

Princess Alice Hospice

Princess Alice Hospice

Inspection report

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

Ratings

Overall rating for this location

Outstanding 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Outstanding 

Are services responsive to people's needs?

Outstanding 

Are services well-led?

Outstanding 

Summary of findings

Overall summary

Our rating of this service stayed the same. We rated it as outstanding because:

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

Summary of findings

Our judgements about each of the main services

Service

Hospice services for adults

Rating

Outstanding



Summary of each main service

Princess Alice Hospice provides inpatient, outpatient and community hospice services. We rated it outstanding because care was safe, effective, caring, responsive, and well led.

Summary of findings

Contents

Summary of this inspection

Background to Princess Alice Hospice

Page

5

Information about Princess Alice Hospice

5

Our findings from this inspection

Overview of ratings

7

Our findings by main service

8

Summary of this inspection

Background to Princess Alice Hospice

Princess Alice Hospice provides palliative and end of life care on an inpatient and community basis. The inpatient unit has 24 beds, most of which are in private en-suite rooms. Community services include hospice at home, wellbeing care, and outpatients services based at the location.

The provider is a registered charity and provides services funded from a variety of sources, including fundraising activities. The service provides care to patients living in Surrey, south west London and Middlesex.

The service operates in a complex local health economy that incorporates four clinical commissioning groups (CCGs) and two integrated care systems (ICSs).

The provider has a significant learning, teaching and research remit and works regionally, nationally, and internationally to increase awareness and knowledge of hospice care.

From April 2021 to October 2021, the service received 1,532 referrals. Of these, 62% were made by a hospital team and 33% were made by a GP. Care homes, other hospices, and other or unknown sources of referral accounted for 5% of referrals.

We last inspected Princess Alice Hospice in September 2016. The inspection was led by an Adult Social Care inspection team using methodology that has since been updated. Our latest inspection was carried out by a Hospitals inspection team using new criteria and guidance to help us identify outstanding practice.

How we carried out this inspection

We carried out an inspection using our comprehensive methodology on 11 November 2021 and 6 December 2021. We gave the service short notice of the inspection. Our inspection team consisted of a lead CQC inspector, a CQC inspector from our medicines optimisation team, and two clinical specialist advisors. We carried out a number of remote interviews after the inspection.

We undertook this inspection as part of a random selection of services rated Good and Outstanding to test the reliability of our new monitoring approach.

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

Outstanding practice

We found the following outstanding practice:

- The service operated a compassionate neighbours scheme whereby volunteers were trained to offer friendship and listening space for people who are isolated or lonely. The team facilitated safe spaces to talk about death and dying.

Summary of this inspection

- Staff continued to deliver care to patients' loved ones after they died. The wellbeing, community engagement, and wider teams delivered targeted support for those who had been bereaved. Staff implemented bespoke support programmes in response to people's needs.
- There was a tangible sense of flexibility and adaptability amongst staff to meet people's needs and requests that exceeded what would usually be expected.
- The hospice at home team tailored their services to individual needs, often at short notice and beyond the remit of the team. This included staying late with relatives or carers when a patient died at home and there were delays in reaching the out of hours doctor and undertakers.
- The hospice team had delivered a summer school in 2020 for young people aged 16-19. This aimed to attract future healthcare talent to the palliative care and end of life care sectors through de-stigmatisation of the specialty and raising awareness of its work. As part of the summer school, the hospice supported students to complete a level 2 award in awareness of end of life care.
- Staff were empowered to explore and pilot new approaches to care, including emerging technology such as artificial intelligence and virtual reality.

Areas for improvement

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

We told the service it SHOULD:

- The service should ensure staff report medicines incidents, including for Controlled Drug incidents, quickly (Regulation 12).
- The service should ensure documentation relating to medicines consistently includes reasons for non-administration, the sequence of medicines to administer, and guidance for staff on manufacturer's instructions, such as for the use of patches (Regulation 12).
- The service should ensure medicines reconciliation is carried out and documented consistently (Regulation 12). These three areas are required as part of Regulation 12 on management of medicines, but we considered that it would be disproportionate to result in a judgement of a breach of the regulation overall at the location.
- The service should consider the workload of all staff to understand their worries about burning out and reduction in service capacity.

Our findings

Overview of ratings

Our ratings for this location are:

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



Hospice services for adults

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

Are Hospice services for adults safe?

Good



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

Mandatory training

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

Staff received and kept up to date with their mandatory training. At the time of our inspection, 87% of staff were up to date with mandatory training. Modules included infection control, safeguarding, moving and handling, and fire safety.

The mandatory training was comprehensive and met the needs of patients and staff. Staff told us standards of training were excellent and they were pleased face to face training had resumed following pandemic restrictions.

Managers monitored mandatory training and alerted staff when they needed to update their training. The senior management team audited and reviewed this information quarterly.

Staff reviewed the relevance and content of mandatory training regularly to ensure it remained effective and up to date. For example, the health and safety team had restructured training to reduce the focus on law and increase the relevance to daily practice in the hospice.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. All staff were trained to safeguarding adults and children level 2 as a minimum and clinical staff were trained to level 3 as a minimum.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Safeguarding incidents were relatively common given the nature of the service and the vulnerability of many patients. Staff used case studies and scenarios to ensure they remained vigilant and aware.



Hospice services for adults

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff had training to recognise patients at risk of self-harm, self-neglect or suicide and discussed how they would respond in such scenarios. The community team had undertaken additional training to support patients who wished to voluntarily end their life when they were distressed and experiencing pain. They worked with them to manage symptoms and liaised with local safeguarding teams for enhanced support.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. A safeguarding lead was in post and staff knew how and when to contact them. Community staff worked on a 24-hour basis and they maintained an up to date record of location-specific contacts in order to make urgent out of hours referrals.

Staff worked to a safeguarding policy that was up to date and regularly reviewed. The policy was based on 10 specific guidance documents and laws, such as the Human Rights Act, and focused on empowering people to seek support and help.

The safeguarding lead provided case studies and training across the organisation to help them identify how to identify areas of concern or people at risk. This reflected good practice for non-clinical staff who spent time around patients but did not have prolonged periods of direct contact. Volunteers undertook training specific to their roles and in recognition of the time they spent with patients who were often highly vulnerable.

There was an open culture about safeguarding in the service. Posters were displayed around the hospice and staff openly discussed learning opportunities.

The safeguarding lead facilitated regular safeguarding forums. These were open to the whole hospice team and staff in diverse roles and they encouraged staff to join as part of an approach to embed wider understanding of how safeguarding matters influence care planning and delivery. Staff provided positive feedback about the forums and a consistent theme was that non-patient facing staff felt it provided them with a new perspective on cultural issues that can affect care.

There was evidence of learning from safeguarding incidents. For example, the service investigated and implemented new assessment protocols for patients who had experienced changes to their cognition, including where they experienced uncontrolled behaviour changes.

Cleanliness, infection control and hygiene

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

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. All clinical areas were compliant with the Department of Health and Social Care Health Building Notice (HBN) 00/10 in relation to reducing the risk of contamination and infection.

A dedicated housekeeping team were responsible for cleanliness in the hospice and were supported by an infection prevention and control (IPC) lead. Staff had undertaken enhanced IPC training that enabled them to safely work in the inpatient unit (IPU), including around patients who had tested positive for COVID-19.

Cleaning records were up-to-date and showed staff cleaned all areas regularly. A sample of cleaning records for 14 areas, including clinical and public areas, showed cleaning had been completed consistently.



Hospice services for adults

Staff followed infection control principles including the use of personal protective equipment (PPE). Alcohol hand gel was readily available in all areas. Staff adhered to the provider's bare below the elbows policy in clinical areas.

Disposable privacy curtains in consulting and treatment areas were labelled with expiry dates and all the curtains were within their safe use date. Staff adhered to the aseptic non-touch technique (ANTT) in the IPU in line with the National Institute for Health and Clinical Excellence (NICE) guidance.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Contractors adhered to local IPC safe working practices.

The service had implemented a range of measures to reduce the risk of COVID-19 infection. A risk assessment was in place and the deputy director for health and safety updated this whenever local or national guidance changed. Volunteers proactively engaged with visitors to support them to adhere to the current rules.

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

Environment and equipment

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

The design of the environment followed national guidance.

Protocols were in place to manage risks such as Legionella in line with Health and Safety Executive (HSE) guidance.

Staff had access to evacuation routes and emergency equipment. All areas of maintenance and safety had an associated protocol and checklist, and staff showed a good knowledge of these. A new member of the health and safety team was updating risk assessments and risk protocols across the hospice.

Inpatient bedrooms and consulting areas were fitted with call bells. Staff responded quickly to bells and ensured patients could reach them at all times.

Staff carried out scheduled safety checks of specialist equipment. Staff documented a range of safety checks on emergency equipment, including the resuscitation equipment and automatic emergency defibrillator (AED). These items were located in the IPU. Checks included daily, weekly, monthly, and annual audits to ensure equipment, consumables and guidance were up to date. The senior team had updated printed guidance on the use of emergency equipment with the Resuscitation Council UK's August 2020 amendments to provide life-saving treatment during the Covid-19 pandemic.

Emergency oxygen was available in the IPU. Staff documented daily checks on oxygen cylinders to ensure they were stored in line with national guidance and maintained at a minimum volume.

The service had suitable facilities to meet the needs of patients' carers and families. All areas of the hospice were accessible by wheelchair. Waiting rooms were spacious and well equipped and garden and nature reserve areas were well maintained. Two lifts connected the day hospice on the first floor with the ground floor and car park. Staff had implemented a one-way system of movement for patients who needed to use the lifts to reduce the risk of COVID-19 cross-infection.



Hospice services for adults

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

Staff completed practical fire safety and evacuation training that included the use of support equipment such as evacuation chairs. A fire warden was always on duty and was responsible for coordinating an evacuation. Staff in the IPU completed evacuation training appropriate for patients who could not walk and who may be sedated or unable to understand instructions.

The service had enough suitable equipment to safely care for patients. Allied health professionals used specialist equipment to support treatment, including in patient's own home through the hospice at home service. Maintenance was planned in advance and in line with manufacturer guidance. Team leaders managed contingency plans for equipment failure and community staff worked with continuing healthcare (CHC) providers to procure equipment for patients at short notice.

