

Phyllis Tuckwell Memorial Hospice Limited

The Beacon Centre

Inspection report

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Ratings

Overall rating for this service

Outstanding 

Is the service safe?

Good 

Is the service effective?

Good 

Is the service caring?

Outstanding 

Is the service responsive?

Outstanding 

Is the service well-led?

Outstanding 

Summary of findings

Overall summary

This inspection was carried out by one inspector on 16 and 18 January 2017 and was announced to ensure the Hospice at Home staff we needed to speak with would be available.

Phyllis Tuckwell Hospice Care (PTHC), also referred to as 'the hospice' throughout the report, serves the adult population of West Surrey and part of North East Hampshire. Services are provided from two locations; the Hospice in Farnham (In-Patient Unit, Community Services, Day Hospice, Out-Patient appointments and through Patient and Family Support) and at the Beacon Centre in Guildford. This inspection looked at the services provided at the Beacon Centre which included an Outpatient service, Day service; Community team and the Hospice Care at Home Team. In 2014 a joint proposal was submitted by PTHC and another local provider to their four Clinical Commissioning Groups (CCG) to integrate the EOL community services across the area. A new service contract was drawn up and the Beacon Centre was incorporated into PTHC in 2015. The PTHC has a large multi-professional team consisting of medical staff, nurses, social workers, therapists and chaplaincy supported by people facing volunteers.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The Beacon Centre provided an outstanding service that creatively enabled people to have the choice to receive end of life care (EOL) at home, if this was their preference, and responded promptly to clinical deterioration in times of need. People spoke of a service that was tailor-made for them, highly personalised and focussed on their individual needs and that of their families. PTHC had developed their community service innovatively with local agencies to ensure their local population would receive the support they needed at the time they needed it and in a way and place that best suited them.

People, their relatives, staff and professionals spoke overwhelmingly of the positive support, guidance and healthcare interventions people had received. They were full of praise for the staff in terms of their exceptional kindness, compassion and knowledge about end of life matters. Staff went out of their way to ensure people were involved in decisions about their care and used technology creatively to stay in touch with people. The day service used gardening interventions creatively as a therapeutic activity to entwine spirituality with rehabilitative palliative care. People told us this had brought them and their families hope and peace through the rhythms and cycles of life seen within nature and horticulture.

Managers showed outstanding leadership and they recognised, promoted and implemented innovative ways of working in order to provide a high-quality service. This forward thinking approach had resulted in a creative provider led commissioning arrangement to ensure people received high quality integrated community care to support their preference to receive end of their life care at home. The integration of the Beacon Centre into PTHC was managed creatively ensuring staff and people were involved in the

development of the values and vision of the service. Governance of the service was of a high standard and robust quality assurance systems were in place that showed people were right to have confidence in this local hospice.

The hospice offered end of life care training opportunities for their staff and other health and social care professionals. Through this training and other service developments the hospice had enabled people to receive end of life care closer to home and reduced the need for hospital admissions. Staff were involved in the development of working practice, listened to and supported to offer high quality end of life healthcare and support. The management team promoted a culture of openness, reflection and excellence.

People's informed consent was embodied into all work that was undertaken at the hospice and people who did not have capacity to consent to their care and treatment had their rights protected under the Mental Capacity Act (MCA) 2005. The various departments within this hospice worked well together so that people had a seamless experience of moving from one department to another as the need arose.

People were protected from harm and abuse and robust staff recruitment procedures were followed to keep people safe. There were sufficient staff to meet people's individual needs and to respond flexibly to changes and unforeseen emergencies. Systems were effective to manage known risks associated with people's care and treatment needs such as falls, pressure sores, poor nutrition and hospice acquired infections.

Guidance was provided to ensure people were supported to eat and drink sufficiently and adjustments were made to ensure people at risk of choking could eat and drink safely. Regular reviews took place of people's symptoms and changes were made as required to ensure people's pain would be well managed.

The service listened to people, families and staff, involving them in the running and development of the service. They actively sought out their views and used feedback as an opportunity to improve and develop the service. There was a kindness and warmth about the management team that made them approachable to everyone and people knew them by their first names and told us they were visible and solved matters when they were raised.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

People felt safe when supported by staff and staff understood their responsibilities to report abuse.

