

## Phyllis Tuckwell Memorial Hospice Limited

# The Beacon Centre

### Inspection report

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

### Ratings

Overall rating for this location	Good	
Are services safe?	Good	
Are services effective?	Good	
Are services caring?	Good	
Are services responsive to people's needs?	Good	
Are services well-led?	Good	

# Summary of findings

## Overall summary

Our rating of this service went down. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- People were involved in decisions about their care and treatment when approaching end of life and staff documented these in their records. There were joint electronic systems with local GP surgeries and hospitals to ensure effective communication about people's medicines. Staff gave people information about their medicines in a format they could understand. There was a good medicine incident reporting culture and the service engaged in educating other healthcare professionals about end-of-life care medicines.
- Staff provided excellent care and treatment, delivered by highly trained, professional staff who received specialist development. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available flexibly and at short notice.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers. The service constantly asked people for feedback, which was persistently and overwhelmingly positive and exceeded the provider's expected standards. The team's internal audit system and care ethos that focused on patient centred, compassionate care furthered these standards.
- The service planned care to meet the needs of people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it. Staff integrated the complementary range of clinical specialties were seamlessly and there was a clear focus on system-wide, coordinated care provision.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values and applied them effectively and innovatively in their work. Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

# Summary of findings

## Our judgements about each of the main services

### Service

**Hospice services for adults**

### Rating

Good



### Summary of each main service

The Beacon Centre provides outpatient and community hospice services. We rated it good because care was safe, effective, caring, responsive, and well led with a number of outstanding features.

# Summary of findings

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# Summary of this inspection

## Background to The Beacon Centre

The Beacon is a community-based centre providing a base for the community multi-professional team for home-based care, as well as outpatient and living well group services. It operates on a day hospice basis to patients referred by GPs and other clinicians and pre-assessed by clinical nurse specialists. The provider has a range of additional services and teams, including care at home, living well, bereavement support, and pastoral care. We included additional services in our inspection where they were provided from, or as an extension to, this location.

From April 2020 to April 2021 this location, including the care at home service, cared for 2,013 patients. This was an increase of 3.2% on the previous year. In this period, 71% of patients were living with cancer. The living well team supported 699 patients in the same period and carried out 6,774 remote contacts. This was an increase of 111% on the previous year.

## How we carried out this inspection

We carried out an inspection using our comprehensive methodology on 20 October 2021. We gave the service short notice of the inspection. Our inspection team consisted of a lead CQC inspector, a CQC inspector from our medicines optimisation team, and a clinical specialist advisor. We carried out several remote interviews after the inspection and took into account data and evidence supplied by the provider.

We last inspected The Beacon Centre in January 2017. The inspection was led by an Adult Social Care inspection team using methodology that has since been updated. Our latest inspection was carried out by a Hospitals inspection team using new criteria and guidance to help us identify outstanding practice.

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

## Outstanding practice

We found the following outstanding practice:

- Staff were empowered to drive training and professional development according to the needs of patients, the service, and their career plans.
- Staff had a sustained, dedicated focus on holistic health promotion and wellbeing that aimed to improve people's lives significantly beyond palliative care. Staff at all levels worked together to harness multidisciplinary opportunities through joint working between medical specialties, therapists, and community services.
- Policies and procedures were underpinned by an exhaustive review of national and international standards set by specialist, credible organisations. Such reviews went above and beyond the most common agencies in the UK to ensure patients were central to care delivery and efficiency.
- The values and ethos of the provider meant staff and volunteers were empowered to constantly explore opportunities for improvement and development. This was reflected in the work of the clinical education and research teams, which sought out leading-edge innovation in the wider health sector.

# Summary of this inspection

- Staff were dedicated to improving patient outcomes across the regional health economy. They recognised that patients did not experience care and treatment in the isolation of a single provider and that excellent outcomes required consistent, streamlined practices.
- Staff had undertaken research using focus groups of patients and carers as part of a 'terminology project' to establish the language to be used in descriptions and publications about the service. This was one element of a strategy to demystify hospice care and ensure people could access useful, meaningful information that could help them or their loved ones.
- The service had demonstrated an ability to adapt quickly and effectively to changes in demand. This included a 200% increase in capacity in the overnight care service and delivery of a 72% increase in family member counselling.
- Staff were demonstrably focused on embedding multidisciplinary working across all aspects of the service. This included integrated digital records systems with GPs and paramedics to streamline care and prescribing and the extension of specialist training to adult social care and urgent and emergency care colleagues.






# Our findings

## Overview of ratings

Our ratings for this location are:

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

# Hospice services for adults

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

## Are Hospice services for adults safe?

Good 

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

### Mandatory training

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

Staff received mandatory training and at the time of our inspection, 86% were up to date. Modules included infection control, safeguarding, moving and handling, and fire safety. All staff in the service undertook training in end of life care and palliative care.

Mandatory training was comprehensive and met the needs of patients and staff. Staff told us standards of training were excellent and included clinical simulation training when pandemic restrictions allowed. The service had resumed in person training where practical. The education team had adapted training delivery to meet remote working requirements during the pandemic, which ensured staff kept access to training resources.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff audited this process monthly and the senior management team reviewed results quarterly.

The service had adapted to COVID-19 restrictions and provided staff with resources to access and complete mandatory training remotely and online where feasible.

### Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. All staff were trained to safeguarding adults level 3 and safeguarding children level 2 as a minimum. Counselling staff supporting young family members were trained to level 3. The safeguarding lead was trained to level 4. Staff had undertaken safeguarding training for patients and carers living with a range of conditions, including learning disabilities and advanced dementia. This included positive behaviour support and de-escalation training that helped manage fractious situations and reduce risks to wellbeing.



# Hospice services for adults

The safeguarding lead was part of the senior clinical team and provided leadership and training on safeguarding and mental capacity. They maintained oversight of safeguarding incidents and represented safeguarding on the clinical governance sub-committee.

Staff prepared individualised support plans for patients identified with psychological or physical conditions that made them more vulnerable. This enabled the team to prioritise them for on-demand care and to provide more frequent reviews.

The safeguarding lead joined regional forums with integrated care system (ICS) colleagues to address safeguarding concerns where patients were known to multiple providers. A social worker advisory team worked at provider level and supported clinical multidisciplinary teams to work with an integrated approach.

Staff gave examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff identified adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff trained to recognise patients at risk of self-harm, self-neglect or suicide and discussed how they responded in such scenarios.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. An overall safeguarding lead was in post and staff knew how and when to contact them. For example, staff had raised a safeguarding concern after a patient living with a disability that affected their ability to communicate used an electronic messaging system to allege abuse against a family member. We saw evidence of a thorough investigation, which highlighted a need for better understanding of the individual's home situation and improved communication between family members. There was no safeguarding risk, but staff monitored the patient more closely out of an abundance of caution.

The safeguarding lead provided case studies and training for staff across the organisation to help them identify how to identify areas of concern or people at risk. This reflected good practice for non-clinical staff who spent time around patients but did not have prolonged periods of direct contact.

There was an open culture about safeguarding in the service. Staff said it was an element in all their work and one member of staff said, "It's on everyone's mind." Staff in the patient and family support team noted concerns about safeguarding risks increased when people were isolating or shielding during COVID-19 lockdowns. They worked collaboratively to ensure potential signs of safeguarding need were flagged early and followed up.

Staff discussed safeguarding concerns during multidisciplinary meetings and daily handovers and described their approach to meeting individual needs as focused on diversity and individuality. Staff had a good understanding of how some safeguarding concerns became more common during pandemic lockdowns, such as domestic violence. The safeguarding team supported all staff to escalate such concerns and worked with local authority and regional NHS safeguarding teams to increase response capacity.

Staff reported 91 safeguarding incidents in the previous 12 months. This included 21 in the most recent quarter. Of these, 12 related to harm prevention, six were early intervention, and three were referrals to the local authority. Staff acted quickly in the three referrals, each of which had potential to cause patient harm. For example, in one incident the care at home team found a care worker was administering morphine from a teaspoon rather than a syringe. In another incident a nursing home had no staff trained to use a syringe driver. This meant a patient underwent frequent injections instead.

# Hospice services for adults

The safeguarding system meant staff had access to a defined escalation system across regional health services that enabled them to liaise with the patient's other care providers to ensure a coordinated response.