Safe practices were embedded in all aspects of the hospice operation. Staff were encouraged to engage with site-wide safety strategies and the senior team sought participation from staff representative of all departments. For example, there were 10 fire marshals, 10 health and safety representatives, and 16 mental health first aiders in the hospice. Staff in these groups undertook enhanced training. Fire marshals undertook training based on case studies of how people react to evacuations when being care for as inpatients to help support safety in the IPU.

A head of operations was responsible for front of house services, gardening, facilities, and housekeeping. They carried out a series of risk assessment that enabled volunteers to return to the hospice safely following pandemic lockdowns. The head of operations had worked with the IPC lead nurse to deliver FFP3 mask fit-testing training to the housekeeping team. Along with risk assessments, this enabled the team to safely clean and sanitise clinical areas used to care for patients infected with COVID-19.

Assessing and responding to patient risk

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

Staff responded promptly to any sudden deterioration in a patient's health. They used the national early warning scores (NEWS) system to identify deterioration in medical condition. The NEWS tool enabled all clinical staff responsible for care to observe changes and deterioration.

Staff used a range of individual risk assessments with patients. These included a falls risk assessment and an occupational therapy risk assessment. This approach helped to minimise risks of injury or harm to patients during their treatment and care. The community team tailored risk assessments to patients' home environments, which helped to ensure care was delivered safely. This also protected staff from harm, such as by assessing risk from pets or health and safety hazards in the home. Risk assessments were evidence-based. For example, risk assessments for falls followed NICE clinical guidance 161 relating to the prevention of falls in older people. Staff on the IPU had introduced the SBAR ('situation, background, assessment, recommendation') tool as part of the standard portfolio of risk management for patient admission.

The service had access to a clinical psychologist, mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. Staff understood how to initiate this process and clinicians understood how



Hospice services for adults

to escalate mental health care in the case of an acute crisis, including out of hours. Staff could access emergency mental health support 24 hours a day seven days a week for patients with mental health problems, learning disabilities and dementia. Clinical staff referred patients to external providers for psychology support where they found they were not coping with their treatment or where they noted acute distress or crisis.

Staff shared key information to keep patients safe when handing over their care to others. Staff on the IPU carried out handovers three times daily. Multidisciplinary staff attended these where needed. For example, social workers and allied health professionals attended to support discharge planning. Community teams carried out handovers at each change of shift. They invited staff from other services to attend where this would lead to improved patient care, reflecting the complex health landscape in which palliative and end of life care was delivered.

All staff were trained in basic life support (BLS), which included resuscitation, and all clinical staff were trained in immediate life support (ILS). The IPU was equipped with emergency medical equipment including for airway management, oxygen, intubation, and resuscitation. Staff maintained an accurate and up to date record of each patient's wishes regarding resuscitation given the nature of the service.

Three senior nurses led a triage service. This was the first point of contact for referrers and meant patients were appropriately assessed to identify if the hospice could meet their needs. The triage team coordinated contact with consultants, allied health professionals, and social workers to establish the most appropriate care pathway for each patient.

Staffing

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

The service had enough clinical and support staff to keep patients safe. Five palliative medicine consultants, including the medical director, were in post and they were supported by three consultants who worked under practising privileges. Two palliative medicine registrars, two palliative medicine specialty doctors, three GP trainees and four junior doctors completed the medical team. The service had a good skill mix of medical staff on each shift and reviewed this regularly. All doctors had a named clinical and educational supervisor.

Consultants led weekly ward rounds in the inpatient unit (IPU). This included a holistic symptom assessment and review of medication including pain management. The ward medical team supplemented ward rounds with daily reviews when patient's needs changed.

There was dedicated consultant support allocated each day to both the community team and IPU to review patients with complex symptoms and new admissions. Clinical staff led daily board rounds on days without a consultant ward round. Consultants supported junior doctors to discuss patients they had reviewed, which helped to ensure clear management plans were in place.

We received mixed information about support of doctors. Some doctors told us they felt supported while others told us about late finish times and the provider responded that there were no reports regarding excessive hours. Some doctors said they felt appropriately supported. They spoke positively about the training opportunities open to them and the usefulness of clinical time with consultants. However, other doctors noted they often finished work late because of a culture of over-reliance on clinicians in the clinical delivery of care. They told us this was reflective of the quantity and pace of work and staff described tension between the overwhelmingly positive feedback and achievements of the



Hospice services for adults

hospice and their capacity to deliver such outcomes. After our inspection the provider noted there had been no exception reports submitted by junior doctors in the previous two years and that the service fully complied with working time rules for specialty trainee doctors. The provider supplied a wide range of evidence of their approach to supporting staff wellbeing. We were unable to establish why the provider was unaware of the feelings of some doctors or why they had not raised this issue with the senior team.

A typical shift on the IPU included a nurse in charge, two doctors, a senior staff nurse, staff nurses, HCAs, therapists and social workers. Staff said this structure worked well.

The senior team reviewed the establishment for clinical and non-clinical roles annually to benchmark against vacancies and patient needs. At the time of our inspection the clinical establishment was 119 full time equivalent (FTE) hours of clinician cover and 79 hours of non-clinical cover per week. Vacancy rates were typically stable with three FTE hours of non-clinical roles uncovered and 19 hours of clinical roles uncovered. Both were similar to the average for the previous two years.

Six services provided hospice care. This structure consisted of a clinical team, a medical team, a wellbeing team, a therapies team, a hospice at home team, and an IPU team. A diverse range of professionals made up each team. For example, 45 FTE staff delivered the hospice at home service including 12 community clinical nurse specialists (CNSs), two rapid response CNSs, four staff nurses and seven nurse specialists. Senior healthcare assistants (SHCAs) and specialist therapists were also part of this team. A multidisciplinary staffing approach was evident across all six services, which included nurses and therapists. The therapies team was highly specialised and included a lymphoedema therapist, a senior dietitian, a senior speech and language therapist, physiotherapists, social workers, occupational therapists and discharge co-ordinators.

Volunteers were an integral part of the service. They worked in a dedicated, trained team, and provided, practical, logistical and holistic support. For example, volunteers supported wellbeing sessions and helped patients navigate the building and available services.

The number of nurses and healthcare assistants matched the planned numbers at the time of our inspection. Staff said the numbers of nurses and HCAs on shift routinely matched the planned numbers although community staff noted demand significantly outstripped capacity.

The service had low vacancy rates. Between September 2020 and August 2021, the average vacancy rate for registered nurses was 6%. Senior staff used a succession plan to ensure staff numbers remained consistent.

The service had variable turnover rates. From October 2020 to September 2021, the turnover rate was 15% for clinical staff. This was the same as the average from June 2019 to September 2021 with a quarterly range from 10% to 22%. In the same period, non-clinical staff had a 6% turnover rate. This was lower than the average since June 2019, which was 11%.

The senior team monitored reasons staff gave for leaving the service and how many left within the first 12 months of recruitment. This was relatively high and between October 2020 and September 2021, 21% of clinical recruits and 30% of non-clinical recruits left the service. Recruitment and senior staff recognised the nature of the clinical environment was challenging for some staff and worked with them from the point of recruitment to provide more targeted support on demand.



Hospice services for adults

The service had average sickness rates. Between April 2020 and September 2021, the average sickness rate was 5%. This reflected a range from 2% to 7% and both non-clinical and clinical teams maintained consistently low levels of sickness.

Records

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

Clinicians used an electronic patient records system (ERS) to document and track patient care. The system was shared between primary care and the hospice setting, which meant clinicians could access each other's notes for more efficient appointments and care planning. This was a recent initiative following considerable multidisciplinary project working and the head of quality improvement and other colleagues had offered training sessions to meet the needs of all staff, including those working out of hours and primarily in the community.

The ERS included the summary care record, which significantly improved the ability of staff to deliver care based on advanced planning. The system enabled shared records storage and access across teams and providers, which meant the multidisciplinary team had easy access to reviews, assessments, and notes. This enabled them to plan and coordinate care safely and efficiently.

The head of quality improvement and colleagues had established data sharing agreements to help staff in different providers access and edit patient information safely.

In five patient records, including three patients being cared for in the IPU and two patients who received hospice at home care, note keeping was of an excellent standard. Records included a range of assessments, care plans, outcome measures, and advance care planning information.

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

Records were stored securely. The service had transitioned to a digital system, which was protected by industry-standard encryption. Staff undertook specialist training in data security and records access management.

Medicines

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

Staff followed systems and processes when safely prescribing, ordering, administering, recording and storing medicines. An external community pharmacy supplied medicines. A pharmacist visited twice a week to review prescriptions, order medicines, and respond to medicine queries. Pharmacists were contactable for advice outside of this time.

Medicines were prescribed by doctors and administered by nurses. The nursing staff had undergone training and competency assessments to allow them to do this safely. There was a system allowing Single Nurse Administration of Controlled Drugs to ensure there was no delay in administration of medicines. If medicines were required urgently and could not be obtained through the regular pharmacy, hospice staff dispensed medicines and labelled them appropriately following a strict procedure. Emergency medicines were available should they be required. This ensured people always had the correct medicines when they were discharged from the hospice.



Hospice services for adults

Nurses with a Nursing and Midwifery Council (NMC) recorded qualification as a nurse independent prescriber (NIP) worked within a safe practice policy guided by the Royal Pharmaceutical Society competency framework. This provided extra capacity and flexibility in the service as NIP nurses could prescribe medicines without the need for doctor oversight.

Staff ensured prescribing and medicines management met guidance issued by NICE, including clinical guidance 151 in relation to the prevention and management of neutropenic sepsis in people with cancer. Prescribing was clear, safe, and appropriate to be able to respond to symptoms that patients may experience during their stay.

Medicines were prescribed off-label and occasionally unlicensed medicines were used within the hospice. This meant the use of the medicines was not covered by the manufacturer. This prescribing was guided by standard practice within palliative care although there was no information given to patients about this.

Staff told us that they could communicate with GPs easily about people's medicines through their joint electronic systems. The service had processes so medicine recommendations made by clinical nurse specialists were actioned promptly.

