs and other health care professionals who identified patients who may be experiencing challenging symptoms and required advice on their management.

The medical team worked in local hospitals and had good links with other specialist teams such as respiratory, cardiology and neurology teams.

Compton Care was working with a local trust with patients with end stage heart failure and respiratory

disease to improve access and coordination to palliative care for these patients. There were monthly multidisciplinary clinics for each of these groups of patients. The joint working was being evaluated to demonstrate benefits to patients.

The service hosted a transitions MDT meeting (every 6 months) - liaising closely with other services to plan for palliative transition for patients nearing 18 years of age. This MDT and steering group were chaired by a Compton Care specialty doctor who had a special interest and had previously worked in paediatrics.

The service had close links with other specialist palliative care teams in neighbouring organisations and particularly within the Black Country as doctors had a shared on call rota with these services.

Staff within the inpatient unit and community nursing and clinical nurse specialist teams had close working relationships with the community nursing teams, care homes and acute palliative care teams. This ensured they worked together to provide integrated care to patients. We saw this when referrals to the inpatient unit were received and discussed during the twice daily bed management meetings to assess patient priorities and bed availability.

Each of the four community nursing teams had a monthly case review of their patients with a palliative consultant. Community nurse specialists also told us they could also speak to consultants on the inpatient unit if they required any patient advice.

The services had recently appointed a head of care coordination to review and further improve coordination and multi-disciplinary and multi-agency working.

Seven-day services

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

The inpatient unit was open 24 hours a day, seven days a week. Patients could access consultant and doctor advice seven days a week. At least one consultant was available Monday to Friday on the inpatient unit, weekends and evening there was a registrar and consultant on call to provide palliative care advice for other staff.

Hospice services for adults

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Clinical nursing specialists CNS were available seven days a week between 8am and 10pm. The CNS team carried out visits seven days a week but not at night. A clinical nurse specialist was also on-call from 5pm to 10pm for telephone advice seven days a week. Between 10pm and 8am calls went directly to the inpatient ward who when needed could speak to a doctor for advice.

The day therapies unit was open from Monday to Thursday and was open 10am to 3pm. Clinicians and therapists provided different clinics and support sessions on different days.

Health promotion

Staff gave patients practical support to help them live well until they died.

Staff assessed each patient's health and provided support for any individual needs to live a healthier lifestyle. People who used services were empowered and supported to manage their own health, care and wellbeing and to maximise their independence. We observed clinical nurse specialists providing advice to support patients to have improved quality of life at the end of their life.

There were health promotion materials displayed throughout the service displayed on the walls, in the form of leaflets and helplines and organisations to support ongoing health promotion.

Consent and Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act 1983, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. The service had a policy and procedures relating to the Mental Capacity Act 2005. The service provided training on Mental Capacity Act and Deprivation of Liberty Safeguards that was mandatory.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were able to provide examples of how and when to assess whether a patient had capacity. They had appropriate levels of knowledge on how to gain consent and how to assess it. The service had appropriate assessment tools for doing so.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions.

We looked at four patient records which had a 'Do not Attempt Cardio Pulmonary Resuscitation' (DNACPR) directive in place. We saw the directives were appropriately completed and met national guidance. We observed nurse specialists discussing choices about ongoing treatment such as provision of antibiotics and intravenous fluids for patients should they become unwell.

The service participated in the DNACPR regional research project. The project compared patient involvement and discussion before and after a court ruling that an NHS trust had failed to involve a patient in the decision to include a DNACPR order in their medical notes. The findings of the audit were presented in October 2018 by West Midlands Collaborative Actioning Research in End of Life and Supportive Care (WM CARES). Whilst the data could not be specifically identified for Compton Care all five hospices involved in the study identified an improvement post the court ruling in discussing the DNACPR with both patients and relatives.

The service was not auditing completion of the patient DNACPR directives. Doctors did have a daily checklist which included completion of DNACPR although this was not audited. The service was reviewing the DNACPR template within the new patient electronic records to enable auditing and this was to be included in the annual audit plan for the financial year 2020 to 2021.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty (DoLS) Safeguards.

The service had made two applications for DOLs and had notified CQC of these applications in line with required CQC regulations.

Hospice services for adults

Are hospice services for adults caring?

Good 

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

Compassionate care

Staff provided exceptional care and compassion and ensured patients privacy and dignity were maintained at all times. People were truly respected and valued as individuals and were empowered as active partners in their care, practically and emotionally, by an exceptional and distinctive service.

Throughout our inspection and without exception we observed patients and families were at the centre of everything staff did. Staff responded compassionately when patients or their relatives and loved ones needed help. Support was given by caring staff to meet the needs of the patient and their families and feedback from people who used the service was continually positive about the way staff treated them. We saw staff identified people who needed extra support and compassionately discussed changes to patients care and treatment with patients, their families and care givers.

Patients and their loved ones told us staff were caring, responsive to their needs and provided high quality care. We observed staff interacting with patients and their loved ones and engaging in kind and compassionate way.