People's risks to their health and safety had been identified and staff knew how to protect people from the risks associated with their care and treatment.

There were enough suitably skilled staff deployed to meet the needs of people. Recruitment processes for new staff were robust to ensure they were suitable to work with vulnerable people.

The provider had appropriate arrangements in place to safely administer people's medicines when required and staff understood the risks associated with people's medicines.

Is the service effective?

Good ●

The service was effective.

People received effective care, treatment and support from a multi-disciplinary team, who received the training and support they needed to perform their roles. People were supported to manage their pain and breathlessness effectively.

People's rights were respected because staff understood their responsibilities in relation to the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS). Where people lacked mental capacity families and other professionals were consulted when decisions needed to be made about people's care and treatment.

People were appropriately supported and encouraged to eat and drink a balanced diet that met their individual needs, preferences and wishes. Professional advice was sought and followed for people's nutrition where required.

Is the service caring?

Outstanding 

The hospice was exceptionally caring.

People and their families were supported by kind and compassionate staff who went the extra mile to ensure people continued to have life enhancing experiences.

People and their families were involved in planning their care which included what they would like at the end stages of life and staff found innovative and creative ways to ensure people's views were sought.

The hospice focused on people's wellbeing and developed innovative ways to promote quality of life. The occupational therapy lead Social and Therapeutic Horticulture for Palliative Care programme was an outstanding example of how gardening interventions could be used in palliative care to create a sense of optimism, purpose and achievement for people and their families.

Is the service responsive?

Outstanding 

The hospice was outstandingly responsive to the needs of people and their families.

The hospice worked innovatively and in partnership with other agencies to respond to the needs of the people in their local community. For example, the hospice had worked with the ambulance service to share information to ensure when people experienced a significant change in symptoms, which may have necessitated a hospital admission, they would receive support to enable them to remain at home.

Staff had outstanding skills and an excellent understanding of how to support people to lead their lives as they wished when they chose to receive EOL care at home. We heard many examples of how staff supported people in a highly personalised manner regardless of ethnic background or social circumstances.

Complaints investigations were thorough and the hospice used complaints to challenge their practice and improve the service provided for people.

Is the service well-led?

Outstanding 

There was excellent leadership.

The registered manager had developed and sustained a positive culture encouraging staff and people to raise issues of concern with them and to be actively involved in improving the hospice.

The values and aims of the hospice were visible throughout the service and were developed and sustained through creative and innovative methods.

The service worked in partnership with other organisations to make sure they were following current practice and providing a high-quality service. They strived for excellence through consultation and reflective practice. We saw evidence of the hospice sustaining their outstanding practice and improvements over time.

The Beacon Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was carried out by one inspector on 16 and 18 January 2017 and was announced to ensure the Hospice Care at Home staff we needed to speak with would be available. We had not previously inspected the service.

Before the inspection, the provider completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR, previous inspection reports, notifications and all contacts we had about the service. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with five family carers attending the carer support group, four people attending the Social and Therapeutic Horticulture for Palliative Care programme and five people attending the Physiotherapy Exercise Group. We also spoke with one person and three relatives by phone who used the Hospice Care at Home service.

We spoke with the registered manager (who is also the Director of Patient Services), the Hospice Care at Home Services Manager, the Day Services Lead, Clinical Nurse Specialists (CNS) Team Lead, two Clinical Nurse Specialists, a staff nurse, an administrative assistant, a healthcare assistant, HR and Training Manager, three volunteers, a physiotherapist, the Hospice Care at Home Team Lead, Therapy and Day Services Manager, Chief Executive and an occupational therapist. We also spoke with a service commissioner that worked closely with the hospice.

We attended the weekly multi-professional team (MDT) meeting and the weekly case review meeting. We viewed a range of records including five care documents for people who used the service, four personnel files and records relating to the running of the service.

Is the service safe?

Our findings

People and their relatives told us they had no safety concerns when people received support in their own homes or attended the day service. One person told us "I like them, I always feel safe when they are here". They said they would be confident speaking to any member of staff or the registered manager if they had any concerns. Staff and volunteers had completed adult and children safeguarding training as part of their induction and ongoing training. They were able to identify the procedures they needed to follow should they suspect a person in their care had been or was at risk of abuse. The registered manager was aware of their responsibility to report allegations or suspicions of abuse to the local authority and had not needed to report any safeguarding concerns relating to the hospice.