Staff followed current national practice to check patients had the correct medicines, although there was no data available to see if this check (medicine reconciliation) was carried out in a timely manner. Ideally this should be completed within 72 hours of admission to ensure that people's normal medicines are continued appropriately.

Staff completed their medicines competencies and had annual syringe pump updates.

It was not always clear in which order medicines were to be administered and it was left up to the nurse to use their clinical judgement, in communication with the prescriber if necessary, to ensure the most appropriate medicine was used. The effect of the medicine was clearly documented on the chart to allow staff to make an informed decision about what had worked. The current medicine chart was under review to ensure it matched local prescribing guidance.

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

There was a procedure to allow people to self-administer their own medicines if they wished but there were no facilities available within patient's rooms so they could keep their medicines safely with them. This meant patients were fully reliant on staff even if they were able to self-medicate.

If medicines were not administered, reasons were not always documented within the electronic record. This meant staff were unable to track concerns about non-compliance with prescribed doses, which could impact care outcomes.

Staff provided patients with information on their medicines when these were administered at home. For example, patients prescribed steroids for use at home used an information sheet based on guidance from the Palliative Care Formulary about potential side effects and lifestyle-related management. At discharge, patients were provided with a list of their medicines and how to take them.



Hospice services for adults

People receiving medicines by syringe pumps (medicines delivered under the skin) were regularly monitored although the diluent was absent from the prescription. This gives clear guidance on how to safely assemble the drugs within the syringe pump. People receiving medicines via patches on the skin were also monitored. However, it was not clear from the records that the site of application of the patches on the skin were being rotated as recommended by the manufacturers.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Prescription stationary was securely stored, and usage controlled

The service conducted audits to assess compliance against the medicines policy including management of Controlled Drugs. Audits demonstrated consistently good practice with policy and best practice standards.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

The service had medicine related leaflets available in both English and commonly spoke other languages. These were regularly checked for readability. Translators were often used for people when needed so they could understand their treatment.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Staff reported medication incidents and near misses. The service reviewed incidents at quarterly medicine management meetings. There was evidence actions had been completed and learning shared with staff.

The service reported one serious incident in relation to medicines. This involved a missing batch of a controlled drug (CD). The service reported the incident to the drug liaison officer, and NHS England to share with the CD local intelligence network (CDLIN). The senior team reported the incident to the police and to CQC. The police took no further action following their initial investigation and clinical governance staff implemented a range of learning points. While the CD was stored securely and in line with guidance, learning centred on staff actions after the incident where it was found reporting processes could have been implemented more quickly.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff raised concerns and reported incidents and near misses in line with provider policy. Staff reported positive, confident attitudes towards incident reporting.

Staff knew what incidents to report and how to report them. From April 2021 to September 2021, the service reported no never events, no serious incidents, and 47 incidents. Of these, 26 were medicines errors, 11 were post-admission pressure ulcers on the IPU and nine were patient falls. The service reported falls data to Hospice UK for national benchmarking against services of a similar size. In the previous 12 months, 71% of falls resulted in no harm and 29% resulted in low harm. There were no instances of moderate or major harm.



Hospice services for adults

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

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Changes to practice took place as a result of learning from incidents. For example, staff restructured safety planning assessments after a member of staff experienced a situation in which a patient needed help for rapid deterioration, but the member of staff was at risk due to the behaviour of unexpected presence in the home.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. Clinicians said the threshold for the duty of candour was set by the medical director and chief executive officer in line with the appropriate regulation. The provider's policy reflected national requirements.

Staff received feedback from the investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. This took place in team meetings and through provider communications. Where incidents involved other services, staff liaised to find a solution. For example, where a patient's family became distressed because paramedics tried to take their relative to an emergency care department, the hospice at home team liaised immediately and followed up with the ambulance trust to prevent recurrence.

The senior team monitored notifications from the Central Alerting System (CAS). The registered manager tracked alerts and ensured they were embedded across the clinical provision. The manager communicated with all clinical staff when a CAS alert was issued using an electronic system. This required staff to acknowledge when they had read the alert and document changes they had made.

Are Hospice services for adults effective?

Good



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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to international best practice and national guidance. Policies, training, and corporate standards were mapped to the latest available information and the quality and governance teams maintained a central, digitised library of policies. This included material issued by organisations such as the National Institute of Health and Care Excellence (NICE), NHS England/Improvement, and the Royal College of Nursing (RCN). This was a comprehensive resource that staff could access remotely and provided an on-demand search function to efficiently find specific guides. During the pandemic, the information and knowledge lead and their team had substantively overhauled the library to ensure every piece of content was relevant and up to date.



Hospice services for adults

Staff recognised the findings from national reviews and research in policies, such as from the National Forum of People with Learning Disabilities and non-profit organisations in the betterment of providing care for people living with a learning disability. They enacted these by ensuring staff were trained in advanced communication and adapted standard assessment and care tools to individual needs.

At the time of our inspection there were no national clinical audits or national confidential enquiries for which hospice palliative care providers were eligible. The service evaluation and clinical audits committee had oversight of a programme of 10 local audits. Audits covered a cross-section of clinical safety measures such as use of remote consulting during the pandemic and palliative care for patients living with dementia. The audit team checked compliance with NICE guidance. For example, in 2021 they audited treatment of patients living with cancer who also received palliative care against NICE clinical guideline 89.

The service had tested and introduced the national outcome assessment and complexity collaborative (OACC) suite as part of the portfolio of evidence-based patient care tools. OACC is an innovative, developing tool aimed at dynamic assessment of need for patients under the care of hospice pathways.

Staff used evidence-based practice to enhance person-centred care and treatment. Such work triangulated national codes of practice and charters to apply policies and guidance in way that enhanced patient empowerment and independence.

Clinicians followed national best practice when prescribing selective serotonin reuptake inhibitors (SSRIs) to treat a significant increase in patients experiencing depression connected with the COVID-19 pandemic.

Staff provided evidence of challenging accepted practice and implementing more effective use of treatment policies to ensure care meets individual needs. For example, the medical team rapidly coordinated a multidisciplinary approach to ensuring a patient at home could receive subcutaneous (SC) fluids to manage dehydration. This required district nurses to manage the fluids, which the hospice team understood was not something they could normally do. The clinical team worked with the district nurses and GP and found there was a policy for nurse-led SC fluid management but that it had never been used. They worked together to obtain equipment and nurse training within 24 hours. This ensured the patient was more comfortable and died peacefully at home

Nutrition and hydration

Staff followed best practice guidance when managing nutrition and hydration. Staff undertook a nutritional assessment of each patient at the point of admission. They referred patients with more complex needs to the dietician. Dietitians worked with clinicians to identify nutritional needs and targets for each patient using accepted tools. For example, they adhered to NICE clinical guidance 32 in relation to oral nutrition support, enteral tube feeding, and parenteral nutrition and to GMC guidance on clinically assisted nutrition and hydration for those at the end of life.

The education team secured specialist training sessions from a range of professionals to help support nutrition and hydration planning. This included overfeeding, overhydration, and refeeding syndrome, the international dysphagia diet, and nutrition for patients living with diabetes. The range of training meant staff had opportunities to improve their knowledge and care for patients with complex needs.

Pain relief

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



Hospice services for adults

Staff prescribed, administered, and recorded pain relief accurately. The provider had access to a dedicated specialist chronic pain relief team who assessed and provided interventional pain relief procedures. Pain management was a key element of the service. Clinical staff led management symptom control, medication and side-effects from treatment. The education team delivered specialist training in managing syringe drivers for clinical staff and community partners. The team used a policy to support carers and relatives to administer urgent prescribed pain relief at home. This helped to empower carers to deliver pain relief expeditiously and safely without a clinical present.

We found consistent use of pain assessments in patient records. Staff used the Abbey pain score, a recognised tool, to assess and monitor each patient's pain. Hospice at home staff adapted the tool to patients receiving care in their home and helped carers to use and interpret the tool.

Staff encouraged patients to keep a pain diary when they were taking a prescribed course of medicine, such as long acting morphine tablets. They used this to understand each patient's pain needs and identify how advice and guidance could be individually tailored in their care plan.

Staff worked closely with patients, their carers, and relatives to help them understand pain and use a greater understanding to better manage symptoms. For example, the wellbeing team offered pain management sessions to help people understand how opioids worked and consider non-medical methods of pain management. A palliative care consultant offered monthly question and answer sessions that focused on pain and symptom management to help people become more accustomed to clinical approaches and terminology.

Patient outcomes

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

Staff recognised outcomes could be measured beyond the clinical aspects of care and ensured a holistic approach contributed to patient's care and treatment. For example, one patient in the IPU was unable to sleep comfortably in bed and preferred to sleep in a recliner chair. Staff sourced several chairs to test which model the patient preferred and then transferred the chair with them to a nursing home on their discharge. This was a significant effort for inpatient staff during a period of high demand on the service.

Staff worked with colleagues in other settings to drive good patient outcomes. The service operated in an area with four clinical commissioning groups (CCGs) and two integrated health systems (ICSs) and the clinical and senior teams worked across multiple systems and NHS grants to drive the best outcomes for patients.

The clinical team was proactive in seeking new evidence-based tools to measure patient outcomes. They had embedded the outcome assessment and complexity collaborative (OACC) suite of measures into the service and were developing this new system to improve patient outcomes. This was a new initiative and the first set of revised impact framework figures were due to be reviewed in January 2022.

Staff were proactive in identifying new care and treatment opportunities when traditional pathways had failed. For example, a specialist physiotherapist undertook training in acupuncture to support a patient who experienced uncomfortable oral symptoms not relieved by medicine. Acupuncture resulted in a significant improvement in their condition and comfort. In another example, the community team sourced specialist moving equipment to help a patient access their bathroom upstairs so they could take a bath, which was important to them.



Hospice services for adults

Staff monitored patients who died in their preferred place of death (PPD). This is a national indicator of outcomes in end of life care services. From September 2020 to September 2021, 92% of patients achieved their PPD.

Competent staff

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

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

The senior team recognised the continuing development of staff skills, competence, and knowledge as being integral to ensuring high-quality care. Senior staff proactively supported and encouraged their teams to acquire new skills, use transferable skills, and share best practice. This led to a range of developmental opportunities that enabled staff to move between departments and undertake specialist training.