The safeguarding lead coordinated the safeguarding policy to mirror regional multi-agency procedures and the national 2018 intercollegiate document. They were also active in the national safeguarding conference. This activity reflected the importance the whole team placed on remaining up to date with leading-edge practice.

## Cleanliness, infection control and hygiene

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

Clinical areas were clean and well-maintained. Furnishings were not always optimal for infection prevention and control (IPC) purposes but the senior team had appropriate risk control measures. For example, carpeted flooring was not compliant with the Department of Health and Social Care Health Building Notice (HBN) 00/10. However, staff mitigated the risk of contamination and infection through regular steam cleaning and decontamination.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Dedicated housekeeping staff were always on shift when the centre was open, and we saw this team worked diligently in accordance with best practice.

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

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. This worked well in practice and all equipment labelled as ready for use was clean and sanitised.

The provider had established a Covid-19 screening system at the main entrance. A dedicated member of staff spoke with each patient and carer and checked for recent risk factors, such as exposure to an infected person. We saw this process in practice and our inspection team were screened to be able to enter the building. The process worked well and offered assurance for staff, patients, and visitors.

The service had implemented a range of measures to reduce the risk of COVID-19 infection. A risk assessment was in place and the registered manager updated this whenever local or national guidance changed. All staff, patients, and visitors, except for those with a clinical exemption, wore fluid-resistant surgical masks whilst in the centre. Alcohol hand gel was readily available in all areas. Staff were informative and kind when enforcing rules and we saw several instances where a member of staff provided assistance. Patients and staff had to provide negative COVID-19 lateral flow test before entering the building and staff undertook weekly polymerase chain reaction (PCR) testing.

Nurses provided lateral flow tests for patients on arrival if they had not already taken a test. While this demonstrated a proactive approach to service, we saw staff undertook testing in a room not equipped for clinical procedures. The room had soft furnishings and carpet, which presented a risk of contamination from droplets and aerosols. We spoke with the manager who noted the room was scheduled to be refurbished and the carpet removed.

A dedicated housekeeping team led IPC in the centre and the housekeeping manager audited standards regularly. The frequency of cleaning had been increased for high-touch points and staffed sanitised their own workspaces with antibacterial products.

# Hospice services for adults

Spill kits were available, and a biological hazard protocol guided staff in its use using an established response plan. All staff completed training in the control of substances hazardous to health (COSHH).

The provider's quality lead was the appointed person for IPC in relation to COVID-19. They led emergency planning meetings and worked with partner organisations to interpret and apply Public Health England guidance to clinical practice. As part of enhanced governance and senior oversight, staff undertook advanced IPC training to help reduce the risk of infection, including fit testing for face masks.

The senior team had coordinated procurement of PPE during the pandemic through working with resilience forums and engaging with the national supply disruption response with the regional integrated care system (ICS). This ensured staff had access to emergency supplies when usual supply chains failed to deliver.

Staff adapted IPC processes, such as hand hygiene and PPE use, to match the community nature of the service when staff delivered care in peoples' homes. This included a policy for staff to carry supplies of PPE in their vehicle and guidance on delivering care in peoples' homes when others may be present.

## 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.**

Consultation and group therapy rooms were fitted with call bells. The nature of the service meant it would be rare a patient was left alone and needed to use the call bell. However, the system was maintained as a best practice safety measure.

The design of the environment followed national safety guidance. Staff demonstrated how they had access to evacuation routes and emergency equipment. Staff had identified infrequently used water outlets and sinks and flushed these to reduce the risk of Legionella build-up in line with Health and Safety Executive (HSE) guidance.

The service had suitable facilities to meet the needs of patients' families. All areas were accessible by wheelchair.

Staff disposed of clinical waste safely. Waste preparation and disposal areas were segregated in line with national guidance and adhered to Department of Health and Social Care Health Technical Memorandum HTM 07-01, in relation to the management and disposal of healthcare waste.

Staff completed practical fire safety and evacuation training that included the use of support equipment such as evacuation chairs. A fire warden was based on site at all times the service was open and was responsible for coordinating an evacuation. The premises were located adjacent to an NHS hospital and the property services on-call team responded to each fire alarm to provide support.

## Assessing and responding to patient risk

**Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration**

Staff responded promptly to any sudden deterioration in a patient's health. They used the national early warning scores (NEWS) system to identify deterioration in medical conditions where people were at risk at home. The care at home team used this system jointly with district nurses to ensure they maintained an understanding of each patient's needs.

# Hospice services for adults

Staff used a range of individual risk assessments with patients. These included a falls risk assessment and an occupational therapy risk assessment. This approach helped to minimise risks of injury or harm to patients during their care.

All staff were trained as chaperones and this could be requested, by the patient or their clinician, at short notice.

The service had access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. Staff understood how to initiate this process and clinicians understood how to escalate mental health care in the case of an acute crisis. Staff referred patients for mental health assessments when they showed signs of mental ill health including depression. This included where patients disclosed, or staff suspected, self-harm or suicidality.

Staff shared key information to keep patients safe when handing over their care to others. Consultants and nurses provided handover information in line with clinical requirement and according to patient consent.

All staff were trained in basic life support (BLS), which included resuscitation. Each room in the building had a portable CPR mouthpiece. Emergency equipment on site included oxygen and an automatic external defibrillator. The service was not equipped to provide advanced life support and staff called 999 in the event of a medical emergency.

A night support nurse and healthcare assistant provided out of hours response to patients who deteriorated quickly or unexpectedly. They provided this service to patients who wished to be cared for at home at the end of their life where home was their preferred place of death.

## 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 all staff a full induction.**

The service had enough clinical and support staff to keep patients safe. Five consultants, including the medical director, the clinical lead for palliative care, and a specialist registrar led clinical care. This team worked across the provider's services. One consultant worked jointly with an NHS trust, which helped the service to implement changes to best practice and to work to alleviate pressure on the wider system. Specialist trainee doctors worked in the service as part of their rotations with GPs. A team of clinical nurse specialists (CNSs), registered nurses, healthcare assistants, therapists and "living well" staff delivered the care at home service.

The service had healthcare assistant vacancies in the hospice at home team following a decision to increase this aspect of care provision. There were no other clinical vacancies at the time of our inspection and staff described the team as stable. They said it was rare to need agency or bank staff. The housekeeping manager was recruiting two new members of the team. Senior staff described local recruitment as very challenging and noted poor turnout for interviews, which reflected a national challenge. They were working with healthcare recruitment specialists to overcome the challenges.

The service had a good skill mix of clinical staff on each shift and reviewed this regularly. The senior team had a developmental approach to the service and actively sought new clinical specialties when these were in demand by patients.

# Hospice services for adults

The service directly employed consultants. The medical director was the responsible officer for medical revalidation in line with the provider's policy. One consultant was in post in an NHS hospital and there was an established system for appraisals and the transfer of information.

The senior team managed contingency plans for staffing during the peak of the COVID-19 pandemic to reduce the impact on patients. This included a daily review and plan of community staffing availability and support for staff who had medical conditions that made them more vulnerable to infection.

All staff and volunteers undertook an induction before they were able to begin work. This was appropriate to the services provided and reflected the specialist needs of palliative and end of life care. At the time of our inspection all staff were up to date with their induction tasks.

## Records

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

The service used an electronic patient records (ERS) system for clinical notes and records. The system enabled shared records storage and access, which meant the multidisciplinary team had easy access to reviews, assessments, and notes. This enabled them to plan and coordinate care safely and efficiently across partnership working arrangements.

We found note keeping was of an excellent standard and included a range of assessments, care plans, outcome measures, and laboratory test results. Records were person-centred and staff included considerable personal, holistic, and wellbeing information as part of their assessments and narratives.

The patient records system enabled GPs and hospital staff in the region to access patients' latest records and results. This reflected good practice because it meant if a patient was seen by a GP, or admitted to hospital, local staff could access their recent care and treatment history.

When patients transferred to a new team, there were no delays in staff accessing their records. For example, consultants, GPs, and occupational therapists could readily access care records. Similarly, clinical staff provided transfer summaries to professionals providing onward care.

Records were stored securely. Electronic systems were digitally encrypted with restricted access and industry-standard back-up protocols.

Staff had established protocols to support patients who received care from providers that could not access the ERS. This occurred when patients lived between healthcare boundaries and meant some providers did not have data sharing agreements to access electronic details. This system reduced the risk of missing records and meant all professionals involved in a person's care had access to up to date records.