Patients said staff were exceptionally caring and compassionate. Every patient and relative we spoke with told us staff treated them well. This was also reflected in the comments the service received following treatment. For example, from January and March 2019 the service received the following comments from patients and their families:

- “Total care - all the staff were outstanding”.
- “Treated with care, consideration and respect from all staff. Treated as an individual not just another case history”.
- “The care is second to none. You could not ask for more. My husband was looked after with such gentle and extremely caring professionals. My daughter and I were much calmer knowing that our loved one was

being watched over and very carefully looked after while we got some much-needed rest. It is such a privilege to be offered such a marvellous service. The dedication is amazing, keep up the good work. Wonderful people”.

- “ Understanding and compassionate. Non-judgmental. It was good to have someone to talk to away from the family. Brilliant service to families”.

The service and its staff had a strong patient centred culture. Staff were motivated and inspired to offer care for patients with kindness and compassion. Staff respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff were empathetic to patients living with a learning disability and patients with mental health needs and we saw this during our inspection.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. The service respected the diverse nature of each individual and were responsive to the needs of the multi-cultural nature of their patient population. The service was careful to ensure dignity and privacy in the way they delivered physical care. At every opportunity, curtains were drawn, and blinds were closed on bedroom doors by staff when intimate care was being provided to the patient. We also saw staff closed blinds to give patients and their relatives privacy when they were distressed.

The ward manager of the inpatient unit told us, and we observed special consideration had been made to ensure deceased patients were treated with respect. We saw deceased patients had a pillow, sheets under a thermostatic duvet to preserve them until they were collected by funeral directors.

We observed clinical nurse specialists went over and above the expected to ensure patients received appropriate care and treatment. One family told us the clinical nurse specialist had taken and collected a patient’s prescription to ensure they had timely pain relief.

Staff supported patients to experience their last wishes and displayed determination and creativity to overcome obstacles to delivering care. Patients’ individual preferences and needs were reflected in how care was

Hospice services for adults

delivered. Patients were supported in accessing things of value that gave them comfort. There were lots of examples; pets could stay with them on the ward. Staff had arranged a movie night especially for one patient who had wanted to attend the cinema with a friend. Staff had arranged a projector screen in the patient's room, tickets, popcorn and other drinks and snacks. The friend has since fundraised to buy the service a projector as a thank you for giving them special memories. Another patient told staff they would have loved to have gone to the seaside. Staff made arrangements for their room and patio to be a 'mock' seaside for them and their family to enjoy.

The hairdresser would ensure patients had their hair done when requested, this included if they or their families wished it after their death.

Staff followed policy to keep patient care and treatment confidential. The service had an information governance policy and staff were compliant with it. Conversations between staff and patients were kept private and sensitive information was never shared in the presence of those not authorised to hear it.

Between 1 April 2018 and 31 March 2019, the service received 107 thank you cards from patients, families and carers.

Emotional support

Staff provided a high level of 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. People who use services and those close to them were active partners in their care. Staff were fully committed to working in partnership with people and making this a reality for each. We observed the approach staff took when interacting with patients, which was supportive and put patients at ease.

The supportive services team offered a range of services for patients and families with complex psychosocial needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. The bereavement service offered with pre and post

bereavement support for families. In addition, the bereavement service employed a children's counsellor, and delivered pre-bereavement support and counselling to children in the school environment.

The service employed a full time 'spiritual coordinator' who was supported by volunteers and had close links to other local religious groups and had facilitated patient visits to religious centres such as the local mosque and temples. The 'sanctuary' had been designed by the spiritual coordinator to be a quiet place to reflect and was open to all.

Staff supported patients who became distressed and helped them maintain their privacy and dignity. There were rooms available which could be used for difficult conversations and for people to take time to reflect.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff and volunteers were experts in using empathy and opening conversations about an individual's emotional and social needs.

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. Family and visitors were able to share mealtimes with inpatients by ordering meals from the kitchen.

Understanding and involvement of patients and those close to them

Staff involved and supported patients, families and carers to ensure they were active partners in their care.

Staff made sure patients and those close to them understood their care and treatment. We observed staff discussing care with patients clearly. Patients told us they understood what was happening and what treatment/care they required. We observed staff and patients agreeing when and how treatment/care would be delivered.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. One patient living with a learning disability said "I don't have any questions because you explained everything to me in a way I could understand".

Hospice services for adults

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. A survey was in use within the service which enabled patients, families and carers to provide feedback on the care received.

Staff supported patients to make advanced decisions about their care. Staff were proactive with advance care planning, documenting in the electronic patient record an individual's future wishes around treatment escalation and place of care. This helped staff to know they were always acting in line with what the patient wants even when they lost the capacity to make decisions about their own care.

Staff supported patients to make informed decisions about their care. Staff encouraged patients to identify their physical symptoms and they were addressed using the skills of the whole multidisciplinary team. One patient and their family told us, "the community nurse specialist has made such a difference in 24 hours. The pain is much better and I've had a good night sleep".