Managers gave all new staff a full induction tailored to their role before they started work. This included a standardised induction relevant to all staff, with additional role-specific training.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff underwent monthly supervision and said this process was positive and conducive to their development. Amongst all staff groups, the appraisal rate was 76%.

In line with NHS England and NHS Improvement guidance, all consultants had undergone an appraisal in the previous 12 months. The medical director ensured doctors employed substantively elsewhere completed appropriate appraisals at their main place of work.

Staff used their annual appraisal to review continuing professional development. Where staff maintained mandatory registration, such as nurses and physiotherapists, they used appraisals to identify training and development opportunities to support this.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism, and dementia.

A team of 17 clinical supervisors had delivered 68 clinical supervision sessions to 127 participants from May 2021 to November 2021.

Each member of staff had an individual training and development plan. In addition to mandatory training, the education team delivered a range of specialist courses focused in improving staff skills to be able to deliver highly specialised, individualised care. Courses included nurse-led verification of expected death venepuncture, and male catheterisation.

The education team planned a rolling calendar of specialist training sessions for staff aimed at broadening knowledge and improving care planning. Topics included clinical specialties such as lymphoedema management in palliative care and tracheostomy care. The team worked with clinicians to support junior staff development, such as providing apprentice practitioners with practical experience before they progress to college.



Hospice services for adults

The education team ensured non-clinical staff had access to development opportunities. For example, the head of quality improvement and colleagues organised super user training for staff in new digital systems and patient records systems. Super users were embedded in specific teams to help transition them to new systems and formed a core element of the overarching education provision.

Staff spoke candidly and very positively about training and development opportunities. Each person described how the provider had supported them to progress on a timescale and plan important to them. This included postgraduate certificates in palliative care for some staff and Masters degrees for others. One member of staff said, “Succession planning is brilliant. Training is always available and there are mentors all over the place; this is a brilliant place to learn.”

Nurses had access to advanced training and development opportunities. For example, a CNS was completing an advanced assessment course. This would enable them to carry out differential diagnosis practices to detect conditions such as a chest infection.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. There was a holistic approach to planning people’s discharge, transfer or transition to other services, which is done at the earliest possible stage.

Evidence of multidisciplinary working was widespread across the service and reflected a focus on holistic, multifactorial care. Non-clinical staff such as chaplains and wellbeing clinicians often joined such processes to ensure staff fully understood all aspects of a patient’s needs.

Staff used weekly multidisciplinary meetings to review all patients in the service. In-house teams as well as social workers, safeguarding staff and other healthcare professionals contributed to this process. Where patients had complex care that required multi-professional input, staff arranged this in advance with other professionals such as psychologists and GPs.

Clinicians provided details of referrals, treatment, and discharge to patients’ preferred care provider, including doctors with other organisations and NHS GPs. In all cases, clinicians ensured patients accessed the care they needed from their preferred providers.

Allied health professionals provided a range of services to outpatients. This included physiotherapy, social work, occupational therapy, dietitian and speech and language therapy (SaLT).

The service was formed of a diverse range of staff and specialties, and some staff held joint contracts with a local NHS acute trust. The multidisciplinary structure worked well and ensured patient care and treatment was seamless no matter how many professionals were involved in their care. Staff proactively involved other services to join meetings where this would improve care planning and delivery.

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

The hospice at home team joined weekly multidisciplinary meetings with NHS trust colleagues to review planned admissions and discharges.



Hospice services for adults

Seven-day services

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

The IPU was open 24-hours, seven days a week. Staffing levels were maintained consistently and a nurse in charge was always based in the unit. A consultant was available on call out of hours and the CNSs in the community team provided additional capacity and support on demand. The hospice shared a first and second 24-hour medical on call rota with a neighbouring hospice.

The hospice at home team provided 24-hour cover, seven days per week. Between 9pm and 8am, a dedicated night response service operated from the IPU and attended people in the community for symptom control. This was the case in two areas where district nursing teams did not provide an overnight service.

On-site services such as the chaplaincy and wellbeing facilities were accessible seven days a week during daytime hours. Staff provided examples of how they facilitated exceptions to this on request to meet specific needs in complex circumstances.

Health promotion

Staff are consistent in supporting people to live healthier lives, including identifying those who need extra support, through a targeted approach to health promotion and prevention of ill-health

The service had relevant information promoting healthy lifestyles and support in patient and visitor areas. The information was broad in scope and relevant to the nature of the care provided. Staff supplemented this with a pragmatic view of health promotion during end of life care. For example, while smoking was counterintuitive to good care, staff recognised this comforted some patients and they supported them to access smoking areas on site.

Physiotherapists in the wellbeing team offered seated exercise groups to maintain muscle function and a range of movement. This was in addition to clinical treatment and aimed to help people maintain the usual daily activities important to them.

An occupational therapist in the wellbeing team offered fatigue management sessions to people with life-limiting disease. This was a complementary programme that aimed to maximise the benefits of the range of treatments and care patients received.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available.

Staff had a clear understanding of the role of consent in decisions about care and treatment. For example, where clinical staff gave patients advice about lifestyle habits that would impact care, such as smoking or alcohol use, they also understood patients were able to make their own decisions.



Hospice services for adults

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff received and kept up to date with training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards. The key principles of the MCA were displayed in clinical areas as quick reference guides.

Staff knew how to access policy on Mental Capacity Act and Deprivation of Liberty Safeguards. Policies were stored electronically and were readily accessible.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. This included regular checks of documented mental capacity checks in patient records and mental health assessments when patients' needs or behaviour changed.

Staff protected the rights of patients subject to the Mental Health Act and followed the code of practice and understood how they related to the duty of care. The education team provided dementia friend training to staff internally and to professionals across the sector.

A mental capacity assessment tool and a best interests decision-making tool were embedded into the electronic patient records system. Staff completed both to understand the ability of each patient to understand their condition and make treatment decisions. The assessment tools were evidence-based and enabled staff to deliver individualised care with appropriate levels of consent.

Are Hospice services for adults caring?



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

Compassionate care

Feedback from people who used the service, those who were close to them and stakeholders was continually positive about the way staff treated people. People thought that staff went the extra mile and their care and support exceeded their.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. The hospice had a wide range of indoor and outdoor spaces for private discussions, including landscape gardens and a nature reserve. Staff got to know people, found out where and how they preferred to talk, and facilitated this on people's own terms and schedules. Volunteers were selected for their natural empathy and undertook extensive training to support care delivery.

Staff followed the provider's policy to keep patient care and treatment confidential. They achieved this by carrying out conversations in private rooms or in the gardens out of earshot of others. Staff utilised outdoor spaces to their full potential to meet people's needs. For example, volunteers facilitated use of a DIY shed in a private part of the garden to enable patients and carers to build skills and engage in distraction activities as a key element of compassionate care.



Hospice services for adults

Virtual conversations online were by invitation only and staff paid attention to detail when ensuring their environment protected confidentiality. For example, staff said they were aware that when speaking remotely, patient experience might be influenced by their perceived location and environment. Staff approached this transparently and explained to patients where they were and gave them the opportunity to ask questions that would improve their compassionate approach and setting.

Managers of non-clinical teams, such as housekeeping and clinical administrators, encouraged and empowered their staff to engage with patients and their relatives and to build positive relationships. This contributed to the overarching ethos of compassionate care and meant patients were treated kindly wherever they encountered staff in the hospice. We saw examples of this during our inspection, such as in the restaurant, an environment in which staff, volunteers, and visitors could openly mix. For example, catering and housekeeping staff readily welcomed conversations with visitors and suggested more private seating areas where people wanted peace and quiet. We observed this was an intuitive understanding from staff, which helped maintain discretion and compassion.

The community engagement team delivered a compassionate communities programme aimed at establishing a range of bereavement and carer support services and supporting individuals to care for their friends when they suffered a death. This included a compassionate neighbour's scheme, which had matched 221 people from June 2020 to March 2021, a bereavement book club toolkit, and remembrance services. Compassionate neighbours are volunteers trained to offer friendship and listening space for people who are isolated or lonely. The team held eight 'death cafes' online and led the Dovetail group, which supported children, young people and parents. Death cafes encouraged discussions about death, dying, grief and loss, and helped reduce stigma and reluctance around these discussions.

Staff demonstrated initiative in their kindness and efforts to make people comfortable and happy in their last days. The service provided many examples of staff and volunteers who had gone above and beyond their role in planning and delivering new ways of providing patients with positive experiences. In one example, the discharge coordinator had contacted a major league football club to request memorabilia, which would make a patient approaching the end of their life happy. The coordinator secured a personally signed photo of the squad, framed it, and presented it to the patient shortly before they died. Staff said such efforts provided patients with comfort that could not be measured.

In another example, a chef single-handedly prepared refreshments for the Christmas tree light-up event in 2020 after several members of the catering team had to self-isolate. This was a challenging scenario and the chef's efforts meant a young family with children were welcomed and catered for despite pressures due to COVID-19. Staff noted this scenario as 'typical' of the efforts of staff to ensure people were looked after. A member of the community engagement team said about the meal, "[The chef presented the refreshments] in such a way that it looked like he had prepared a feast. He dressed the table superbly and the [children] were very pleased and excited to tuck in to their early supper."

All staff were trained as chaperones and this could be requested, by the patient or their clinician, at short notice in the inpatient unit (IPU).

Staff provided thoughtful, effortless care and support to the loved ones of patients. They understood the impact of realising a person would soon die and applied compassion to supporting people struggling with logistics and structure. For example, a clinical administrator had spent an evening researching hotels for a family visiting their loved one in the hospice from out of the area. They were unfamiliar with the locality and overwhelmed by the patient's diagnosis. The help of the administration meant they could focus their energy on their loved one. In another example, a nurse engaged with a community care provider to help them interpret cultural influences on the behaviour of a care worker who was



Hospice services for adults

causing distress to the family of a dying person. The actions of this individual meant they could confidently manage an escalating situation and refocus their attention on the needs of the patient. The service provided numerous examples of staff providing care that was unrelated to clinical delivery but had a significant impact on people's feelings and wellbeing.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. People's emotional and social needs were seen as being as important as their physical needs.