## Medicines

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

Staff worked closely with GPs and district nurses to prescribe and administer end of life care medicines to people. People with complex needs were referred to clinical nurse specialists and palliative care consultants for specialist input.

# Hospice services for adults

Hospice nurses liaised with district nurses to share capacity in the local care system and manage syringe pumps (medicines that are mixed in a syringe and given through the skin) safely. Community medicine charts were scanned into the system after medicines had been administered by a nurse from the hospice. The service had joint IT systems with local GP surgeries and hospitals, which meant there was good communication about a person's medicines.

Staff completed medicines competencies and had annual syringe pump updates.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Hospice staff worked collaboratively with GPs and district nurses involved in peoples' care to review medicines in response to their needs. One person who used the service told us that the consultant had discussed their medicines with them. They felt they understood what they were for, side effects they may experience, and knew who to contact if they needed help. Staff regularly used interpreters to support people to understand their treatment.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

The service did not hold any medicines except adrenaline (a medicine used to treat anaphylaxis; a severe, potentially life-threatening allergic reaction). Staff working in the community had systems to safely store anaphylaxis kits when visiting peoples' homes. Medical gases were stored appropriately with the correct signage.

Prescribers used the FP10 system for prescribing medicines and monitored this for security. Prescription pads were stored in a locked safe in a secured room. The provider had not changed the access codes for 18 months and raised this as a security risk with the senior team. They resolved this issue whilst we were on site.

Staff followed current national practice to check patients had the correct medicines.

Staff told us that they communicated with GPs readily about people's medicines through their joint electronic systems. The service had processes so medicine recommendations made by CNSs were actioned promptly.

The service had systems to ensure staff knew about safety alerts and incidents.. The clinical governance sub-committee tracked medicines safety alerts and maintained an audit trail to demonstrate action taken.

Staff reported medicine incidents involving both external prescribers and internal staff. These were discussed at meetings and followed up appropriately. Safety alerts were actioned as necessary. Staff were informed of learning from incidents and safety alerts regularly via 'quality matters' and 'medicine matters' leaflets. To improve safety of end of life medicines, the service also held regular education sessions with other healthcare professionals involved in end of life care.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Consultants led these processes as part of advance care planning and worked with patients to ensure consent was obtained for prescribing.

The service used the Palliative Care Formulary and their own guidelines to support prescribing. A 'ring back service' was available to support staff whilst visiting peoples' homes so that they could check medicines calculations and prescribing decisions. Staff had conducted an audit to check prescribing of end of life care medicines at home to see if medicines in syringe drivers were increased appropriately and adjusted according to a person's medical condition. Results found consistently good practice.

# Hospice services for adults

Staff took time to explain the purpose of each prescribed medicine and discussed the known common side effects of each. This reflected a very high standard of practice and meant patients fully understood their treatment. Patients spoke positively about their discussions with staff about medicines. One patient said, “Everest would not be high enough, that’s how high my opinion is.” A carer said, “How can you better the best?”

Consultants worked with GPs to manage opioid prescribing and provided feedback to GPs where prescribing had been inappropriate. The senior medical team had a relationship with the Clinical Commissioning Group (CCG) and liaised with them to optimise prescribing by GP practices.

CNSs provided a medicines support and advice telephone line and consultants delivered ad-hoc training sessions for prescribing. This reflected the safety and learning culture of the organisation.

Between April 2021 and June 2021, the care at home team reported five incidents relating to syringe drivers. Two incidents related to faulty equipment and two related to pressures on the wider healthcare system. In each case we saw staff had taken effective action to resolve the issue. For example, one syringe driver was faulty, and the responsible family member had been unable to identify this. In response, the care at home team sourced new equipment and provided the family with additional education.

## 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 used an electronic system to document and report incidents. The senior team operated this as a learning tool and encouraged staff to report near misses or observations of risk. These were discussed in team meetings and contributed to improved working practices and risk management.

Staff raised concerns and reported incidents and near misses in line with provider policy. Staff reported positive, confident attitudes towards incident reporting. The provider embedded a visible, collaborative safety culture that involved all staff.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. The provider set the threshold for the duty of candour in a policy. The senior management team kept this up to date and benchmarked key characteristics against national guidance from the Health and Care Professions Council, the nursing and Midwifery Council, and the General Medical Council. The policy incorporated the ten principles of being open, which staff embedded in their approach to care.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Changes to practice took place as a result of learning from incidents. For example, processes to protect staff from abuse had been reinforced after an incident in which a patient behaved inappropriately.

There had been no serious incidents and 119 other incidents in the 12 months before our inspection. The clinical governance sub-committee monitored incidents for severity and outcomes and reviewed each on a quarterly basis.

## Hospice services for adults

There were 29 incidents reported in the most recent quarter. Six related to pressure ulcers identified by the care at home team that had not been reported by the referrer. In each case the nurse leading the person's care took appropriate action, such as ordering pressure relieving equipment.

The provider reported on incidents related to patients whose care was shared with other organisations. Staff reported 12 such incidents in the previous quarter. Three of the incidents related to issues with care plans and two related to delays in catheterisation. The provider demonstrated how they worked closely with external teams as part of shared care to find solutions, reduce incidents, and improve pathways and communication.

Staff met to discuss the feedback and look at improvements to patient care. This took place in team meetings and through provider communications.

The senior team monitored notifications from the Central Alerting System (CAS) and national patient safety alerts (NPSA). In the previous 12 months staff had acted on 39 alerts to maintain patient safety and best practice. The clinical governance sub-committee tracked alerts and ensured they were embedded across the clinical provision.

### Are Hospice services for adults effective?

Good 

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

#### Evidence-based care and treatment

**The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.**

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies, training, and corporate standards were unfailingly based in extensive research of best practice guidance and care and treatment standards such as those issued by the National Institute of Health and Care Excellence (NICE), the Association for Palliative Medicine of Great Britain and Ireland (APM), NHS England/Improvement and the Royal College of Nursing (RCN).

The director of patient services monitored changes in national guidance and updated policies and references guides accordingly. They coordinated changes to care delivery in 2020 in relation to COVID-19 provided by NICE, including for managing symptoms at the end of life for patients in the community. The clinical governance sub-committee reviewed compliance and benchmarking quarterly as part of their quality and patient safety function.

Staff recognised the findings from national reviews and research in policies, such as from the learning disabilities mortality review (LeDeR) and worked with a regional forum to embed learning and improvement.

Consultants and GPs worked to General Medical Council (GMC) guidance on co-working best practice, to work collaboratively and show effective leadership.

Staff demonstrably used evidence-based practice to enhance person-centred care and treatment. Policies were holistic and humanistic by nature and staff detailed, extensively, how they applied to individuals.



# Hospice services for adults

Palliative care was clearly part of wider care and treatment pathways and staff ensured patients could access other specialist services as part of their care and treatment. For example, consultants worked with oncologists to arrange radiotherapy for patients if this was in their best interests.

The clinical team used a range of evidence-based tools when considering new referrals and during patient assessments. The team chose tools based on international merit and best practice guidance and incorporated examples such as the Rockwood Clinical Frailty Scale and the Australian Karnofsky Performance Status.

The research team provided staff with access to international peer-reviewed journals to help them remain up to date with the latest understanding of best practice.

Clinical audits were based on established national standards and policies. For example, the care at home team audited the administration of medicines against the standards set in NICE clinical guidance (CG) 140 and national guidance (NG) 31. The most recent audit found consistently good standards of practice with no avoidable patient risk.

## Nutrition and hydration

Staff assessed and monitored nutrition and hydration as part of care planning. They worked with patients and their carers to support good nutritional intake and good levels of hydration. Dietitians were available in the locality and staff referred patients for specialist assessment. The care at home team prescribed nutritional supplements as part of holistic health assessments.

Staff had reviewed how the service met patients' nutrition and hydration needs at the end of life as part of the 2020/21 audit and evaluation programme. Staff used the community nutritional screening tool to identify when a patient would benefit from a rapid dietitian review.

## Pain relief

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

Staff prescribed, administered, and recorded pain relief accurately. Staff provided care for patients who experienced chronic pain, including interventional pain relief techniques. We found consistent use of pain assessments in patient records. Staff used the Abbey pain score, a recognised tool, to assess and monitor each patient's pain. The team used this tool for patients unable to verbalise their pain.