The service was aware of their wider safeguarding responsibility to keep people safe from abuse and discrimination. They had a dedicated safeguarding lead who received and reviewed all safeguarding concerns to ensure they were actioned in accordance with local safeguarding procedures. Staff gave examples of safeguarding alerts they had raised when people had been deemed as being at risk of avoidable harm at home. For example, when people lived alone and refused care, arrangements had been made to prevent self-neglect occurring. Staff had supported safeguarding investigations as required and where able to describe the positive outcomes this had brought for people.

Staff knew how to follow whistleblowing procedures and how to raise concerns anonymously if required. They told us they were confident that any issues they raised would be addressed to keep people safe and to improve the service people received. One staff member told us "I have no doubt if I ever raised any concerns about any of my colleagues that it will be taken seriously and investigated". Staff were also aware of other organisations with which they could share concerns about poor practice or abuse.

Risks to people's safety and staff supporting them had been identified using screening tools, effectively managed and reviewed. These areas of risk included any potential hazards in people's home environment, risks when people were supported by staff to move or transfer, risk of falls, weight loss, choking and the development of pressure ulcers. Staff demonstrated that they knew what action to take to keep people safe in accordance with their care plans.

Records showed staff had alerted the local district nurses when they identified any risks to people's skin breaking down or observed any pressure ulcers. People's skin was then reviewed at each visit. Staff could describe the plans the district nurses had put in place to manage people's wounds and pressure ulcers and how to identify and report further concerns. People who could not change their position independently were provided with air mattresses and air filled cushions to relieve the pressure on their skin. Records showed they had also been supported to reposition regularly to protect their skin from pressure damage. People were supported to understand the risks and encouraged to take preventative action. One relative told us "They will always tell me if her skin looks healthy or if there is anything they are concerned about then they will let the district nurse know or tell me to put more cream".

People at risk of falls had been assessed to ensure appropriate arrangements were put in place so staff and

relatives would know how to support people to mobilise safely. Where needed people were assessed by the hospices physiotherapists and provided with the necessary equipment at home such as grab rails, slide sheets and wheelchairs. This meant their care could be provided safely and they could remain safely independent at home. Staff had received training in safe moving and handling techniques and told us the hospice's physiotherapists would show them how to use any new equipment safely.

People's changing health and fluctuating strength meant their risks could change rapidly. We found risks to people were reviewed continuously to ensure their risk management plans would remain effective. For example, when a person suddenly developed difficulties swallowing that put them at increased risk of choking, staff promptly ensured they received soft food and contacted the district nursing team and their GP for an urgent assessment. Staff were able to describe the correct emergency first aid procedure for responding to choking incidents and knew who were at risk of choking. Staff had a good understanding of people's risks and how to support them to remain safe.

Staff had been required to undertake full pre-employment checks before they were offered employment and could work with people unsupervised. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). Nursing and Midwifery Council (NMC) checks had been completed to ensure health professionals were fit to practice. The provider had used the interview process to demonstrate staff's relevant skills and experience and to support the registered manager to plan the induction for new staff. The provider had taken into account all known risks relating to each candidate's suitability when making recruitment decisions.

There were enough staff to meet people's needs and keep them safe. The provider used a systematic approach to determine how staff were to be deployed on a daily basis. New referrals to the service and the changing needs of people in receipt of a service were reviewed daily. This ensured that the available staff would be allocated to people with the highest need and risks. One relative told us "They always let us know if they are coming and are very reliable. We do understand though that if there is a referral with a higher need we might only get a visit the next day and another agency would visit instead". Systems were in place to ensure where the hospice could not provide a home visit other care agencies or the district nurses would provide a service to ensure people received the care they required.

People's prescribed medicines were predominantly administered by the district nurses at home. Staff had received medicines administration training and occasionally administered people's medicines when directed to do so by the district nurses. The district nurse team held the responsibility for community medication administration and worked in the knowledge that all providers were following the community protocol for medication administration. The service kept minimal emergency medicine on site if required. We saw this was stored securely and in accordance with manufacturer's guidelines. This meant the risk of people's prescribed medicines being inappropriately used was reduced. Staff understood the risks associated with some medicines for example opiates and oxygen. One nurse described how they had identified opiate toxicity in one person and took the appropriate action to ensure they received the required medical treatment to remain safe. Opiates are strong pain medicines which can cause significant side-effects if too high a dose is taken. People received their medicines safely as prescribed.

