

# St Giles Hospice - Walsall

## Quality Report

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

### Ratings

#### Overall rating for this location

Outstanding 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Outstanding 

Are services responsive?

Outstanding 

Are services well-led?

Outstanding 

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

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

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

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

# Summary of findings

## Letter from the Chief Inspector of Hospitals

St Giles Hospice - Walsall is operated by St Giles Hospice Group and opened in March 2011.

The hospice at Walsall offers the following services:

- 12 inpatient beds for specialist palliative care needs.
- A 'Hospice at Home' service. This is led by a registered nurse and a team of health care assistants, who provide practical and emotional care in the home for patients in approximately the last two weeks of life.

All other services such as, spiritual support, complementary therapy, allied health professionals and community palliative care services were provided by a local NHS Trust.

Furthermore, all back office, education and governance structures were supported from a sister site organisation.

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

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 6 - 8 March 2019.

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

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

### Services we rate

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

#### Areas of outstanding practice

- 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 involved other service providers, particularly for people with multiple and complex needs. The service made extensive efforts to meet patients and family's individual needs. For example, services for children, young people and their families that allowed them to undertake activities together. There was extensive ongoing support and follow-on family support groups specifically for children and young people after they had suffered a bereavement.
- There was a commitment to continuing development of the staff's skills, competence and knowledge. This was recognised as being integral to ensuring high-quality care. Staff were proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice. The service also used objective structured clinical examinations (OSCE) to assess staff competence in a live manner.
- There was compassionate, inclusive and effective leadership at all levels. Leaders demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. There was a deeply embedded system of leadership development.
- There was an embedded and extensive team of volunteers who helped support the service. There was a volunteer strategy, a volunteer induction and training programme. Volunteers were proactively recruited, valued staff who were supported in their role in the same manner as substantive staff. The service regularly updated its policies and processes for using volunteers and innovative practice, and the use of volunteers helped to measurably improve outcomes for people.

# Summary of findings

- Services were developed with the full participation of those who used them. The service took a leadership role in its health system to identify and proactively address challenges and meet the needs of the population.
- Staff displayed determination and creativity to overcome obstacles to delivering care. There was strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences.
- There were consistently high levels of constructive engagement with staff and people who used services. Rigorous and constructive challenge from people who used services, the public and stakeholders was welcomed and seen as a vital way of holding services to account.

We found areas of good practice:

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. Staff had access to a robust training and competency programme to ensure they had the skills required to provide good quality care.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- The service planned and provided services in a way that met the needs of local people. The services provided reflected the needs of the population served and they ensured flexibility, choice and continuity of care. The facilities and premises were appropriate for the services that were delivered.
- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- People who used the service were encouraged to contribute to improvements and developments to ensure the service was a reflection of the people who used it.
- Staff felt positive and proud to work in the organisation. The culture centred on the needs and experience of people who used services. Staff told us that they felt pride in the organisation and the work they carried out to ensure patients received good quality care.

However:

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

**Heidi Smoult**

**Deputy Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

#### Hospices for adults

### Rating

Outstanding



### Summary of each main service

St Giles Hospice - Walsall provided hospice care to adults through inpatient, day hospice and community services. We rated the service outstanding overall because the service was outstanding in caring responsive and well led.

# Summary of findings

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Outstanding



# St Giles Hospice - Walsall

**Services we looked at**

Hospices for adults

# Summary of this inspection

## Background to St Giles Hospice - Walsall

St Giles Hospice - Walsall is operated by St Giles Hospice. The hospice opened in March 2011. The hospice operates within an NHS palliative care centre. The hospice has a registered manager in post who was also the nominated individual. The service provides care for adults and primarily serves the communities of Walsall and Staffordshire. It also accepts patient referrals from outside this area.

St Giles Hospice Walsall also has a sister site that operates as 'head office' for other service locations. At Walsall, the St Giles Hospice is commissioned to provide the nursing establishment and medical cover to a 12 bedded inpatient unit within an NHS palliative care centre. Supportive care such as, spiritual support, complementary therapy, allied health professionals and community palliative care services are provided by the neighbouring NHS Trust. Furthermore, all office, education and governance structures and some support services are provided from the sister site. The hospice at Walsall offers the following services:

12 inpatient beds – for specialist palliative care.

Three diversional beds for admitting patients for a number of agreed interventions (instead of NHS hospital admission).

Hospice at Home – led by a registered nurse. This team of health care assistants provide practical and emotional care in the home for patients in approximately the last two weeks of life. This service can provide up to 1,369

visits per month. Bereavement help points – drop in centres for families and bereaved relatives to seek support or sign-posting to other services. This service is run by suitably trained volunteers. Advice and referral centre at sister site – operates 24 hours a day, seven days a week for advice to any professional, patient known to St Giles Hospice or member of the public.

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

Phoenix service - bereavement service developed by and for young people experiencing bereavement.

Specialist women's cancer support service.

A wide range of learning and development are offered, ranging from individual study days to master's level study either independently or in conjunction with other education providers and available to both internal and external staff. In May 2017, the hospice launched its new five year strategy and as part of this underwent a re-brand. The re-brand focused on the key messages, via consultation with stakeholders, which were important in expressing the vision of St Giles Hospice. Part of the re-brand was also reviewing the impact of the brand and therefore public awareness. The new brand portrays a vibrant, more engaging and modern image of hospice care; core to the rebrand is the philosophy, 'it's your life, and that's what matters'.

## Our inspection team

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

## Why we carried out this inspection

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

# Summary of this inspection

## How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 6 and 8 March 2019.

## Information about St Giles Hospice - Walsall

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

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

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

There were no special reviews or investigations of the hospice/service ongoing by the CQC at any time during the 12 months before this inspection. The hospice/service had been inspected previously and the most recent inspection took place in December 2015, which found that the hospice was meeting all standards of quality and safety it was inspected against.

Activity for January – December 2018.