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. They were aware of how the stigma attached to hospice care in some communities impacted people's access and experience of care and had found this reflected in perception of their service as a charitable organisation. In response, staff worked closely with community partners and patient's carers to drive a clearer understanding of the type of service and how it could benefit people at the end of life.

Staff showed they prioritised emotional and holistic support in the same way they did clinical treatment. For example, each team had wellness and wellbeing staff and access to counsellors and psychologist input. Staff considered each patient's daily needs by asking what was important to them and how the team could facilitate their usual daily routine. Staff used advance care planning records to document a holistic assessment for each patient, which helped to structure non-clinical interventions such as access to chaplains and social groups.

The registered manager gave examples of how staff went above and beyond their duties to provide patients and their loved ones with exceptional standards of emotional support. For example, an inpatient asked staff to collect a musical instrument from their home. They said music comforted them and this was an important consideration in the final days of their life. Staff visited the patient's home and video chatted with them to help find their favourite instrument. They brought the instrument to the inpatient unit (IPU) and the patient played some music for staff and other patients before they died. In another example, staff accessed community leaders to engage with an adult social care provider that had provided a care worker of severely opposing cultural and religious beliefs to a patient who was actively dying. This action avoided a serious incident and reduced anxiety and pressure on the patient's relatives.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff gave patients and those close to them help, emotional support, and advice when they needed it. This was reflected in consistently positive feedback in the patient survey. From April 2020 to August 2021, 99% of patients said they had confidence in the staff who provided care. This met the organisation's target of 99% in this measure of care.

Staff provided support and guidance and informal carers, such as a patient's spouse. Carers described these relationships as crucial and said they provided access to clinical information and guidance unavailable through other channels.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. The education team facilitated a range of specialist training to help staff deliver individualised care. This had recently included shared trauma, secondary trauma, and stress and a course in dealing with existential distress. This reflected the holistic focus of the service and staff recognition that responsive care extended beyond immediate clinical need.



Hospice services for adults

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

Staff described requests to support patients and carers with “overwhelming decisions” during the COVID-19 pandemic when they could not obtain support from other sources. This included phone calls from carers asking nurses to make complex clinical decisions relating to resuscitation when patients were brand new to the service and had not yet been fully assessed. Staff also described requests for advice on euthanasia. Staff described such scenarios as challenging and indicated the substantive support available to them as key to maintaining morale and good mental health.

A dedicated patient and family support team ensured those who received hospice at home and community care had appropriate support packages during COVID-19 lockdowns. Staff built a comprehensive information package to help people understand the latest restrictions and how they impacted care availability.

The wellbeing team offered a dealing with anxiety programme to manage symptoms of anxiety and promote breathing and relaxation techniques. The programme was open to patients and their carers and relatives and staff adapted delivery to individual needs, such as by adjusting access times and providing sessions virtually.

Staff involved patients and carers in emotional care. They used an ‘About me’ document to understand more about each patient’s needs, such as things that made them worried or anxious. Staff used the document interactively to learn from patients the action they preferred to help reduce their anxiety.

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. For example, initial assessment included consideration of specific needs relating to culture and religion, such as if patients or carers needed a specific gender of doctor or nurse. The hospice at home team researched cultural standards and religious rules before delivering care and worked respectfully with patients and carers to make sure these were met. For example, staff had delivered care to one patient whose religion usually precluded end of life care and whose relatives were reluctant to accept help from staff. The hospice at home team worked with the family collectively to show how care could be beneficial and still respect their beliefs. Staff repeatedly told us how proud they were of the kindness and compassion the whole team provided to patients and their loved ones.

Understanding and involvement of patients and those close to them

Staff supported, involved patients, and empowered families and carers to understand their condition and make decisions about their care and treatment and be active partners in their care.

Staff undertook advanced communication training to help discuss death and dying with patients and their loved ones. This included supporting people to deal with fear and de-escalating situations in which people became angry. Staff approached clinical appointments with excellent communication skills and focused on listening and understanding rather than talking.

Staff made sure patients and those close to them understood their care and treatment. From April 2020 to August 2021, over 99% of patients said staff clearly explained their care and treatment. This was better than the target of 98%.



Hospice services for adults

Staff supported patients to make informed decisions about their care. From April 2021 to August 2021, 100% of patients said staff had involved them in their care as much as they wanted to be. This was better than the organisation's target of 98%. A palliative care consultant provided a monthly question and answer session for patients and their carers. Previous topics included cancer treatment and side effects and pain relief, and the consultant encouraged attendees to ask any questions they wished.

Patients gave positive feedback about the service. From April 2021 to August 2021, 100% of patients said they were likely or extremely likely to recommend the service. This result reflected experiences during fluctuations in service due to COVID-19 restrictions, which provided additional evidence of service quality.

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

Hospice at home staff intervened to help patients and relatives whose usual healthcare services had moved to online only provision during the COVID-19 pandemic. Staff reconfigured the wellbeing support service to be delivered virtually during COVID-19 lockdowns. Staff worked with patients to ensure they had the necessary IT equipment at home and had the skills to use it to join group sessions and clinical appointments.

Staff continued to deliver care to patients' loved ones after they died. The wellbeing, community engagement, and wider teams delivered targeted support for those who had been bereaved. Staff implemented support programmes in response to people's needs. For example, one member of staff noted bereaved spouses sometimes struggled to cook good meals at home if their partner had been the main cook. They implemented two-week cooking classes and gave people skills and confidence to prepare their own meals. The course culminated in a social meal with the participants. In another example, a member of staff had established a mindful art group in recognition of the comfort and distraction from stress this could bring. This reflected dedicated attention to detail amongst the team.

Staff talked with people about their end of life treatment and recorded this in the nationally recognised recommended summary plan for emergency care and treatment (ReSPECT) document. Two completed examples showed a person-centred approach to care that included wider discussions about beliefs, final wishes, and significant lifestyle factors.

Are Hospice services for adults responsive?



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

Service delivery to meet the needs of people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan flexible, patient centred care, particularly for people with multiple and complex needs.

Managers planned and organised services so they met the changing needs of demand from patients. The senior team had a developmental approach to the service and actively sought new clinical specialties when these were in demand



Hospice services for adults

by patients. The community team had launched a new programme to engage with the local traveller community. This was in recognition of heightened needs in the community for palliative care and a need for greater cultural knowledge within the hospice team. Staff understood people in the traveller community often did not get the help they needed and were working to address this with new engagement strategies.

A nurse in the wellbeing service led a community of practice in building a portfolio of specialist care and support for patients with complex needs. The head of community engagement and volunteering led a programme to address the needs of underserved communities. The team used a regional analysis and review of social deprivation to identify communities underserved by hospice care. This led to new in-reach work with traveller communities and more tailored work with male carers.

Staff had assessed regional unmet health needs to identify vulnerable groups who may benefit from access to hospice care. The hospice was situated in an area with low levels of deprivation, but staff provided care across a broad geographic area and found evidence of need amongst people experiencing homelessness in some areas. They worked with local authorities and community care services to ensure people could access palliative and end of life care as provided in their local area.

Staff described supporting large numbers of patients in acute distress during COVID-19 restrictions, who were unable to secure other medical review because services had closed or were unavailable.

The community team used an 'open access' caseload to support patients known to clinical nurse specialists (CNSs) who were relatively stable but who needed support in condition management.

The service implemented a range of additional training and development opportunities for staff to deliver holistic services across organisational boundaries. Courses included cultural sensitivity at the end of life, helping children and young people after the death of a significant adult, and engaging with hard to reach groups.

The hospice team had adopted Project ECHO (extension for community healthcare outcomes) in 2019, aimed at delivering 13 specialist areas of training and education to colleagues in other healthcare services. The range of education sessions was varied and included essential clinical skills such as palliative emergencies, to areas focused on personalised care such as advance care planning. The project reflected the hospice team's focus on holism and included sessions on namaste, bereavement support and ethics. Sessions to date had reached NHS hospitals teams, paramedics, care home staff and community clinicians.

The hospice at home team led a programme of support for adult social care staff. This included bespoke training, group knowledge sessions, and tailored training to assist staff in the care of residents living with specific conditions and needs. This helped to increase capacity in the system as it meant care home staff relied less on hospice colleagues for tasks they could complete themselves.

The dedicated education team worked across multidisciplinary teams and settings to deliver an extensive range of specialist training courses. Between January 2021 to October 2021, the team delivered 221 education sessions to 2559 participants from the NHS and independent health services. The education team recognised the impact cross-sector education had on patient outcomes and broader understanding of palliative and end of life care and targeted appropriate settings for delivery. For example, the team regularly included staff from other hospices, from care homes and from specialist clinical services such as community cancer care. Such services regularly provide care aligned with the hospice approach and the education team promoted knowledge sharing to improve standards and consistency.



Hospice services for adults

A hospice at home team provided person-centred care for people whose health was deteriorating by providing palliative care at home. Nurses, healthcare assistants, and support staff delivered this service and replicated the ethos of the inpatient hospice service in patients' own homes. Nurses were participating in an advanced dementia support service with three local care homes. This aimed to improve joint working to improve care outcomes for patients living with dementia who also received palliative care.

The hospice was equipped with a range of spaces for patients and visitors to use in addition to clinical care. They included quiet, private spaces for reflection, a sanctuary, a flower preparation room and a children's play area.

Staff adopted a new death certification process during the COVID-19 pandemic. In addition, staff had worked to improve the process for patients who died out of hours and had religious burial or cremation needs. The new process meant that a doctor who had seen the patient in the previous 28 days could authorise a medical certificate of cause of death (MCCD). This could be pre-planned with the medical examiner or discussed upon the completion of the death certificate and meant there was no delay in certification.

Staff used the care support needs assessment tool (CSNAT) to identify how they could best support carers. This enabled staff to provide structured, targeted support such as to help alleviate anxiety, signpost carers to community services, and provide technical training on the use of equipment such as hospital beds.

The wellbeing team led a comprehensive range of holistic services for patients, carers, and relatives, included the bereaved. The multidisciplinary team, such as therapists and staff nurses, led individual sessions. The programme included clinically focused sessions such as managing breathlessness and sessions designed to promote good mental health and focus, such as a music group and a patient discussion and support group.

A multidisciplinary team provided the enhanced support service. This team provided urgent support to people with significant needs in the community, some of whom were experiencing delays in accessing continuing healthcare or needing rapid support on discharge from hospital.