Staff encouraged patients to keep a pain diary when they were taking a prescribed course of medicine, such as long-acting morphine tablets.

We saw staff worked collaboratively with patients to manage pain. For example, staff offered one patient top-up pain medicine to take home with them. The patient refused the offer and said they preferred to try and manage with the medicines they had already been prescribed. Staff did not pressure them to accept more opioids and instead worked with them on pain management strategies.

# Hospice services for adults

Carers and relatives noted variable standards of pain relief in the provider's survey. In 2020/21, 40% of respondents noted pain had been relieved completely all of the time and 38% noted complete relief some of the time. However, 20% of respondents said pain had been only partially relieved and 2% said pain had not been relieved at all. We saw consultants asked patients in depth about their pain during appointments in the centre and community staff increased the frequency of discussions about pain.

## Patient outcomes

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

The multidisciplinary team used the integrated palliative outcome score (IPOS) at the beginning and end of the seven-week living with illness programme. All patients undertook this programme as their palliative care commenced and use of IPOS meant staff could quantify and track their progress as part of a strategy to ensure care was as effective as possible.

Patient outcomes were clearly at the forefront of each team's plan. Staff spoke enthusiastically about this and note they had adapted to new ways of working during the pandemic to ensure patient's needs were met as far as possible. One member of staff said, "I've never once gone home thinking we've left a patient in need. If we can't get something done [during our shift], there is always another person to hand it over to."

Most patients who used the service wanted to die at home and, if this was their preference, staff used this as a measure of a successful outcome. The care at home team coordinated various elements of the service to help patients achieve their preferred place of death (PPD). This included factors such as arranging for the installation of a hospital bed in a patient's home and preparing their relatives for the patient's death, including education about recognising dying, symptom control, emotional needs, and post death care. Between April 2020 and April 2021, 66% of patients achieved their PPD. This reflected a 5% improvement on the previous monitoring year and was supported with positive results in the provider's survey of carers and family members. In the same period, 99% of respondents said they felt the patient had died in the right place and 88% said the patient had enough choice about their PPD. The multidisciplinary team monitored PPD this on a weekly basis. In the seven days before our inspection, all 11 patients who wished to die at home had been able to do so.

All patients had an individualised care plan and staff went to great lengths to ensure this reflected peoples' own preferred outcomes in addition to clinically directed outcomes. Staff followed best practice principles in planning care that focused on living well and holistic wellbeing, including considering complementary therapies and supporting activities that made patients feel happy. This embodied the ethos of the personalised service and included important elements of empowering patients and carers, such as in coping skills. During COVID-19 restrictions, staff moved wellbeing discussions online and met with patients and carers virtually, adapting advice and signposting to digital resources. This helped patients to retain elements of care and support their desired outcomes.

Between April 2020 and April 2021, care at home services prevented 1,000 hospital admissions through their coordinated community-based approach to care.

Staff used a last days of life (LDL) care plan when they identified a patient to be approaching the end of life. This was a continuation of their standard or advance care plan and enabled staff to focus on the most important final elements of clinical care, such as pain management. Between April 2020 and April 2021, 82% of patients who died whilst receiving hospice care did so with an LDL. This reflected best practice and an increase of 5% from the previous audit year.

# Hospice services for adults

## Competent staff

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

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff used their annual appraisal to review continuing professional development. Where staff maintained mandatory registration, they used appraisals to identify training and development opportunities to support this.

The service continued consultant appraisals during the pandemic, which reflected good practice. Amongst all staff groups, including nurses and HCAs, the appraisal rate was 78%.

Staff underwent monthly supervision and told us this process was positive and conducive to their development. For example, staff said senior colleagues asked them what was working well and what needed improvement as part of a structured process. Clinical leads had increased the availability and frequency of clinical supervision during COVID-19 to ensure staff had access to support and guidance for both practice and their wellbeing.

Planned clinical supervision for revalidation purposes and as part of rolling supervision schedules was scheduled in advance. Clinical staff could request supervision on demand, such as to help with a complex range of comorbidities or as a check and balance of their decision-making in a care plan. This was part of a strategy to empower staff to make their own evidence-based care and treatment decisions.

A clinical psychologist provided staff with supervision following patient deaths.

Clinical educators supported the learning and development needs of staff. Each member of staff had an individual training and development plan. Clinical educators led the education strategy, which focused on educational development for staff and colleagues in the wider community.

Staff were responsible for managing their own training and ensuring it was up to date. Managers ensured staff had protected time for training and the tracking system reminded them when training was due for renewal. Staff told us they were pleased in-person training had resumed after Covid-19 restrictions, which meant they had improved access to interactive instruction and development.

Six specialists, including a practice development nurse and clinical educators, formed the clinical education team and delivered a wide-ranging education strategy that extended beyond direct colleagues. For example, the team had worked with a local university to incorporate end of life care training into an undergraduate paramedic programme and to deliver targeted teaching sessions on a physician associate programme.

The clinical education team supported student nurse placements and trained staff to become practice assessors and practice supervisors.

All staff in the centre were Dementia Friends. This meant they had completed nationally recognised training to provide care, support, and understanding to people living with dementia.

# Hospice services for adults

## Multidisciplinary working

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

Evidence of multidisciplinary working was widespread across the service and reflected the focus on pastoral care as part of the palliative pathway. Nurses and allied health professionals, such as occupational therapists, were embedded in all aspects of care.

Staff held regular and effective multidisciplinary meetings to review patient needs and improve their care.

Staff used a weekly multidisciplinary meeting to review all patients in the service. It was attended by an extended team of multidisciplinary professionals and that reviews were thorough. Staff reviewed new patients and deaths and included pastoral and complementary services in the reviews. On the day of our inspection staff reviewed 32 patients on the palliative care pathway and 11 deaths using a comprehensive process. This included therapy input and a discussion of the emotional and psychological status of each individual.

Consultants worked closely with GPs to plan and deliver care and carried out joint home visits to ensure decision-making was reflective of the whole team's input.

## Seven-day services

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

The centre was open Monday to Friday from 9am to 4.30pm for multi-professional outpatient and wellbeing appointments. It was also the base for the care at home team who provided care in patient's homes 8am-6pm, seven days per week. A registered nurse and a healthcare assistant were available overnight and at weekends to provide assessments, advice, care and support in the home setting. Between home visits, they were based at the centre overnight. An on-call consultant rota enabled out of hours symptom control advice.

The provider's inpatient unit, a different location, was open 24-hours, seven days a week. Staff referred home care patients for admission out of hours if this was clinically indicated.

## Health promotion

**Staff gave patients practical support and advice.**

The service had relevant information promoting healthy lifestyles and support in patient areas. This was balanced with each patient's stage of care and defined treatment goals and planned outcomes.

Staff were demonstrably focused on health promotion and the improvement of patient wellbeing. Specialists linked with community service providers, counsellors, and complementary therapists to build holistic treatment programmes that incorporated patient's wishes for their lifestyles. Staff incorporated areas such as complementary therapies and stress management into care planning and service development.

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

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

# Hospice services for adults

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Two psychologist consultants worked in the service and provided support and consultations following referrals. Consultants and GPs referred patients to this team and ensured they received mental health care alongside physical care and treatment.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in patient records, which was implied or verbal in most cases. Staff told us the process to obtain consent was a key element of their duty of care.

Staff received and kept up to date with training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The key principles of the MCA were available in clinical areas, including virtual spaces, as quick reference guides for staff. Policies were stored electronically and were readily accessible by all staff.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act 2007, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. The clinical team had implemented processes to obtain rapid support in the event a patient became acutely mentally unwell.

Managers monitored how well the service followed the Mental Health Act and made changes to practice when necessary. Staff said they had noticed significant and profound changes in patient's mental health during the pandemic and had increased their ability to secure ad-hoc mental health support. They had developed new links with local mental health services, including crisis services.

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could update.

Mental capacity and consent were integrated into the electronic patient records system, which ensured 100% compliance with required assessments during care and treatment. Clinical staff maintained up to date training in best interest decision making, which was a mandatory element of clinical assessments and care planning. The service had implemented new GMC guidance from November 2020 in relation to decision making and consent.

Staff had a clear understanding of the role of consent in decisions about care and treatment. For example, staff understood patients could make clinically inadvisable decisions and respected these accordingly.

The senior team had carried out a review of mental capacity policies to encompass DoLS and safeguarding more fully. This reflected the complex, specific needs of patients receiving palliative or end of life care and meant staff were better equipped to carry out needs assessments.