For this period there were 341 patients (73 hospice at home, 268 inpatients) under the hospice care who could be classified as palliative. Unfortunately, the service's existing system meant that they were unable to report any further breakdown as their data was not categorised in these ways. As part of their future planning the service was investigating new systems and would take this point forward.

Track record on safety for St Giles Walsall-

- No Never events
- Two serious incidents – one outbreak of Norovirus and one outbreak of Clostridium Difficile
- No incidences of healthcare acquired Meticillin-resistant Staphylococcus aureus (MRSA).
- No complaints for St Giles Walsall.

Some services were outsourced to other providers:

- Medical consultant and on-call doctors
- Catering services



# Summary of this inspection

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Are services safe?

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

Good



We found the following areas of good practice:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The service had enough medical staff. Patients had access to a 24/7 medical on-call service.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medicine at the right dose at the right time.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

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

# Summary of this inspection

## Are services effective?

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

**Good**



- There was a holistic approach to assessing, planning and delivering care and treatment to all people who used services. This included addressing, where relevant, nutrition, hydration and pain relief needs.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Wide ranging evidence-based techniques and tools were used to support the delivery of high-quality care. Managers checked to make sure staff followed guidance.
- There was an embedded and extensive team of volunteers who helped support the service. There was a volunteer strategy, a volunteer induction and training programme. Volunteers were proactively recruited, valued staff who were supported in their role in the same manner as substantive staff. The service regularly updated its policies and processes for using volunteers and innovative practice, and the use of volunteers helped to measurably improve outcomes for people.
- There was a commitment to continuing development of the staff's skills, competence and knowledge. This was recognised as being integral to ensuring high-quality care. Staff were proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. Innovative approaches to care were actively encouraged.

# Summary of this inspection

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

## Are services caring?

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

- People were truly respected and valued as individuals and were empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service. This included families and other people involved in patient care.
- People valued their relationships with the staff team and felt that they often go 'the extra mile' for them when providing care and support.
- Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between people who used the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders.
- Staff recognised and respect the totality of people's needs. They always took people's personal, cultural, social and religious needs into account and found innovative ways to meet them. People's emotional and social needs were seen as being as important as their physical needs.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Patients and their families and carers told us that staff went over and above what they expected.
- Staff provided emotional support to patients to minimise their distress. The service looked after staff and supported their wellbeing.
- Staff involved patients and those close to them in decisions about their care and treatment. Staff were creative and innovative in their approach to ensure people who used the service had their requests met where possible.

**Outstanding**



## Are services responsive?

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

**Outstanding**



# Summary of this inspection

- The service planned and provided services in a way that met the needs of local people. The services provided reflected the needs of the population served and they ensured flexibility, choice and continuity of care. The facilities and premises were appropriate and adaptable for the services that were delivered.
- The service took account of patients' individual needs. There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs. For example, a dementia support worker role included working within care homes to improve care of people living with dementia and enabling more people to die in their home (including care homes) rather than in acute hospitals.
- The hospice worked in partnership with the neighbouring NHS Trust. Joint initiatives aimed to divert NHS admissions and provide 'crisis bed' for palliative care patients.
- The services were flexible, provided informed choice and ensured continuity of care.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results and shared these with all staff in the Hospice group. The service at Walsall had not received any complaints in 2018.
- The hospice group was inclusive of all life limiting conditions and worked hard to meet the individual needs of these patients.

## Are services well-led?

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

- There was compassionate, inclusive and effective leadership at all levels. Leaders demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. There was a deeply embedded system of leadership development.
- Leaders had a deep understanding of issues, challenges and priorities in their service, and beyond. The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care.

**Outstanding**











# Summary of this inspection

- The strategy and supporting objectives and plans were stretching, challenging and innovative, while remaining achievable. Strategies and plans were fully aligned with plans in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership.
- There were consistently high levels of constructive engagement with staff and people who used services. Rigorous and constructive challenge from people who used services, the public and stakeholders was welcomed and seen as a vital way of holding services to account.
- There was strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences. Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.
- The service engaged exceptionally well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.
- Comprehensive and successful leadership strategies were in place to ensure and sustain delivery and to develop the desired culture.

# Detailed findings from this inspection






## Overview of ratings

Our ratings for this location are:

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

### Notes

# Hospices for adults

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

## Are hospices for adults safe?

Good 

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

### Mandatory training

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

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

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

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

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

### Safeguarding

**Staff understood how to protect adult patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse in children.**

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

All staff completed a safeguarding adults e-learning module annually following attendance on induction. Further levels of training were mandatory for staff depending on their role.

There were systems in place to safeguard children. While the service did not provide care to children, staff may have contact with children during their work. Staff at the service were trained in safeguarding children.

The following compliance figures included the sister hospice site staff data. Sixty seven percent of staff had received safeguarding adults training at level 2, 100% had received safeguarding adults training at level 1. All clinical staff had received safeguarding children level 2 training; 25% of clinical staff had received level 3 safeguarding children training. Depending on role, staff safeguarding skills were monitored to ensure they were competent in recognising and managing safeguarding issues.

All registered nurses had an observed structured clinical examination (OSCE) to identify areas of learning. The OSCEs demonstrated nurse's knowledge and ability to escalate concerns relating to safeguarding. The training



# Hospices for adults

and observation sessions promoted six safeguarding principles. Facilitators used various teaching and learning activities to meet the learning outcomes including videos, group work and a 'fish bowl' exercise using volunteers. The teaching session was mandatory for all registered practitioners and the programme was near completion. Sessions were evaluated with positive feedback. As a result, the programme was extended to health care assistants.

A safeguarding lead for children and a separate one for adults were in place, together with nominated deputies. There was a comprehensive training programme in place to support staff understanding of mental capacity and safeguarding, led by a clinical educator.

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

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

## Cleanliness, infection control and hygiene

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

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

Staff had recorded two incidences of healthcare acquired infections in the 12 months prior to our inspection. During the period January 2018 to December 2018, there was one outbreak of Norovirus and one outbreak of Clostridium Difficile. As a result, root cause analysis investigations were completed. This measure was put in place to avoid reoccurrence.