The IPU team had worked with a clinical commissioning group (CCG) during the pandemic to supply four beds for patients who were at the end of their life who were being discharged from an NHS hospital whilst infected with COVID-19. This reduced pressure on the NHS trust by freeing beds for emergency admissions. This demonstrated the flexible partnership working approach of the hospice team.

Staff had access to translators for patients who needed language support. This included during hospice at home visits and IPU consultations. While this was a rarely used service, staff maintained awareness of how to access support at short notice.

Staff undertook training to help them provide effective care to patients who could not effectively communicate verbally. This included communication with patients living with conditions such as dementia and learning disabilities that was specialised to hospice care and helping patients understand the dying process.

Meeting people's individual needs

The service was inclusive and promoted equality. It was proactive and identifying and meeting patients' individual needs and preferences, especially when those needs were complex. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.



Hospice services for adults

There was a tangible sense of flexibility and adaptability amongst staff to meet people's needs and requests. Staff worked together to find solutions to barriers to care or access as part of a personalised service. For example, the facilities team helped a bereaved relative to visit the book of remembrance on an important date for them despite the building being under COVID-19 restrictions.

The hospice at home team tailored their services to individual needs, often at short notice. This included staying late with relatives or carers when a patient died at home and there were delays in reaching the out of hours doctor and undertakers.

Staff were trained to ensure care and treatment was delivered without discrimination, including on the grounds of protected characteristics under the Equality Act. This included training on unconscious bias and inclusivity. For example, staff actively avoided making assumptions about people's lifestyle and worked with them to understand how they could tailor care and treatment. The service had introduced gender-neutral toilets and launched an inclusivity campaign to help staff recognise when additional measures might be needed to ensure equity of care.

A multidisciplinary team led the wellbeing centre, which included social groups and interest clubs such as an art therapy group and a creative writing group. Groups were open to patients, their loved ones and the bereaved as part of a collaborative approach to peer care support and wellbeing.

The wellbeing team adapted groups to take place online during the COVID-19 pandemic when they could not meet in person. They ensured participants had access to remote video technology and held weekly sessions with different themes. Where wellbeing support groups moved online, staff facilitated access for patients who could not effectively communicate verbally. For example, they provided time and patience for people to type messages in a chat rather than speak.

In the art therapy group, people displayed their artwork as a means of distraction or expression and the team prepared an online exhibition of knitted toys, paintings, and other work, during winter 2020. Staff collected items from people's homes and the communications team prepared a video of the exhibition that enabled people to watch it online in their own time. One member of staff said, "It was a lovely demonstration of imagination and creativity amidst the confines of the lockdown."

A nurse and physiotherapist led a weekly breathlessness group to help manage patient's breathing. They had adapted the group to run virtually during the pandemic and offered in-person opportunities as soon as it was safe to do so.

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

This was reflective of the provider's approach to ensure systems to provide additional support were up to date, evidence-based, and had specialist input. For example, the policy to support staff in delivering care to people living with a learning disability was based on best practice guidance, research, and care-centred directives from multiple appropriate organisations, including those with specialist remits to provide care. The hospice at home team worked closely with learning disability care services to ensure care plans were fit for purpose.



Hospice services for adults

Staff across multiple services recognised the additional stress experienced by patients living with dementia who also received palliative care. The education and research team supported staff in the completion of dementia friend training. The wellbeing team had partnered with a charity that helped facilitate the creation of personal music playlists for people living with dementia to support memory evocation and strengthen relationships with loved ones.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Policies were up to date, evidence-based, and reviewed regularly by an appropriately experienced team member. Staff used a wide range of evidence, including leading-edge research, to ensure policies reflected the latest understanding of care and communication. For example, the policy that guided staff in delivering care to people living with a learning disability incorporated findings from national non-profit health promotion campaigns and accepted standard of how learning disabilities impact capacity, understanding, and care needs.

Staff had provided care for increasing numbers of patients with profound learning disabilities, including those who could not effectively communicate verbally and who had complex needs. For example, hospice staff worked with paramedics, district nurses and a hospital acute medicine team to balance a patient's final wishes about their place of care with increasing needs around pneumonia and medicines management. The coordination of specific staff teams and out of hours provision for the patient and their carers meant they experienced a death in line with their wishes.

Staff described how they prepared patients for death. A key focus was to build an understanding of what was important to the patient and how and where they wanted to die. The wellbeing service provided a broad scope of care, including with family members and carers, to prepare them for the progression of end of life care. The team introduced patients and their families to the concept of advance care planning and helped build a plan that supported their needs.

Staff had the option to undertake training in British Sign Language (BSL). Two members of staff had completed an introductory course and were preparing to progress to a more advanced level. A member of staff had secured bursary funding as part of a broader deaf awareness programme, which enabled an additional four members of staff to complete training.

Staff provided numerous examples of how they exceeded their roles and care plans to deliver exceptional, personalised care. In one example the community team worked with the owners of a small care home for people living with learning disabilities. Staff engaged with the community learning disabilities team, provided training for the home provider, and worked with other residents to help them understand the dying process and what to expect. Hospice staff coordinated a short-notice religious funeral and liaised virtually with the patient's friends and relatives including to explain UK laws regarding recreational drug use for pain management. The patient experienced a peaceful death and hospice staff minimised the distress of their friends in the home as far as possible.

The hospice at home team coordinated equipment, therapy, and symptom control to optimise patient's comfort at home. The team supported patients and their loved ones through changes in clinical condition and ensured basic needs, such as a wheelchair to be able to go out and see friends, were met without barriers.

Staff worked with services and providers across the locality and region to coordinate care. This reflected the complexity of patient's needs. Typical cross-working included with social services, local authority safeguarding teams, and NHS and private doctors. Staff expanded opportunities for joint working to meet demand and ensure care addressed holistic and urgent needs. This included planning and delivery with NHS paramedics and residential care homes.



Hospice services for adults

Across the service, staff demonstrated attention to detail in softening the clinical impact of complex, often upsetting treatment. For example, a healthcare assistant on the IPU had crocheted colourful bags for patients to use to store syringe drivers. The items provided some colour to a clinical procedure and staff said they were very popular.

Staff were empowered to explore and pilot new approaches to care. For example, staff had introduced virtual reality technology based on research findings that it can reduce anxiety and stress. The service had introduced a guided virtual reality service that patients and relatives could access. The technology created computer generated imagery that people could design or choose in advance. For example, patients and their relatives could recreate a favourite place and 'visit' it together virtually, which provided comfort in their final days.

Access and flow

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

The service offered a single point of response telephone service that helped patients and carers reach the most appropriate person more quickly. This improved access time and staff said it helped reduce people's anxiety during pandemic lockdowns. The team audited response times for urgent referrals and admissions. In the previous 12 months, 85% of patients were admitted to IPU within 48 hours of presentation and staff actioned 99% of urgent referrals within two working days.

Staff had quickly adapted the entire service during the COVID-19 pandemic to ensure care, treatment, and holistic services could still be delivered. The wellbeing team moved services online and worked with patients and participants to ensure they could access virtual groups. The senior leadership team had reconfigured the service during COVID-19 lockdowns to meet government requirements and balance these with the needs of the most vulnerable patients. For example, the day hospice and wellbeing groups moved online whilst essential inpatient service continued. Hospice at home services continued in a modified model, which included remote contact and working for some elements of the service.

Staff were consistently flexible in delivering services. For example, the breathlessness team offered ad-hoc one-to-one appointments to patients who could not attend the scheduled sessions due to other medical appointments.

Patients accessed the service by referral from their GP, district nurses, or the community therapy team. A clinical professional assessed them clinically before making a referral to ensure the service was the most appropriate care pathway for them. Between March 2020 to March 2021, the wellbeing team received 371 referrals and completed 4,525 attendances and contacts. Quality and governance staff noted an increase, from 8% to 17%, of the number of referrals returned due to incomplete information in 2021. The previous head of quality improvement worked with referrers and the monthly audit committee to review the increase and identify contributing factors. The hospice had improved referral documentation and monitoring so that staff could identify trends in referrals by category. Staff reviewed data on a monthly basis.

The head of quality improvement had reviewed patient flow from referral to the first point of response to better understand how processes could be streamlined. This work had led to a paperless referral system with the integration of GP and community healthcare provider patient records into a single digital system. The new system improved access and efficiency and provided staff with an audit trail to track patient assessments and other elements important to their care.



Hospice services for adults

The head of community services led daily admissions meetings. This was a multidisciplinary process with the IPU and community teams and staff used it to identify and prioritise admissions. Community CNSs were able to arrange out of hours IPU admissions where this was in the best interests of the patient.

Staff worked together to achieve safe transfers for patients who wished to change their place of care. For example, one patient in the IPU, cared for with a tracheostomy, wished to go home for short periods of time. The clinical team coordinated three home visits with an ambulance, trained nurses and clinical equipment. The patient was able to spend six hours at home over the course of the visits, which staff noted significantly improved their state of mind.

Carers described a highly responsive service that worked with them to understand when they needed support. For example, staff established a ceiling of care for each patient and when their carer at home felt this had been reached, clinical staff carried out a home review.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas and on their website.

From June 2020 to March 2021, the service received six formal complaints. Three complaints were not upheld, two were fully upheld and one complaint was partially upheld. There were no themes in complaints, each of which was an individual issue.

Staff understood the policy on complaints and knew how to handle them. Staff were empowered to resolve or escalate minor concerns at the time they were raised.

Managers investigated complaints and identified themes. Investigations were comprehensive and the service used innovative ways of looking into concerns, including using external people and professionals to make sure there was an independent and objective approach. The registered manager discussed how these processes worked in practice, such as coordinating complaint investigations and responses at committee level. Trustees came from a range of professional and clinical backgrounds and used their expertise to support complaint reviews and outcomes.

Staff knew how to acknowledge complaints. Patients and carers received feedback from managers after the investigation into their complaint. For example, two complaints related to care provided by a domiciliary care agency. The senior team worked with complainants and the care agency to help find a resolution.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff said they regularly heard from senior colleagues with information about learning opportunities as a result of feedback, such as in the case of relatives who wanted clearer communication about end of life symptoms. Staff could give examples of how they used patient feedback to improve daily practice. For example, the hospice at home team worked with relatives and carers to help them understand the scope and capabilities of the service.