The safeguarding lead was working with local authorities to explore the increasing trend for DoLS applications at community level and how this might be affected by the government's move to the Liberty Protection Safeguards system. This work aimed to ensure DoLS were always appropriate and in the best interests of the patient and their circumstances.

# Hospice services for adults

We spoke with the relatives of two people whose care needs included consideration of mental capacity. Both individuals were very positive about the service. For example, one individual noted their relative could not move or communicate verbally. They said staff had worked with them and their loved one to identify how best to establish a care plan that reflected their known wishes. They described staff as, “inexhaustible and endlessly patient,” and said they always knew staff had their loved one’s best interests at heart.

## Are Hospice services for adults caring?

Good 

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

### Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff delivered care in this way naturally and as an embedded part of the service.

Staff followed policy to keep patient care and treatment confidential and in line with the provider’s privacy and dignity standards. For example, they talked to patients and carers about what was important to them at the first point of contact and then continually during care. Staff recognised each person had different expectations and values in relation to privacy and dignity and made sure they adhered to them. Staff understanding of the emotional nature of hospice care underpinned all elements of the service and care with dignity was evident throughout. In the provider’s survey in 2020/21, 99% of respondents noted staff had treated their loved one with dignity and respect

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. Staff and carers repeatedly told us how proud they were of the kindness and compassion the whole team provided to patients and their loved one. One member of the clinical team said, “Everyone is so dedicated to compassion and kindness. It’s palpable and not like other [places] I’ve worked in.”

Compassionate care was a consistent element of the service and staff embedded this in all aspects of delivery. For example, holistic care was a standing agenda item in clinical team meetings, including multidisciplinary meetings. Staff incorporated specialist tools into discussions and patient reviews for those living with conditions such as learning disabilities, dementia and Alzheimer’s disease.

Staff engaged well with patients and their relatives to build positive relationships. This contributed to the overarching ethos of compassionate care and meant patients were treated kindly wherever they encountered staff in the centre.

Carers and family members reported good experiences of the care at home and community service. For example, carers said staff provided them with time and patience to listen to their concerns. This helped them to feel less alone and understand the nature of hospice care.

# Hospice services for adults

## Emotional support

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

Staff gave patients and those close to them help, emotional support, and advice when they needed it. This formed an early, essential element of care planning from the first point of contact with a referred patient. Staff clearly understood the differences in levels of support needed between patients, carers, and relatives and adapted their communication and approach accordingly.

Staff incorporated anxiety assessments into clinical care and provided patients with counselling referrals and targeted psychology support where intervention was likely to be beneficial. Clinical staff referred patients to in-house psychologists or to external providers where they found they were not coping with their prognosis or where they noted an acute distress or crisis episode

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. We observed this in practice when staff discussed a challenging prognosis with someone new to the service.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff had set up working strategies with local communities to ensure they offered tailored approaches to care and support. They worked individually with people to help them plan for the end of life and the complexities this brought, such as organising finances and property.

Carers and relatives spoke very positively about their experiences with the service. One carer said, "The hospice has been our lifeline. It's almost as if everyone else left us but [hospice staff] are there no matter what."

Staff provided support and guidance for informal carers, such as spouses. Carers described these relationships as crucial and said they provided access to clinical information and guidance unavailable through other channels. One carer said, "If not for the hospice [team], we would've been in great difficulty. Our GP is not specialist enough and doesn't provide any help for [patient's condition]."

Staff demonstrated a consistent focus on understanding and supporting emotional care. For example, consultants spoke with patients about the emotional impact of their illness. They ensured each person had time to reflect, such as in a session where a patient wanted to reflect on leaving their partner behind. Staff helped patients to understand their limits of emotional challenge and empowered them to contact the service for support when they felt overwhelmed.

A dedicated patient and family support team ensured those who received hospice at home and community care had appropriate care packages during COVID-19 lockdowns.

A dedicated pastoral support team ensured patients could access appropriate emotional support, including adapted access during COVID-19 restrictions, such as a chaplain and complementary therapist.

Staff had enhanced bereavement counselling support services to reflect the increased needs and anxieties of relatives during the pandemic. This involved an offer of bereavement support within one week of a death, reflecting a reduced gap from the usual nine-week post-death offer. Staff reflected that enhanced support was important due to the complexities of people who died whilst admitted to hospital or in a nursing home when relatives were unable to visit.

# Hospice services for adults

Staff increased contact and the frequency of assessments for patients deemed to be slowly dying over periods of the year likely to be more challenging for them and their carers. For example, staff implemented a “Connected at Xmas” scheme to better understand the emotional impact and needs of patients whose condition was deteriorating over the Christmas period.

Staff and volunteers increased individual support for patients separated from their loved ones. For example, some people’s relatives lived outside of the UK and could not visit during end of life care.

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

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

Staff made sure patients and those close to them understood their care and treatment.

The service timed appointments, assessments, and group sessions to ensure patients had enough time to ask questions and to ensure staff had enough time to explain treatment plans. Staff spoke positively of this approach. One individual said, “When I’m speaking to patients or their relatives, I never feel I have to watch the clock. We’re given the time we need.”

The reception team had implemented processes to support patients who wished to have a family member or carer accompany them to appointments, whilst adhering to COVID-19 safety restrictions. For example, patients were encouraged to attend appointments alone to reduce the number of people in the building. However, if a relative or carer wanted to attend, staff facilitated this within appropriate risk management protocols.

Clinical nurse specialists trained and supported family members who held current registration to use syringe pumps for anticipatory medicines at home. Such medicines included an anti-convulsant if a patient was prone to fitting. We spoke with a carer who had undergone such training. They said the ability to safely manage medicine had provided them with assurance at home they could manage their loved one’s pain or other serious symptoms.

A dedicated multi-professional team led the seven-week living with illness programme, designed to help patients learn more about living with advanced or terminal illness. Staff started with a session titled ‘The Story of Me’ which was demonstrably patient led. The programme provided patients with skills and tools to promote better diet, sleep and exercise and reduce fatigue. Staff had resumed in-person wellbeing sessions following the easing of pandemic restrictions, which patients and carers said they appreciated. The process was demonstrably patient-led, and staff started by asking them what was important in their lives, what made them happy, and what made them upset. This formed part of a wider discussion about what patients wanted to achieve from participation. A multidisciplinary team delivered the programme and worked with patients individually and in group sessions to ensure they remained involved in planning and delivery.

Patients and carers gave positive feedback about the programme. We spoke with one carer who noted the importance of being able to speak with other people experiencing similar challenges to them. They said, “Very happy, very nice and very caring, it’s nice to speak to others.”

We observed clinical appointments with patients and found staff approached them with excellent communication skills focused on listening and understanding rather than talking. They offered patients time, space, and empathy to share their worries and concerns.



# Hospice services for adults

The service subscribed to a carer's charter, which directed staff in providing structured support and guidance to patient's carers, including informal carers. The social care team maintained up to date information about local carer's organisations and support services.

Staff reconfigured the living well support service to be delivered virtually during COVID-19 lockdowns. Staff worked with patients to ensure they had the necessary IT equipment at home and had the skills to use it to join group sessions and clinical appointments.

Patients gave positive feedback about the service. The service used the NHS Friends and Family Test (FFT) to evaluate patient and carer experience and supplemented this with feedback collected by contact card, phone call, e-mail, and any other method people found convenient. In 2020/21, FFT results demonstrated very high levels of satisfaction. For example, 100% of respondents described care and service as good or very good.

The senior team demonstrated a focus on continual development and improvements based on patient feedback. Staff facilitated connections between patients and their loved ones during COVID-19 restrictions by using digital technology. This was part of a strategy to reduce the risks of social isolation and staff helped people stay in touch by ensuring they understood how to get the most out of the technology available to them. A team of living well volunteers worked with patients and carers to help them make the most of the technology available to them for remote communication.

The service had a wellbeing lounge for relatives and carers. Staff facilitated this as a safe, supportive space that enabled time to talk and for reflection.

A key element of care at home was communication around how and where people wished to die. Staff incorporated such discussions into community interventions and presented them during weekly multidisciplinary meetings. The community team actively worked with colleagues in care homes, NHS acute trusts, and NHS ambulance services to ensure communication was collaborative and effective.