Is the service effective?

Our findings

People told us they received high quality care from skilled staff. Comments received included "They really know when I am not doing well and they will organise for me to see the doctor" and "They are all very knowledgeable and can always explain my symptoms to me or answer my questions". One relative told us "They are the best of all the professionals that visit us, my only regret is that we did not contact them earlier". Staff gave us positive feedback about the skills and knowledge of the staff they worked with. Care staff told us the nurses were confident in making clinical decisions and always gave them support. One care worker told us "The nurses are very approachable if I have any questions or concerns they will always help and explain things to me. I have learned a lot from them".

Staff had the skills and knowledge to meet people's needs. Care staff had undergone an induction programme that met the requirements of the Care Certificate standards. The Care Certificate standards are nationally recognised standards of care which care staff need to meet before they can safely work unsupervised. There was an induction programme for newly appointed nurses and the provider had developed a competency framework for the nursing and care team to evidence staff had all of the skills needed to meet the needs of people. All new volunteers were provided with an orientation programme and mandatory training.

Staff were complimentary of the training opportunities they were provided. Their comments included "We always get the opportunity to attend training", "I had a very good induction with a lot of opportunity to develop my confidence" and "There is always in-house training or discussion groups going on and we also get to reflect on complex cases to learn how we can do things better next time". A programme of ongoing training for care and clinical staff covered health and safety related topics and also topics relevant to the support needs of the people at the end of their life.

The hospice also contributed to developing the EOL knowledge and skills of the community health professionals they worked with. For example training had been provided to the ambulance team to support them to identify people's symptoms at end of life and raise awareness of advance care planning which enables people to plan to receive their EOL care at home. The hospice also provided the district nursing team with syringe driver training so that people would receive consistent care from the hospice and the district nurses.

Nursing staff described good support for professional development. This included an active professional development team who supported staff with training and organised in-house education initiatives. Nurses are required by their regulatory body to have their practice re-validated every three years and nurses told us they had been supported to ensure they would be assessed and their NMC revalidation dates identified.

Staff told us they felt supported in their role and there were a variety of methods for keeping staff informed and updated of changes in practice. These included monthly staff meetings, regular supervision sessions and an annual appraisal. Staff told us and records confirmed, supervision had been taking place regularly and their supervision gave them the opportunity to reflect on their practice, to identify their training needs

and to contribute to the improvement of the service.

Some people did not have the mental capacity to independently make decisions about their care arrangements. Staff had undertaken training on the Mental Capacity Act (MCA) 2005. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lacked mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

Staff showed a good understanding of the MCA and were able to tell us about their responsibilities under the MCA. They could describe how they sought consent before carrying out care tasks and explaining the procedures they were about to carry out, for example when asking people if they wanted any pain relief. One member of staff told us, "You have to assume capacity, but people's capacity can change from visit to visit. So at every visit you assess their capacity and if you have any concerns then you make a decision in their best interest. For example, if they cannot agree to receiving personal care you might decide to deliver it in their best interest if your assessment shows they lack capacity on that visit". Staff told us how people's capacity to consent to their care, could at times fluctuate when they were in pain or taking medicine which made them drowsy. They could describe how they would ensure when people had to make important decisions about their care, that discussions would take place at a time when people were best able to understand the information.

All staff were responsible for undertaking mental capacity assessments when people were deemed to lack the mental capacity to make decisions about their care and treatment. They had received relevant training and records showed they had a good understanding of the legal process and the documentation they needed to complete. Staff had encouraged people to make decisions about their care, treatment and preferred place of death whilst they still had the mental capacity to make these decisions independently. For example, one person's swallowing ability was deteriorating. After assessment by the community speech and language therapist and dietician, the nurses discussed the option of inserting a feeding tube directly into the person's stomach. This would provide nutrition if in future they couldn't get enough food or liquids by mouth and is called a percutaneous endoscopic gastrostomy (PEG). Through full discussion and demonstration to the person of what the PEG would involve the person was supported to make an important decisions about their future care while they still had the mental capacity to do so.