Are Hospice services for adults well-led?



Hospice services for adults



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

Leadership

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

Staff said there was consistent and visible leadership. They said they were on first name terms with the trustees, board, chief executive officer (CEO), directors and registered manager, all of whom worked with an open-door policy that encouraged staff, visitors, and patients to visit them informally. Staff spoke positively about leadership culture and said members of the senior team were genuinely approachable. One member of staff said, “The hierarchy is not something you really feel. They [senior managers] are there to help and support but it’s literally an open-door culture – I can go and speak to [CEO] or [registered manager] whenever I want a chat or to get something off my chest.” Another member of staff said, “It’s never ‘us and them’ – it really feels like everyone works well together.”

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

A dedicated senior member of staff led each of the six core teams. Leadership roles were based on the specialist service and in community teams, on the locality. For example, two leads were responsible for the hospice at home service, based on two designated locality areas.

The hospice had delivered a ‘stepping into leadership’ programme for new and aspiring leaders. The senior team had delivered training for managers whose teams were working remotely during COVID-19 lockdowns. Both strategies reflected the forward-thinking nature of the senior leadership team and a focus on succession planning through staff development.

Senior staff told us the team had intentionally chosen a distributed leadership model that empowered staff at all grades and provided support and direction. This embedded a collaborative approach to recognising and addressing priorities and issues, such as increasing demand and increasing complexity across local clinical commissioning groups (CCGs).

Two members of staff had been awarded Florence Nightingale Scholarships in recognition of leadership development standards. Senior staff said such opportunities, “...helped the organisation thrive and flourish.”

Consultants and GPs worked to General Medical Council (GMC) guidance on co-working best practice, to work collaboratively and show effective leadership, including to address key challenges the service faced.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services, aligned to local plans within the wider health economy and demonstrated commitment to system-wide collaboration and leadership. Leaders and staff understood and knew how to apply them and monitor progress and providing evidence of a positive impact on quality and sustainability of services.



Hospice services for adults

The senior leadership team and trustees had been reviewing the vision and strategy for the previous five months to enable them to transition to the next strategic period. A key focus of the team was to ensure the hospice was fully integrated into the regional healthcare system and reflective of the complex new ICS structure in which it operated.

Integration was also a focus of the hospice's requirements with the Charities Commission, to whom they were responsible in a regulatory capacity. Senior staff noted trustees and committee members were all active participants in strategic development.

The senior team recognised 75% of people approaching the end of life could benefit from palliative or end of life care and that services in the region typically engaged with 25% of the population. This underpinned the vision and strategy and helped direct care resources with stretching goals. For example, the COVID-19 pandemic had created significant challenges for the team and their resources. However, the overarching strategy remained focused on progress and improvement rather than simply on survival and maintenance.

Staff delivered care and treatment according to the provider's mission statement and ethos and were supported to contribute new ideas and ways of working. Staff recognised the pressures on the service and used these to identify how they could better deliver long-term strategic improvements. For example, several staff groups felt overwhelmed by the demand on the service. As a result, the senior team planned a new project to consider when, how, and why specific staff roles felt pressure. A dedicated team would shortly implement this work, which would consider how staffing could be restructured whilst adhering to the provider's five hospice values.

The corporate behaviour of the provider was evidence of their belief in staff abilities and in the standards they delivered. This was reflected in the long-term, sustained strategy in which staff at all levels were included. Senior staff valued feedback, challenge, and suggestions and staff told us this helped them remain confident and interested in the strategic direction of the service.

The senior team identified advocacy as a key opportunity going forward. They noted the hospice had been "shy" at promoting hospice work and overcoming stigma and misinterpretation of the meaning of end of life care. They said this was the case at national and local levels and they were working with national organisations to address it and amplify the voice of the charity sector as a strategic concern.

The local community had a central role in the establishment and development of the provider's hospice at home and community neighbour services. The vision embedded the importance of this collaborative work by recognising how the community played a pivotal role in driving progress.

Culture

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

The digital, technology and data team had developed a new online inclusion hub to drive a culture of learning around differences in people's identities. This was a key piece of work across the organisation that aimed to ensure all staff and volunteers felt comfortable and confident in the workplace. The development team noted, "We know that we cannot do our best work unless we cultivate a sense of belonging", which reflected the ethos of the inclusion work.



Hospice services for adults

The senior team had launched a new inclusivity programme across the organisation. This aimed to raise awareness of the challenges people from diverse backgrounds often face on a day to day basis. The programme aimed to improve understanding and give staff tools to work more inclusively and address prejudice or discrimination. Staff spoke positively about these efforts and noted new work, such as the implementation of a black history resource centre, helped to increase knowledge. The senior team were working at pace to apply new inclusion training and standards to protect staff from abuse from patients. This followed incidents in which some staff from black and minority ethnic (BAME) backgrounds disclosed they routinely dealt with racist abuse from patients and relatives and accepted this is a norm. All six directors and the CEO were leading this comprehensive, urgent programme to address the issues.

Staff had readily engaged with the programme and provided examples of how they were working to improve standards of work and care. For example, a clinical administrator used bursary funding to organise British Sign Language training for six members of the clinical team. This formed part of a broader deaf awareness programme as part of inclusion and diversity work. Staff spoke positively of this experience and articulated how the training made a difference to patients and their loved ones.

Staff said they worked to the ethos of delivering care to every patient as if they were a member of their family. Several staff told us patients were human beings, not numbers, and they worked to maintain this work ethic in all aspects of interaction.

A Freedom to Speak Up Guardian worked across the site to support staff in raising anonymous concerns or where they had concerns about issues such as safety or practice integrity. There was a well-established whistleblowing policy. Senior staff promoted this system as part of a culture of openness and honesty and the guardian actively worked to break down barriers to reporting concerns. The service had a range of options for staff to gain support during periods of conflict, including where they wished to raise a whistleblowing concern. Two management representatives, on a rotational basis, facilitated staff forums. These were safe spaces for staff to raise concerns and issues and seek support from the senior team. Minutes for the most recent meeting showed staff were confident and empowered to contribute and freely raise issues and challenge decisions.

Six staff had trained as restorative facilitators. This was an accredited post to help staff resolve conflict and avoid a formal grievance process. These systems formed part of the speak up policy, which enabled staff to choose the most comfortable form of support for them.

The senior management team continually sought out ways to enhance staff wellbeing and to facilitate an environment that supported inclusivity and a positive culture. For example, the staff restaurant had been awarded gold, a significant achievement, in the national Eat Out Eat Well accreditation scheme, which reflected the range of nutritious options available. In addition, the director of people services had led accreditation by the national Mindful Employer initiative, supporting good mental health at work. Other accreditation and recognition work included with the national Disability Confident Committed scheme and promotion of World Kindness Day.

Staff routinely shared challenges and successes with each other as part of a culture of empowerment and wellbeing support. For example, staff shared stories by e-mail and in meetings after particularly difficult or uplifting shifts as a means to support the wider team during very challenging periods. Staff told us this was motivational, and they appreciated colleagues taking the time to share their experiences. The head of quality improvement had started a project to compile such feedback into a library for everyone to access as a part of a strategy to showcase what went well and what could be done better.

Staff had access to counselling and chaplaincy support on demand, such as after the difficult death of a patient.



Hospice services for adults

HCA's spoke positively about their experiences working with the wider clinical team. They said nurses and doctors treated them with respect and that they were part of a collaborative clinical team. For example, one member of staff said they felt valued by consultants and doctors because they asked them for an opinion and input into their patients. They said, "I don't feel like an HCA when a consultant asks me for my opinion. It makes sense because we spend so much time one-to-one with patients, but it makes me feel that my work counts when I'm included in discussions."

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

Governance

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

The board of trustees was responsible for overseeing strategy and performance. The board and the senior leadership team had clear focus on integrity and ensuring governance was embedded in the charity's work. In 2019/20 the hospice carried out a self-assessment against the charity governance code, which outlines seven principles of practice and 76 points of recommended practice. The assessment found the charity was compliant with all seven principles and the board implemented an action plan to address areas for improvement.

A range of trustees, independent specialist advisors, senior managers and deputy managers made up six committees, which had delegated authority to make decisions and implement changes. The audit and risk committee and clinical strategy and governance committee oversaw performance and outcomes in clinical care.

Trustees and senior staff engaged partner organisations in governance processes as part of their work to embed care pathways in the local health economy. This included work with local NHS trusts, private care services, and adult social care services to monitor how referral and multidisciplinary care pathways were working.

The provider operated a range of services with complex, interlocking clinical and holistic provision. The governance and staffing structure was well equipped to maintain order, safety, and efficiency. Six distinct teams led service provision and operation with clear lines of management and responsibility in each. Each team also differentiated between clinical and non-clinical functions and continually mapped capacity to demand.

Policies, standard operating procedures (SOPs) and guidance were stored online. Staff knew how to access these, including those who worked in the service only occasionally or whose main employment was with another organisation.

The registered manager had worked with the senior team to change the focus of the governance agenda to quality improvement and patient safety. This resulted in renewed consideration of learning, improvement, and safety. An early outcome of the new approach was improved care for patients living with a learning disability. This occurred after clinical staff highlighted gaps in knowledge and understanding of how to provide effective care to a patient with profound learning disabilities. The governance committee worked with the education team to bridge the gap.



Hospice services for adults

Policies reflected the culture of consistent governance based on best practice. For example, the policy on care delivery for people living with a learning disability ensured staff adhered to national guidance on planning hospital admissions and for the actions they needed to take in the event of a patient's death, in line with the NHS England Learning Disability Mortality (death) Review (LeDeR) principles. Such up to date guidance underpinned corporate principles and enhanced standards of care.

Staff from each clinical department met monthly as part of a quality and governance process. Meeting minutes showed consistently good attendance and an environment in which feedback, ideas, and challenge were welcomed. The process enhanced the quality and safety of care and treatment by deploying a well-established, risk-based system to help staff understand key patient outcome and operational measures. While the process was a key element of the governance framework, staff worked to ensure it incorporated patient-centred care and the needs of people who used the service. For example, senior staff documented how they reviewed patient feedback, including virtual exercises during pandemic restrictions, and applied this to wider learning from governance.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Team meetings were held monthly and involved staff representing all roles and levels of seniority in the department.