The hospice was visibly clean and clutter-free. There were facilities to support good infection prevention and control in all patient rooms. For example, there were two

wash facilities with hot and cold running water in each room, one for staff and another for patients. There were good supplies of personal protective clothing, for example, gloves and aprons.

All clinical staff were observed to be arms bare below the elbows as outlined in the policy. All staff were observed using appropriate protective equipment such as gloves and aprons to carry out procedures and personal care activities.

Suitable equipment, such as colour coded mops and buckets were available. Waste disposal systems were suitable. Substances potentially hazardous to health were stored securely.

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

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

The quarterly infection prevention and control forums also looked at infection control policies and ensured that they were reviewed when due. We saw that infection policy and the Legionella policy had both been recently updated.

Cleaning schedules were used and signed off to record completion of tasks.

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

## Environment and equipment

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

The hospice environment was provided within an NHS building. The cleaning of the hospice environment was provided by the NHS trust. St Giles Hospice Walsall and





# Hospices for adults

the NHS trust were jointly responsible for the maintenance of the building. However, the maintenance of services, equipment provision and servicing were the responsibility of the provider, St Giles Hospice.

There was an equipment and maintenance register held to ensure that safety and maintenance checks were completed.

Staff discussed issues relating to environment and equipment at their team meetings.

There was equipment available to allow patients to be as independent as possible. For example, electronic tablets were linked to the beds so that patients could move them as they wished. The electronic tablets also provided patients with control of other areas of their environment including the curtains, doors and the television.

All the equipment we checked had been serviced and tested for electrical safety.

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

Staff were able to access equipment through NHS stores, to ensure that everything was in situ ready for a patient when discharged from the unit.

Clinical waste disposal arrangements were in place throughout the hospice. People could access bins clearly labelled, for example, clinical waste only or domestic waste only. Bins were lidded and operated with a foot-pedal in clinical areas and toilets, to prevent hand contamination.

## Assessing and responding to patient risk

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

Staff carried out risk assessments on admission for each individual patient and they were regularly reviewed. All inpatients were subject to a holistic daily assessment process, which included mental capacity. A multi-professional review of risks also took place weekly.

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

transfer to hospital was considered, the out of hours doctors would be asked to review. Within working hours, a member of the medical team would review. All unplanned transfers were reported to the inpatient operational group. Managers told us a work stream to review unplanned transfers for learning and improvement was planned.

Staff managed the increased risks experienced by people at the end of life. Individual risk assessments were carried out to manage these risks. All patients were risk assessed for skin integrity, pressure ulcers and falls using evidence-based tools. The information was used to form management plans, which were stored in patient records. There was also a lead tissue viability nurse to support staff, ensuring good practice.

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

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

## Nurse staffing

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

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



# Hospices for adults

For the inpatient unit, usual staffing levels were three qualified nurses and two healthcare assistants for day shifts. On nights there was typically two qualified nurses and two healthcare assistants.

Demand for hospice at home services fluctuated. Managers told us that staffing levels needed to increase for the hospice at home service to cover all shifts on occasions. There had been one occasion where an admission had occurred because the service was working at full capacity. If on some occasions, there were no hospice at home calls, staff worked on the inpatient unit.

Managers gathered and reviewed data about responsiveness to referrals and admissions. They also reviewed patient safety indicators, complaints and significant events where staffing may be an influencing factor. Staff linked with a network of colleagues from other hospices about variations in structures and outcomes to inform service reviews. This was influenced by external demands and legislative changes but considered the health economy.

We were provided with and reviewed data related to staff at the hospice. We reviewed their medical, nursing, allied health professional and health care assistant staffing. The hospice had zero full time medical staff, four full time nursing staff, 12 full time full time health care assistants (HCAs) and four other non qualified staff. They had four part time medical staff, 10 part time nursing staff, nine part time HCAs and five part time non qualified staff.

We were provided with the staff sickness rates for a three month period from 1 September to 30 November 2018. There was a rate of 0% for medical staff, 2.4% for qualified nurses and 8.9% for HCAs.

We were also provided with data relating to vacancies. There were zero for medical staff, one whole time equivalent (WTE) for nurses and AHPs and one WTE for HCAs.

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

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

There were 52 volunteers who worked at the service and across its sister site. A volunteering strategy was launched in December 2018. A volunteer administrator to support the volunteer development manager was employed. Volunteers were supported in being competent in their roles. For example, volunteers working within bereavement services completed an accredited 10 week working with loss programme.

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

Managers told us staff were passionate and flexible in their work, with a willingness to change shifts to accommodate patient's needs. Sometimes staff worked on either site – Walsall and sister site to help with covering shifts.

A social worker was employed on a bank contract while the role was being reviewed in line with the development of the services' carers strategy. A counsellor was employed on a self-employed basis. Both staff attended an induction and completed e-learning in line with other substantive staff.

## Medical staffing

The service had enough medical staff. Patients had access to a 24 hour, seven day a week service. A medical on-call cover was provided by an external service.

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

## Records



# Hospices for adults

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

Staff used a paper record system. All records we looked at were comprehensive, clear and up to date.

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

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

Patients were assured that information about them was treated confidentially, in a way that complied with the Data Protection Act. Staff supported people to make and review choices about sharing their information. Only trained staff could access patient information. There was evidence of consent with regular updates recorded in documentation.

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

## **Medicines**

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

During the inspection, we checked patient records and prescription charts for six patients, and we spoke with eight members of staff in relation to the management of medicines.

Medicines and medicines related stationery were managed, ordered, transported, stored, and disposed of safely and securely (including medical gases and emergency medicines and equipment). Comprehensive medicines policies and procedures were in place. A pharmacist was employed by the hospice, and other

support services and supplies were obtained through a service level agreement with the local trust. There was a system in place to ensure that medicines alerts or recalls were actioned appropriately.

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

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

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

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

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

The service had eight non-medical prescribers working in the inpatient department.

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

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



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inform patients when their medicines were used in this way. There were suitable systems for auditing the use of medicines and these identified any issues that needed improvement.