The service discussed with people their end-of-life treatment and recorded this. Staff used the national recommended summary plan for emergency care and treatment (ReSPECT) process to ensure clinical teams and relatives understood a patient's wishes when their condition deteriorated. ReSPECT forms were typically completed by inpatient staff and care at home staff reviewed them once a patient moved into their care. Where care at home staff completed the form, the senior team audited these in line with the ReSPECT policy. We saw two completed examples and found both demonstrated a person-centred approach to care

Clinical staff undertook advanced front line communication training to help them engage with people experiencing crisis and those with complex needs. The training included effective discussions around establishing do not resuscitate (DNACPR) protocols on an individual basis.

Staff supported patients to make informed decisions about their care. In the 2020/21 provider survey, 95% of respondents said they had been involved in decisions about their loved one's care as much as they wanted.

The service assessed information published for patients and the community against the NHS England Accessible Information Specification. This ensured information was accessible and free from unnecessary jargon.

## Are Hospice services for adults responsive?

# Hospice services for adults

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

## Service delivery to meet the needs of people

**People's individual needs and preferences were central to the delivery of tailored services. There were innovative approaches to providing integrated person-centred pathways of care that involve other service providers, particularly for people with multiple and complex needs. The services were flexible, provided informed choice and ensured continuity of care. Facilities and premises were innovative and met the needs of a range of people who use the service.**

Managers planned and organised services, so they met the changing needs of demand from patients. This led to a range of additional training and development opportunities for staff to deliver services that met needs whilst adhering to changing restrictions relating to COVID-19. Clinical teams were working to extend non-malignant care provision. This included working with partner organisations to develop care and services for people with heart failure, respiratory disease, and neurological conditions.

Facilities and premises were appropriate for the services being delivered. While services were holistic by design, there were clear separations between clinical areas and those for therapy and talking.

A care at home team provided person-centred care for people whose health was deteriorating by providing palliative care at home. Nurses, healthcare assistants and support staff delivered this service and replicated the ethos of the outpatient hospice service in patients' own homes.

Staff managed patient caseloads in collaboration with NHS community colleagues, including district nurses. This reflected the complexity of care provided by multiple organisations under differing contracts and areas of responsibility. We saw clear, consistent coordination of care packages and treatment management, which supported good standards of safety.

Staff were dedicated to improving patient outcomes across the regional health economy. They recognised that patients did not experience care and treatment in the isolation of a single provider and that excellent outcomes required consistent, streamlined practices. The nursing team developed online training tools for care home staff and community healthcare professionals to support clinical management and care in the last days of life.

Care, treatment, and support at all levels and stages were personally adapted to individual patients and their comorbidities. Criteria for admission to the service was designed to ensure patients would gain tangible benefit and were able to contribute to the wider programme of care as part of a peer support structure. For example, patients were required to participate in group discussions and care activities, be able to contribute to group work, and have no needs relating to aggression or inappropriate behaviour to others.

Staff shared their understanding and strategies of compassionate care with colleagues across the sector. They held a series of showcase events that included clinical presentations to demonstrate person-centred care and clinical effectiveness in hospice care at home and in living well services. The events raised awareness of hospice care standards and best practices amongst hospital and community colleagues. This was part of a continuous strategy to enhance regional capacity and standards of care.

# Hospice services for adults

Staff worked with the NHS ambulance service in the area to reduce avoidable hospital admissions through coordinated patient management and clinical data sharing. This enabled paramedics to access patient's hospice records and review their advance care plans, such as a wish to avoid hospital admission.

Staff had undertaken research using focus groups of patients and carers as part of a 'terminology project' to establish the language to be used in descriptions and publications about the service. This was part of a strategy to 'demystify' hospice services and make the type of care as accessible as possible.

An advice and referral team provided a seven-day service between 8am and 6pm for patients, carers, and relatives. During the peak of the COVID-19 pandemic, clinical staff supplemented on-call services with enhanced community response patient assessments that included peer support and out of hours prescribing.

The education team delivered specialised skills-based training for staff and partner organisations throughout pandemic restrictions as part of a strategy to ensure the regional health structure could continue to meet people's needs. This included areas critical to delivering responsive end of life care, such as syringe driver management and verification of expected death (VOED) with clinical remote support. Such work enabled the provider's wide range of partners to continue delivering.

Staff had access to language interpretation and translation services for patients and carers who needed support. This included translated care information in printed format and in-person services that staff pre-booked or accessed on-demand.

## Meeting people's individual needs

**There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met these needs, which was accessible and promotes equality. This included people with protected characteristics under the Equality Act, people who may be approaching the end of their life, and people who were in vulnerable circumstances or who had complex needs.**

Staff made sure patients living with mental health conditions, learning disabilities and dementia, received the necessary care to meet all their needs. Staff undertook extensive training in caring for people living with dementia. This was part of a dedicated dementia care pathway that ensured staff adhered to national best practice in line with National Institute of Health and Care Excellence (NICE) 2018 guidance, Department of Health and Social Care 2018 training and the Royal College of Nursing 2013 professional guidance.

This was reflective of the provider's approach to ensuring systems to provide additional support were up to date, evidence-based, and grounded in high quality staff training. For example, the policy to support staff in delivering care to people living with a learning disability was based on best practice guidance, research, and care-centred directives from multiple appropriate organisations, including those with specialist remits to provide care.

Staff used adapted versions of the national 'This is Me' document for patients with different support and communication needs, including those living with learning disabilities and those living with dementia or delirium. Staff used national standards and evidence-based practice, such as those issued by the Alzheimer's Society, to ensure processes and documentation were fit for purpose. Where a patient presented without a learning disability communication passport or equivalent, staff had access to an instant digital download and were trained to complete this at the point of care delivery. This was incorporated into the provider's comprehensive, up to date policy and staff we spoke with demonstrated good understanding.

# Hospice services for adults

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Policies were up to date, evidence-based, and reviewed regularly by an appropriately experienced team member. Staff used a wide range of evidence, including leading-edge research, to ensure policies reflected the latest understanding of care and communication.

We saw consistent future care planning during our review of patient records. This included a psycho-spiritual assessment for each patient that took into account broad holistic beliefs and needs that might impact care outcomes.

Staff described how they prepared patients for death. A key focus was to build an understanding of what was important to the patient and how and where they wanted to die. The senior team demonstrated a continual focus on improving and streamlining services to reduce the impact of complexity on patient experience and outcomes.

During the pandemic the provider suspended day hospice services to reduce the risk of infection. The team quickly planned and delivered remote, digital alternatives to ensure patients and carers continued to receive specialist support. This included extended telephone contact hours, virtual online groups, and virtual one-to-one reviews and support sessions.

## Access and flow

**People could access services and appointments in a way and at a time that suits them. Technology was used innovatively to ensure people had timely access to treatment, support, and care.**

Patients accessed the service by referral from their GP, district nurses or the community therapy team. A multidisciplinary advice and referral team operated a single point of access for referrals. Clinical Nurse Specialists were integral to this team and used their skills to advise, prioritise and triage to the most appropriate service according to the patient or family member's needs. A clinician was part of this team and required clinical assessment from the referring team to progress the patient's care. Times from referral to first assessment were based on the urgency of each patient's needs and initial assessment typically took place within 24 hours.

Managers monitored and took action to minimise missed appointments scheduled to take place in the centre. Patients received automatic reminders about appointments and offered alternatives where their plans were affected by the pandemic. The nature of care provided meant missed appointments were rare and could occur if a patient was experiencing a deterioration in their health. Clinical staff maintained an up to date understanding of each individual to ensure the service could continue to meet their needs.

Carers described a highly responsive service that worked with them to understand when they needed support. For example, staff established a ceiling level of treatment for each patient and when their carer at home felt this had been reached, clinical staff carried out a home review. This was an individualised process and staff had a deep understanding of the influences on thresholds for each person.

The senior team had reconfigured the service during COVID-19 lockdowns to meet government requirements and balance these with the needs of the most vulnerable patients. For example, outpatients and living well services were suspended temporarily whilst essential inpatient service, provided from another location, continued. The hospice at home services continued delivering face to face care and telephone support utilising re-deployed staff including retired nurses, to respond to increased care at home needs.

# Hospice services for adults

The service had a range of tools and resources to help people access the service. Staff facilitated access to interpreters and large print information was available for people with visual impairment. Community speech and language therapists prepared visual communication aids and voice recognition devices to support complex communication needs.