A new head of quality assurance had been recruited and was due to take up the post in March 2022. The head of quality improvement and wider quality and governance staff had fulfilled this role in the interim and effectively managed clinical governance, quality assurance, and engagement processes.

Management of risk, issues and performance

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

The senior team had prepared a contingency plan for 'winter pressures' and had strategies in place to ensure the most vulnerable patients continued to receive care if the service came under exceptional pressure. They achieved this by ensuring carers and patients had access to the equipment and medication needed at home and by working with key partner services, such as NHS ambulance trusts, to respond appropriately when carers needed support or advice.

While staff were committed to the service and the needs of patients, the senior team recognised the risk of exhaustion and excessive pressure on staff. The education team delivered training for clinical staff on the boundaries of care and how to practice effective self-care. Operational leads implemented mental wellbeing strategies for staff, including on-demand one-to-one discussions with senior staff and signposting to specialist support services.

A health, safety, and business continuity lead was responsible for organisational non-clinical safety. A health and safety trainee was developing skills in risk assessments and provided additional specialist capacity once they had completed their competencies.

Community staff used a comprehensive tracking and monitoring system to keep them safe when working alone. Staff used small buddy groups to maintain awareness of each person's location and carried out home visits overnight in pairs. Staff assessed some patients as suitable for a night sitter service, where they were in significant clinical need. In such cases, staff carried out enhanced safety and security checks to ensure staff could work safely.



Hospice services for adults

The senior leadership team managed the risk register and director-led sub-committees monitored risks specific to their area of responsibility. The greatest risk at the time of our inspection was the workforce. While staffing was relatively stable, the senior team recognised it was vulnerable following COVID-19 pressures and persistent increases in demand. The second greatest risk related to cybersecurity and was being mitigated through additional staff training and investment in the latest security systems.

The director of operations and finance and the registered manager had revamped the risk register monitoring system, and this was awaiting board approval at the time of our inspection. The new system meant each department would have their own risk register, which would improve the depth of insight and monitoring. The clinical risk register was a standing agenda item in the monthly governance meeting with new protected time to discuss risks. The committee then took exceptions to the quarterly clinical strategy committee, which a Trustee chaired.

There was a culture of continual scrutiny of existing processes to understand how systems and norms could be changed for patients' benefits. For example, during the COVID-19 pandemic staff removed a form in the carer information pack that asked them to document how the service should release the body after the patient died. Staff recognised this needed to be a personal conversation and not completed through a form and adjusted the system accordingly.

In another example, a business development analyst had completed an apprenticeship focused on improving operational efficiency in the hospice. This led to a much-improved room booking and facilities access system.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

The digital, technology and data team had developed a new intranet that empowered staff from all departments to share their stories, training, policies, and other content relevant to their work. The new site represented a high level of achievement in using organisational knowledge for everyone's benefit and enabled staff to develop new digital skills.

All staff subscribed to the provider's information governance policy to support appropriate handling of confidential data.

Confidentiality and data-sharing access protocols were in place for the use of the electronic patient records system. The education team delivered training on record management to help staff understand their responsibilities and best practices when sharing patient information across multidisciplinary teams.

The senior team had audited information governance and the service was fully compliant with the NHS digital, data security and protection toolkit. The information and knowledge lead had arranged a series of events for charity fraud awareness week, including involvement from the national fraud advisory panel. A team of eight information asset administrators supported information asset owners to ensure risks were mitigated and registers maintained.

Engagement

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



Hospice services for adults

The service had a sustained, deeply embedded place in the regional community. Community engagement was evident across the organisation and staff discussed how such work maintained the reputation of the service, staff motivation and pride, and helped to destigmatise hospice-led end of life care. Staff led a rolling programme of fundraisers with stakeholders and partners that were interactive, fun, and engaging. Such work was always linked with the purpose of the hospice, such as the 'Under our wing' appeal that enabled people to remember loved ones who had died.

Staff were clearly dedicated to community engagement events and worked tirelessly to overcome obstacles. For example, delivery of costumes and suits was delayed for a Santa fun run that meant the event might be cancelled. To avoid this, staff hand-delivered costumes and suits to people so they could still take part. This reflected the level of personal commitment the organisation.

The community engagement team delivered bereavement café training partner organisations. This helped a broader range of services to provide bereavement support services, enhancing the regional capacity and reducing the pressure on the service as the sole provider of some services.

The hospice team had delivered summer schools in 2020 and Autumn 2021 for young people aged 16-19. This aimed to attract future healthcare talent to the palliative care and end of life care sectors through de-stigmatisation of the specialty and raising awareness of its work. As part of the summer school, the hospice supported students to complete a level 2 award in awareness of end of life care.

The organisation carried out a staff survey in October 2020. Participation was high, with 87% of staff completing a return. The survey found 96% of staff were proud to work for the hospice and 98% believed in its aims.

The CEO maintained open and regular communication with staff and teams through a mix of face to face, email and virtual sessions. This was an opportunity for staff to present their work and discuss successes and challenges. Staff said this was an effective manner of staying up to date of work in other teams and departments. Staff felt their opinions mattered and were proactive in seeking input from colleagues across the organisation so that all angles could be covered when planning or delivering a new scheme.

The head of quality improvement worked across all services with regards to engagement and feedback. They led user surveys, process mapping exercises, and involvement strategies as part of a strategy of continual improvement. This member of staff was the main link between clinical teams and the digital and data team. This helped staff to understand performance audit data and apply it to patient and carer experiences.

There was a culture of learning and engagement in the service, particularly with the introduction of new or pilot projects. For example, the multidisciplinary team leading the virtual wellbeing service evaluated the service to understand if it was meeting its aims. Across two surveys in November 2020 and June 2021, 83% of patients said the sessions helped them to better manage their symptoms and 90% of respondents said the sessions improved their mood.

Staff had implemented extensive work with adult social care services, particularly with residential care homes and domiciliary care agencies. Engagement with patients and community social care staff highlighted significant gaps in knowledge about end of life care best practice. The hospice at home and education teams worked with services in the local area and used feedback from staff and leaders to identify how they could improve end of life care. For example, permanent care home staff noted the rapid turnover of care assistants and reliance on agency staff meant skills and knowledge built in the home were inconsistent. The hospice team responded by increasing the frequency of training and empowering patients and their loved ones to have more input into care.



Hospice services for adults

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services and staff were empowered to lead and deliver change. Leaders encouraged innovation and participation in research with a strong record of sharing work locally, nationally and internationally.

There was a culture of continuous learning and innovation amongst staff that was evidence throughout our conversations and reviews of evidence. Staff felt the service was not 'just a place to work' and noted their personal and professional investments in the success of the service and the care it provided. Each member of staff understood how their contribution made a difference and staff sought opportunities to establish new inter-departmental relationships.

Staff described positive momentum to maintain care standards and staff morale during the pandemic. They described loyalty and commitment to the provider and patients because of how well they were looked after.

Staff ambitions were bold, patient-centred, and evidence-based. The provider encouraged research to drive innovation in palliative and end of life care. A dedicated research team, including a research lead, medical lead for research, and the deputy director of skills, knowledge and research were responsible maintained an ambitious portfolio of work. A research committee, attended by multidisciplinary staff, academics, and a service user, provided coordination for research projects. The research team had a fully integrated governance system, maintained links with academic research centres and had set up a hospice research collaborative. This enabled hospices across the region to work together to establish and deliver research to improve patient care and outcomes. Research took place within a standard operating and all research staff were trained in the National Institute for Health Research (NIHR) good clinical practice (GCP) research standards.

The research team had completed four research projects in 2021, were planning a new project in 2022 and had a significant track record of journal publications and conference attendances.

The service was working towards five key areas of improvement in 2021/22. These were focused on enhancing care and capacity, such as continuing to develop technological innovation, expand bereavement support, and support patients and carers in their preferred place of care.

The head of operational services and a deputy director led the hospice's environmental strategy and environmental sustainability programme. They were working across hospice functions to reduce environment impact. They demonstrated attention to detail in this work, which had included fitting showers with water regulators to reduce wastage. The team had restructured how the building was heated. Heating and temperature were now based on outside temperature so that the building was not heated excessively and used only the heating power that was essential. The team supported biodiversity across the grounds and managed a natural habitat area for the benefit of patient, visitor, and staff wellbeing.

A multidisciplinary steering group, representing clinical care, communication expertise, and engagement, had led an adapted Schwartz round process for the past five years. Schwartz Centre Rounds aimed to address the physical and psychological distress staff encountered through the course of their work and offered a collaborative space to reflect, build emotional resilience, and access support. During the pandemic the rounds successfully adapted from in-person to a remote structure in order to continue to provide a safe space to reflect and talk about the personal impact of their work and the importance of the human connection. All staff, volunteers, and trustees across the organisation could access the resource.



Hospice services for adults

Staff described the volume and pace of projects and opportunities as a key challenge. They noted the interest in work from CCGs and community organisations as very positive and noted it was difficult to identify the work that would be of most benefit to patients and prevent teams from being overwhelmed with the quantity of work. Senior staff we spoke with were aware of this challenge and helped their teams to focus on work that was within their capacity and that had the greatest potential for the development of care. The senior team was carrying out a review of workloads to identify if staff were feeling pressure because of the volume of patients or if this was more related to the culture of going the extra mile for each patient.

The hospice was a host coordinator centre for the European Certificate in Essential Palliative Care. This was a multi-professional, internationally recognised certificate of competence that underpinned the level of specialism and evidence-based practice in the service.

The IPU team was participating in a pilot project with a medical examiner at a nearby hospital to understand patients' clinical treatment in their lead up to death. The pilot involved a review of the medical cause of death certificate, referrals, and cremation instructions. As part of the project, specialist hospital staff offered relatives bereavement support and spent time with them explaining the medical causes of death as part of a process of reassurance.

The IPU team, supported by the head of quality improvement, had integrated a quality improvement (QI) function in daily handovers between teams, such as during shift changes in the IPU. Such handovers typically focused on clinical matters and the introduction of a QI element helped to embed a focus on patient experience into all aspects of the service.