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

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

There were easy to read guides available on common medicines such as strong painkillers. These guides detailed what the medicine was and how it might affect the patient.

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

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

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

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

Staff safely administered medicine, checking the wristband and identity of the person and speaking to the patient about the medicine they were being offered.

## Incidents

### **The service managed patient safety incidents well.**

Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff had access to an electronic incident reporting system. Incidents were reviewed by managers. Trends and learning were shared with staff, the relevant trustee board governance aspect committee and operational governance groups. The governance and learning from incidents was integrated and shared across the St Giles Hospice group and sister site.

Staff recorded 150 inpatient deaths at St Giles Hospice Walsall and 61 hospice at home deaths from December 2017 to December 2018. There were no never events. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

There had been two serious incidents, which were an outbreak of Clostridium Difficile and an outbreak of Norovirus. The service had managed these incidents appropriately containing the outbreaks to one patient.

There was a policy in place to advise staff how to adhere to the principles of the duty of candour. The duty of candour is a duty, which requires every healthcare professional to be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. This means that healthcare professionals must tell the patient when something has gone wrong, apologise to the patient, offer an appropriate remedy or support to put matters right (if possible), explain fully to the patient the short and long term effects of what has happened.

The electronic incident reporting prompted staff to consider if the duty of candour process needed to be followed. The most common reason for being open and honest with patients and those close to them was tissue



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damage, the service had a tissue viability lead to provide support to staff on tissue care. Between January 2018 and December 2018, there had not been any occasion where the duty of candour had been applied.

Staff were trained in, knew and understood the principles of duty of candour. They could access an organisational policy to support duty of candour in practice. Clinical incidents were checked daily by managers for statutory reporting requirements. This included duty of candour.

## Are hospices for adults effective? (for example, treatment is effective)

Good



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

### Evidence-based care and treatment

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

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

There was a rolling programme of clinical audit and monitoring in place with action plans. Outcomes were shared with staff through email, meetings and publications. We looked at audit documentation and related reports. For example, tissue viability audit and monitoring report for period October 2018 to March 2019 with related action plans.

All staff actively engaged in activities to monitor and improve quality and outcomes. The service was actively engaged in several research projects and had a comprehensive research program and plan. An example

was a study around the prognosis in palliative care patients. This study was looking at the prognosis of patients with life limiting diseases and aimed to provide an evidence-based study in this area.

Another example of challenging and testing evidence base was a study in progress which was looking at specific assessment and care tools interacted and their effectiveness.

Patients were supported in developing advance care plans, emergency care plans and ceilings of care. These were shared with the greater multi-disciplinary team including external providers of end of life care.

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

### Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs and improve their health.** They used special feeding and hydration techniques when necessary. The service adjusted for patients' religious, cultural and other preferences.

Staff could access a nutrition policy, which was updated every three years or sooner if required.

Each patient on admission had a nutrition assessment that considered physical, psychological, spiritual and social aspects to ensure nutritional wellbeing.

Staff used a Malnutrition Universal Screening Tool (MUST) score. They used the information using this tool to assess diet and any practical points which affected nutritional intake. For example, poor fitting dentures. There was specific nutrition treatment plan available for patients at high risk of malnutrition. This was an easy to follow algorithm with prompts. The plan was based on best practice national guidelines.

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



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

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

There was also a catering support assessment which looked holistically at a patient's nutrition needs and preferences. This included areas such as food allergies, cultural considerations and plate size.

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

## Pain relief

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

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

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

Symptom management was considered a priority to ensure patients were as pain free and comfortable as possible. A range of pain management systems were used, including syringe drivers.

Patients records included a range of pain relieving medicines, some of which could be used as required to manage breakthrough pain. Records of administration were fully completed for all aspects including syringe drivers and patches.

## Patient outcomes

### **Managers monitored the effectiveness of care and treatment and used the findings to improve them.**

They compared local results with those of other services to learn from them.

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

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

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

100% of patients had an individualised care plan in place, that set out their advance care preferences. It covered activities of daily living, family and carer support, infection control, mental capacity, tissue viability, advance care planning and symptom management. There was provision for recording preferred place of care and death within records. The records were regularly reviewed and audited.

There was a specialist women's cancer support service, which was funded by a charity. The service supported women who had been affected by cancer and focussed on empowering them to self-manage their ongoing emotional, psychological and physical symptoms. It had been running for a year and had seen 58 clients in the 12 month period. The service undertook a year review of the support service and this showed that 79% of referrals were 'self-referred' and 96% of all enquiries were



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responded to in 48 hours. In the survey sent out to all referrals, the question posed was 'how likely are you to recommend St Giles to friends and family if they needed similar support?' 89% of patients said they would be extremely likely to recommend the service and 11% would be likely to recommend the service.

The service undertook a tissue viability audit to specifically look at outcomes for patients in this group. The audit showed that in 100% of cases audited, correct care was provided to patients. It also showed that in 36% (four) of pressure areas they showed improvement, in 45% (five) no change was identified and in 19% (two) there was a deterioration.

The service was registered with and working towards Outcome Assessment Complexity Collaborative outcome frameworks where applicable. The Outcome Assessment and Complexity patients' opinions on the IPOS questionnaire (Integrated Palliative care Outcome Scale). The IPOS are a family of tools to measure patients' physical symptoms, psychological, emotional and spiritual, and information and support needs. The results showed that most people found the questionnaire easy or needed a little help completing it. The majority of patients (eight out of nine) agreed or strongly agreed that the questionnaire had helped them describe their symptoms. Eight out of nine patients also agreed or strongly agreed that using IPOS helped them talk with the nurse about their symptoms and concerns.

## Competent staff

**The service made sure staff were competent for their roles. Managers appraised staffs' work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.**

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

All staff had an induction ensuring they fully understood their role and the part they played in the wider

organisation. The induction program was comprehensive and provided staff with the information they needed. It helped them gain an understanding of the hospice and wider group.