The service used 'I want great care' leaflets which were given to patients, families and carers and asked about the care they had received. These leaflets were service specific and were given out at agreed times. Between 1 April 2018 and 31 March 2019, 233 completed forms were received 99% of people stated that they would recommend the service to their friends and family if they needed similar care or treatment. The feedback was based on the friends and family test but adapted for specialist palliative care providers. The data was uploaded to the [iwantgreatcare](http://iwantgreatcare.com) website, so anyone could view the feedback received.

The service identified their ongoing reviews of 'iWantGreatCare' leaflets demonstrated that the service provided outstanding care, staff were kind, caring, professional and listened to patients and their families. Feedback recognised how all family members were included in the care provided.

Are hospice services for adults responsive to people's needs? (for example, to feedback?)

Outstanding 

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

Service delivery to meet the needs of local people

The service planned and provided innovative approaches care, providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs.

Managers planned and organised services, so they met the changing needs of the local population. The organisation provided holistic care and its services reflected the needs of the diverse population it served. They had achieved this through community engagement, patient experience feedback and individualised care planning. Induction and mandatory training taught staff how to engage patients in conversations about characteristics and to liaise closely with other key professional teams e.g. social services and community health care to ensure patients accessed the right help and support at the right time.

Compton Care was part of the Wolverhampton Integrated Care Alliance (ICA) with representation in all clinical and non-clinical groups to review end of life care. A senior manager attended the steering group for end of life care at the local trust. Compton Care had been working on an integrated community model for end of life care which had been approved by the ICA and a business case was being developed to coordinate this.

The service was a member of Wolverhampton Dementia Action Alliance. Compton Care was awarded a National Dementia Friendly Award, recognising the efforts being made to make the city a welcoming place for people living with the condition.

There were facilities for patients and their families to enable them to remain close by. There was an overnight relatives' room, on site coffee shop, drinks machines and family meals when require. There was a day therapy area

Hospice services for adults

and family room (orangery). The onsite sanctuary and new designed garden provided areas to give peaceful reflection. There was free onsite parking and pleasant landscaped gardens.

There were multiple quiet rooms which were used for sensitive and confidential conversations and meetings.

Staff could access emergency mental health support for patients with mental health problems, learning disabilities and dementia. Within the service, there were trained counsellors and staff who could provide mental health support to patients.

The service had systems to help care for patients in need of additional support or specialist intervention. Services were tailored to individuals. The rapid response team was a new service which was being piloted at the time of our inspection. The service provided nurse specialist advice and support within four hours and would also visit community patients.

There was a specialist palliative care nurse who provided palliative care support to the local prison population.

The service had developed specific services to manage patient groups, particularly those with non-malignant conditions. There were joint heart failure and respiratory project to improve access and coordination to palliative care for patients with end stage respiratory disease and heart failure with a local trust. The respiratory project had been ongoing since 2015. The project had received national recognition, posters had been published and the service had an award for this work.

The service had successfully developed a community development team which were working across the diverse and dispersed communities in Wolverhampton and South Staffordshire to raise awareness of the compassionate communities' approach.

During 2018/19 the community development team had supported Wolverhampton Dementia Action Alliance to work towards creating a dementia friendly community at Compton Care. Key actions and priorities were identified to help make these improvements not only for patients but communities. The service had received an award for 'Working to become Dementia Friendly'.

Over the last 12 months the community development team had delivered a range of events, initiatives and activities to engage and encourage communities to

become more compassionate. They had successfully implemented four bereavement information hubs to help support communities who were affected by pre and post bereavement and this had been facilitated by a trained cohort of Compton Care volunteers. The hubs had successfully supported 87 people in the community and had recruited six volunteers to help support this initiative.

The community development team had developed two condition focused community support groups, 'Café Neuro' and 'Motor neurone disease (MND) Coffee and Chat'. These groups were held in Wolverhampton to encourage people to meet others who were living with a complex, advanced or incurable condition. Over the last 12 months more than 50 people had accessed these groups to obtain information, advice and support from Compton Care, Healthwatch, Motor Neurone Disease Association and nurses from the local NHS trust.

The service had delivered sessions focusing on difficult conversations and care planning. These had been facilitated utilising tools such as Life Cafés and Grave Talks in a range of settings: community centres, support groups, social housing providers, voluntary sector groups and residential homes. These sessions had a positive impact and encouraged people to think about their future wishes and what good care looked like.

Compton Care were member of Interfaith Wolverhampton. There were arrangements in place to develop and improve care of renal palliative care patients.

The service had an ongoing project which looked at understanding the views and experiences of the South Asian community in Wolverhampton. Various methods had been developed to create opportunities to meet with people to capture their experiences, views and cultural beliefs relating to end of life and palliative care. To support the delivery of the project, a video of the engagement activities was to be produced and was to be used to support future engagement with the communities and provide professionals a valuable educational tool to support conversations around advanced care planning and pathways of care.

Hospice services for adults

The service had recruited a South Asian community link worker to aid personalised and advance care planning for people in these groups from the South Asian community. The advanced care plan documents were to be translated into the five main south Asian languages.