Staff promoted the importance of good nutrition and hydration. People were given advice in relation to healthy eating and drinking at home and at the day service. Staff occasionally supported people with meal preparation and to eat. Some people who used the service had a reduced appetite or difficulty eating and drinking. Where concerns were identified with people's nutrition, relevant health care professionals were consulted and staff followed their advice and instructions where required. Staff could describe how the supported people whose swallowing had diminished by encouraging small spoonful's of food and ensuring food was of the correct thickness to prevent choking.

Staff monitored people's health and wellbeing at each visit and when they came to the day centre. Changes in people's health were identified promptly and records showed staff alerted the district nursing team, GP's or the hospice's palliative consultant when for example, concerns relating to people's skin, pain management, swallowing or mobility had been identified. Where people lived with chronic respiratory conditions staff monitored their general wellbeing and were prompt to discuss any increased breathlessness with the local respiratory team. One nurse told us "I recently realised one person was using their oxygen more often and was generally looking more frail so I supported them to make an appointment

with their GP and the respiratory nurse". Staff were familiar with people's pain management plans and nurses would prescribe additional pain relief if required at short notice. A representative of the local district nursing team would also attend case review meetings, if required. This ensured any changes in people's health were discussed and shared management plans agreed to ensure people would receive the support they needed to manage their symptoms and pain.

Is the service caring?

Our findings

People valued their relationships with staff and felt that they often went 'the extra mile' for them, when providing care and support. As a result they felt really cared for and that they mattered. One relative told us "I do not think I would still be here if it was not for them. The support, kindness and care they have shown me are the main reason why I can still look after my [loved one] at home. Another bereaved relative said "I never thought I would survive [my loved one's] death but they have been brilliant! They regularly call me, intuitively know if I am not doing well and gave me all the advice I needed at the end". People and relatives spoke overwhelmingly of the trust they had in staff and the comfort and peace of mind that gave them. One person told us "It is such a relief to know that they are highly skilled. If they say I don't need to worry about a symptom then I know I can believe it I do not have to phone my GP to check if it is true". Another person said "I know when they say I need to get to my GP that I can trust they would not alarm me but need me to check things out".

We heard numerous exceptional examples of staff having an in-depth appreciation of people's individual needs around the end of their lives or preferred place of death and how staff went out of their way to honour people's wishes. This was evident in staff caring for people's pets when they were too frail to do so, staying with people hours after their shift ended till they were safe, ensured they had received the religious rituals they requested out-of hours, stayed longer so that people did not die alone and till distressed relatives had found some comfort. Staff had arranged weddings and special trips for people and their families so that they could achieve their 'bucket lists' and fulfil their dying wishes. Family support was seen as key to people's wellbeing and the needs of people's families were also supported.

The hospice had a strong, visible person-centred culture and was exceptional at helping people to express their views so that those involved in their care and treatment understood things from their point of view. We heard outstanding examples of staff supporting people who could not easily express themselves because of their dementia, learning disability, language barriers or speech difficulties to make their views known and involve those who knew them well to advocate on their behalf. This had involved numerous meetings with people, their families, and health and care staff and using technology to assist the decision making process. For example, one person was supported to source a larger stylus so that they could more easily type their views, other's families lived abroad and were involved in decision via telephone or video link.

The hospice was also trialling SpeakSet; this provided a video connection from the hospice to a person's TV in their own home. One nurse told us "We are using this for people who live some distance from the hospice and might not require a daily visit. But we need to monitor their condition and they might not be able to use the phone. The video is ideal for this and we can see them daily and they can see us which makes communication easier. We can then make a better judgement whether we need to make a home visit". This technology empowered people to live independently at home and to inform decisions about their EOL care.

The hospice focused on people's wellbeing and developed innovative ways to promote quality of life. The occupational therapy led Social and Therapeutic Horticulture for Palliative Care programme was an outstanding example of how gardening interventions could be used in palliative care to create a sense of

optimism, purpose and achievement for people and their families. We heard many examples of how this activity had been personalised and had supported people to prepare for death, entwining spirituality with rehabilitative palliative care and bringing hope and peace through the rhythms and cycles of life seen within nature and horticulture. People told us how much they enjoyed the programme and valued the opportunity to "still learn and do stuff". One person said "It is brilliant and the homework means I spend time just being in the garden with my family or doing my 'Sowing Seeds at Home' activity. Everything they give us grows quickly so you can enjoy it with your family". Some people were making plant gifts for their family members to leave as a legacy. The occupational therapist told us "Each plant gift is personal, either filled with plants that the family member likes or those that will remind them of the person". People were also guided through visualisation and memory work to develop a route to nature that they could access in future if they were to become too frail to access their garden. The hospice used activities creatively to enhance people's wellbeing and spirituality at the end of their life.