Staff competencies were managed using a competency-based education passport. The passports were designed to meet the educational needs of the role. For example, a registered nurse passport and a healthcare assistant passport.

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

Nursing staff competences were observed using an annual programme of structured clinical examinations. These observations were recorded in education passports. Regular updated training opportunities and personal development plans were devised within individual appraisals. For example, tracheostomy care competencies were checked for registered nurses. They would be observed in practice and in training. The facilitators used questions and answers to test knowledge, for example, to describe how tracheal trauma could be reduced.

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

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

Staff were offered either peer supervision or one-to-one clinical supervision. This was facilitated by either level 2 psychology trained staff or a level 4 clinical psychologist. All volunteers were offered individual induction 'Know Your Own Organisation' study day, communication training and bereavement training. Mentorships and coaching were available if identified as a need.



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All staff and volunteers attended training that helped develop skills to support people in distress. For example, Level 1 communication training.

There was a comprehensive system of training and annual competency checks for nurses regarding medicines management. The pharmacist had input into the training and induction programme, which included training for junior doctors. There were link nurses for a number of areas for example, nutrition, infection control and manual handling. Additional training days were allocated for link nurses to enable them to support their colleagues.

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

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

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

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

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

## Multidisciplinary working

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

Staff worked with external primary care providers on developing a more integrated care service approach with

shared records, processes and procedures. The aim was to reduce duplication and enable a more collaborative and consistent approach to care provision ensuring patient's needs were shared and understood by all.

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

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

Observations of a multidisciplinary meeting confirmed explanations were provided to patients and those close to them about the care provided. Social needs were considered and staff knew family's individual circumstances.

## Seven-day services

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

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

## Health promotion

**People who used services were empowered and supported to manage their own health, care and wellbeing and to maximise their independence.**





# Hospices for adults

**There was lots of work with community engagement. Staff worked with a local children's nursery to dispel myths and encourage them to attend the hospice, which they did.**

There were rooms in the hospice dedicated to complementary therapies and patients looking after their own wellbeing. There were health promotion materials displayed throughout the hospice; displayed on the walls, in the form of leaflets and helplines and organisations to support ongoing health promotion.

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

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

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

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

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

Staff could access guidance on Deprivation of Liberty Safeguards. There was eLearning and policies and procedures for staff to follow should either a standard or urgent authorisation need to be made. There were no occasions in the past year where applications had been made to deprive a patient of their liberty.

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

Do not attempt cardio pulmonary resuscitation forms were completed for some patients. We reviewed two of these. No records were available to confirm patients and relatives had been consulted, one did have a mental capacity assessment completed.

## Are hospices for adults caring?

Outstanding



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

### Compassionate care

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

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

Staff displayed determination and creativity to overcome obstacles to delivering care. Patients' individual preferences and needs were reflected in how care was delivered. Patients were supported in accessing things of value that gave them comfort, even when they were inpatients at the hospice. There were lots of examples. Staff arranged multiple movie nights and takeaway evenings and had facilitated a visit from the owl sanctuary for the patients on the inpatient unit.

The hospice told us that a member of staff spent three days of her own time, writing family 'goodbye letters' for a patient who was unable to write themselves.

Patients were supported in accessing things of value that gave them comfort, even when they were inpatients at the hospice. Staff told us they tried to make every day a meaningful for people who used the service. Family trips had been arranged and made possible by staff at



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patients' individual requests, including to a Santa's grotto and a visit to a wildlife park. On inspection we observed a patient who wanted a specific hymn and the chaplain identified this hymn from a couple of words given and then they started singing a hymn to the patient at their request.

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

Staff approached patients in a kindly manner and with a smile, we observed care was delivered in an unhurried manner.

Pets were welcome and could stay with patients on the ward. Other examples of caring for patients were shared with us. One patient had a wish to go out and this was arranged. Feedback from a relative was that the normality of being able to go for a walk with their dog was highly appreciated by the patient.

There was staff flexibility and we were told of examples where staff stayed beyond their shift to provide care when circumstances changed at short notice.

We saw records where patients had been asked about what was important to them. Examples recorded included: wanting to be as independent for as long as possible and having a wash before breakfast.

People were always treated with dignity by all those involved in their care, treatment and support. Consideration of people's privacy and dignity was consistently embedded in everything that staff did, including awareness of any specific needs and these were recorded and communicated.

Staff found innovative ways to enable people to manage their own health and care when they could and to

maintain independence as much as possible. Staff gave us examples of when they supported patients with challenging personal circumstances. Staff told us they continually sought to adapt to accommodate people.

Staff understood and respected the personal, cultural, social and religious needs of people and how these may relate to care needs. They took these needs into account in the way they delivered services. There was a dedicated room for prayer, contemplation, where ceremonies had taken place.

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

Staff told us they felt safe to raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes. No one we spoke with could provide us with any examples of when this happened.

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

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

Staff were thanked by patients who used their service for their caring and compassionate input. Staff did not formally collect compliment data. However, compliments and thanks were received frequently. We were told that between January 2018 to December 2018, one unit received 72 thank you cards and approximately 256 compliments counted manually, for example, from Patient Reported Outcome Measures.

People who had died at the service awaiting the undertakers, continued to be cared for with dignity and



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respect. Care was taken to discharge people via a discreet, private and enclosed space to continue to offer compassionate care until the point of discharge. Families could spend time with their loved ones in a private space.

## Emotional support

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

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

Staff understood the impact that a person's care, treatment or condition had on their wellbeing and on those close to them, both emotionally and socially. People were given appropriate and timely support and information to cope emotionally with their care, treatment or condition. For example, patients could self-refer for psychological support for surviving cancer. This was provided as an outpatient service supporting patients and their families to re-build relationships, discuss issues and concerns related to intimacy and sexual health.

Staff recognised that people needed to have access to, and links with, their advocacy and support networks in the community and they supported people to do this. They ensured that people's communication needs were understood, they looked for best practice and learned from it. Family members and carers could stay with their loved ones and were encouraged to do so. We saw chaplains involved with patients and their families providing them with religious and spiritual support when they requested it.