Meeting people's individual needs

The service had a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met their needs, which was accessible and promoted equality. They proactively coordinated care with other services and providers.

The service used personalised care plans and goal setting and included both patient and their families in the assessment and care planning process. Patients were actively encouraged to maintain their interests both on the inpatient unit and day therapies centre and participate in activities.

Staff organised carer assessments as necessary and coordinated and signposted financial support and benefits to patients and carers. We saw examples of this during our inspection which provided enormous support to patients and their families who were worried about finances.

The community team visited patients wherever they called home, this included, care or nursing homes, mental health facilities, prisons, tents, and boats. The community team arranged any equipment that the patient required through the local NHS community nursing service.

The service used the local advance care planning documents "Me" and "My Care" and supported patients to complete 'Advance Decisions to Refuse treatment' when they wished this. End of life care discussions with patients and families and their preferences were embedded and reviewed frequently as preferences could change during disease progression.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Dementia was identified as a key priority and over the last 12 months over 20 'Dementia Friends' sessions had been delivered in Compton Care and out in the community. The service was delivering 'Playlist for Life' sessions to support

people who were affected by dementia through music and therapy. The service was developing a pathway which included a designated key worker for patients with dementia and learning disabilities to ensure their needs were fully met.

The service delivered targeted activities within the community to start conversations, utilising the Life Café model. Conversations about planning for the future were encouraged and helped individuals to think about what good care looked like. The work targeted all ages and helped to give people the opportunity to think about their future wishes.

Children and young person's bereavement counselling and pre-bereavement support sessions had been undertaken in six schools within Wolverhampton (11 sessions had been delivered).

The service had a doctor and a nurse who were members of the regional transition group. They worked with children's services to support children and families as they transitioned to adults with specialist palliative care needs.

Compton Care were part of Wolverhampton Lesbian, Gay, Bisexual and Transgender (LGBT) Alliance and attended quarterly meetings to help improve access to palliative care services for people who identify as transgender. The service was developing a training programme for clinical and non-clinical staff to help improve the care given to patients and their families who identify as being transgender. This programme was being delivered in partnership with Inspiring Healthy Choices.

Two doctors had been trained to carry out ultrasound in a palliative care setting and new ultrasound equipment had been purchased. This meant that patients requiring a procedure to remove excess fluid did not have to be transferred to hospital.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. The service recruited volunteers from many different ethnic and social backgrounds to try and accommodate patient preferences and religious faiths. This was to ensure that language, as well as cultural and religious sensitivities, were not a barrier to accessing the service.

The Accessible Information Standard aims to make sure that people who have a disability, impairment or sensory

Hospice services for adults

loss get information they can access and understand, and any communication support that they need from health and care service. The service met the standard. Patients needs were assessed and support was made available Part of the initial assessment would be identifying how the person communicated and facilitated it on an individual basis. Specialist communication equipment was available. Patients were encouraged to bring in their own specialist communication aids, if required the service would hire this equipment. The service had of its own iPad which could be used with applications to support people with communication difficulties. The day therapies unit had a communication book which had a variety of visual tools and aids to help communication. The leaflets were in easy read format and patients and families were given service information verbally on assessment such as raising a concern etc. The service had a plan to recruit volunteers to support patients with communication difficulties for example reading newspapers to them.

Staff told us about additional arrangements that were in place for deceased patients. Funeral directors had been contacted and asked to collect deceased patients after 3pm after patients attending the day therapy unit had left. These arrangements were in place whilst the service had a temporary mortuary and would remain until the new mortuary had been completed.

The environment and equipment supported the service to deliver personalised care, for example bariatric equipment was available and a relative's room facilitated patients with large families visiting.

Staff worked with people to understand their life history and what was important to them. The service had facilities for family members to stay overnight when requested. There was an open visiting policy up to 8pm, although the service was flexible to meet the needs of the patient and their loved ones. The service also encouraged loved ones to bring patients' pets to visit the inpatient unit for short stays.

Access and flow

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

Staff worked with people to understand their life history and what was important to them. The service had facilities for family members to stay overnight when requested. There was an open visiting policy up to 8pm, although the service was flexible to meet the needs of the patient and their loved one's family. The service also encouraged loved ones to bring patients' pets to visit the inpatient unit for short stays.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. There was a waiting list for inpatient admissions which was managed by the multi-disciplinary team, including a triage nurse. The patients on the list were discussed twice daily and beds were allocated according to clinical priority. Those patients categorised as priority one and should be admitted within 48 hours. Waiting times were audited regularly and reported to the clinical governance committee and clinical commissioning group. The service worked closely with partners across the region, including; other palliative care services, community providers and acute trusts, to coordinate admissions. When an inpatient bed could not be immediately offered to an individual, they were provided additional support in the community. For example, care at home or given the option of access to bedded care in another environment, when appropriate. We reviewed data relating to the waiting list for inpatient admissions for September 2019. For priority one patients, eight patients were admitted within 48 hours and two patients were not, a further patient was admitted to an alternative place of care.