People told us staff treated them with dignity and respect. They told us staff adhered to standards which promoted dignity and respect when delivering personal care in people's homes. In the day service we observed staff asking for people's consent before supporting them and waited for people to respond before proceeding. Staff took time to listen and did not leave the person until they were comfortable and settled. For a person who was feeling unwell, staff demonstrated an understanding of the symptoms they were experiencing, providing reassurance and comfort. We heard many examples of how staff worked sensitively with people as they became increasingly frail and required more support to maintain their personal care to ensure their dignity was maintained.

Is the service responsive?

Our findings

People, relatives, staff and professionals working closely with the hospice told us people received a service that was outstandingly responsive to their needs and wishes. One person told us "Staff really understand me. They know what scares me and how to motivate me; they are the reason I come to the exercise group and push myself to get stronger. I would never have had the confidence to do this in a gym". A relative said "They just get me. They can always see when I am having a bad day and when I am worried about my loved one. They know caring for them is the most important thing for me and will offer support and advice if I am worried".

Staff had an excellent understanding of people's social and cultural diversity, values and beliefs that may influence their decisions on how they wanted to receive care, treatment and support. They listened to what was important to people and their family and understood how each person defined what a 'normal' life was from their individual perspective. The service was flexible and found creative ways to enable people to live as full a life as possible at home in the last weeks of their life. For example; it was important to one person's adult children to provide care for their parent in their home at the end of their life according to their cultural tradition. Additional care was provided to support the family to continue caring as they had wished. Another person's sense of value was strongly defined by their role as homemaker; as they became increasingly frail staff adjusted their support and provided practical assistance to enable this person to continue maintaining their personal appearance and fulfil their role at home for as long as possible. Staff had outstanding skills and an excellent understanding of how to support people to lead their lives as they wished when they chose to receive EOL care at home regardless of ethnic background or social circumstances.

The hospice was outstandingly responsive to the needs of their community. The provider continuously reviewed the needs of their local population and developed services in partnership with for example; the NHS England Area Team, local district nursing team and Clinical Commissioning Group (CCG) to better respond to the needs of their local population. This had ensured people promptly receive the care they needed to be able to remain at home at the end of their life. For example, several of the hospice's Community Specialist Nurses (CNS) had been trained to prescribe medicines in agreement with the local GP practices. This meant when people required additional medicines at short notice to manage unanticipated symptoms and distress at the end of their life this could be prescribed and immediately administered by the CNS. We heard examples of how this had supported people to have a pain free death and prevented their admission to hospital.

The provider had developed an arrangement with the local ambulance service that enabled hospice staff to enter information about people's EOL symptom/pain management plan, their mental capacity to make treatment decisions and their EOL wishes in the ambulance's database. This meant when the ambulance was called to people's homes they had information available to inform their treatment plan and to manage people's symptoms at home where possible. We heard of several examples where the information shared with the ambulance staff for example in relation to people's oxygen use and anticipatory medicine plan had enabled the ambulance staff to provide support so that people could die at home with their relatives as they had wished.

Hospice senior staff had been given the right to authorise equipment from the community equipment store which meant people had the necessary equipment promptly available to them when needed so that they could remain at home. We heard examples where specialist beds had been delivered to people's homes at short notice and staff had remained after hours to ensure people were settled and understood how to use their equipment safely. The hospice worked closely with their Nepalese community and had hosted events to support people and their relatives to understand the work the hospice did. We heard examples of how staff's understanding of this community had enabled people to accept support that was in accordance with their cultural values. Joint working had ensured people had received care and support at home when they needed it so that their wish to die at home could be fulfilled.