The service offered a rapid response clinician daily between 8am and 6pm and overnight on-call services in liaison with the provider's inpatient location. Carers and patients had information on when to escalate a need out of hours and staff encouraged them to make contact to alleviate anxiety and worry.

In 2020 the service recruited a registered nurse and health care assistant to provide a night visiting service. This provision was new and complemented the overnight planned night care in a patient's home. This resulted in an additional 972 night visits, representing a 200% increase in capacity on the previous year.

The care at home team worked with NHS acute trust colleagues to support rapid discharges where this would help patients to die at home, or their preferred place of death (PPD). This process had a significant impact because it meant patients were more likely to achieve their PPD and it reduced pressure on regional hospitals

Demand on the service was consistently high. In 2020/21, staff supported 1,046 carers, a 33% increase on the previous year. The team documented 4,209 contacts with family members and 918 family members supported with counselling, a 72% increase on the previous year.

## Learning from complaints and concerns

**People who used the service and others were involved in regular reviews of how the service managed and responded to complaints. The service could demonstrate where improvements had been made as a result of learning from reviews and that learning was shared with other services.**

Patients, relatives, and carers knew how to complain or raise concerns. The service reported 22 complaints and 198 compliments in the previous 12 months. The service had received one complaint in the most recent reporting quarter. This related to information provided about government financial support for the bereaved. It did not relate directly to clinical care or regulated activity, and we saw evidence staff acted on the complaint to improve practice. For example, the counselling team took a more active role in initial family contact and staff added information about government support to printed material. In each case we saw the senior team had resolved complaints within the provider's timescales.

The senior team discussed complaints handling with carers, patients, and trustees to ensure processes were fit for purpose.

Staff understood the policy on complaints and knew how to handle them. Staff were empowered to resolve or escalate minor concerns at the time they were raised. The policy included a clear escalation policy and details of independent arbitration arrangements.

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and used learning to improve the service. Staff said they regularly heard from senior colleagues with information about learning opportunities as a result of feedback.

# Hospice services for adults

Staff could give examples of how they used patient feedback to improve daily practice. For example, they briefed patients before they arrived on what to expect in relation to COVID-19 measures after finding patients presented with a range of different expectations and tolerance levels for safety measures.

Details on how to complain was on display in the centre. These were also available on the service's website and directly from staff. The complaints policy clearly defined the process to follow if a complaint could not be resolved and signposted people to the Fundraising Regulator for some types of complaint.

The provider's complaints policy was up to date and included milestone dates in complaint investigation timelines as well as resolution guidance to help staff identify the difference between a formal complaint and a minor concern.

## Are Hospice services for adults well-led?

Good 

Our rating of well-led went down. 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.**

A president, chair, two vice-chairs, and a chief executive officer (CEO) led the organisation overall, with leadership functions delivered by a senior management team. The director of patient services, who was the registered manager, and the medical director led daily operations, including clinical services. Five directors led specific organisational functions. The board of trustees included six sub-committee chairs, including for clinical strategy and clinical governance.

The director of patient services was responsible for the clinical team, including nurses, therapists and patient and family support. The medical director was responsible for the consultants and medical team and was the Caldicott Guardian. The director of patient services and medical director led clinical care and had established flexible working systems during pandemic pressures to ensure the service continued safely

Staff said there was consistent and visible leadership in the centre. They said they were on first name terms with the CEO and registered manager, both of whom worked with an open-door policy that encouraged staff, visitors, and patients to visit them informally.

Staff respected the leadership team and spoke positively of collaborative work in all aspects of work. Senior staff supported their teams to be ambitious and persistent in their career goals.

Staff spoke highly of the senior management team (SMT). This was reflected in the 2021 staff and volunteer survey, in which 87% of respondents said they had confidence in the CEO and SMT. This compared favourably with the national average of 73% amongst similar hospices.

# Hospice services for adults

## Vision and Strategy

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

The corporate behaviour of the provider reflected the whole team's belief in the impact of hospice care, staff abilities, and in the standards the service maintained. This was evidenced in the long-term, sustained engagement approach from all levels of the senior team.

The provider's five-year 2019-2024 strategy incorporated a vision, a mission, and five strategic priorities. Compassionate care, empowerment and high-quality end of life care underpinned each of these.

A change in CEO had taken place during the strategy. We found the transition had taken place seamlessly and the provider maintained a clear awareness of progress, milestones, and risks. The board of trustees maintained an up-to-date awareness of challenges and achievements and staff spoke positively about the strategic direction of the service.

The service had a digital solutions and technology strategy that had resulted in the implementation of new data management software to streamline reporting, such as for incidents, complaints, and other monitoring requirements.

The education and research teams had each established a vision and strategy to support and direct their work. These were five-year plans to drive innovation and learning in palliative care that involved staff across the organisation and supplemented the provider's overall plans.

The staff and volunteer survey indicated positive feelings about the vision and strategy. In the 2021 results, 97% of respondents said they believed in the aims of the organisation. This was higher than the national average of 94%.

## Culture

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

Staff were unwaveringly positive about working in the service. One individual told us, "Some of us have been here for more than 20 years. We're treated fairly and it's like being amongst family not colleagues." Staff consistently said the happiest element of working in the department was teamwork and support from management. For example, one clinician said, "I come here, and I can practice good medicine. I enjoy being a doctor here. It's a supportive environment with nice people providing excellent care."

Staff described a supportive, meaningful, and developmental work environment. One member of staff said, "This is a lovely place to work." Another member of staff described the workplace as "joyful" and said they felt everyone had worked to support each other during a very challenging period.

A Freedom to Speak Up Guardian was in post and delivered confidential support to staff and volunteers who wished to raise a concern about safety or integrity.

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Staff said the senior team worked within a no-blame culture when things went wrong. One member of the team said, “No-one is afraid to say, ‘I’ve failed’ – this is an organisation that lets you learn from mistakes.”

We spoke with one member of staff who had worked for the provider for over 25 years. They noted it was a rewarding place to work that continually built life skills and, “...never stops changing or getting better.”

The senior team had increased resources to support staff wellbeing during the COVID-19 pandemic. This included regular support meetings and on-demand contact when staff felt under pressure or needed help. Staff were encouraged to prioritise their workload to reduce the risk of exhaustion and ensure the patients most in need of care received this. The senior clinical team carried out risk assessments for staff who were worried about working during the pandemic to ensure they had the training and resources they needed.

Senior staff ensured their teams could contact them as needed used remote video technology during home-working requirements. They ensured this process mirrored the provider’s usual ‘open door’ culture and provided staff with access to senior support as needed.

Results from the 2021 staff and volunteer survey indicated an overall positive place to work, consistent support from senior staff, and a working environment that ensured people feel valued. In five questions about wellbeing, staff and volunteers rated the provider better than the national average. For example, 78% said they felt the provider encouraged them to improve their physical and mental wellbeing. This was significantly higher than the national average of 64%.

## Governance

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

The quality and audit lead was responsible for clinical governance alongside the registered manager and medical director. A quality improvement and patient safety meetings process ensured staff recognised patient and carer feedback and incorporated it continuously into policy and service standards. Senior staff shared outcomes and findings with their teams during meetings and reflected themes and trends in a variety of communication methods, including staff newsletters.

Policies, standard operating procedures (SOPs) and guidance were stored online. All staff we spoke with knew how to access these. This meant care and standards were maintained consistently in line with expectations and best practice. The governance lead and registered manager used a monitoring system to update SOPs on pre-planned review dates. They reviewed SOPs more frequently where new standards were released or learning from incidents or practice identified an opportunity for an update.

Policies reflected the culture of consistent governance based on best practice. For example, the policy on care delivery for people living with a learning disability ensured staff adhered to national guidance on planning hospital admissions and for the actions they needed to take in the event of a patient’s death, in line with the NHS England Learning Disability Mortality (death) Review (LeDeR) principles. Such up to date guidance underpinned corporate principles and enhanced standards of care. Staff had reviewed four deaths as part of this work and identified a need for improved training on the documentation of needs relating to the Mental Capacity Act as an area of learning.



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Managers made sure staff attended team meetings or had access to full notes when they could not attend. Team meetings were held monthly and involved staff representing all roles and levels of seniority in the department. Staff told us they could request role-specific meetings, such as for housekeepers, if they needed to discuss issues specific to their team.