There was a system of triaging referrals to ensure the service were using their resources appropriately and offering individuals the right choices at the right time for them.

The integrated community team developed an urgent response system. A nurse and health care assistant were available daily between 8.30am and 5pm to respond to requests for assistance within four hours, by either visiting the patient at home co-ordinating other community services the patient required. This meant even when an individual's named clinical nurse specialist was not available, there was always access to face to face palliative care support. An out of hours clinical nurse specialist on call service was available from 5pm to 10pm for telephone advice. After 10pm people could contact

Hospice services for adults

the inpatient ward who would either provide advice or arrange for an on-call doctor to call them back. This could be used for telephone advice. This meant there was always access to support for those caring at home. Any complex medical queries were escalated to the out of hours consultant on call service. Information about the number and support provided by the rapid response team during September 2019 identified: There were 67 appropriate patient referrals, all received an initial telephone follow up within four hours, 59 patients received a patient visit and were seen within four hours.

Referrals to the lymphoedema service were triaged as high, medium and low priority, high priority should be seen within four weeks, medium priority within eight weeks and low priority within 12 weeks. Staff told us that patients on the waiting list were contacted monthly and were advised if their symptoms got worse to contact the service for further advice. All high priority patients were seen within the required timescale, 11 of the 13 medium priority patients and 14 of the 17 low priority patients.

Patients who had been known to the service before and discharged, could trigger a re-referral by telephoning in. In this circumstance, the patient's GP was contacted and asked to send any up to date clinical information.

Managers and staff worked to make sure patients did not stay longer than they needed to. Staff engaged with patients about advanced care planning at the earliest but most appropriate opportunity, to establish what their preferred place of care was. This meant care plans could be implemented and action was taken to ensure patients were cared for where they wanted. If it was a patient's wish to be cared for at home, and it was safe to do so, discharges would be planned, and provision made to facilitate this. However, if it was the patient's wish to be cared for within the inpatient unit this was facilitated.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Discharges were coordinated with third party health and social care providers to ensure patients, wanting to be cared for at home, were safe. Staff appropriately liaised with local authorities and community healthcare providers to secure appropriate care packages and then worked alongside them to deliver the care which reflected patient wishes.

All community palliative care team referrals were triaged and allocated to a caseload using the first contact system. There was no waiting list system for community input. Patients on clinical nurse specialist caseloads were followed up by a registered nurse in the hospice at home service to maintain timely review. This was done by using the tasks and ledger process on the electronic patient record. Patients were discharged from a caseload when their condition and symptoms were stable.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. Patients were issued with a patient information booklet once they started to receive care from the service. The booklet outlined how they could use to raise a concern.

The service clearly displayed information about how to raise a concern in patient areas. The service had a complaints and concerns section on their website, featuring a telephone option and an option to write. They also received reviews on social media where people could publicly share their feedback.

Staff understood the policy on complaints and knew how to handle them. The management of complaints policy identified in the first instance staff should always attempt to resolve the persons complaint swiftly unless there were serious or significant concerns. If staff were unable to resolve the complaint within 24 hours, then it was escalated to a formal complaint

In line with the complaints policy the service aimed to respond to complaints within 30 working days. The service would offer to meet with complainants to understand their concerns and to feedback the outcome of investigations. As part of the review of complaints the service reviewed its systems and procedures to identify if any areas of improvement were required. All actions from complaints were monitored by the Clinical Quality Committee.

Hospice services for adults

Staff knew what the complaint procedure was and could explain what they would do if a patient wanted to raise a formal concern about their care.

The service received three complaints from 1 April 2018 to 31 March 2019. Three complaints were partially upheld. The service acknowledged all complaints within 48 hours, both verbally and in writing. The service had a 30 day target for investigating complaints. One complaint was resolved by the target date, the other two complaints were not. However, a senior manager told us they were responsive and sensitive to families needs; one family had expressed a wish to be given more time and another identified further questions which had extended the time scale before the investigations were complete.

Managers investigated complaints and identified themes. We reviewed two complaints files both before and during our inspection. We saw each was appropriately investigated and learning had been identified.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Within the complaints files we reviewed, we saw complaints were appropriately acknowledged and patients received feedback on their complaints. Their questions were addressed, and they were notified of what changes had been implemented or learning identified. In addition, anyone who had an issue and wanted to bring it to the service's attention had the option to discuss it with the head of human resources. The head of quality and compliance held organisational responsibility for coordinating responses to all complaints.

Managers shared feedback from complaints with staff and learning was used to improve the service. Feedback, compliments and complaints were shared. Identified learning was shared and actions taken to improve care. Services were adapted to ensure the service was fulfilling changing patient and family's needs and expectations. For example, the service had introduced the rapid response team for patients who were in crisis.

The service reviewed all feedback to identify any areas for improvement or any trends or themes and celebrate successes and positive feedback and encouraged staff to visit the website and read the feedback left for them. For

example, all in-patient bedrooms had been refurbished and had new flooring, which enabled faster turnaround and cleaning of rooms to facilitate more timely admissions.

The service also received feedback and compliments through social media, these were all captured, reviewed and responded to.