The Department of Health's End of Life Care Strategy (2008) recommends provision of 24/7 care that is easily accessed and responds quickly to all end of life care patients regardless of where they are cared for. It states provision of such care can avoid unnecessary hospital admission and enable more people to die in their place of choice. The provider had developed their Hospice Care at Home and community service with two other local providers to ensure where required, there was a rapid response to people's changing care needs and advice on care and support was available round the clock. The provider's evaluation of these services demonstrated that the vast majority of people had been able to achieve their preferred place of care and death. Working protocols between the three services ensured exceptional handover of information between day and night staff which had enabled people to receive rapid support during the night and over weekends when their condition suddenly deteriorated to enable them to die at home.

The hospice worked pro-actively with their local acute hospital to ensure people who wanted and could safely receive EOL care at home were identified promptly and transferred from hospital without delay. A hospice representative attended two-weekly fast track meetings to identify people appropriate for EOL care at home. They were also trialling weekly meetings with the hospital's discharge co-ordinator to see if this would further enable people to be discharged more promptly. The hospice had also supported with the joint review of the rapid hospital discharge guidelines and communication form so that all agencies worked to the same guidelines to prevent people's discharge for hospital being delayed unnecessarily.

People's care were planned and delivered to meet their health, social, emotional and spiritual needs. People received holistic care because staff understood the importance of working together as a team to provide seamless care for people. Weekly multi-disciplinary team (MDT) meetings were attended by medical and nursing staff, therapy staff, social workers and the chaplain. Comprehensive discussions took place about the care of each person and of close family members. A future plan of care was agreed which reflected people's views about how they wished to receive their end of life care and support. Multi-disciplinary decisions made about changes in people's care and pain management were appropriately documented in people's care records. People told us they had been involved in planning their care and they were satisfied that the service they received met their needs.

People and relatives told us they would feel comfortable raising concerns with staff if they had any. The provider's complaints process was available to people and their representatives. One relative told us "I have never had any concerns but if anything bothered me I will talk to the nurse". One person told us "No concerns at all, they are always asking for feedback and I have no doubt they will go out of their way to fix things if I ever had any concerns".

The registered manager told us they had received six complaints in the past 15 months. There was a process for ensuring people's complaints and concerns were logged, investigated and responded to. The registered manager told us that they had analysed the themes of the complaints and concerns received and used this information to improve the service. For example, they had realised people at times raised concerns because

they were not clear about the role of the hospice and which agency to contact for advice. They told us "We made sure people have information in their home about all the different services involved with their care and make sure before we leave they know who to contact especially after hours". People's complaints had been dealt with in accordance with the provider's policy and action taken as a result was used as an opportunity to improve the service for people.

Is the service well-led?

Our findings

Managers showed outstanding leadership and they recognised, promoted and implemented innovative ways of working in order to provide a high-quality service. In 2014 a joint proposal was submitted by PTHC and another local provider to their four Clinical Commissioning Groups (CCG) to integrate the EOL community services across the area. A new service contract was drawn up and the Beacon Centre was incorporated into PTHC. This provider driven, collaborative contracting reflected the vision, values and trust between these parties. It reflected risk sharing arrangements proportionate to the charitable status of the PTHC. The agreement was clear and easy to understand therefore making best use of resources by reducing the need for costly external legal advice.

The new delivery model created increased flexibility and a coherent EOL community service for people. For example, a single point of contact was created streamlining referrals which ensured people received an integrated service appropriate to their needs more promptly. Effectiveness was enhanced by creating systems which enabling people's care plans and notes to be shared between providers, providers shared training, working protocols and governance arrangements so that people received a coherent service of consistent quality when they received care from the different parties. Staff told us they were clear of their roles and responsibilities in the new model. People and relatives described the impact of this new model in terms of the satisfaction they experience with the service. One person told us "It is so much better now. It is like a one stop shop, you come in and see everyone you need to and it gives me peace of mind". A relative told us "They organised everything and it went without any problems from the equipment to the night carers and the GP and district nurses were all up to date the whole time". The provider was forward thinking and worked creatively with providers and the local commissioners to ensure people received high quality integrated community care to support their preference to receive end of their life care at home.