The senior team actively worked with statutory partners across the region as part of contract monitoring and service development strategies. This included contribution to the integrated care system (ICS) end of life care strategy developing and steering groups and integrated strategic planning with a partner NHS trust. This cross-working approach ensured governance systems were effective and balanced.

The clinical governance sub-committee had developed links with the clinical commissioning group (CCG) quality lead to improve safety incident monitoring. The new partnership working had resulted in a review of the methods used to present monitoring information, which resulted in clearer identification of safety trends.

Five teams led patient and family support services, including chaplaincy and pastoral care, counselling, and clinical psychology. Each team had a governance structure appropriate to their work and purpose.

## Management of risk, issues and performance

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

The senior team noted the service had filled a role in community care previously delivered by NHS services. They noted challenges in adapting to the existing model and the risks associated with significantly depleted community NHS support services. The national drive to increase the number of people able to fulfil their wish to die at home added further pressure to resources and the senior team were carrying out a review to identify key pressure points in the region and how the service could adapt.

Senior staff held monthly performance meetings that reviewed key markers such as time from referral to care and capacity and demand. Staff used the meetings to review patient and carer feedback, feedback from staff discussions, and performance measures in work with local partners.

The senior team had prepared a contingency plan for 'winter pressures' and had strategies to ensure the most vulnerable patients continued to receive care if the service came under exceptional pressure. This reflected a wider business continuity plan that focused on patient safety and the delivery of key services.

The service used an external, technology-driven assistance system to protect the safety of staff working alone in the community. The system meant staff could obtain rapid support from emergency services and enhanced their safety and security.

The senior team monitored risks through risk registers at organisational and service level. The board of trustees reviewed risks annually and the senior team monitored risk through monthly governance processes. The team identified ten strategic risks for 2021/22 and used an on-going review and monitoring system to reduce impact on the service.

The quality and risk team worked with staff across the provider to identify, monitor, and mitigate risks using a system of planned review and proactive assessment. This involved identifying risks from near misses or feedback from staff and

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establishing dynamic risk assessments. This was in addition to the provider's risk register used to maintain oversight of risk specific to services and teams. Senior staff identified the impact of COVID-19 as the key risk to the service including pressure on staffing and finance. Risk assessments were up to date, had been reviewed regularly and reflected the latest evidence of mitigation.

## Information Management

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

Staff spoke positively about communications between teams and levels of seniority. They said this helped patients to access specialist services quickly and meant discussions between teams were focused and effective.

All staff subscribed to the provider's information governance code to support appropriate handling of confidential data. The code consisted of nine directives for data handling and included verbal handling of personal information.

Staff had adapted quickly to the evolving COVID-19 pandemic and used digital technology to maintain contact with patients and access to clinical records. Staff access the electronic patient record (ERS) system remotely, which enabled more streamlined care and fewer delays in referrals.

An information governance steering-group maintained oversight of information and data security. Confidentiality and data-sharing access protocols were in place for the use of the ERS and the steering group had benchmarked these against the general data protection regulations (GDPR 2016/679).

## 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.**

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service carried out a rolling survey of patient and carer experience and analysed results quarterly. Feedback was consistently excellent, and the service demonstrated a substantial track record of patient ratings that exceeded targets.

Staff demonstrated considerable engagement with people who used the service and with wider healthcare service providers. This formed part of a strategy to make a complex healthcare system accessible and seamless.

The provider led monthly meetings with staff across all departments and services to discuss concerns, feedback, and needs. Meeting minutes showed staff were encouraged to speak up. Senior staff were proactive when they received requests and feedback, such as by implementing support structures for staff particularly worried about their personal level of COVID-19 risk.

Various displays around the building engaged patients, staff, and visitors in the activities and operation of the service. For example, a different team was highlighted each month on a board display that explained the various roles within the team and what they did.

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The living well team engaged with patients and carers to evaluate groups such as creative therapies, staying power and mood management. Evaluative feedback was consistently positive and included a focus on wellbeing and relaxation. For example, one person noted they, "...feel pampered and uplifted." Another said creative activities helped to establish goals to improve their mood.

Positive engagement with local communities was integral to the service and staff in all roles worked to improve understanding of hospice care and reduce stigma and misconceptions. During pandemic lockdowns the marketing team launched a campaign to provide reassurance of the continuation of services. Named 'Different World, Same Care', staff aimed to ensure people were confident and empowered to access the service without worrying about pressures outside of their control.

We found extensive evidence of consistent, timely engagement with staff and volunteers. The provider commissioned an external specialist organisation to carry out a staff and volunteer survey. This took place with Hospice UK as part of the national All Hospices 2021 benchmark, with a total of 4,000 staff surveyed in similar services nationally. Results were very positive and 99% of staff said they would recommend the service to a friend or relative. Staff rated the provider highly for engagement. In all seven measures of communication and leadership, the service performed better than the national average. For example, 80% of respondents said they felt well informed about the provider's work, compared with a national average of 72%.

The service had considerable partnership capacity across the region. Staff were part of the clinical commissioning group (CCG) end of life care steering group and joined fortnightly forums in frailty, care home services and in-reach care. The forums provided joint working opportunities for recruitment, community working, non-malignant care, and training and practice developments. This work contributed to improved patient outcomes. For example, the clinical team led a partnership research programme with other providers to explore new hospice care referral pathways for hospital inpatients experiencing frailty.

## Learning, continuous improvement and innovation

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

Staff described positive momentum to maintain care standards and staff morale during the pandemic. They spoke of loyalty and commitment to the provider and patients.

The collaborative working culture fostered in the service meant staff were confident and competent to use their initiative when faced with challenges. Staff were professionally curious by nature and the provider fostered this approach as a core value. It meant staff were empowered to explore opportunities to measure the effectiveness of the service and build a continual evidence base of best practice. This extended beyond clinical audit and evaluation. For example, in 2021 the senior clinical team opted in to the national APM Famcare survey. The survey enabled the provider to benchmark feedback of bereaved carers and relatives against performance in similar organisations.. The project team were preparing to publish a discussion, recommendations, and an action plan in 2022.

The senior team operated a 'time to care' system that helped to support staff maintain their high standards of care by providing protected time to reflect and decompress after difficult appointments. This was often used by the hospice at home team and meant they had time immediately after a challenging home visit, such as those where a patient had died, to decompress and reflect on the situation.

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The service had undertaken an innovative pilot scheme with two residential nursing homes to see if implementation of the integrated palliative outcomes scale (IPOS) with patients at the end of life could be used to trigger more responsive referrals to the specialist hospice team. The pilot team worked collaboratively with GPs, the clinical commissioning group (CCG) and care home matrons.

The focus on continual improvement was reflected across departments, which worked collaboratively to better understand how they could drive development together. For example, clinical teams and the director of marketing and communications worked together to explore patient experiences six months into the COVID-19 pandemic.

Staff had adapted to rapidly changing guidance and restrictions by repurposing service access, increasing remote services, and enhancing crisis care by redeploying staff and increasing service hours. Initiatives were organised in a way that meant staff could increase provision or suspend them in response to patient needs and local pandemic conditions.

The education team provided a comprehensive, resilient training programme to care homes in the area as part of a strategy to ensure people at the end of life received good quality, competent care in the community. This was a significant multidisciplinary programme to upskill adult social care professionals and improve knowledge and understanding of specialist care.

Clinical psychology staff were addressing challenges in delivering bereavement support to children and young people following the death of a loved one. This was in response to variable uptake and success of remote support during the pandemic that indicated this age group did not readily engage with the modified approach.

Allied health professionals prepared individually tailored exercise plans for patients. They worked with patients to help them overcome barriers to exercise caused by the physical impact of cancer. Staff had developed innovative approaches to helping patients undertake more exercise, acknowledging how difficult this could be depending on the progression of cancer. For example, one physiotherapist used an 'exercise snacking' technique in which they built plans for patients to undertake short periods of bitesize exercise, where were less intensive than long, sustained periods of activity.

The provider had a significant research impact footprint. The research team worked with universities and specialist organisations to ensure staff were connected to leading-edge research that improved patient care. Projects were wide-ranging and had recently included input from clinicians on the practice of eye donation following a death and work with the Hospice Biographers charity to help staff gain an understanding of people's experiences in hospice care. The service was undertaking research with a university to consider the effectiveness of 'needs rounds' in care home settings. This was a nurse-led programme to explore how a social care setting could better meet palliative needs. This project reflected the attention to detail staff placed on exploring new and innovative ways of working.