Are hospice services for adults well-led?

Good 

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

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

Leaders within the service had the required skills, knowledge and experience to run the service. The chief executive officer (CEO) had been in post for three and a half years and had been central to the change in vision and strategy for the organisation. The medical director had been in post for two years but had worked as a palliative care consultant at Compton care for 10 years. The director of nursing was the new member of the senior team had been in their role for five weeks but had extensive experience as a director of nursing in acute hospitals and palliative care services. The head of quality and compliance had been acting as director of nursing for the preceding year and had been in their substantive role for four years. The head of quality and compliance had applied to be the registered manager.

The challenges to quality and sustainability were understood by the leaders and they had identified actions needed to address them. Leaders told us the challenges were centred around funding and recruitment and retention of staff. Actions had been identified to address the challenges. For example, the service had identified new services to meet the needs and ensure access to its palliative care services for the diverse population it served.

Hospice services for adults

Leaders were visible and approachable. Staff told us all levels of leadership were visible and approachable. Staff felt they could raise concerns, issues and ideas with their line manager or escalate to senior leadership without hesitation.

The relationship between senior leaders, including trustees, and operational staff was effective. We spoke with senior leaders and operational staff. All described their relationship as being effective. We were told there was an environment within the service and governance structures where challenge was welcomed and encouraged.

Trustees met their governance responsibilities and had a good understanding of quality and safety of care. The chair of the clinical governance committee was a trustee and one other trustee sat on the committee. Many of the other trustees had a background or expertise in health care and held roles within acute or community NHS trusts.

The service had two safeguarding leads. The safeguarding leads had direct lines of responsibility to the chief executive. The deputy chair of the board of trustees was the board champion for safeguarding.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy plan which was stretching, challenging and innovative, while remaining achievable and was 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 and there was a demonstrated commitment to system-wide collaboration and leadership.

There was a clear vision and a set of values, with quality and sustainability as the top priorities. An independent study was undertaken in 2017 to identify the views of patients, carers, staff, volunteers, referrers, commissioners and supporters to better understand how Compton Care (then Compton Hospice) and its services were perceived. The feedback had provided a clear direction for the service to provide effective contemporary palliative care for the community it served. Because of the study, a new brand and identity were created to reduce fear of hospices and improve access from more diverse communities.

A new vision, mission and values for the organisation were developed from the feedback and a new three-year strategy to provide clarity of direction for Compton and its services.

The three core elements of Compton's new strategy were:

- Earlier identification of patients and enabling greater access to services earlier in their journey.
- Improve the patient experience and provide a more flexible and responsive service for the diverse communities it served.
- Support and ultimately care for more palliative care patients and families through better care coordination to meet future demand.

The leaders have proactively responded and implemented the new strategy. Within two years they have responded to public and staff and demonstrated they not only supported patients who were dying but also supported them and their families to have an improved quality of life. To enable the strategy to be realised new information technology systems have been introduced to ensure timely and effective information was available to support care delivery.

The first year of Compton's new strategy had focused on putting the correct foundations in place such as improved learning and development for staff, better onsite and personal security, new technology and automated systems and meeting new contractual and legislative requirements.

New services had been developed which had included Compton's community engagement team which supported patients and carers through bereavement and new support groups had been set up. Compton's new rapid response service was started in May 2019 to attend to patients in urgent need and prevent avoidable admissions to hospital. This service had been phased in gradually and was being integrated into Compton's community services.

Improvements and extension to the Compton Hall site buildings had been identified as part of the Compton Care strategy. The new extension was to house the care coordination centre. The extension was to also

Hospice services for adults

improve the existing old building, refurbish the mortuary area and provide a new viewing area, extend the reception to Compton Hall with disabled facilities and a discreet relatives room.

Staff knew and understood what the vision, values and strategy were, and their role in achieving them. The values of the organisation were; delivering quality care, improving access for all, sharing expertise, working collaboratively and changing attitudes. The values were displayed within the organisation and staff were aware of what they were. We observed staff living the values during our inspection. Staff were aware of how they were helping the organisation achieve its vision. Staff and volunteers were encouraged to inform the organisation's strategy, through open forum sessions.

Progress against delivery of the strategy and local plans were monitored and reviewed. We spoke with the CEO and reviewed the most recent strategy and associated action plans. A strategic subgroup of the board of trustees was set up to enable trustees to conduct their responsibilities to lead and develop the new strategic plan with the executive team and ensure deadlines were met so it could be launched ahead of the next financial year.

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.

All staff we spoke with felt supported respected and valued. Staff told us how supportive their immediate line manager was but told us they had support from senior leaders.

The culture of the service centred on the needs and experience of the people who used the services. Staff at every level and within each service were passionate about delivering care and treatment which addressed their patients' needs. Leaders were focussed on ensuring patients received care and treatment which was safe and of the highest quality. This was demonstrated in the care being delivered, the focus on ensuring lessons were learned when issues arose and the attitude of staff we spoke with.

Staff felt positive and proud to work for Compton Care.