The hospice could access specially tailored emotional support for children and young people from the patient's family (Phoenix service). This allowed patients to

undertake activities with the children and young people close to them whilst being offered emotional support. This included advice and support, sibling sessions and activities such as arts and crafts.

The provider had also developed a specialist women's cancer support service, which was funded by a charity. The service supported women who had been affected by cancer and focussed on empowering them to self-manage their ongoing emotional, psychological and physical symptoms.

People could access a therapeutic spiritual suite. The dedicated room, (which faced east) promoted tranquillity. Patients and their family members could use the room as a place of contemplation and prayer. Prayer mats and a range of religious texts, for example, a Koran for use by Muslim patients were available. There were a range of chaplains available and other spiritual support. Weddings had taken place at the hospice in the spiritual room. The latest wedding was supported by the local community in the provision of dresses, flowers, and food.

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

Sensory bathrooms were available, with equipment to support those with mobility needs. These included lighting and music to support emotional well-being and relaxation. Portable sensory equipment was also available.

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

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

Staff communicated with people so that they understood their care, treatment and condition and any advice given.



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Family support and bereavement also triaged referrals to explore individual's needs with them directly and the appropriate intervention by either the hospice or alternative providers if appropriate.

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

Staff routinely involved people who used services and those close to them (including carers and dependants) in planning and making shared decisions about their care and treatment. Records were available to show regular discussions were held with those close to patients. The opportunity to raise questions were given and answers provided. People told us they felt listened to, respected and had their views considered. Information was provided to support families, for example where children were affected by illness/bereavement information was provided.

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

Staff made sure that people who used services and those close to them were able to find further information, including those with protected characteristics under the Equality Act and those in vulnerable circumstances. For example, patients suffering with motor neurone disease alongside multiple co-morbidities including diabetes and respiratory issues.

Patients and their loved ones could ask questions about their care and treatment. They were supported to access further information through direct conversations with staff, leaflets, inhouse services and partner agencies who worked on or off-site including community and advocacy services. The service also provided a comprehensive information pack for patient's relatives and friends.

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

Patients were empowered and supported, where necessary, to use and link with support networks and advocacy, so that they had a positive impact on their health, care and wellbeing. Links with the community and information was stored on a central spreadsheet accessible by all staff in the St Giles Hospice group.

There was a family support service provided by the hospice which offered a range of emotional, practical and psychological support to people and their affected by a life limiting illness. The family support team allowed relatives to be involved in the patient's journey. Family support was offered both pre and post bereavement. Those close to patients could stay overnight at the hospice. On occasions this could be beds side-by-side to allow patients the normality of sleeping with a partner.

Where patients wished to go home to die and this was possible, all attempts were made to respect the patients wish to die at home.

## Are hospices for adults responsive to people's needs?

(for example, to feedback?)

Outstanding



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

### Service delivery to meet the needs of local people

#### The service planned and provided services in a way that met the needs of local people.

The services provided reflected the needs of the population served and they ensured flexibility, choice and continuity of care. The facilities and premises were appropriate for the services that were delivered. There were eight single beds and two double rooms. A separate family suite was available for overnight stay. There was room at the side of the beds for a camp bed should this be required.

The grounds were maintained well and suitable for the people who used the service. The rooms had access to a private seated area and gardens.

People could access ample car parking and Wi-Fi. Relatives who had difficulty with transport had potential



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access to a volunteer driver to support visiting. Visitors were able to make tea and coffee and there was the ability to purchase food whether to eat with their relative or in a separate space.

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

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

A carers' buddy system was piloted with non-recurrent funding from a local authority. The project funded a specific carers coordinator post and volunteer training to widen access to carers support at end of life. Funding was not continued to fund the project long term. However, there were benefits and learning from the project which was incorporated into the delivery of a family support team's work. This including widening the development and use of volunteers to support carers and family members.

Patients could access a range of therapies, including complementary therapies, either at the complementary therapy suite or at their bedside.

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

St Giles Hospice employed a dementia support worker who worked with care homes providing support and care to patients living with dementia.

## Meeting people's individual needs

### The service took account of patients' individual needs.

Peoples individual needs and preferences were central to planning and delivery of tailored services.

Staff carried out comprehensive individualised care plans to identify and meet the information and communication

needs of people with a disability or sensory loss. These additional needs were recorded in care records. All shared patient information required consent, which was recorded in patient care records.

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

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

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

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

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

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

There was a dementia support worker employed by St Giles Hospice group covering the Walsall area. The pilot project began 2015 and was made permanent in 2018. The aims of the role included working within care homes to improve care of people living with dementia and



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enabling more people to die in their home (including care homes) rather than in acute hospitals. They provided support and education to the care homes. For example, using the gold standard framework with care homes to look at causes of hospital admissions when people living with dementia are at the end of life. Spiritual care coordinators linked with local faith leaders, including from the local Muslim community. This meant that they could work together for the benefit of patients. There were facilities to enable people to wash prior to praying if they wished to.

The hospice group was inclusive of all life limiting conditions and worked hard to meet the individual needs of patients in these groups. They did this by offering access to specialist nursing and other support staff such as an after-cancer support service. Disease specific sessions were regularly held at the supportive care centre including a multiple sclerosis group and a pulmonary fibrosis support session. The content of these sessions was tailored to meet the needs for each patient group. For example, the multiple sclerosis group arranged exercise sessions which helped with symptoms of the disease. Some patients requested the withdrawal of treatment. In each case a review was held involving key stakeholders. For example, families, carers, respiratory staff, primary care staff and human rights experts. Processes were in place to ensure that this was managed openly and sensitively so that people had a comfortable and dignified death.

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

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

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

Staff could access support to meet patients and family's individual needs. An example of this was the Phoenix service for bereaved children and young people (from the patient's family). This service allowed families to undertake activities together. It also provided advice,

support and guidance through one-to-one, family support groups and peer support groups. This service also provided a follow-on family support group for children and young people after they had suffered a bereavement. The Phoenix service also worked with local schools to support young people.