Prior to transitioning across to Phyllis Tuckwell the Beacon Centre was known as The Beacon Community Palliative Care Service. The provider implemented a highly successful and innovative change programme to integrate the Beacon Centre in Guildford and their inpatient unit in Farnham into a single seamless service. Through their change programme they had created a shared vision, values and working culture across both sites and raised their profile in the local community. This was done through the creation of new service values with the input from existing staff and staff who transferred when PTHC acquired the Beacon Centre. The Chief Executive told us "The challenge was to bring two separate services together and we soon saw what we shared were the same vision, values and commitment to the people using the service. We then knew that the way to bring us all together was under the same values and we did a lot of work with staff, really finding out what their work values were and the ones we decided on really reflect the whole staff team's views".

Staff and people had high praise for the managers of the service. One person told us "They have created a very positive place. Staff seem happy and everything is well organised. One staff member told us "I have never worked in such a well-managed service. The managers know what is happening with staff, they reflect on what we do and are always looking at ways we can improve things". Staff told us they had been encouraged to share their views during the change programme and had contributed to the new service

model. One nurse told us "There were many meetings with all of us, although the change was difficult, it was clear they wanted it to work for us and listened to our concerns and suggestions".

The provider changed their name from Phyllis Tuckwell Hospice to Phyllis Tuckwell Hospice Care to further reflect the increased focus on community provision. This change was communicated through the local radio and press. The provider also commissioned a creative independent study to determine the clearest terminology to use for describing the work PTHC did. This study was carried out with community stakeholders and including interviews with local GPs, staff, volunteers, family carers, people using the service, interviews and questionnaires to the general public. We saw the provider had taken account of people's feedback and the study's recommendations. They had described their service in terms of the community's suggestions which were 'PTHC provides supportive and end of life care for patients and families living with terminal illness'. We saw this definition was used throughout the service and in the hospice's literature. Through this creative re-branding which allowed the community, professionals, people and staff to engage with the aims and values of the service; the provider had created a joint vision and integrated service with a strong local profile which was evident from all we spoke with.

The hospice found innovative ways of working with local services to implement national good practice guidelines. This included working with other providers and commissioners to support young people to transition from children's services to accessing adult hospice support. Supporting local care homes and nursing homes to develop their skills and knowledge so that people could receive EOL care in these services and not be admitted to hospital unnecessarily. The hospice worked with other agencies to develop a local working protocol for people who might find themselves homeless at the end of their life to ensure they would have equal access to quality EOL care. The provider had taken account of Hospice UK's guidance in relation to developing a rehabilitative approach to palliative care to which empowers people to actively manage their care, live fully and enjoy the best quality of life possible. PTHC's rehabilitative approach was evident in their Social and Therapeutic Horticulture for Palliative Care project. They facilitated people's earlier discharge from hospitals and worked with other agencies to reduce the need for hospital admissions. PTHC had developed and improved their community services in accordance with national good practice guidelines to ensure people received a high-quality service.

The registered manager understood the improvements that needed to be made across the hospice community services. The provider had an array of systems for auditing and reporting to ensure a high quality service delivery. This included, but not limited to, patient safety and quality, medicines management, reports to the board of trustees and PTHC's quality governance and risk committees. We had sight of a range of governance reports which demonstrated how the service was scrutinised and how safety was being monitored and reported effectively. This showed a transparent organisation that had clear links of accountability from the 'floor to the board'. Information on matters such as infection control, falls prevention, medicines incidents, staff recruitment/competencies, complaint management, safeguarding and finances were known about by those responsible and accountable within the organisation. Effective methods of communication were in place as well as systems to address any matters arising. For example, we saw the registered manager took prompt action to improve staff lone working arrangements when they identified a risk to staff's safety. In addition we saw the hospice monitored the quality of experience of people and their families with a variety of feedback methods.

The safety and wellbeing of staff was considered and monitored. For example, due to the nature of this service staff may work in own homes on their own which may place them at risk of unforeseen events. Lone working was well managed, the hospice had a policy and procedure in place all staff knew and we saw evidence of it being regularly reviewed. The provider had recently introduced an electronic lone worker safety system that gave staff a pendant alarm linked to an external call centre 24/7, which enabled them to

be remotely monitored or to press the alarm if they were in danger. The call centre had a process for alerting the PTHC managers if this happened so that action could be taken to ensure staff's safety. Staff also had the necessary emergency contact details at hand. This was good practice to ensure all staff returned safely from any visit within the community.