The culture encouraged openness and honesty at all levels within the organisation, including with people who used services and leaders and staff understood the importance of staff being able to raise concerns without fear of retribution. The duty of candour was understood by all staff we spoke with. Staff felt able to raise concerns and told us there were no barriers when escalating incidents or complaints. Staff said they were open with patients when things went wrong and were encouraged to do so by leadership.

Appropriate learning and actions were taken when concerns were raised. We saw from minutes of governance meetings there were agenda items focussed on learning from incidents, complaints and feedback. We also saw recommendations and learning being highlighted in incident reports which was fed back to staff.

There were mechanisms for providing all staff at every level with the development they need, including high-quality appraisal and career development conversations. As discussed in the competent staff section above, staff received an annual appraisal where career development would be discussed. Following which, actions would be agreed, and steps taken as and when appropriate.

There was a strong emphasis on the safety and well-being of staff. Staff including clinical nurse specialists (CNS) often worked on their own when treating patients in the community. The service had a lone worker policy which was used to ensure there were processes to keep staff safe with staff using an electronic device which 'tracked them' them and they could use to summon help if needed.

The service had a staff well-being strategy. Staff told us that external counselling was available to them to support them. We spoke with one member of staff who told us they had received this counselling and much they valued it.

Staff attended Asian communities and PRIDE events within Wolverhampton to promote their services and highlight the support they provided for everyone.

Governance

Hospice services for adults

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 governance systems within the service. Compton Care had made significant improvements to its governance structures and processes over the last two years to increase quality monitoring, incident reporting and risk management to better scrutinise and analyse areas of service delivery and put plans in place to improve them. The assurance reporting framework had been refined and improved and supported managers and the board to have better oversight and monitor progress as it developed.

The executive leadership team and board of trustees reviewed their performance and the organisations against the charity commission good governance code and time and investment had and was being placed in developing the skills of both the leadership and board which both had new membership.

The trustee board and clinical quality committee met on a quarterly basis to review quality and safety for the service. The clinical quality committee reported to the board of trustees

The service had separate committees and groups which met quarterly and fed into the clinical quality committee and leadership meetings for example, there was a medicines management, policy sub group, infection prevention and control, research, audit and service group (which included learning from death reports). The membership of the groups included operational and leadership staff. Meetings were summarised and presented at the clinical governance meetings.

The head of department managers (HoDs) and the Compton Operations team (management team next level down from executive team) met monthly. These meetings discussed operational information about the service including development of the service, risks, incidents, complaints and patient feedback. Minutes of the meetings were taken and circulated afterwards.

We reviewed clinical governance meeting minutes for January, May and July 2019. Each meeting had standing agenda items which included but were not limited to activity monitoring, clinical policy updates, clinical audit

updates, risk register and patient and carer feedback. Minutes were not always detailed for each agenda item but there was enough detail when issues arose. An action log was taken and discussed at each meeting.

There were board meetings quarterly. At these meetings the senior leadership team reviewed the performance and development of the service, identified risks, incidents and complaints. These were formal meetings and minutes were taken and circulated.

Managing risks, issues and performance

Effective systems were in place to identify and manage risk and performance.

Service performance was monitored and reviewed and included in a dashboard which was updated monthly. The service reviewed performance in relation to inpatient bed days, day therapies activity, average length of stay, rapid response team activity, specialist palliative care team activity, number and type of discharge and therapist activity. Planned activity was reviewed against actual service delivery for each service line. There was a new management information system in place to review patient quality and safety including reported incidents, medicine errors, patient falls, complaints and pressure ulcers for the service or department.

Managers monitored incidents and complaints for any trends relating to practitioners. This was discussed at executive board and clinical governance meetings.

The service leadership team also reviewed clinical audit reports, National Institute of Health and Care Excellence (NICE) guidance compliance, complaints and mandatory training compliance. Minutes we looked at showed audit reports and NICE guidance were discussed. When issues with performance were identified, actions were taken. For example, additional information about the length of time people waited for an inpatient bed.

Risks were identified, understood and recorded appropriately and were regularly reviewed by department managers and senior managers. The executive team were aware of the top risks for the service and able to explain how they were mitigating them. The service had an overall risk register which had 16 risks on it. The highest risk was 'people and workforce'. Each risk had the date

Hospice services for adults

the risk was put on, the date it was last reviewed, who owned the risk and the mitigating actions, which enabled trustees and executives to focus their attention accordingly.

The executive and business development team maintained a 'live' risk register that assessed governance, operational and strategic risks.

The executive team was responsible for the management of risk through the clinical quality committee and its sub groups and ensured actions were taken to minimise and remedy identified risks. There were systems to share good practice and continually improve the quality of care, clinical effectiveness and leadership across the organisation.

Managing information

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

Performance measures and data were being collected, monitored and reviewed. Each service line had separate performance measures based on activity. As described above, in the management of issues, risks, performance, data relating to safety and performance were collected monthly and discuss at relevant meetings. The appropriate people were made aware of performance whether good or bad. Information was reviewed monthly/bi-monthly/quarterly by the various committees and leadership teams.