Staff were involved in a research study with a University to explore the experiences of people attending the service multiple sclerosis support groups. The study found that the participants valued the contact with other people with multiple sclerosis and liked the fact that the group was based around exercise that improved their wellbeing. The findings from the research led to a service review.

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

A smoking room designed by the NHS was available. This allowed those who wished to smoke to continue to do so.

Patients from all clinical services could access a range of therapies, including complementary therapies. There was a dedicated room for this.

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

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

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

The service had a comprehensive procedure for care after death. This included all points of the patients' needs and the needs of their family. It gave staff a clear procedure to



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

## Access and flow

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

The hospice had joint initiatives with the neighbouring NHS Trust. The first initiative related to five diversionary pathways. The project aimed to divert patients from the NHS hospital into beds for a number of agreed interventions:

hypercalcaemia treatment

intravenous antibiotic therapy for exacerbation of respiratory conditions

intravenous furosemide for patients with decompensated heart failure at end of life

blood transfusion

lymphoedema pathway for cellulitis

The second initiative was the provision of a 'crisis bed' to which community palliative care consultants directly admit patients at end of life. People could access services in a timely way. There was a 24 hour a day seven day a week advice centre which could be accessed by people known and unknown. The local community could self-refer and the same standards would be met.

Patient care and treatment was tailored to the individual their preference and need. Patients were offered a service at the Walsall palliative care unit and in the community. Patients had fast track admissions 24 hours, seven days a week, either direct from the community or transfer from hospital. To prevent unnecessary delays, for example, in accessing transport an advanced nurse practitioner could clerk the patient in the community. This ensured a medical review, drug chart and do not attempt resuscitation (if appropriate for admission).

Patient referrals were processed through the advice and referral centre. Once triaged, a team member contacted the patient directly to discuss their personal needs and

check the information was correct. Patient centred care plans were developed to manage symptoms. This ensured that the patient accessed the right service and intervention type for their needs.

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

The hospice service had undertaken an innovative dementia service around reducing unnecessary admissions from nursing homes to acute hospitals, particularly for end of life care. This service provided support from a dementia support worker to educate nursing home staff and provide an additional level of support and advice. The service was well received and had won awards for the innovation.

The average length of stay for inpatients was 12 days.

## Learning from complaints and concerns

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

Patients we spoke with told us they knew how to make a complaint or raise concerns and felt comfortable doing so. Staff understood the system and had access to policy and procedures to guide them in managing complaints. People were encouraged to raise concerns in several ways. For example, using a free text option within Patient Reported Outcome Measures or directly on the service website.

Concerns and complaints were used as an opportunity to learn and drive improvement. From January 2018 to December 2018, there were no complaints at Walsall. However, managers provided us with examples of where they had identified a theme from complaints at the sister site and they had introduced training to staff because of the learning from the theme. Staff received training in communication throughout the St Giles Hospice group.



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There had been 72 written compliments received in the past 12 months. A word cloud image had been generated to reflect some of the comments that had been received.

## Are hospices for adults well-led?

Outstanding



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

### Leadership

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

The St Giles Hospice Walsall worked managerially closely with the sister site, including a shared leadership team; although each location had a separate registered manager. The provider's headquarters were at the sister site and many administrative tasks were operated from there.

There was compassionate, inclusive and effective leadership at all levels. Leaders demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. There was a deeply embedded system of leadership development and succession planning, which aimed to ensure that the leadership represents the diversity of the workforce.

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

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

behaviours aligned with the service values. The chief executive officer was consistently representing the service and had achieved an honorary lecturer at a local university.

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

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

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

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

There were clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership. There was leadership planning and succession planning. External business schools were used to work with the leadership team in understanding trusteeship, business and strategy. Trustees had annual appraisals. As part of the skills audit and to ensure trustees critically challenged performance and strategy, 'areas of interest' were identified. This meant trustees were expected to have some awareness of external issues that might impact the hospice. For example, a trustee with an interest in workforce would keep up to date with NHS workforce strategy developments.





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

Managers had dedicated time allocated to enable them to complete administrative tasks.

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

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

## Vision and strategy

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

The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups. This was an overarching strategy for all the services offered by the provider. There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans.

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

Grow the capacity of the bereavement service.

Develop services for young people who were bereaved.

Provide increased support and opportunities to those who wanted to make written plans of their wishes.

Work with schools and young people to change future attitudes around dying.

Campaign for improvements in end of life care with national and local partners.

Extend work with local businesses and organisations to increase openness and confidence about dying and bereavement.

Improve engagement with the community, recognise and build on support.

There was a clear vision and set of values, with quality and sustainability as the top priorities. Staff and volunteers took part in a consultation to agree the service values. It was agreed 'Ask what matters, Listen to what matters, Do what matters'. This agreement was inspired by a dementia awareness guest speaker. The guest speaker was asked permission to adopt the values, to which they agreed.

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

The vision, values and strategy been developed using a structured planning process in collaboration with staff, people who used services, and external partners. When a business case was proposed for a new service, the template required how the service would involve stakeholders and how it would be evaluated. Leaders monitored and reported on a range of human resource metrics to review the wellbeing of the workforce, this included biennial staff surveys. There was a workforce plan which was developed in parallel with a 3-year service plan and education strategy.

Staff knew and understood the vision, values and strategy, and their role in achieving them. Staff and key stakeholders were involved in the development of the strategy, vision and values. Carers and Family Support strategy and engagement days were planned with carers and key organisational stakeholders.



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

## Culture

**There was strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences. Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**

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

There was a culture of inclusiveness to support people who worked for and used the services. For example, training to understand equality, diversity and inclusiveness of those with protected characteristics. Staff felt supported, respected and valued. We saw this evidenced in the commitment to staff learning and development. There was support in ensuring staff were competent and there was scope for career progression. Staff were nominated by each other for a 'What Matters' award scheme. This was a way to identify staff who made a difference to others, highlighting care and support of patients, carers and each other.