As identified within the vision and strategy section above new modern information technology systems have been introduced to ensure timely and effective information was available to support care delivery. There were new technology systems for electronic patient records, incident reporting, human resources (which included staff recruitment and staff training) and the management of maintenance and servicing of equipment.

The data collected was easy to understand and was clear on whether performance was within or outside an expected/planned range. The information was shared at relevant meetings and staff were aware of how their service line was performing.

Information relating to outcome measures was being implemented but not yet embedded. As described in the patient outcomes section above, the service had implemented new electronic patient records which included patient outcome information.

With the growth of services and review of service design for the future Compton Care had invested in a human resources information system which was built within the organisation. The information system was to provide information to help resource planning in terms of data around sickness and absence, age profile metrics, managing training and development information to aid in succession planning and developing a 'talent pipeline'.

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.

Information for patients about the services provided was available through the Compton Care website. Patient folders were available in all bedrooms on IPU with relevant information. The service also provided various information leaflets for patients about Compton Care services.

Feedback from patients, families and carers was gained by the service asking them to complete an 'I Want Great Care' leaflet. These leaflets were service specific and were given out at agreed times throughout the year. They were collated, and the number received was included in quarterly reports. Trustees and senior managers had sight of the number received and were provided with a sample. Data was included in the quality report

All service leads read the collated comments and drew out learning and developed actions specific to their departments based on patient feedback. An example of a response to carer feedback had been the development of the rapid response team to support patients and their families.

The service sent out a monthly newsletter, 'The Compton Express', to staff. Items in the newsletter included but were not limited to introduction to new staff and the board of trustees, service developments, community initiatives and fundraising information.

Hospice services for adults

The service received letters, cards and 'I Want Great Care' information from patients, their families and carers. Any letters or cards received, containing feedback, were handed to the governance department.

The service worked alongside and supported a range of community and patient groups which included: Motor Neurone Disease (MND) and hosted MND cafes at Compton Care. The CCUES Project: Complex and Incurable Conditions: Understanding the views and Experiences of the South Asian community in Wolverhampton to capture their experiences, views and cultural beliefs relating to end of life and palliative care.

Learning, continuous improvement and innovation

There was a fully embedded and systematic approach to improvement, which made consistent use of a recognised improvement methodology. Improvement was the way to deal with performance and for the organisation to learn. Improvement methods and skills were available and used across the organisation, and staff were empowered to lead and deliver change. There is a strong record of sharing work locally, nationally and internationally.

Work was being carried out to continuously improve the care and treatment provided by the service. In line with the new strategy, Compton Care had invested substantially in learning and development.

The service had a research and development governance committee and were actively participating in research. The group had oversight of research and approved new research projects. The service sent us information about its ongoing four research projects with a further five studies proposed. The organisation had strong links within the region with other palliative research organisations to share research and practice developments.

Compton Care delivered end of life and palliative care conferences which were attended by professional's from across the country.

Compton Care had showcased their work through posters presentations at the national hospice conference. The last two years the poster competition at a regional palliative organisation were won by one of the lecturer practitioners.

Compton's bereavement volunteers were awarded the Queens Award for Voluntary Service. This prestigious accolade was bestowed upon the bereavement visitor volunteers who provided comfort and support to people who have lost loved ones. The award was created by Her Majesty the Queen in 2002 and is the highest award given to volunteer groups across the UK. The award was presented for outstanding achievement by people who regularly volunteered in their own time to enhance and improve the lives of others.

Compton's Lymphoedema service had achieved two awards from the British Lymphoedema Society the national professional body for excellence in practice.

The service displayed the greatest number of best practice posters of any palliative care provider at the national Hospice UK conference covering many topics including Lymphoedema care, nutrition, condition management and brand.

The service's 'Our Christmas isn't cancelled' video had achieved over 70,000 views and was listed in the top five charity campaigns, the only non-national charity to do so.

In November 2018 Compton Care launched the "Atlas" programme which aimed to support those working in schools to help young people who were affected by bereavement. The Atlas Programme combined workshops and study days for staff, along with focused support for schools. The aim was to raise awareness of the effects of loss on young people as well as create effective policy and practice to help and empower anyone working in the school environment to support pupils as through their experiences of grief. The programme had helped various schools to be able to support young people experiencing grief.

Outstanding practice and areas for improvement

Outstanding practice

- The service had developed a sepsis identification tool with a national charity as no tool had previously been available to identify sepsis for palliative care services. This tool was now available for use by other services for palliative care patients.
- The joint respiratory project had improved access and coordination to palliative care for patients with end stage respiratory disease and had received national recognition and an award for this work.
- The service has received an award for 'Working to become Dementia Friendly'.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure the continued delivery of effective staff hand washing and identification of infections to protect patients, staff and others from the risk of infection. (Regulation 12(2))
- The provider should ensure that the programme to deliver safeguarding level 3 training to required staff is undertaken. (Regulation 13(2)).
- The service should consider displaying information on patient harm for staff, patients and visitors.