Staff felt positive and proud to work for the organisation. The culture centred on the needs and experience of people who used services. Staff told us that they felt pride in the organisation and the work they carried out to ensure patients received good quality care.

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

The culture encouraged openness and honesty at all levels within the organisation, including with people who used services and in response to incidents. Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution. We saw evidence of learning and action taken because of concerns raised.

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

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

There was a strong emphasis on the safety and well-being of staff. Clinical psychology supported staff individually if needed. They attended multidisciplinary meetings to help explore and guide care. Clinical staff were trained to level two psychology. Wellbeing messages were spread across the service in the form of posters, leaflets and messages of positivity. If a patient died at home with staff present it was routine for staff to return to base before going home. This provided emotional support to staff.

## Governance



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

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

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. These were regularly reviewed and improved. There were five sub-committees that met quarterly, each with terms of reference and nominated attendance from trustees and managers. These were care services; workforce, education and research; finance and estates; income generation; and marketing, public and community relations.

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

There was a rolling programme of clinical audit and monitoring in place with action plans. These were reported and monitored by the relevant operational groups and reported to the relevant trustee board governance aspect committee. Outcomes were shared with staff through email, meetings and publications.

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

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

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

There was evidence of regular engagement with other professionals within the health economy to improve care outcomes. For example, discussions with other Staffordshire hospice senior leadership teams to consider how to best approaches to shared issues. There was a planned workshop with Care Governance Trustees, senior clinicians and senior management teams to consider patients of the future which was being facilitated by a professor in the field.

The hospice has a medicines management committee responsible for policy and practice within the hospice.

There was drugs formulary in place to support practice.

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

## **Managing risks, issues and performance**

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

There were robust arrangements for identifying, recording and managing risks, issues and mitigating actions. There was alignment between the recorded risks and what staff say was 'on their worry list'.

Potential risks were considered when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. There was a risk register and a corporate risk register that was reviewed by leadership team and completed quarterly. The trustee board aspect governance committee and board meeting addressed the risk register. The register included risks from across the organisation. New risks were added as they as they occurred, which made the risk register a live document and process. Risks were clearly communicated through the effective governance structures in place and reached the senior staff they needed to. The structures also allowed for the flow of information from board level to frontline staff.



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There were a broad range of policies and procedures that set out the hospice's expectations and approach to safety in key areas such as recruitment, risk assessment and management, medicines management, safeguarding and Mental Capacity Act and Deprivation of Liberty Safeguards. These were accessible electronically by all staff. There was a clinical policy group to ensure these are reviewed in line with best practice, new legislation, national standards or latest guidance.

The care services governance committee played a key role and function in the management of risks within the service. This committee looked at and scrutinised key information about risks within the service and ensured action was taken to mitigate them. An example of this was the regular presentation of incidents at the group including their grading and a summary of the incidents themselves. The committee would look for themes and trends and scrutinise the actions taken to reduce the risk of recurrence.

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

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

## Engagement

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

Staff were engaged and listened to using a variety of methods. For example, there had been a listening in action pilot event where staff views could be used to shape the service. There were staff comments boxes, internal briefs available on YouTube and Yammer a social media platform where staff could exchange views and

support development. The referral process for the Family Support and Bereavement service was reviewed and redesigned following feedback regarding responsiveness and choice.

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

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

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

Clinical teams used patient and family reported outcome measures via questionnaires (Patient/Family Reported Outcome Measures), to access peoples experiences and what could be done differently by the service.

There was a quarterly St Giles Hospice group magazine produced. This included patient experience stories.

St Giles Hospice group engaged well with the public and valued the input provided by volunteers. For example, staff worked with a local children's nursery to dispel myths and encourage them to attend the hospice, which they did.

St Giles Hospice group collaborated effectively with partner organisations. The hospice had joint initiatives with the neighbouring NHS Trust. For example, use of three beds aimed to divert patients from the NHS hospital into beds for a number of agreed interventions.



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St Giles Hospice group was a registered charity and fund raising was crucial to enable the service to continue to provide care to patients. Two thirds of the costs of running the service came from the public. A wide range of events and initiatives were put in place to raise money. This included sponsored events, fairs, raffles and events where those who used the hospice services were remembered. A planned schedule of events was in place for 2019.

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

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

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

## Learning, continuous improvement and innovation

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

The service was committed to learning and improving the service. An example of this was a recent improving inpatient unit processes project review. This review sought to identify and assess improvements that had been made or could be made to improve patient care on one of the wards. There were several streams looked at which included ward rounds and discharge. There were a number of processes which were identified for improvement and to ensure efficiency in the streams. As a result, actions were planned and monitored, and this ensured continuous improvement. Staff were seeing the results of the actions and provided feedback to the project about the positive impact they had experienced.

The service participated in relevant quality improvement initiatives, such as local and national clinical audits. There was an annual audit programme which was

created using tools designed by Hospice UK. Audit outcomes were shared with local teams, the wider multidisciplinary team and care services trustee governance aspect committee and commissioners.

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

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

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

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

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

The service submitted 14 posters for national conferences in 2017 and had nine accepted. In 2018 they submitted five and four were accepted.

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

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

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

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

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



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

The dementia support service had been presented at multiple conferences including the UK Dementia Congress (2017) and Hospice UK conference. The service had also been:

- Highly commended at the Celebration of Innovation Awards (2016) for person centred care innovation.
- Finalist at the 8th Dementia Care Awards (2017) for best dementia training initiative.
- Won best innovation award (2018) at The Great People Awards.

# Outstanding practice and areas for improvement

## Outstanding practice

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

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

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

The range of speciality services at the hospice were exceptional. The services were person centred and could be tailored to meet peoples' complex needs. There were bereavement services and a comprehensive complementary therapy provision that had been extended to those people who required it for extended periods. This was following feedback from patients and people who used the service. There was a day service where people could have refreshments, access activities and spend time with other people who had similar experiences. Local communities, families and schools were engaged in service provision.

## Areas for improvement

### Action the provider **SHOULD** take to improve

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